30 DAY MATERIALS AND GENERAL SCHEDULE
NCOIL SPRING MEETING
APRIL 11 - 14, 2024

As of April 2, 2024, and Subject to Change

The Sheraton Grand Nashville Downtown Hotel
Nashville, Tennessee

NCOIL SPRING MEETING
Nashville, Tennessee
April 11 - 14, 2024
SCHEDULE

Note: There will be a room (Melody B 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. The meeting room is sponsored by The Interstate Insurance Product Regulation Commission (IIPRC)

THURSDAY, APRIL 11TH

Tour of Tennessee State Capitol	1:00 p.m.		
NCOIL CIP President's Policy Roundtable ***Open to President's Roundtable and Speaker's Roundtable CIP Members Only***	2:00 p.m.	-	5:00 p.m.
Welcome Reception	6:00 p.m.	-	7:00 p.m.

FRIDAY, APRIL 12TH

Registration *Exhibits Open: 8:00 a.m. – 5:00 p.m.*	7:00 a.m.	-	5:00 p.m.
Workers' Compensation Insurance Committee	8:15 a.m.	-	9:30 a.m.
Welcome Breakfast	9:30 a.m.	-	11:00 a.m.
First Time Attendee Legislator & Staff Meeting	11:00 a.m.	-	11:15 a.m.
First Time Attendee Interested Party Meeting	11:00 a.m.	-	11:15 a.m.
Networking Break	11:00 a.m.	-	11:15 a.m.
Joint State-Federal Relations & International Insurance Issues Committee	11:15 a.m.	-	12:45 p.m.

The Institutes Griffith Foundation Legislator Luncheon Reinsurance: Exploring Fundamentals & Considering Linkages to Insurance Pricing ***Open to Public Policymakers and Staff Only***	12:45 p.m.	-	1:45 p.m.
NCOIL – NAIC Dialogue	1:45 p.m.	-	3:00 p.m.
General Session The Latest on Weight Loss Drugs: A Discussion on Access, Cost, and Coverage	3:00 p.m.	-	4:30 p.m.
Networking Break **Sponsored by Aflac**	4:30 p.m.	-	4:45 p.m.
Life Insurance & Financial Planning Committee	4:45 p.m.	-	6:00 p.m.
Adjournment	6:00 p.m.		
CIP Member & Sponsor Reception ***Open to Public Policymakers, CIP Members, and Spring Meeting Sponsors***	6:30 p.m.	-	7:30 p.m.

SATURDAY, APRIL 13th

Registration *Exhibits Open: 8:00 a.m. – 5:00 p.m.*	8:00 a.m.	-	5:00 p.m.
Property & Casualty Insurance Committee	9:00 a.m.	-	10:30 a.m.
Networking Break	10:30 a.m.	-	10:45 a.m.
General Session Affordability and Availability Crises in the Auto and Home Insurance Markets: How Did We Get Here and How Do We Fix It?	10:45 a.m.	-	12:15 p.m.
Luncheon with Keynote Address	12:15 p.m.	-	1:45 p.m.
Financial Services & Multi-Lines Issues Committee	1:45 p.m.	-	3:30 p.m.
Adjournment	3:30 p.m.		

SUNDAY, APRIL 14TH

Registration *Exhibits Open: 8:00 a.m. – 11:00 a.m.*	8:00 a.m.	-	10:00 a.m.
The Institutes Griffith Foundation Legislator Breakfast Autonomous Vehicles: Evolution and Impact on Insurance Frameworks ***Open to Public Policymakers and Staff Only***	8:00 a.m.	-	9:00 a.m.
Health Insurance & Long Term Care Issues Committee	9:00 a.m.	-	10:45 a.m.
Executive Committee	10:45 a.m.	-	11:15 a.m.

******Please note all speakers listed are scheduled to speak as of April 2, 2024. There will be modifications between now and the start of the Meeting.******

******Note: There will be a room (Melody B 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. The meeting room is sponsored by The Interstate Insurance Product Regulation Commission (IIPRC)******

Thursday, April 11, 2024

Tour of Tennessee State Capitol
Thursday, April 11, 2024
1:00 p.m.
*****Please reach out to Pat Gilbert at pgilbert@ncoil.org if interested in attending. Space is limited.*****

NCOIL CIP President's Policy Roundtable
Thursday, April 11, 2024
2:00 p.m. – 5:00 p.m.
*****Open to President's Roundtable and Speaker's Roundtable CIP Members Only*****

President's Welcome Reception
Thursday, April 11, 2024
6:00 p.m. – 7:00 p.m.

Friday, April 12, 2024

Workers' Compensation Insurance Committee
Friday, April 12, 2024
8:15 a.m. – 9:30 a.m.

Chair: Sen. Lana Theis (MI)
Vice Chair: Rep. David LeBoeuf (MA)

1.) Call to Order/Roll Call/Approval of November 16, 2023 Committee Meeting Minutes
2.) Workers' Comp Alternatives for Independent Contractors

Brad Nail, Partner, Multi-State Gov't Relations – Converge Public Strategies
Mike Saporito, Sr. VP for Accident & Health – Zurich

3.) Structured Settlements 101

Susan Stauss, Member - Cozen O'Connor (on behalf of the National Structured Settlement Trade Association (NSSTA))
Brian Dear, General Counsel – National Association of Settlement Purchasers (NASP)
Sally Greenberg, Executive Director – National Consumers League

4.) Overview on Experience Ratings and the Subrogation Process

Tim Tucker, Washington Affairs Executive, Regulatory Division – National Council on Compensation Insurance (NCCI)

5.) Any Other Business
6.) Adjournment

Welcome Breakfast
Friday, April 12, 2024
9:30 a.m. – 11:00 a.m.

1.) Welcome to Nashville

The Hon. Randy McNally – Tennessee Lieutenant Governor

2.) **Hon. Tom Considine**

-Introductory Comments from NCOIL CEO

3.) **Rep. Tom Oliverson, M.D. (TX)**

a.) President's Welcome
b.) New Member Welcome and Introduction

4.) **Will Melofchik, NCOIL General Counsel**

-Agenda Overview

5.) Any Other Business
6.) Adjournment

First Time Attendee Legislator & Staff Meeting
Friday, April 12, 2024
11:00 a.m. – 11:15 a.m.

First Time Attendee Interested Party Meeting
Friday, April 12, 2024
11:00 a.m. – 11:15 a.m.

Networking Break
Friday, April 12, 2024
11:00 a.m. – 11:15 a.m.

Joint State-Federal Relations & International Insurance Issues Committee
Friday, April 12, 2024
11:15 a.m. – 12:45 p.m.

Chair: Rep. Rachel Roberts (KY)
Vice Chair: Asm. Jarett Gandolfo (NY)

1.) Call to Order/Roll Call/Approval of November 18, 2023 Committee Meeting Minutes
2.) Basel III Endgame – Disruptive to the U.S.?
Kevin McKechnie, Executive Director, Health Savings Accounts Council – American Bankers Association (ABA)
3.) Overview of New Prior Authorization Rules from the Centers for Medicare & Medicaid Services (CMS)
Randy Pate, ***Former Deputy Administrator & Director, Center for Consumer Information and Insurance Oversight (CCIIO) at CMS - Founder, Randolph Pate Advisors, LLC***
4.) Continued Discussion on NCOIL Mental Health Parity Model Act
Rep. Rachel Roberts (KY) – Sponsor
Melissa Bartlett, Senior VP, Health Policy– The ERISA Industry Committee (ERIC)
Jess Kirchner, Senior Policy Analyst, Children and Families – National Governors Association (NGA)
David Lloyd, Chief Policy Officer – Inseparable
Tim Clement, VP of Federal Gov't Affairs – Mental Health America
5.) Discussion and Consideration of Resolution Reaffirming Support for the U.S. State-Based System of Insurance Regulation in Response to Growing Federal Encroachment
Rep. Tom Oliverson, M.D. (TX) – NCOIL President; Asw. Pam Hunter (NY) – NCOIL Vice President; Sponsors
6.) Any Other Business
7.) Adjournment

The Institutes Griffith Foundation Legislator Luncheon
Reinsurance: **Exploring Fundamentals & Considering Linkages to Insurance Pricing**
Friday, April 12, 2024
12:45 p.m. – 1:45 p.m.

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

Jim Hilliard, Ph.D.
Associate Professor of Instruction
Dep't of Risk, Actuarial Science, and Legal Studies
Fox School of Business – Temple University

NCOIL – NAIC Dialogue
Friday, April 12, 2024
1:45 p.m. – 3:00 p.m.

Co-Chairs: Rep. Tom Oliverson, M.D. (TX) – NCOIL President
Asw. Pam Hunter (NY) – NCOIL Vice President

1.) Call to Order/Roll Call/Approval of November 17, 2023 Committee Meeting Minutes
2.) Recap of NAIC Spring Meeting and Discussion on NAIC 2024 Priorities
3.) Update on Implementation/Adoption of NAIC's Model Bulletin on The Use of Artificial Intelligence Systems by Insurers
4.) Update on NAIC's "Framework for Regulation of Insurer Investments", Including Proposal Relating to SVO's Ratings Discretion Process
5.) Auto and Home Insurance Affordability and Availability Crises
    a.) Preview of NCOIL General Session
    b.) Discussion on NAIC's Property & Casualty Market Intelligence Data Call
6.) Discussion on NAIC's Efforts to Support Financial Literacy Courses in High Schools
7.) Update on Work of NAIC's Accelerated Underwriting (A) Working Group
8.) Any Other Business
9.) Adjournment

General Session
The Latest on Weight Loss Drugs: A Discussion on Access, Cost, and Coverage
Friday, April 12, 2024
3:00 p.m. – 4:30 p.m.

Moderator: Rep. Jim Dunnigan (UT)

Melissa Bartlett
Senior VP, Health Policy
The ERISA Industry Committee (ERIC)

Kristin Niakan
Sr. Pharmacy Benefits Analytics Manager
Milliman

Randy Pate
Former Deputy Administrator & Director, Center for Consumer Information and Insurance Oversight (CCIIO) at the Center for Medicare & Medicaid Services (CMS)
Founder, Randolph Pate Advisors, LLC

Cristy Gallagher, MPAff
Research Project Director
STOP Obesity Alliance

Networking Break
Sponsored by Aflac
Friday, April 12, 2024
4:30 p.m. – 4:45 p.m.

Life Insurance & Financial Planning Committee
Friday, April 12, 2024
4:45 p.m. – 6:00 p.m.

Chair: Rep. Carl Anderson (SC)
Vice Chair: Sen. Vickie Sawyer (NC)

1.) Call to Order/Roll Call/Approval of November 16, 2023 Committee Meeting Minutes
2.) Presentation on Developments in Life Insurer's Use of Wellness Programs
Matthew Gibson, Head of Behavioral Insurance Enablement – John Hancock/Manulife
Brenda Cude, Ph.D., Professor Emeritus, Financial Planning, Housing and Consumer Economics – University of Georgia
3.) Presentation on Efforts to Promote Lifetime Income
Bret Hester, EVP, General Counsel, Strategy, Policy & Operations; Government Relations & Public Policy – Teachers Insurance and Annuity Association of America (TIAA)
Brenda Cude, Ph.D., Professor Emeritus, Financial Planning, Housing and Consumer Economics – University of Georgia
4.) Consideration of Re-adoption of Model Laws
a.) Model Unclaimed Life Insurance Benefits Act – Originally Adopted on 11/20/11; Updated Version adopted on 11/23/14; Re-adopted on 3/17/19
b.) Life Settlements Model Act – Originally Adopted 11/17/00; Amended on 7/16/04 and 11/16/07; Re-adopted on 3/9/14 and 3/17/19
Life Insurance Settlements Association (LISA) Representative
Jill Rickard, Regional VP, State Relations – American Council of Life Insurers (ACLI)
5.) Any Other Business
6.) Adjournment

CIP Member & Sponsor Reception
Friday, April 12, 2024
6:30 p.m. – 7:30 p.m.
*****Open to Public Policymakers, CIP Members, and Spring Meeting Sponsors*****

Saturday, April 13, 2024

Property & Casualty Insurance Committee
Saturday, April 13, 2024
9:00 a.m. – 10:30 a.m.

Chair: Rep. Forrest Bennett (OK)
Vice Chair: Rep. Michael Sarge Pollock (KY)

1.) Call to Order/Roll Call/Approval of November 17, 2023 and February 2, 2024 Committee meeting Minutes
2.) Introduction and Discussion of NCOIL Strengthen Homes Program Model Act
    Rep. Jim Dunnigan (UT) – Sponsor; Rep. Matthew Gambill (GA) – Co-sponsor
    Brian Powell – Catastrophe Risk Resilience Specialist, NAIC's Center for Insurance Policy and Research (CIPR); former Director of Alabama Strengthen Homes Program
    Wes Bissett, Senior Counsel – Independent Insurance Agents & Brokers of America (IIABA)
    Hilary Segura, AVP & Counsel, State Gov't Relations, American Property Casualty Insurance Association (APCIA)
    National Association of Mutual Insurance Companies (NAMIC) Representative
3.) Continued Discussion on NCOIL Catalytic Converter Theft Prevention Model Act/Resolution in Support of Strengthening State Laws to Prevent Catalytic Converter Theft
    Rep. Tom Oliverson, M.D. (TX), NCOIL President; Rep. Edmond Jordan (LA), NCOIL Secretary – Sponsors
    Eric DeCampos, Senior Director, Gov't Affairs – National Insurance Crime Bureau (NICB)
4.) Discussion on Liability Related Issues Within the Sharing Economy
    Byron Wobeter, Associate General Counsel, Insurance - Airbnb
5.) Any Other Business
6.) Adjournment

Networking Break
Saturday, April 13, 2024
10:30 a.m. – 10:45 a.m.

General Session
Affordability and Availability Crises in the Auto & Home Insurance Markets: How Did We Get Here and How Do We Fix It?
Saturday, April 13, 2024
10:45 a.m. – 12:15 p.m.

Moderator: Asm. Tim Grayson (CA)

Jay Feinman
Distinguished Professor Emeritus
Rutgers Law School

Paul Martin
Vice President – State Relations
Reinsurance Association of America (RAA)

Christine Ashburn
Chief, Legislative & External Affairs
Citizens Property Insurance Corporation

Kevin McKechnie
Exec. Director, Health Savings Account Council
American Bankers Association (ABA)

Robert Gordon
Senior VP, Policy, Research & International
APCIA

Luncheon with Keynote Address
Saturday, April 13, 2024
12:15 p.m. – 1:45 p.m.

Financial Services & Multi-Lines Issues Committee
Saturday, April 13, 2024
1:45 p.m. – 3:30 p.m.

Chair: Sen. Mary Felzkowski (WI)
Vice Chair: Asm. Tim Grayson (CA)

1.) Call to Order/Roll Call/Approval of November 17, 2023 Committee Meeting Minutes
2.) Introduction and Discussion of NCOIL Transparency in Third Party Litigation Financing Model Act
   Rep. Matt Lehman (IN) – Sponsor
   Harrison Hosker - American Legal Finance Association
   Eric Schuller, President – Alliance for Responsible Consumer Legal Funding
   Daniel Hinkle, Senior Counsel for Policy & State Affairs - American Association for Justice (AAJ)
   Hilary Segura, AVP & Counsel, State Gov't Relations, American Property Casualty Insurance Association (APCIA)
   Jon Schnautz, VP, State Affairs - National Association of Mutual Insurance Companies (NAMIC)
3.) Discussion on Development of NCOIL Earned Wage Access Model Act
   Asw. Pam Hunter (NY), NCOIL Vice President – Sponsor
   Matt Smith, Director of Gov't Relations and Consumer Affairs – Connecticut Dep't of Banking

Monica Burks, Policy Counsel - Center for Responsible Lending
Ben LaRocco, Senior Director, Gov't Relations – EarnIn
Elyse Hicks, Gov't Relations Manager for East Coast and Major Markets - DailyPay

4.) Discussion on NAIC's "Framework for Regulation of Insurer Investments", Including Proposal Relating to SVO's Ratings Discretion Process
The Hon. Nathan Houdek – Wisconsin Insurance Commissioner; Chair, NAIC's Financial Condition (E) Committee

5.) Any Other Business

6.) Adjournment

Sunday, April 14, 2024

The Institutes Griffith Foundation Legislator Breakfast
Autonomous Vehicles: Evolution and Impact on Insurance Frameworks
Sunday, April 14, 2024
8:00 a.m. – 9:00 a.m.

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

Bryant Walker Smith
Associate Professor, Univ. of South Carolina School of Law and School of Engineering
Affiliate Scholar, Stanford Law School

Health Insurance & Long Term Care Issues Committee
Sunday, April 14, 2024
9:00 a.m. – 10:45 a.m.

Chair: Rep. Jim Dunnigan (UT)
Vice Chair: Rep. Tammy Nuccio (CT)

1.) Call to Order/Roll Call/Approval of November 16, 2023 and January 26, 2024 Committee Meeting Minutes

2.) The State of Healthcare Cost Transparency Requirements (this will include consideration of re-adoption of the NCOIL Healthcare Cost Transparency Model Act – Originally Adopted 12/13/19)
IQVIA Representative
Scott Woods, Vice President, Policy & Research - PhRMA
Jonathan Buxton, Senior Director, State Affairs - Pharmaceutical Care Management Ass'n (PCMA)
Bailey Reavis, Manager of Gov't Relations – Families USA
James McSpadden, Senior Policy Advisor - AARP Public Policy Institute

3.) Presentation on Site-Neutral Payment Reforms

Randi Chapman, Managing Director, State Affairs – Blue Cross Blue Shield Association (BCBSA)

Stuart Hagen, Ph.D., Managing Director, Health Policy Analytics - BCBSA

Joanna Hiatt Kim, VP of Payment Policy – American Hospital Association (AHA)

4.) Medicaid Redeterminations – How Have States Done?

Miranda Motter, Senior VP, State Affairs & Policy – America's Health Insurance Plans (AHIP)

5.) Introduction of NCOIL Value Based Purchasing Model Act

Sen. Mary Felzkowski (WI) – Sponsor

JP Wieske, VP, State Affairs – Campaign for Transformative Therapies

6.) Any Other Business

7.) Adjournment

Executive Committee
Sunday, April 14, 2024
10:45 a.m. – 11:15 a.m.

Chair: Rep. Tom Oliverson, M.D. (TX) – NCOIL President
Vice Chair: Asw. Pam Hunter (NY) – NCOIL Vice President

1.) Call to Order/Roll Call/Approval of November 18, 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 Adopted/Re-adopted Therein

5.) Other Sessions

a.) The Institutes Griffith Foundation Legislator Luncheon and Breakfast

b.) General Sessions

c.) Featured Speakers

6.) Any Other Business

7.) Adjournment

WORKERS' COMPENSATION INSURANCE COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
WORKERS' COMPENSATION INSURANCE COMMITTEE
2023 NCOIL ANNUAL MEETING – COLUMBUS, OHIO
NOVEMBER 16, 2023
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Workers' Compensation Insurance Committee met at The Renaissance Columbus Downtown Hotel in Columbus, Ohio on Thursday, November 16, 2023 at 2:00 p.m.

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

Other members of the Committee present were:

Rep. Brian Lohse (IA)
Rep. Matt Lehman (IN)
Rep. Rachel Roberts (KY)
Rep. Mike McFall (MI)
Rep. Nelly Nicol (MT)
Sen. Jerry Klein (ND)

Other legislators present were:

Rep. Chad Aull (KY)
Rep. Cherlynn Stevenson (KY)
Rep. Jane Pringle (ME)
Rep. Helena Scott (MI)
Rep. Stephanie Young (MI)
Sen. Pam Helming (NY)
Asm. David Weprin (NY)
Rep. Tim Barhorst (OH)
Sen. Bill DeMora (OH)
Sen. George Lang (OH)
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. Matt Lehman (IN), NCOIL Immediate Past President, 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 Sen. Jerry Klein (ND) and seconded by Rep. Nelly Nicol (MT), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 21, 2023 meeting.

NAVIGATING WORKERS' COMPENSATION AND MEDICAL MARIJUANA

Doug Jones, MAAA, FCAS, of the American Academy of Actuaries (AAA), thanked the Committee for the opportunity to speak and stated that for those who aren't familiar with the AAA, the Academy is the group in the U.S. that sets professionalism standards for U.S. actuaries. But our mission is to assist the public and policymakers trying to offer objective expertise and advice on risk, financial security issues. So, earlier this year, the Workers Compensation Committee prepared an issue brief related to medical marijuana. The reason we did that was the landscape continues to evolve as it relates to medical marijuana. The Drug Enforcement Administration (DEA) still treats marijuana as a schedule one drug. So it's illegal at the federal level, but it is increasingly decriminalized across the nation. I think there's something like 38 states across the U.S. that have decriminalized it to some degree but because of the schedule one drug, research is pretty limited so we wanted to just collect some thoughts. We interviewed a variety of participants in the workers comp system. We talked to third party administrators (TPA's), talked to lawyers, claims professionals and being actuaries, we talked to more actuaries. What we focused on really is just talking about some of the things that make the landscape so complex. Medical marijuana when it intersects with workers comp it's not cut and dry. So with research being thin, there are very few things that are clear cut. What I'll try to talk about briefly are some of the prominent cases, some of the case law that we've seen. But also, some of the issues and considerations as it relates to reimbursement for the use of medical marijuana, but also issues as they relate to employment.

So, in terms of what we saw, there's kind of three big themes through some of the high profile cases across the U.S. First is who has jurisdiction over marijuana usage? And is it a crime? And the question is the contrast between federal and state. At the federal level marijuana is cut and dry. It's schedule one, it's illegal. But many states have been moving to decriminalize. So what happens when marijuana is a contributing factor to a workers comp claim? Second is the question of proximate cause. So, was the use of marijuana, recreational or medical, the cause of a workplace injury? And then third is the question of is it the right treatment? So pardon me I'm not a lawyer, I'm not going to get into the details of these cases but I just wanted to highlight a couple of cases here. So, with respect to who has jurisdiction and is it a crime - different states have different conclusions. The New Hampshire case listed here is kind of symptomatic or it's a good example of what happens across many states. Initially, the New Hampshire courts found that an employer that reimbursed for medical marijuana would be violating the Controlled Substance Act and thus aiding and abetting a crime. That was later overturned. So states are struggling to decide which side of the fence they're on. New Jersey is a different example on the spectrum, they have concluded quite clearly that insurers or employers are compelled to reimburse if it's been identified as a potentially useful treatment for pain. They should reimburse. Minnesota raised this as well and again there's a question of who has jurisdiction and do state laws preempt the federal law?

In Minnesota there were a couple of cases that concluded that you can't force an employer to facilitate the potentially illegal or unlawful possession of marijuana. Those cases were pushed to the U.S. Supreme Court, but the Court declined to take them up. So, there's still a lot in flux. For the question on proximate cause, really the question is should or could a workers comp claim be denied if marijuana, even if it was medical marijuana, was determined to be the proximate cause? So, in Florida, there's a lot of debate over sort of how you determine that. It's testing for the presence of

tetrahydrocannabinol (THC), the psychoactive chemical in marijuana. It's not conclusive as to whether the existence or the presence of that means that there was an issue. Kentucky has created a situation that's kind of interesting, they've shifted the burden to the employee who has to demonstrate one of two things. Either that the marijuana did not cause impairment or that the impairment did not cause the injury. So, different issues, different states. So, last in terms of court cases, what's the right treatment? And part of the question here is, was medical marijuana a necessary treatment for the injuries that were sustained. The issue in Maine is that physicians turn to medical marijuana as a last resort. It seemed to be the one source of pain relief that existed but the initial decision was that the employer needed to pay. But they appealed. And it was eventually overturned due to the conflict with the Controlled Substance Act. So again, more fray and unclear treatments.

For employment issues, the impact of medical marijuana on employment. I think there's a variety of issues but think back, following the pandemic, the labor market has been challenging for employers, it's been tough to fulfill jobs. You combine that issue with society's generally increasing acceptance of the use of marijuana, in some case recreational and in more cases, medical. It's led to an adjustment to how many employers treat their drug screens pre employment or drug testing of employees. I think that THC has been in many cases dropped from the list of things to be screened for because it's intended to keep the pool of potential applicants as deep as possible. The flip side though is that there are certain industries where marijuana in any form is an absolute no go. So I think about employers that have federal contracts or the safety sensitive industries. Think about oil, gas, transportation, aviation, trucking, railroads. Those are never going to go and take a step that's contradictory to federal law. So in those cases it's more clear cut. In terms of reimbursement issues, it's interesting. While three quarters of the U.S., state-wise, has accepted to some degree that marijuana is okay, it's been decriminalized. In terms of requirements on employers there's only six states that require reimbursement for the use of medical marijuana and there's another six that are part of the group that have legalized it, but they prohibit reimbursement of medical marijuana. So, there's conflicts, and then there's all the other states where things are just not well defined. But what you find is it does depend on where you are in the industry. TPAs will tend to take a conservative approach in the sense that they will not look to take any steps that might put them afoul of federal regulations. Employers, it's conflicting issues internally. I mentioned earlier, any employer with a federal contract, safety sensitive industries, they're not going to support it. But there is the recognition that medical marijuana could have potential both in terms of helping their employees but also think about cost savings. One of the stats that we cited in our brief was a few years ago Opioids, which are very well known for their pros and bigger cons, they were costing employers something on the order of $18 billion a year. So medical marijuana could be an alternative that could result in some real savings.

Regarding opioids, there's a question about marijuana versus opioids. Opioids have been studied frequently. They're in the news all the time regarding the cost both financial but also to families, to communities, is huge. But it's not crystal clear yet whether medical marijuana is necessarily a better option and it comes back to the original observation that there's not been much research done. Being a schedule one drug, research is pretty thin. So I think there's a thought, maybe an expectation, but it's not been proven that medical marijuana would be helpful. There have been observations that marijuana is less addictive. It may have fewer severe side effects, but

there haven't been a real depth of studies done. And then the cost I mentioned I think that Opioids are certainly expensive but it's not clear how that would be, different with medical marijuana but I think there's a soft optimism that it could be.

Sen. Hackett stated that in Ohio we just passed recreational marijuana. We've had medical marijuana and we passed recreational. One of the problems we saw is that marijuana stays in the system for a longer time. So when a prosecutor deals with a driving under the influence (DUI), they really have to have really bad driving at the time or they just won't even mess with it even though the person from the blood test or the urine test will test positive. He'll just say he smoked it a week ago and it stayed in the system for so long. So do you have any problems on medical marijuana versus people trying to go to work for companies and they only use it for medicinal reasons but it just stays in their system for a while? Mr. Jones stated that I think you're nailing one of the real key issues in terms of the compensability for a workers comp claim - what is the cause? So Joe might take marijuana a week ago and it's still in the system. You can still track it with hair, blood, what have you. So that experience from a week ago may be visible in the system but you almost certainly was not the cause of any sort of problem. So, I think that's one of the trickier issues related to the potential for medical marijuana and marijuana in a general sense of trying to understand how long is that potential impairment? And some of the case law debated some of that exactly so I don't have an answer for you but just an appreciation that you're definitely seeing one of the trickiest parts of this as an issue for workers comp.

Rep. Matt Lehman (IN), NCOIL Immediate Past President, stated I'm from Indiana and we are now an island because Michigan is both medical and recreational, Illinois is both, now Ohio is both, and Kentucky's medical. I'm a border community. I live six miles from the Ohio line. We have a large employer who employs a lot of people from Ohio. The issue isn't so much now of marijuana in their system and they get injured at work, it's if they're working in Indiana now they can be denied their work comp benefits and they can be arrested because in Indiana it is still illegal and is a term for denial of your work comp. So, are you seeing in the places where you have those border states where if I live in one state where I'm taking it absolutely prescribed legal, and I get with recreational is completely different, but I'm taking a prescribed legal product in Ohio and I'm working in Indiana. How's that going to play out in the work comp system? Mr. Jones stated that I think that is one of the issues that employers are going crazy over because it it's impossible to know how things will land. And say you did something in one state and wind up in the other state, what do you do? Employers are at a complete loss for how do they treat things and what the ramifications are on their workforce. So again I don't have a clear response for you but it is definitely something that's been observed and it's kind of a real conundrum. Rep. Lehman stated that many of the large employers simply say now we're just not going to test for marijuana. We'll test for alcohol. But we're not going to test for marijuana. So if it's now recreational use in Ohio and I get injured at work in Indiana, you're not testing for marijuana. How's that different than testing for alcohol which is a legal product? We're creating almost a two-tier system of what is now in Ohio a legal product but we're not going to test for it in Indiana because we don't want to run the risk of losing a good employee. Mr. Jones stated even if you did, it'd be hard to know how long - maybe took a vacation in Ohio for a few days and went back and now facing all these dilemmas when that experience in Ohio practically speaking may have no impact on what I'm doing days later.

Michael Choo, M.D., Chief Medical Officer and Senior Vice President at Paradigm stated with regard to how long marijuana remains in your system, that is a very problematic issue because it can last as long as 30 days or more. And so typically people will say, "Oh I smoked something last week and it should be negative today." And for most of the time if you only smoke once, within seven days it should be out of your system. But for those who have been smoking for a long time, the THC gets absorbed into your fat cells and it gets released over time and sometimes it can last 30 days. And depending upon how much you used, it can last for a few months. And I do drug screen reviews as a medical review officer (MRO) and I see a lot of employers who test their employees with drug screening and their THC comes back positive and the typical routine that we normally follow is we call the employee to understand the situation as to when they may have been exposed but we tend to follow the policies set by the employer as to how we're going to report out if it's a negative or it's a positive because remember the employer doesn't see the drug screen results, they only see the results that come after the MRO review which is the next question that I'd like to answer. In terms of testing, and I know there is the border issue with employers that have employees from Ohio and Indiana, but if the employer is located in Ohio and they're in and they accept medical marijuana as one of the approved drugs for getting a negative drug screen test whether it's pre employment or even I guess post-accident, the MRO who will be reviewing these test results will report out as a negative test if the company has a policy that says that they accept marijuana as an acceptable substance versus maybe those in Indiana they'll be reported as a positive test.

Rep. Rachel Roberts (KY) stated I'm from Kentucky and we're just now facing all of this since we've just passed our first medical cannabis bill. I guess my question is, could you speak a little bit more to if testing positive is a reason for a denial only because of the federal status of cannabis? Or would a worker also potentially be denied if they test positive for legal and properly used opioids or anti-anxiety meds for instance if they were injured in the course of their job responsibilities but were having to go through other medication protocols? Mr. Jones asked if the question is the difference between marijuana and other meds? Rep. Roberts stated I guess the question is, is it a level playing field? If I get injured on the job and it's perhaps because I'm having to take a medication for a treatment that is legal and responsibly used, is it a level playing field if that is a normal prescribed medication or if it's cannabis and if it is not a level playing field, is it only because the status of cannabis at the federal level? Mr. Jones stated that I think the treatment of cannabis at the federal level is a big part of it. I think there's always going to be the issue of the medication, was that the cause of impairment and was the impairment the cause of the injury? But it definitely gets muddier for marijuana. It's just an extra level of headache. So in terms of your question was it a level playing field? I think no. I think cannabis is always going to be one extra level of complication but I think if you were taking opioids or drinking at lunch, if those things cause you to be impaired, and then you caused a workplace injury, I think that there would be room for denial of those claims.

Dr. Choo stated to give a little more insight as to what Mr. Jones was talking about, I think it depends on the employer. So, number one, if you're an employer providing services that are federal or government related, if a cannabis test comes back positive, you will fail the drug test. If you're a not a federal employee or agency that deals with federal services or department of transportation and you would do something different and your policy accepts cannabis as a visible substance, just like benzodiazepines and

other medications that they're taking, and we can prove that person has a medical reason for the positivity which means that they have a medical marijuana card that has been approved for use because of the conditions they have, or they have a prescription from a physician that gives them the medical reason to have benzodiazepines and other substances like Adderall, then it will be reported as a negative test. So the employer will not see that as a positive test. In fact, they'll see it's a negative test. So it does level out the playing field but it depends on the employer.

Rep. Mike McFall (MI) stated that we're focusing on medical marijuana and medical marijuana cards, but we have seen a huge decrease in people applying for medical marijuana cards in Michigan after recreational was passed. We peaked at almost 300,000 at one point. And now we're down to 123,000 or something like that. So, if we're just talking about medical, I think there's a lot of people that are utilizing it because it's become so cheap in Michigan without actually having to go through all those steps to get the medical card. So many people are utilizing it for medicinal purposes without a card. And so, for example as Dr. Choo said about whether or not you talked to them and they have a card, but what if they don't have a card? I guess that's my question? Are we always just relying on them having a card when it comes to these? Dr. Choo said getting back to my comment about the MRO service, if the state has a medical marijuana program but did not allow recreational in that state it's easier for us to go ahead and say that if you have a medical marijuana card then you have a justified medical reason. Therefore, it's a negative test. And if you have a state that has a recreational program in place where obviously people can use marijuana without the medical marijuana card then it will fall back to the employer's policy.

PRESENTATION ON WORK COMP TRENDS AND THE FUTURE OF MEDICINE

Dr. Choo thanked the Committee for the opportunity to speak and stated that it's a pleasure for me to be here this afternoon and to share with you my thoughts and opinions on medical trends in workers compensation. But before I actually start to speak I do want to preface my perspectives. That is based upon two things. One is that I've been a Paradigm Chief Medical Officer for the company for 11 years. And for those who may not be aware, Paradigm is a national accountable care management company that has been specializing in catastrophic injuries. So we specialize in caring for brain injuries, spinal cord injuries, multiple trauma, severe burns and amputations. And we are unique in that we guarantee a clinical outcome for a fixed price or a set price at the beginning of the case which means at the time they get injured and we guarantee an outcome that is a bit of long term either return back to work or returning back to community integration. And because of the outcomes that we guarantee are so long term we reside in the workers compensation space and liability. So I want to make sure you knew that. The other thing is that I still practice. I've been practicing for 33 years so I can give you some sense of what has been happening in the healthcare market as well. So with that, my goal is really to walk through the highlights as well as innovation related opportunities and dilemmas that I think will be faced by the workers competition industry in the years to come. And again these are my perspectives and my perspective alone but hopefully you will agree and hopefully prompt some interesting discussions.

So with the highlights, I'm going to start with the long-COVID. Long-COVID, long haulers, I think those are terms that I think you all heard it before and it's really the terms that were created by the public lay people and the media to describe a condition where

after getting ill or contracting the COVID-19 infection a number of people continue to have ongoing and persistent symptoms lasting more than four weeks. In fact lasting months and some actually lasting more than a couple of years. And this particular condition that will be used to call long-COVID had really three or four big common symptoms. One is obviously people experienced severe fatigue as well as exercise or physical activity induced malaise where you feel terrible after you do stuff and you feel exhausted. And then also experience cognitive brain fog where people really felt like they couldn't really think straight. They had memory issues. They couldn't concentrate. And there were other symptoms like palpitations, chest pains and dizziness but to be candid, there were over 200 symptoms documented across the medical industry within this condition and it was a conundrum for the medical community in that we have all these symptoms that really could apply to every organ system in the body. And it was lasting a long time. So obviously this condition was evaluated and the National Institutes of Health (NIH) finally did agree that it is a true condition. And in 2021 they gave this long COVID long haulers a new term called post acute sequelae of SARS-CoV-2 infection (PASC). So since it was dubbed as being a real condition, there were a lot of questions about what is the prevalence of this long COVID in the industry? So, I helped the National Council on Compensation Insurance (NCCI) and they have the largest data set for all workers compensation related claims. And we actually analyzed the data and we went back to 2020 and we looked at all of the lost time claims with COVID from point of start to 2023. And what we discovered was that in 2020 the overall aggregate prevalence of long-COVID was 26%. So, 26% of the cases that had lost time claims had long- COVID symptoms beyond four weeks. When you looked at the hospitalized population it was much higher like around 47%. And for those who are not hospitalized it was around 20% but in aggregate it was about 26%.

We looked at the cases in 2021. In 2021 it showed a decline in the prevalence where it went down to like 22%. And in 2022, the decline continued and it was only around 11.4%. So, the good news is that long-COVID prevalence has been declining over the past three years since the pandemic started. And I attribute this decline to three factors. One is obviously the vaccinations. Vaccination started in January of 2021. Actually, I got mine in December of 2020, but I think vaccinations have really curtailed the rate of infection. So certainly, if you decrease the frequency of infection, then you decrease the prevalence of long-COVID. The second driver is that it's clear we now have therapeutics that really work for COVID infection. We have Paxlovid. We have Remdesivir. I know there were many other options that were considered but those two drugs currently we use every day and it's been very effective in limiting the impact of COVID-19 infection in patients who actually get them. We also know how to treat the so-called cytokine storm much better. The hyper inflammation reaction from the COVID-19 infection we now know how to immune modulate the inflammatory response so the patients are much better treated. And then lastly, I think that we all have been hearing about this in the news - the Sars-CoV-2 is a coronavirus and they mutate. They mutate naturally. And as they mutate they become less virulent. And so, over the course of two and a half years as it starts with Wuhan virus, now I think through Omicron and I think the most prevalent variant that exists today is the EG 2.5 variant. And it is much less prevalent as compared to his predecessors. And so I think that's the good news. The bad news is that it has become a part of the general group of viruses that we will be be facing every year. It has joined the ranks of the influenza virus as well as the RSV virus, and chicken pox virus. They’re out there and we're going to see these infections ongoing for the years to come.

So that's the long COVID. The next topic is the claims frequency. So, as you all know, NCCI publishes their report annually with regards to the workers compensation claims and the good news is that the workers compensation claim frequency has been declining over the past 15 to 20 years and it has remained so which is pretty amazing. In fact, year over year claim frequency from 2021 to 2022 declined an additional 4%. So, it's all good news. The thing that they noticed this year though, is that even though the frequency has been declining, we noticed that the claim related severity has been on the incline which means that the indemnity severity, what's been paid out for the indemnity side has been increasing. In fact, the year over year change was 6% from 2021 to 2022. The medical severity has also been climbing. It's been increasing at a rate of 5% from 2021 to 2022. The wage I think drives much of the indemnity severity so that's kind of explainable but we wanted to look better at the more detailed information on the medical severity. And so we did some more analysis and what we discovered was that there's a subset of claims within the workers comp claim population which we termed the fast emerging large loss claims. And the definition of that particular group is that within the first two years of experiencing the injury the payout for medical costs alone was over $1 million. And so that's the category we talked about. And what was interesting is that if you look at just that subset of the claims, the large loss claims from 2012 to 2021, that's been growing at a year over year rate of 2% to 3%. And if you take another cut through that particular subgroup, there is a subgroup that deals with traumatic brain injuries, spinal cord injuries and burns. Those three categories, that particular group, actually were when you look at their medical severity it was growing, the frequency has been growing at 7% year over year from 2012 to 2021. So even though the overall frequency has been falling, there has been a subset of the large loss claims that's been growing at a pretty steady state and when we did some further analysis as to where it's coming from, I think it's pretty intuitive these claims were most prevalent in the construction section of the industry as well as transportation. And one of my concerns is that as you all know, Congress has passed the infrastructure bill that's going to be passing down through the States and the biggest I think benefactor of the infrastructure bill I think will be the construction sector as well as transportation. And my question from a workers compensation industry perspective is would that accelerate the frequency of such injuries just because there's a lot more money going into those two segments?

So that's my highlights for workers comp. Moving to the innovation related opportunities, I could spend five hours talking about it but I'm going to be very brief. I've been practicing for 33 years and I would say we are currently living through probably the golden years of medical innovation. It started in the 1980s when I was in medical school and I've been the benefactor of watching this incredible growth in medical science, knowledge and innovations. And most recently what's amazing to me is that the advances that may been introduced with regards to technological advances over the past five to six years have further accelerated the pace of medical innovation. And the innovation is such that I think we have made significant impact to the survival of people who are experiencing catastrophic injuries as well as other really severe complex diseases that years ago they didn't survive but today they do. And unfortunately, because they do survive many of the survivors that I see in workers compensation who experience those catastrophic injuries are left with severe disability and impairments. And what I'm happy to say is that we are also seeing great innovations coming to surface now that are helping those people who have been severely injured with severe disabilities to actually regain some of the functional capacities that will help to reduce

their disability and mobility going forward. So, just a couple of things I'm going to mention. I don't want to give you a whole lecture on the life saving medical innovations but I do think that there are some that I do want to mention that you heard about. I think COVID has really enlightened the whole public about procedures like extracorporeal membrane oxygenation (ECMO) which allows us to oxygenate the blood outside the body and then recirculate back into the body to keep people alive when the lung is basically useless. We have technologies or interventions like left ventricular assistive devices (LVAD) that are mechanically able to pump blood externally back into your system so that we keep the organs alive and this system used to be pretty much an intensive care unit (ICU) based product or intervention but the LVAD has progressed, technology has progressed to the point where now we can give people these LVADs miniaturized so they can wear this device outside out and about and they can actually engage their life as they normally would.

And so it used to be a bridging program to get people to transplants. But now it's destination therapy. People can live with LVADs for a long time. The concept of dying from hemorrhage from trauma is no longer the case. We have incredible interventional radiology procedures that can go in and embolize ruptured vessels, arteries and veins to stop the bleed. We have an interventional procedure that's done in the emergency room like resuscitative endovascular balloon occlusion of the aorta (REBOA). They can actually stop the bleeding internally like abdominal traumas and pelvic traumas so they don't die from hemorrhages anymore. So if you survey the American College of Surgeons Trauma Services they'll say that the number one cause of death today from trauma is not hemorrhage but rather brain injury. So we've made some incredible progress. With regards to what I call survivorship innovations, I do want to mention three because I've been integrally involved with them. And these are the innovations that actually I think improve the mobility and the disability associated with catastrophic injuries.

The first one is osseointegration. And some of you may have heard about these interventions but they're pretty new and out there in the public. Osseointegration is a process where they implant the titanium metal rod into the bones of the amputated limb and through this process we actually anchor the prosthetic right onto the amputated limb and it gives the patient or injured worker with a lost limb the ability to directly control their limb in the prosthetic. It improves biomechanics, improves function, range of motion. It really improves the quality of life. And this has been available since 2021 when the U.S. Food & Drug Administration (FDA) approved the process and the implant. We also have a surgical reconstructive technique called vascularized composite allotransplantation (VCA) and this is an incredible technique where this is the next level of transplants. You heard about organ transplants where we've been transplanting hearts and lungs and kidneys but now because of the advances made in the immunosuppression, we can actually transplant body parts. So this is why when we talk about hand transplants, arm transplants, facial transplants, ocular transplants, these sound like science fiction but they're being done today and in fact, we have a patient in Paradigm who is in his 40s and has significant severe injury from an electrical injury that burned off his face and his eyes and he's lost his limb. We tried everything to reconstruct his facial structures, but it was impossible so the only option for us to do was to seek a facial transplant and ocular transplant because he had no option. And we had this done successfully this past summer at New York University (NYU). And then you may have heard about this because there's been a big new splash in CBS last week and the patient is doing

incredibly well with regaining the function of the face. He can smile. He can kiss his wife. It's been pretty impressive to watch. And then one last innovation I want to share. I think it's very exciting. It's not here yet, but it's coming. And maybe you have heard about this. It's called the brain computer interface and this technology is pretty impressive in that 20 years ago when I was practicing and doing research people will be putting little metal implants micro circuitry in the brain and trying to see how they can help people who could not move with spinal cord injuries but still have brain function to be able to use the computer interfaces to move other external mechanical devices like robots to their function. Well, technology has improved significantly that right now we have a stint which I'm sure you heard of a putting a stint in the heart to keep people from having heart attacks. Well they perfected the stint. They can actually collect their brain signals, the electrical impulses in the brain. And how we do this, we actually put the sensor in the blood vessels of the brain next to the areas of the brain that controls motor functions and cognition and thought. And this signal is then captured by the computer outside the body and then with someone just thinking about doing something the signals then can be translated by the computer and moves the robotic hands and the exoskeletons to do the things for the patient. And so I do foresee this becoming a reality in the years to come where patients who have been paralyzed or have a degenerative disease and can't move will be able to actually engage life again with exoskeletons and robotic care and even those computer based systems can actually voice their wishes. So, it's pretty incredible stuff.

And then lastly because of the technological advancements that are out there, we are seeing a lot of movement toward remote healthcare where we can now monitor patients outside of the hospital. Conditions that we used to admit patients in the hospital for we are now thinking we can send these people home so they can be cared for at home through monitoring. So, pretty incredible stuff, but I'm really excited to be in the field still practicing using these devices that have the options for it. But there is a downside. The downside is these options are very expensive. Some of these options can account for $1 million the first year and that in my mind leads me to the third segment, dilemmas. And I'm posing this to all of you as a way to think about the workers compensation industry as it goes forward because I think these are things that we need to think about because it is coming and the question is how to deal with them? First, is the medical comorbidities. I would say that I think everyone here knows that our U.S. population is getting sicker. More and more people have chronic medical conditions that include diabetes, cardiovascular diseases and we in fact have probably the fastest growth in the immune related diseases as compared to the rest of the world and unfortunately, what I've learned and seen over the past 11 years as being the Chief Medical Officer of Paradigm and dealing with workers compensation cases and catastrophic injuries is that many people who get injured at workers comp have comorbidities. Premorbid conditions. And many times these premorbid conditions get aggravated and exacerbated and now becomes rolled into the workers compensation responsibility. And my question to all of you would be in the years to come when we know that the fastest growing worker population is the elder population and the Bureau of Labor Statistics (BLS) actually predicted that from 2019 to 2029, the fastest growth in the workforce will be in those aged above 65, which I have a hard time believing, but that's what they say. So, if you're saying 55% growth in that particular age category, I'm going to assume they're going to have a lot more medical problems that we'll be bringing to the table. So they will get injured and the question is what does that impart to workers comp?

The next concern that I have is with healthcare access. I think everyone here has been hearing about the growing burnout rate with physicians and healthcare professionals in our country. In fact, Medscape did a survey of the doctors last year and discovered that 42% of the physicians claim that they have burned out. Right now they're practicing, but they've burned down. Modern Health Magazine did a study where they figured out that in 2022, 145,000 healthcare professionals left the industry. Half of them were physicians, 71,000 doctors stopped practicing. And ultimately my question is as we have demand that's increasing, but supply shrinking, how are we going to take care of these patients? And from a workers compensation perspective it's going to be taking much longer to get our injured workers to be seen by the practitioners and if there are delays in the care then I think it's going to impact both the medical costs as well as the indemnity severity as well. And then lastly, the concern I have with healthcare delivery system. I'm not saying anything new when I say that our healthcare system is broken. It's a very complex and very fragmented system that we live in. But there are two factors that I see that are growing and that's going to be a challenge for the workers compensation industry. First is the issue of consolidations. Consolidations are growing in the healthcare market. Consolidation that involves hospital systems combining and merging. Consolidation involves practitioners, physician groups that are combining and consolidating. And other healthcare professionals are consolidating. And when you look at the data and the research out there on the impact of these consolidations, and Robert Wood Johnson did a study on this, they showed that the quality did not improve with consolidations but what they did see was a heightened rate of pricing. The prices go up an average of 10% to 40% after consolidation. And so my concern is what is that going to do to the workers compensation industry when we are the only payer left in the healthcare market that pays the first dollar forward? So, that's my second concern is the fact that the healthcare industry has become efficient and they become proficient in cost shifting. Every payer besides workers compensation has become great at cost shifting. Even Medicare, Medicaid, group health has been doing this for a long time but they've been cost shifting to other people or other entities to pay for cost of care. And the biggest way they do it is through co-pays and deductibles, for some. But others, I think it's time to figure out that, “Hey, if I can get my medical cost paid for by workers comp because when I get injured they may be able to absorb some of my medical care needs that has to do with my comorbidities” - this is a great way to cost shift to workers comp and I think workers compensation is a great system. I think it's the best system. It really cares about the injured worker and does what they can to make sure that the injured worker gets the best care, best level of function and gets back to reality, and back to work. But I wonder how long can we do this when the rest of the healthcare system is set up to exploit workers compensation.

Sen. Hackett stated before I turn it over to the committee, I have a couple of questions. First question - when you talked about and summarized COVID it was that we had good news and bad news. And the second question - commercial real estate is not a great investment in Ohio now because of so many more people are working at home. But you talked about the cost shifting so when we have claims at home are they really workers comp claims? And that's a real dilemma that our state-run workers comp system is facing now if people get hurt at home. So the first question is, in your professional opinion do the pros outweigh the cons? I realized claims have gone down, but severity claims have gone up. We've had a little of a new COVID come in but it's more like the flu, etc. It's not as dangerous as it once has. So in your professional opinion do you think long range, we're going to continue the downward spiral of cost of workers comp or

is it going to level up and start going up again? Dr. Choo stated that my personal perspective is that I think the cost related to COVID is going to go down and the reason I say that is because I think the pandemic was a period of confusion for many. And I think we now have more knowledge and more safety nets and safeguards to make sure that we appropriately manage the COVID related kind of situation. I think that the COVID issue will be on a decline. Now having said that, I know that most of us know that the companies are still in the hybrid situation where a lot of people are working from home and it's my personal perspective that I think more infections occur at home versus at work just because the closest to contact. So I don't know the answer, but I do think that the longer we stay hybrid, it could potentially increase the frequency of COVID infections but I think the severity of COVID has definitely been dampened so I don't think that would amount to a high cost. As far as the other severity that you mentioned, I do think the severity of medical cost will continue to grow and the reason for that is because I do not see the healthcare delivery system as it's set up today to curb the appetite for the increasing costs of medical care.

Sen. Hackett stated one of the dilemmas you talked about was the healthcare dilemma delivery system. I come from a smaller rural town and I was on the hospital board. We're affiliated now with two big city hospitals in Columbus. Actually, if you remember, we went to a time and we still have a little of it where everybody had to have an MRI, everybody had to have this, and we didn't really have good efficiency. One of things we're seeing is the rural hospitals aren't being closed. They're just not being hospitals, instead of being called Madison County Hospital, it's Madison Health. And so, I think we're looking at doing better in efficiency where they send them to Columbus for all the cancer and all the heart and the MRI's etc. So in some ways, don't you think we're getting a little better efficiency because of the forcing of healthcare systems to smaller and to bigger healthcare systems? Dr. Choo stated that I do agree that there is a growing movement toward efficiency in the way you described it where previously I think there were county hospitals and hospitals all around the country to serve the needs of the population and I think that the driver for that was if you have an acute care hospital in the city or in the township and it's easily accessible, that would lead to better care. I do believe that the level of expertise and the specialization has evolved to a point where the specialized care has become much more important. And so some of these outlying hospitals may not have the capacity to be able to be proficient in taking care of such conditions and so it does make sense to have them be efficiently transferred to a center where they do a lot more of those cases. I would say that even though that is true, I still think that there is a way to work out a delivery system in a way that can benefit both - that it can be delivered much more timely and accessible to the local community while at the same time being able to be transferring the appropriate patients to the bigger centers where they can do more of these kind of specialized procedures. But I think the challenge with that is that the big centers would love to be able to go ahead and just pull patients from all over the area to their location because it makes sense for them. But I do think there's a way to take care of some of those people still at the local level through the guidance and through the telemonitoring and telemedicine and other ways to share expertise so that some of the care can be delivered locally.

Rep. Jane Pringle (ME) stated I have more of a statement in response to your comments. There's a large body of literature about the burnout and that the burnout in large part is moral injury. People who go into medicine go in because they want to take care of patients and they want them to get better and they want them not to have

barriers to getting the care they need. So, as we have developed the kind of for-profit healthcare system that we have, we put a lot of barriers to patients getting care. High co-pays. People can't afford it so they go without the medicine they need. We know if we prevent diabetes, you wouldn't have the comorbidities. I spent 43 years as a primary care doctor and I know that I saved a lot of money and a lot of lives but I can tell you I've had two terms nonconsecutive on health coverage and insurance and financial services in my state. And I can tell you it is just discouraging where it's hard to recruit primary care doctors coming out of medical school into primary care. And our medical organizations and other states are pooling together and making public statements that we believe there is a solution and it would be national single payer health system that was evidence based and proven to have good health outcomes and the only thing we need is a national will to do that.

UPDATE ON FEDERAL WORKERS' COMPENSATION INSURANCE ISSUES

Doug Holmes, President of Strategic Services on Unemployment & Workers' Compensation (UWC), thanked the Committee for the opportunity to speak and stated that UWC is a national association that represents business in many states with respect to unemployment insurance and workers compensation legislation and policy. I think the discussion about cost shifting is really a big part of what I do professionally to analyze federal legislation and policy and try to avoid cost shifting to the employer financed state based systems of unemployment and workers compensation. That shifting comes in a number of pieces of legislation. So, I'm just going to take a few minutes to discuss federal impacts on workers compensation and here are ongoing issues that we're engaged in. First of all, many of you may remember that way back in 1972 there was a National Commission on workers compensation that had a series of recommendations. We're still talking about those recommendations, many states adopted some of those recommendations but many states did not oftentimes because of cost or because they did not want to make a new federal mandate matter of state law. But that's still on the agenda it seems every time we have a discussion. Oftentimes we see proposals to shift costs from Social Security disability insurance to workers compensation. There are 15 states that have reverse offset provisions. So there was already a workers compensation law in place going back to as long ago as 2011 in the state based on a state constitution or legislation. Yet we have these proposals that seek to eliminate the reverse offset. So, many states, 15 or so, enacted laws that said, when you make a determination as to what the workers compensation indemnity payment is going to be that there's an offset for Social Security. Social Security also has an offset going the opposite way. So, there are proposals from Social Security on a regular basis to eliminate the reverse offset as a way to save money for Social Security but of course that shifts costs to employers and to states. So, we oppose those.

Shift costs from Medicare and Medicaid to workers compensation conditional payment reimbursement. Many of you may be aware of this that if an individual goes in and receives services under Medicare or under a state Medicaid plan and those are charged because of convenience, because they're unsure about whether there's workers comp coverage but go ahead and provide the services and then seek reimbursement from workers compensation. Unfortunately, the services to be provided don't necessarily match and so you oftentimes have demands for conditional payment recovery made to payers that are inconsistent with what the workers compensation and the state law provides so that creates friction. So, we try to eliminate that as much as we can and we

oppose that kind of cost shifting from usually it's the Centers for Medicare and Medicaid Services (CMS) to workers comp payers and in some cases the states if they're monopoly states like Ohio. Medicare for All, I'll talk a little bit about that. We have proposals again from Senator Sanders and Representative Jayapal and they create federal preemption against states providing items and services under a workers compensation medical plan. That creates quite a transition issue and a series of issues and we're opposed to those pieces of legislation as they have been introduced. There are proposals to expand federal workers comp programs and leverage for state workers comp expansion advocacy. So you will have proposals that seek to require states to make changes in state law and do it as a function of federal law. So, we're always on the lookout for that. The things that we look at are what is the real impact of the change? Is it a cost shift or not? What is the impact for payers? What is the impact for employers? And what is the impact for the individual injured worker? And try to come up with solutions that make sense but preserve the state based workers compensation system.

We also opposed the COVID-19 presumption legislation that was introduced by Representative Frank Mrvan from Indiana who sought to create a new presumption if anyone had an infection due to COVID that they would be presumed to be covered for workers compensation. We oppose that not only at the state level, but also at the federal level with respect to longshore noting that COVID-19 is an infectious disease and you can be exposed and acquire the disease virtually anywhere so it's not an occupational disease. In fact, that was recognized by the Supreme Court in recent case law finding that it was not an occupational disease. So we opposed that legislation as well. We also oppose the quote “monitoring” issue - there are multiple proposals to have federal agencies monitor state workers compensation and to evaluate how the state workers compensation programs are shifting costs to federal programs. Of course, we thought that was sort of an absurdity since workers compensation at the state level was created going back to 1911. We didn't even have Medicare and Medicaid and Social Security disability until decades later. So these programs are built on top of an already mature system that was legislated at the state level and oftentimes under state constitutions. It’s sort of crazy to talk about how that state system is shifting costs to the federal system. Of course, congressional staff have a hard time figuring this out because there are of a mind to protect the federal programs, not the state programs.

Regarding, Medicare for All proposals, I’ll give you a flavor for what is included in those proposals. In H.R. 3421, each workers compensation carrier that is liable for payment for workers compensation services furnished in a state shall reimburse the Medicare for All program for the cost of such services. Of course, that has a problem because the services that are covered for workers compensation under the state law are not the same items and services that are covered for Medicare. So, it doesn't work. Beyond the fact that if there's a presumption or a federal preemption against having workers compensation insurance that creates significant transition issues and of course, tremendous problems for many of the claims that have long tails. Got a workers compensation claim that is for life, how do you end it in the middle because of the new federal preemption? Doesn't make sense. So, we coordinate efforts to oppose those kinds of proposals. Now, on the plus side, what we are doing is working on a proposal we call the COMP Act to clarify that if there is a settlement under an applicable workers compensation law that the workers compensation law determines the terms of the settlement. It seems like an obvious thing, yet you have CMS in its administration of

Medicare second guessing the settlements that are arrived at under the applicable state law and creating lots of confusion and unnecessary administrative costs and unnecessary risk. And so, what our legislation does which we expect to have introduced fairly soon, is to clarify that state workers compensation law applies to state workers compensation and it is not preempted by new federal statutes. I'll stop there and note that a big part of our mission as an association is to protect the employer financed state based programs of unemployment and workers compensation. We actively do that on a regular basis in all policy and legislation at the federal level.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Roberts and seconded by Rep. Nicol, the Committee adjourned at 3:15 p.m.

Atlantic Corporate Center
2317 Route 34, Suite 2B
Manasquan, NJ 08726
732-201-4133
CHIEF EXECUTIVE OFFICER: Thomas B. Considine

National Council of Insurance Legislators (NCOIL)

Model State Structured Settlement Protection Act

Supported by the NCOIL Executive Committee on February 27, 2004, July 22, 2006, July 17, 2011, November 20, 2016, July 18, 2021, November 20, 2021, March 6, 2022, and July 16, 2022.

Originally Sponsored by Sen. Carroll Leavell (NM). July 2022 amendments sponsored by Sen. Paul Utke (MN) and co-sponsored by Rep. Bart Rowland (KY).

This will be referenced during the "Structured Settlements 101" Agenda Topic.

SECTION 1. TITLE.

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

SECTION 2. DEFINITIONS.

For purposes of this Act--

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

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

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

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

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

(f) “independent professional advice” means advice of an attorney, certified public accountant, actuary or other licensed professional adviser;

(g) “interested parties” means, with respect to any structured settlement, the payee, any beneficiary irrevocably designated under the annuity contract to receive payments following the payee’s death, the annuity issuer, the structured settlement obligor, and any other party to such structured settlement that has continuing rights or obligations to receive or make payments under such structured settlement;

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

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

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

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

(l) “renewal date” means the date on which a registered structured settlement purchase company is required to have renewed their registration pursuant to Section 3 of this Act, which date shall be one year after the initial registration or any subsequent renewal.

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

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

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

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

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

(p) “structured settlement agreement” means the agreement, judgment, stipulation, or release embodying the terms of a structured settlement;

(q) “structured settlement obligor” means, with respect to any structured settlement, the party that has the continuing obligation to make periodic payments to the payee under a structured settlement agreement or a qualified assignment agreement;

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

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

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

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

(s) “structured settlement purchase company” means a person that acts as a transferee in this state and who is registered with the [appropriate state agency] pursuant to Section 3 of this Act.

(t) “structured settlement transfer proceeding” means a court proceeding filed by a structured settlement purchase company seeking court approval of a transfer filed in accordance with this Section 6 of this Act.

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

(v) “transfer” means any sale, assignment, pledge, hypothecation or other alienation or encumbrance of structured settlement payment rights made by a payee for consideration; provided that the term “transfer” does not include the creation or perfection of a security interest in structured settlement payment rights under a blanket security agreement

entered into with an insured depository institution, in the absence of any action to redirect the structured settlement payments to such insured depository institution, or an agent or successor in interest thereof, or otherwise to enforce such blanket security interest against the structured settlement payment rights;

(w) "transfer agreement" means the agreement providing for a transfer of structured settlement payment rights.

(x) "transfer expenses" means all expenses of a transfer that are required under the transfer agreement to be paid by the payee or deducted from the gross advance amount, including, without limitation, court filing fees, attorneys fees, escrow fees, lien recordation fees, judgment and lien search fees, finders' fees, commissions, and other payments to a broker or other intermediary; "transfer expenses" do not include preexisting obligations of the payee payable for the payee's account from the proceeds of a transfer;

(y) "transfer order" means an order approving a transfer in accordance with Section 6 of this Act;

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

SECTION 3. REGISTRATION REQUIRED

(a) A person or entity shall not act as a transferee, attempt to acquire structured settlement payment rights through a transfer from a payee who resides in this state, or file a structured settlement transfer proceeding in this state unless the person or entity has registered with the [appropriate state agency] to do business in this state as a structured settlement purchase company.

(b) (1) An applicant's initial registration application shall be submitted on a form prescribed by the [appropriate state agency], and shall include a sworn certification by an owner, officer, director, or manager of the applicant, if the applicant is an [entity, not a natural person], or by the applicant if the applicant is [an individual, a natural person], certifying that the applicant has secured a surety bond, or has been issued a letter of credit, or has posted a cash bond in the amount of $50,000.00, relative to its business as a structured settlement purchase company in this state. The surety bond, letter of credit, or cash bond is intended to protect payees who do business with a structured settlement purchase company.

(2) The bond shall be payable to the State of [name of state].

(3) The bond, letter of credit, or cash bond shall be effective concurrently with the applicant's registration with the [appropriate state agency] and shall remain in effect for not less than three years after expiration or termination of that

registration. The bond, letter of credit, or cash bond shall be renewed each year when the registration of the applicant is renewed.

(4) The applicant shall submit to the [appropriate state agency] a copy of the bond, letter of credit, or cash bond with its registration or renewal application.

(5) The bond, letter of credit, or cash bond is intended to ensure that the structured settlement purchase company will comply with the provisions of this article relative to the payee and perform its obligations to payee under this article, and to provide a source for recovery for the payee should a payee recover a judgment against a structured settlement purchase company for a violation of this Act.

(6) The [appropriate state agency] shall be authorized to set and charge a fee to offset the costs of processing and maintaining the registration required by this section.

(c) Within ten days after a judgment is secured against a structured settlement purchase company by a payee, the structured settlement purchase company shall file a notice with the [appropriate state agency] and the surety providing a copy of the judgment and the name and address of the judgment creditor, and include the status of the matter, including whether the judgment will be appealed, or has been paid or satisfied.

(d) The liability of the surety under the bond shall not be affected by any breach of contract, breach of warranty, failure to pay a premium or other act or omission of the bonded structured settlement purchase company, or by any insolvency or bankruptcy of the structured settlement purchase company.

(e) Neither the bonded structured settlement purchase company nor the surety shall cancel or modify the bond during the term for which it is issued, except with written notice to the [appropriate state agency] at least 20 days prior to the effective date of such cancellation or modification.

(f) In the event of a cancellation of the bond, the registration of the structured settlement purchase company shall automatically expire unless a new surety bond, letter of credit, or cash bond, which complies with this Code section, is filed with the [appropriate state agency]. The cancellation or modification of a bond shall not affect any liability of the bonded surety company incurred before the cancellation or modification of the bond.

(g) An assignee shall not be required to register as a structured settlement purchase company in order to acquire structured settlement payment rights or to take a security interest in structured settlement payment rights that were transferred by the payee to a structured settlement purchase company.

(h) An employee of a structured settlement purchase company, if acting on behalf of the employer structured settlement purchase company in connection with a transfer, is not required to be registered.

(i) A registered structured settlement purchase company shall renew its registration annually, on or before the renewal date, and provide the certifications set forth in this section.

(j) Except as otherwise provided in Section 4, a transfer order signed by a court of competent jurisdiction pursuant to this Act constitutes a qualified order under 26 U.S.C. § 5891. If a transferee to which the transfer order applies is not registered as a structured settlement purchase company pursuant to this Act at the time the transfer order is signed, the transfer order does not constitute a qualified order under 26 U.S.C. § 5891.

SECTION 4. PROHIBITED PRACTICES; PRIVATE RIGHT OF ACTION; PENALTIES

(a) A transferee, a structured settlement purchase company and an employee or other representative of a transferee or structured settlement purchase company shall not engage in any of the following actions:

(i) Pursue or complete a transfer with a payee without complying with all applicable provisions of this Act.

(ii) Refuse or fail to fund a transfer after court approval of the transfer.

(iii) Acquire structured settlement payment rights from a payee without complying with all applicable provisions of this Act, including, without limitation, obtaining court approval of the transfer in accordance with this Act.

(iv) Intentionally file a structured settlement transfer proceeding in any court other than the court specified in Section 8 of this Act, unless the transferee is required to file in a different court by applicable law.

(v) Except as otherwise provided in this paragraph, pay a commission or finder's fee to any person for facilitating or arranging a structured settlement transfer with a payee. The provisions of this paragraph do not prevent a structured settlement purchase company from paying:

(A) A commission or finder's fee to a person who is a structured settlement purchase company or is an employee of a structured settlement purchase company;

(B) To third parties any routine transfer expenses, including, without limitation, court filing fees, escrow fees, lien recordation fees, judgment and lien search fees, attorney's fees and other similar types of fees relating to a transfer; and

(C) A reasonable referral fee to an attorney, certified public accountant, actuary, licensed insurance agent or other licensed professional adviser in connection with a transfer.

(vi) Intentionally advertise materially false or misleading information regarding its products or services.

(vii) Attempt to coerce, bribe or intimidate a payee seeking to transfer structured settlement payment rights

(viii) Attempt to defraud a payee or any party to a structured settlement transfer or any interested party in a structured settlement transfer proceeding by means of forgery or false identification.

(ix) Except as otherwise provided in this paragraph, intervene in a pending structured settlement transfer proceeding if the transferee or structured settlement purchase company is not a party to the proceeding or an interested party relative to the proposed transfer which is the subject of the pending structured settlement transfer proceeding. The provisions of this paragraph do not prevent a structured settlement purchase company from intervening in a pending structured settlement transfer proceeding if the payee has signed a transfer agreement with the structured settlement purchase company within 60 days before the filing of the pending structured settlement transfer proceeding and the structured settlement purchase company which filed the pending structured settlement transfer proceeding violated any provision of this Act in connection with the proposed transfer that is the subject of the pending structured settlement transfer proceeding.

(x) Except as otherwise provided in this paragraph, knowingly contact a payee who has signed a transfer agreement and is pursuing a proposed transfer with another structured settlement purchase company for the purpose of inducing the payee into cancelling the proposed transfer or transfer agreement with the other structured settlement purchase company if a structured settlement transfer proceeding has been filed by the other structured settlement purchase company and is pending. The provisions of this paragraph do not apply if no hearing has been held in the pending structured settlement transfer proceeding within 90 days after the filing of the pending structured settlement transfer proceeding.

(xi) Fail to dismiss a pending structured settlement transfer proceeding at the request of the payee. A dismissal of a structured settlement proceeding after a structured settlement purchase company has violated the provisions of this paragraph does not exempt the structured settlement purchase company from any liability under this Act.

(b) A payee may pursue a private action as a result of a violation of subsection (a) and may recover all damages and pursue all rights and remedies to which the payee may be entitled pursuant to this Act or any other applicable law.

(c) A structured settlement purchase company may pursue a private action to enforce paragraphs (iv), (vii), (ix), (x) and (xi) of subsection (a) and may recover all damages and pursue all remedies to which the structured settlement purchase company may be entitled pursuant to this Act or any other applicable law.

(d) If a court determines that a structured settlement purchase company or transferee is in violation of subsection (a), the court may:

(i) Revoke the registration of the structured settlement purchase company;

(ii) Suspend the registration of the structured settlement purchase company for a period to be determined at the discretion of the court; and

(iii) Enjoin the structured settlement purchase company or transferee from filing new structured settlement transfer proceedings in this State or otherwise pursuing transfers in this State.

SECTION 5. REQUIRED DISCLOSURES TO PAYEE.

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

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

(b) the aggregate amount of such payments;

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

(d) the gross advance amount;

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

(f) the effective annual interest rate, which must be disclosed in a statement in the

following form: “On the basis of the net amount that you will receive from us and the amounts and timing of the structured settlement payments that you are transferring to us, you will, in effect be paying interest to us at a rate of _____ percent per year”;

(g) the net advance amount;

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

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

(j) that the payee has the right to seek and receive independent professional advice regarding the proposed transfer and should consider doing so before agreeing to transfer any structured settlement payment rights.

(k) That the payee has the right to seek out and consider additional offers for transferring structured settlement payments and should do so.

SECTION 6. APPROVAL OF TRANSFERS OF STRUCTURED SETTLEMENT PAYMENT RIGHTS.

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

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

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

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

(b) No direct or indirect transfer of a minor's structured settlement payment rights by a parent, conservator, or guardian shall be effective and no structured settlement obligor or annuity issuer shall be required to make a payment directly or indirectly to a transferee or assignee of structured settlement payment rights unless, in addition to the findings required under subdivision (a), the court also finds that:

(i) the proceeds of the proposed transfer would be applied solely for support, care, education, health, and welfare of the minor payee; and

(ii) any excess proceeds would be preserved for the future support, care, education, health, and welfare of the minor payee and transferred to the minor payee upon emancipation.

SECTION 7. EFFECTS OF TRANSFER OF STRUCTURED SETTLEMENT PAYMENT RIGHTS.

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

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

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

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

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

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

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

SECTION 8. PROCEDURE FOR APPROVAL OF TRANSFERS.

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

(b) At the time an application is made under this Act for the approval of a transfer of structured settlement payment rights, the application of the transferee must include evidence that the transferee is registered to do business in this State as a structured settlement purchase company

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

(d) Not less than twenty (20) days prior to the scheduled hearing on any application for approval of a transfer of structured settlement payment rights under Section 6 of this Act, the transferee shall file with the court [or responsible administrative authority] and serve on all interested parties (including a parent or other guardian or authorized legal representative of any interested party who is not legally competent) a notice of the proposed transfer and the application for its authorization, including with such notice:

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

(ii) a copy of the transfer agreement;

(iii) a copy of the disclosure statement required under Section 5 of this Act;

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

(v) A summary of:

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

(B) any prior transfers by the payee to any person or entity other than the transferee or an affiliate or an assignee of the transferee or an affiliate within the three years preceding the date of the transfer agreement and any

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

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

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

SECTION 9. GENERAL PROVISIONS; CONSTRUCTION.

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

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

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

(d) If the payee cancels a transfer agreement, or if the transfer agreement otherwise terminates, after an application for approval of a transfer of structured settlement payment rights has been filed and before it has been granted or denied, the transferee shall promptly request dismissal of the application.

(e) No payee who proposes to make a transfer of structured settlement payment rights shall incur any penalty, forfeit any application fee or other payment, or otherwise incur any liability to the proposed transferee or any assignee based on any failure of such transfer to satisfy the conditions of this Act.

(f) Nothing contained in this Act shall affect the validity of any transfer of structured settlement payment rights, whether under a transfer agreement entered into before or after effective date of this Act, in which the structured settlement obligor and annuity issuer waived, or have not asserted their rights under, terms of the structured settlement prohibiting or restricting the sale, assignment or encumbrance of the structured settlement payment rights.

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

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

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

Indiana HB 1159 will be discussed during the agenda topic "Discussion on Experience Ratings and the Subrogation Process" -- https://iga.in.gov/pdf-documents/123/2024/house/bills/HB1159/HB1159.01.INTR.pdf

JOINT STATE-FEDERAL RELATIONS & INTERNATIONAL INSURANCE ISSUES COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
JOINT STATE-FEDERAL RELATIONS & INTERNATIONAL INSURANCE ISSUES COMMITTEE
2023 NCOIL ANNUAL MEETING – COLUMBUS, OHIO
NOVEMBER 18, 2023
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Joint State-Federal Relations & International Insurance Issues Committee met at The Renaissance Columbus Downtown Hotel in Columbus, Ohio on Saturday, November 18, 2023 at 9:30 a.m.

Representative Jim Dunnigan (UT), Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Deborah Ferguson, DDS (AR)
Rep. Matt Lehman (IN)
Rep. Michael Sarge Pollock (KY)
Rep. Rachel Roberts (KY)
Rep. Brenda Carter (MI)
Sen. Paul Utke (MN)
Sen. Jerry Klein (ND)
Sen. Bob Hackett (OH)
Rep. Ellyn Hefner (OK)

Other legislators present were:

Rep. Chad Aull (KY)
Rep. Michael Meredith (KY)
Rep. Cherlynn Stevenson (KY)
Rep. Edmond Jordan (LA)
Rep. Jane Pringle (ME)
Rep. Helena Scott (MI)
Sen. Lana Theis (MI)
Rep. Stephanie Young (MI)
Rep. Bob Titus (MO)
Sen. Walter Michel (MS)
Asm. Erik Dilan (NY)
Asm. Jarett Gandolfo (NY)
Rep. Brian Lampton (OH)
Rep. Forrest Bennett (OK)

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. Paul Utke (MN), 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 Rep. Brenda Carter (MI), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 20, 2023 meeting.

CHECKING IN ON THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA) – WHERE DO STATES STAND IN SELF-FUNDED REGULATION?

Rep. Dunnigan stated that first on our agenda is a presentation on ERISA. As many of you know, NCOIL has been on record advocating for ERISA reforms in an effort to provide states with more ability to regulate the state healthcare marketplace. Starting on page 360 in your binders, you can find in ERISA waiver concept that NCOIL has endorsed followed by a resolution that NCOIL has adopted advocating for amendments to ERISA.

Bill Copley, Parter at Weisbrod, Matteis & Copley, PLLC, thanked the Committee for the opportunity to speak and stated that I'm here today to talk about ERISA preemption, and I think when a lot of people think about ERISA they think of a highly technical statute with complex requirements. But I'm really here today to talk about a simple and fundamental issue which is to what extent can states continue to exercise their traditional authority to legislate and enforce laws in the areas of insurance and healthcare. And it's an important issue. There is a prevailing understanding out there that I think is not quite right that any state law in those areas cannot be applied to a self-funded ERISA plan and I think that comes from a fundamental misunderstanding of a risk of preemption, particularly as it's been interpreted recently by the Supreme Court of the United States in a case called Rutledge v. PCMA. I expect you to know a fair amount about ERISA but I'd like to start out with just discussing some basic principles so that we're all on the same page. So, what is ERISA? ERISA is the Employee Retirement Income Security Act of 1974 and it's a federal statute that creates a uniform set of rules for the administration of employee benefit plans sponsored by companies and unions. Congress's goal when it enacted the statute was to protect employers from having to comply with 50 different States and 50 different sets of requirements in setting up benefit plans for their employees. ERISA set standards in a couple of areas. It requires sponsors to act in the best interest of the plan beneficiaries, also known as fiduciary duties. It requires the administrators that the sponsors hire to run the plans to also act as fiduciaries. It requires reporting requirements, information that the plans have to give both to the federal government and to beneficiaries. It sets standards for who is eligible to participate in the plan. And it establishes funding levels to make sure that whatever benefits the plan promises it actually has the resources to deliver. What ERISA does not do, however, is dictate that a plan provide any particular benefit.

So, what is the risk of preemption? Again, Congress's goal when it set up ERISA was to protect plans from having to comply with the patchwork of 50 different state laws when setting up the plans. I've got the actual language from the statute in the PowerPoint but essentially what the statute says is that ERISA preempts state laws that relate to any employment benefit plan. And courts have really struggled with this language. They've noted that it's unhelpful and the reason is because the phrase “relates to” is subject to interpretation. At a certain level of abstraction everything in the universe relates to everything else. So, they've tried to come up with formulations to understand and give substance to that and they've said that a state law relates to an employment benefit plan in two different ways. One, it can refer to an ERISA plan, which means that a state law singles out ERISA plans for different treatment. It also can have a connection with an ERISA plan. A connection with focuses not only on what the state law says but on what it does. And the courts have ruled that a state law has a connection with a plan if it regulates a central matter of plan administration which it notes are things like dictating

what benefits a plan must provide or dictating who can be a benefit. Or dictating different or duplicative reporting requirements to states in addition to what the federal government requires. Those have been examples of what courts have said and the Supreme Court has said ERISA preemption prohibits. Now the preemption clause also contains an exception for state laws that regulate insurance and I think this is where some of the misconception about insurance laws not being able to apply to self funded plans come from. So, what does the insurance exception preserve? The insurance exception applies only if the law would be preempted under the statutes relates to test. And there are two parts to the insurance exception. One is the general exception which says that a state law that regulates insurance won't be preempted. And the other is called the deemer clause which says that a self-funded plan will not be deemed to be an insurance company for purposes of this exception.

So, what does it mean? What is a state law that regulates insurance? There's two parts to that. One is that it must target insurance companies and the second is the law substantially affect the risk pooling arrangement between the insurer and the insured. The insurance exception saves the state law of regulating insurance under ERISA. But importantly, that's only if the law is preempted in the first instance. That is that the Court finds that it relates to an ERISA plan. And so I think this is where we get into some of the misconceptions because ERISA preemption impacts insurance laws in a number of ways. Because you've got organizations that will work with legislators to pass laws that are good for patients and providers. Laws like regulating assignment of benefits. Laws requiring insurers to honor prior authorizations. And laws limiting retroactive denials of benefits. And the insurance companies that manage self-funded plans will simply ignore these statutes under the assumption that they cannot apply to self-funded plans. And so, I think it's important to understand sort of what is the state of the law, because in many cases, that's not correct. And it's not correct under the Supreme Court's recent decision, Rutledge v. PCMA. So, why is this decision so important? It's important because the Supreme Court clarified the types of laws that ERISA preempts and it rejected some of the broad interpretations of ERISA preemption. And this is important because as I've said before, the insurance exception where it matters whether or not a plan is self-funded, that only applies if ERISA preempts the statute in the first instance and Rutledge is a case about whether or not a statute is preempted in that first instance.

And in that case, the Court rejected several broad interpretations of ERISA preemption that had been percolating in some of the Courts of Appeals. One of them was an argument that if a statute applies generally to benefit plans, that inherently is a reference to ERISA plans. And they rejected that saying, “No, that refers to will only trigger preemption if you're singling out an ERISA plan for different treatment.” It also clarified, though, that ERISA preemption under the connection with part should focus on whether state laws interfere with plan administration itself by dictating benefits, by determining who can or must be a beneficiary, or by regulating in an area that ERISA already regulates itself. A state law that passes this Rutledge test means that it doesn't matter whether or not it's a law regulating insurance and it doesn't matter whether or not the law is being applied to a self-funded plan because the law is not regulated in the first instance. So, what was at issue at Rutledge? It's helpful to understand what the Supreme Court was actually looking at and the issue there was whether ERISA preempted Act 900 which was an Arkansas law that basically did two things. It said that pharmacy benefit managers (PBMs) must pay pharmacies their wholesale cost when they dispense generic drugs. The problem was one called negative reimbursements

where PBMs were paying pharmacies less than what the pharmacy had to pay to get the drug in the first place. The law also importantly created enforcement mechanisms including requiring PBMs to set up an appeal process where pharmacists could challenge the reimbursement rates they were being paid. The Court ruled 8-0, a unanimous decision, that ERISA did not preempt the Arkansas statute. It held that ERISA only preempts state laws that dictate benefits or eligibility determinations or that regulate an area that ERISA already regulates. A state law that regulates third party service providers generally does not refer to ERISA plans. ERISA also doesn't preempt cost regulations or regulations that only have a de minimis impact on plan administration.

So, what are the key takeaways? Well, Rutledge addressed whether or not the state law relates to an ERISA plan and that's the first step in the analysis. So again, the Rutledge analysis doesn't depend on whether or not a plan is self-funded and it made clear that a state law that regulates benefits plans generally without treating employee plans differently does not refer to an ERISA plan, and that ERISA does not preempt laws that merely have a change of plans costs or incentives or the way that it participates as a market participant. And it specifically does not preempt regulations that only impact costs or what a plan pays. So how have courts applied Rutledge? It's important now that Supreme Court has spoken to know how are the lower courts interpreting it and there's been two decisions. One with PCMA V. Wehbi in the Eighth Circuit and that case involved some similar restrictions on pharmacies and how PBMs interacted with them and it ruled very closely to Rutledge. It said generally that these regulations are regulations of healthcare and insurance about how PBM's pay pharmacists and that they do not relate to central matters of plan administration. The second case that has come out has been from the Tenth Circuit in PCMA v. Mulready and Mulready took a very different approach. Mulready said that ERISA, despite Rutledge, does not only preempt state laws regarding plan administration but it goes much further and preempts state laws that govern benefit design. And the problem with that analysis is it's very broad. What that means is that if ERISA preempts how benefits are provided, it essentially preempts the entire field of insurance healthcare regulation as it applies to self-funded plans. And so, these decisions conflict, and the Tenth Circuit specifically said that it was disagreeing with the Eighth Circuit which creates a circuit split in the United States and so it's created the situation where ERISA preemption actually applies differently in the states within the Tenth Circuit which are Oklahoma, Kansas, New Mexico, Colorado, Wyoming and Utah, than it applies in the rest of the country.

So, what's going to happen going forward? The ability of states to regulate and to exercise their traditional authority in the field of insurance and healthcare is going to be impacted by how this circuit split is resolved. I expect the resolution is going to come in the next one to two years. The Tenth Circuit is currently considering a request by the state of Oklahoma to rehear the case what's called en banc. The way the Courts of Appeals work is that generally a case is decided by a three-judge panel and then the losing party can request that all of the judges that sit on the court hear the case and decide as a full court. And the Tenth Circuit has actually requested that PCMA respond to that petition. So, I think that shows that there is some serious consideration of that but if the Tenth Circuit doesn't reverse its decision I expect this is going to be a significant issue that the Supreme Court is going to take up again. Because again, you've got ERISA and ERISA preemption being applied very differently in different parts of the country. So how does Rutledge impact state insurance regulation? Assuming

that my reading of Rutledge is correct, and that the Eighth Circuit's reading of Rutledge is correct, it means that states have a lot more authority to enact laws and enforce them, including against self-funded plans, then has traditionally been thought. When you're dealing with matters that don't go to central plan administration but are just about how benefits are being provided, those laws should be enforceable generally because they don't rely on the insurance exception. And so that means it doesn't matter whether or not a plan is self-funded or not. And examples of state laws that have been enacted by many of the states here but that aren't currently being enforced potentially against self-funded plans are laws that require insurers to allow assignment of benefits out of network, laws that regulate retroactive denials of claims after they've been paid, and laws that require insurers to honor pre-authorizations. So, those are just a few examples of laws where those laws are not currently being enforced consistently throughout the states and we think the states actually are well within their authority to apply those laws to all benefit plans whether or not they're self-funded.

Rep. Deborah Ferguson, DDS (AR), NCOIL President, stated that in Arkansas we actually had a bill before Rutledge that didn't hold up in court and we came back and wrote a new bill for PBMs and that's what ended up in the Rutledge decision. I guess my question is, looking at the Oklahoma bill in Mulready, is there something they could do to alter that law so that it might be upheld? It's my understanding in the bill there are things like network adequacy and contracting, and any willing provider. Mr. Copley stated that the Oklahoma bill that was at issue at Mulready primarily dealt with pharmacy density requirements. Requirements that when the PBM's for the plans put together a network of pharmacists that certain thresholds like 90% of the beneficiaries in an urban area had to be within two miles of an in-network pharmacy and in suburban areas they had to be within five miles and in rural areas, they had to be within 15 miles. So that was sort of a simplification of sort of the general thrust of the statute. As far as could it have been rewritten, under the Tenth Circuit's analysis I don't think so because the Tenth Circuit analysis basically took a very broad view that any statute impacting how benefits are provided by plans is preempted so I don't think there's anything that you could have done given the breadth of the Tenth Circuit. I think if that same statute had come up in the Eighth Circuit post-Rutledge the case would come out the other way and I think that's true in most other circuits as well. So when I look at Mulready, it's not necessarily that I look at how the statute was drafted and I say there was some flaw there that triggered ERISA preemption. It's more that I think the Tenth Circuit's analysis on how broad ERISA preemption is, is viewed far too broadly and I think it's out of step with the Rutledge decision but we're going to find out whether or not I'm right or wrong in the next couple of years.

Sen. Bob Hackett (OH) stated that I'm really concerned in Ohio on the two to 50 book of business. I've been in business a long time and it used to be people wouldn't move to self-insured ERISA plans unless they had 500, then 250, then 100. We're seeing a lot of groups that are moving between two and 50 to ERISA groups, self-insured groups. And the reason is in the old days if they had a bad problem with the ERISA group and they try to get back in the public insured plans they would get hammered because of the claims they hit a bad year. But now, and you know this is community rated two to 50 so they can play both sides. So my concern is that that book of business from two to 50, the regular fully insured that we oversee, a lot of it's going to multiple employer welfare associations (MEWAs) and association plans. How do we protect it? And I understand what preemption does, but it still doesn't block companies because you can come right

back in. They don't ask health questions. So, they don't know that somebody went to an ERISA plan and had a bad claim experience and they came right back in and get better rates than probably they should get. And so that book of business from two to 50 it's going to get worse and worse. Will you comment on that because that's what worries me in Ohio. Mr. Copley stated that I'm not sure that I'm in a position to comment on sort of the movement back and forth between the plans but one thing I would say is that the more consistently the law is applied between self-funded plans and insured plans, that removes a lot of the incentive for those plans to operate differently and I think that sort of uniform enforcement law can only help improve that situation. Sen. Hackett stated that our authority in Ohio used to be in the mid to upper teens but now it's 12%. The rest of the people are under ERISA plans which we have some authority because of preemption and that will get resolved but you can see the problem that we're losing a lot and the ones that are staying is not a good book of business.

Rep. Dunnigan asked whether in your opinion, could a state say these ERISA plans or these level funded plans are not allowed in a state's marketplace between two and 50 or that they are allowed but that they have to do community rating? Mr. Copley stated that I don't think that's an ERISA preemption issue. I don't think ERISA preemption has anything to say about that topic. Rep. Dunnigan stated so a state in your opinion could say a group plan between two and 50 employees needs to use community rating? Mr. Copley stated that I'm not sufficiently versed in that particular law to give an opinion on whether or not that would pass ERISA preemption. I'd need to look at the law. Sen. Hackett stated that how they get out now is they go to a MEWA as an association which puts them in a much larger group and then that larger group goes to the ERISA plans so they can ask health questions under that scenario and so they'll know they're a very healthy group. But how can you stop access to somebody telling a MEWA or an association plan even though there are companies under 50 - I don't know.

Rep. Dunnigan stated to Mr. Copley that you listed three things that a state could not regulate - the benefits if it's regulated by ERISA. But how do you determine what's regulated by ERISA? Because to me it kind of says you can't regulate that if it's regulated by ERISA. What's defined as what's regulated by ERISA? Mr. Copley stated that I think that would be the statute itself, the implementing regulations by the Department of Labor (DOL) and what topics do those specifically cover? If ERISA specifically covers that topic then I think there's a good argument that those are matters of central plan administration that the states cannot regulate. An example would be there was a case from 2006 to the Supreme Court called the Gobeille decision and in that case, the state of Vermont tried to enact its own reporting requirements that were similar, but different from the types of information that ERISA plans were required to report to the federal government. And the Court there said because ERISA itself has reporting requirements, that any attempt by the states to impose similar or different requirements is preempted. And that was a 7-2 decision I believe with Justices Sotomayor and Ginsburg dissenting. And justices Sotomayor and Ginsburg would have even allowed that. They wanted even narrower ERISA preemption but the Court did rule that that was sort of a paradigmatic example of states trying to do something where ERISA's already operating in that space.

Rep. Dunnigan thanked Mr. Copley and stated that this has been informative. I think one of my challenges for decades now is we've been told ERISA prevents all this state regulation. You can't do it. And we've just kind of accepted that. And now the Supreme

Court ruling has pierced that to some degree and we're trying to figure out what that degree is but thank you very much.

Miranda Motter, Senior Vice President, State Affairs and Policy at American's Health Insurance Plans (AHIP) thanked the Committee for the opportunity to speak and stated that I appreciate the focus and opportunity to spend a few minutes on preemption. And certainly, from our perspective the importance of preemption for employers in all of your communities has been said. Many of the employers in many of your states all across this country are desperately continuing to look for affordable healthcare coverage and the protections under ERISA preemption give them uniformity. It gives them stability. It gives them an opportunity to continue to provide affordable healthcare to all the employees in your states. And so, from a policy perspective, I would just continue to caution certain ERISA reforms by extending state laws that in our perspective are really overextending states authority. We want to make sure that we're not continuing to put additional pressure on employers so that they end up in a situation where they're unable to provide their employees' affordable healthcare.

PRESENTATION ON RECENT FEDERAL EMERGENCY MANAGEMENT AGENCY (FEMA) AND NATIONAL FLOOD INSURANCE PROGRAM (NFIP) INITIATIVES

David Maurstad, Ass't Administrator, Federal Insurance Directorate at FEMA, and Senior Executive at the NFIP thanked the Committee for the opportunity to speak especially after the 27th short term reauthorization of the NFIP this week. I truly appreciate the opportunity to be here at NCOIL's Annual Meeting especially as a former state senator from Nebraska. NCOIL is valued partner to FEMA and the NFIP in helping to get the word out to Americans about their flood risk and the importance of purchasing a flood insurance policy and I truly consider all of you a part of the NFIP's movement to close the flood insurance gap and reduce disaster suffering. I especially want to recognize and appreciate the concrete actions you are taking including your recent fly-in to D.C. where you advocated for a multi-year reauthorization of the NFIP to Members of Congress. We know these short-term extensions and the uncertainty they bring are not good for the program and not good for our policyholders. Especially right now, given the climate crisis that is making storms more frequent and more severe. From where we sit in Ohio, it might be easy to think this is just about something for coastal areas to worry about. But inland flooding is real, and the Midwest is no exception. This July, a storm dumped nearly nine inches of rain within 12 hours over Chicago while the Chicago River rose by six feet, damaging over 2,000 homes and resulting in a presidential major disaster declaration. And in August heavy rains pounded the Mid-Ohio Valley, causing flooding and damaging multiple homes and apartments. It's a good reminder for the Midwest, where it can rain, it can flood. And when these kinds of disasters hit far too few survivors have the peace of mind and the financial protection provided by flood insurance. And we know the flood protection gap is felt most by folks in disadvantaged communities who have often been pushed into high-risk areas because of years of discriminatory land use planning and systemic inequity. And to underline that point, the U.S. Census Bureau estimates that 30 million black Americans were displaced due to a natural disaster last year. Folks, this is the kind of disaster suffering we need to confront. And that's why FEMA is so determined to break the rinse and repeat cycle of disaster recovery in this country and replace it with more insured survivors and more resilient individuals and communities against the perils of flooding.

So, with that in mind, today I want to share what we're doing under our own authority to transform the NFIP and close the flood insurance gap. Some of you may be familiar with the NFIP through your work. But for those who aren't I have a brief overview. We like to think of the NFIP as a four-legged stool. The first leg is mitigation grants, which can be used by communities to fund eligible mitigation measures that reduce disaster losses by targeting repetitive loss properties. The second leg is flood hazard mapping and risk identification which can be used by communities to determine which areas have the highest risk of flooding. Now I want to be clear, these maps are not predictive. They cannot tell us where or when or how much it will rain. This is sometimes misinformation you may read in the press. Rather, they help communities make informed decisions about how to best protect lives and property, plan development and make infrastructure improvements to manage or reduce flood risk. The third leg is flood management. It's used by communities to manage risk in this special flood hazard area. This can include zoning, building codes, education and other efforts to help communities adopt and enforce higher standards to both minimize harm and preserve the natural and beneficial function and value of floodplains. And finally, we have the fourth leg, flood insurance, which is used to protect against the financial impacts from flood disasters. As you know, a flood insurance policy is required for homes that have government backed mortgages in designated high-risk areas. But the reality is, and this surprises many, that a lot of our claims, almost 30% a year, come from outside the special flood hazard area. And from where I sit as the head of the NFIP, despite the growing threat, flooding remains a woefully underappreciated risk.

Let's take a look at this map of penetration rates here. Where we sit in FEMA region five. They're far, far lower than what they need to be given our new normal. And it's not just the Midwest. I know you all know this, it's starting to feel like a broken record, but nationwide only about 4% of homeowners inside and outside the special flood hazard area have flood insurance. Nearly all U.S. counties have experienced some level of a flood event which makes sense because according to the Insurance Information Institute (III), 90% of U.S. catastrophes involve flooding. Thankfully, it's not all gloom and doom. Even as some insurance companies have made the decision to pull out of areas of the country with the highest impact from climate change, the private flood insurance market overall now accounts for a bigger piece of the growing pie to quote a recent report from the III. As you can see on the screen in 2016, 12.6% of flood coverage was written by 18 private companies. Fast forward to 2022 and 32.1% of flood coverage was written by 77 private companies. An overall increase of 24%. For whatever reason, we're glad to see it. We've encouraged for years private insurers to share in the nation's flood risk. And there's plenty of room in the market for options. After all, the goal is to close the flood insurance gap so we have more insured survivors and less disaster suffering. So, I won't quibble how we get there.

That in mind let me pivot to some of the work we're doing to transform the NFIP. I'll start with our modern rating approach. As of April 1st of this year, our full book of business, that's roughly 4.7 million policies in force across 22,600 participating communities is now being rated under Risk Rating 2.0. Under this approach every policyholder now pays for their own flood risk. Not someone else's. And as a reminder, a significant aspect that doesn't seem to generate much attention is reduced premiums for some policyholders. Under legacy rating, 23%, nearly one million policyholders, were paying more than their full risk rate. Low value property owners were subsidizing high value property owners. The current pricing approach charges these policyholders only their fair share of risk

resulting in significant savings for these policyholders. For policyholders who are experiencing increases under the modern rating approach, these increases are distributed gradually, not suddenly, as most premium increases are capped by Congress at 18%. Meaning, these policyholders will be on a glide path to reach their full risk rate. We estimate that 95% of policyholders will reach their full risk rate by 2037 or longer for those policies who were previously mispriced and discounted the most. The next initiative I'll highlight is something our stakeholders have been requesting for a while. Not only has Risk Rating simplified the process for insurance agents to generate quotes for potential customers and renew policies for current customers, but we're also researching other options to reduce barriers to purchasing flood insurance. And that includes how we can make installment plans work so that our policyholders have the option to make manageable monthly payments. I'm sure many of you are familiar with the community rating system or CRS. But for those who aren't, CRS is a voluntary incentive program that rewards communities who participate in mitigation activities that reduce flooding. Those rewards show up in the form of discounted flood insurance premiums for policyholders in CRS communities. We're currently looking at how we can improve the program through our CRS Next initiative, focusing on making access and participation in the program simpler, more equitable and feasible for all communities. And of course, we're working with our stakeholders every step of the way. These are a sample of some of the things the NFIP is doing to meet the urgency of the moment under our own authority.

So now on to what we need Congress to act on to keep the transformation train moving forward. First and foremost is a long-term reauthorization of the NFIP. If we are to build an enduring NFIP that lasts for generations we need Congress to pass a ten year reauthorization of the NFIP, something we've proposed with the support of the Biden administration. Now, along with the longer multiyear reauthorization, we've proposed a set of 17 legislative reforms as part of our strategy to set the NFIP up for long term success. They're spelled out in detail on fema.gov, which I encourage you to visit. But I'll highlight a few here. The first is affordability, which is the most significant barrier to accessing flood insurance and one of FEMA's recommendations addresses this critical factor. We know from the research that too many families are being forced to prioritize putting food on the table over purchasing a policy which is why FEMA engaged the broader policy community, including academia and other government agencies, and developed an affordability framework that was delivered to Congress in 2018. Moreover, NFIP's flood insurance means tested assistance legislative proposal has been included in the administration's 22-23 and FY24 budgets. But let me be clear, absent legislative authority FEMA is constrained in its ability to offer more affordable premium rates to those who need it. As they say, the ball is in Congress court. To achieve our affordability goal, the NFIP must have a sound financial framework. As you probably know, when disasters exceed the NFIP's capacity to pay, Congress has repeatedly raised the NFIP's borrowing authority rather than address this structural flaw of the program.

The NFIP is currently saddled with $20.525 billion in debt at an average interest rate of 3.02% every day. The NFIP accrues $1.7 million in interest on its debt. As future notes mature and are refinanced at higher interest rates, the NFIP's debt service will only grow and become an ever-increasing drain on the program. This is why debt cancellation is integral to getting the NFIP's financial house in order. So clearly there's a lot riding on Congress. And so, as I wrap up, my goal today was to give you a snapshot of some of

the work we're doing to transform the NFIP. And while we're making important progress, there's still a long road ahead of us to close the flood insurance gap and this is where the power of relationships really matter. We continue to build those relationships with realtors, lenders, private insurance companies, local elected officials, community advocates and various associations like NCOIL. These are the trusted voices in communities that can share, that can change the hearts, relative to the importance of having a flood insurance policy because we can't do it alone. There's so much more at stake. So, I would just ask you to use your spheres of influence so that you can persuade your individuals in your communities, your constituents, of the importance and the need of flood insurance protection and mitigation and continue to help us build momentum to our movement to build a resilient nation and reduce disaster suffering.

Rep. Matt Lehman (IN), NCOIL Immediate Past President, stated that I want to preface what I'm about to say with noting that this is not insulting to you or to the NFIP, but it is getting extremely frustrating to have the NFIP come every year and all I hear is "we've accumulated more debt." In 2017 you were $25 billion in debt and Congress canceled $16 billion of that so you could pay claims. Are we on the path of Congress cancelling more debt as you said that needs to happen? You have paid claims right? You used the term "long term solution." I don't know if Congress's definition of long term is anything more than 60 days or six months but long-term solution has to be a long term solution. And we've argued for some time that the private market needs to engage in this. And as you pointed out, the private market in percentages have increased. But I think you're still going to have a segment that will never engage in the private market. The private market will never engage in it. We've asked Congress why would you not look at this similar to how you handled the government handled the Terrorism Risk Insurance Act (TRIA) where you said we know you can't handle a Hurricane Katrina but you can handle a flood in Ohio and Indiana. But you don't want to take that risk because you'd be on the hook for a Katrina. So, we'll be your backstop but we're not going to be that first dollar. Do you think the carriers would engage in filling that gap if they knew what their stop loss would be? Then you're not going to be $20 billion in debt. TRIA's funded. Now we haven't had any terrorist activity, but the bottom line is policyholders are paying for TRIA. It's works. To me it seems like a logical example of where government can work with the private market. But there doesn't seem to want to be any discussions on that. We go to Congress every year on our fly-in and we bring this up and it's like, "hey, that's a that's a darn good idea." But nobody does anything other than we've got to reauthorize NFIP. We'll do it for another three months. Another six months. In the meantime, what is the long-term solution? What can we do at our end to have you come back and say, "you know what things are getting better" instead of it's the same old same old and actually financially it's getting worse." So my challenge is what can we do to make this better?

Mr. Maurstad stated first of all, you're absolutely right. The NFIP is essentially a residential flood insurance program and the program still writes about 96% of all residential flood insurance coverage that's provided currently in the country. On the debt, your figures are spot on. We were successful in 2016 of being able to have $16 billion of the debt cancelled so that wouldn't saddle current policyholders to pay interest on a debt that was accumulated by federally backed claims that were paid in the past. It violates actuarial principles for one. I think it's morally reprehensible, number two. Congress decided back after Katrina that unlike every other disaster program across the federal government space for when there's an event that exceeds the amount of dollars

appropriated for that year, they pass a supplemental appropriation for that amount. The NFIP is unfortunately a distinction from that practice. The big problem with why the program continues to have its challenges is because people don't understand how it's funded. The policyholders cannot fund the entire cost of the program because in addition to the insurance that they receive, there's also a mitigation grant program, a flood hazard mapping program, and as I indicated in my comments floodplain management program that benefit all the citizens of the country. Policyholders themselves can't fund the program themselves because our program violates a key principle of insurance and that's concentration of risk. Private sector companies can spread the risk throughout a state, country and underwrite to the standards that they set. The NFIP on the other hand, regardless of where a property is, regardless of the loss experience of that property, if that property is in one of our 22,600 communities, we provide a policy.

So, we have a concentrated risk that the policyholders themselves cannot have the full burden on. So, our proposal for developing a sound financial framework is to address this and transparently show that the taxpayers need to participate in part of this program. And here's how they can do it. There's three things that we propose. First is that we cancel the debt, so the current roughly $600 million of interest could be used for the benefit of the program and the current policyholders. Second, we say hold the program accountable for losses exceeding an annual level of a one in 20 year loss exceedance event. Roughly now that's about $11 billion. If an event exceeds that amount, the administrator of FEMA would be required to request the additional amount over and above that from Congress in a supplemental appropriation. The third key part is what we're calling an equalization payment. The actuaries say we're supposed to collect $10 dollars. Because of the limitations that Congress has placed on the program relative to our rating structure and our cap on increasing premiums only 18% of the year, we're only able to collect about $7.50. So, the program is recommending with the support of the administration that if you want to provide this level of benefit that's great. Just fund it. And so, we request an annual appropriation for that difference on an annual basis. What can you do? You can do the same thing that you've been doing and that's expressing the need for a sound financial structure that is transparent. That shows what the policyholders can pay. What the taxpayers need to be paid for, and to do it for, we say at least a ten-year period, so the program can have the stability to put in place the transformative recommendations that the subject matter experts have brought forward.

Rep. Brenda Carter (MI) stated that you mentioned climate change and you also mentioned the Midwest. I'm from Michigan and last year we had substantial flooding. My concern is, according to what I've read and you can correct me if I'm wrong, you have to participate in the NFIP. Have you evaluated these new areas that may have been affected by climate change to see whether or not they can participate? I'd be particularly interested if any area in Michigan is considered. Mr. Maurtad stated first of all, since the program started in 1968 one of the primary functions was to try to have every community that had land use authority to be a part of the program and participate in the program. We're now at roughly 22,600 communities. So there’s a small percentage of communities, generally low in population in rural areas with limited resources, that are not a part of the NFIP. So, we continue to work through our regional offices with the states in identifying those communities and seeing what we can do to assist them in becoming a part of the of the NFIP. Rep. Carter stated thank you for that, but I'm specifically interested in finding out whether or not areas affected by climate

change like you mentioned in the Midwest and particularly Southeast Michigan that was hit very hard, whether or not they are participating in the NFIP. And if not, what could we do? Mr. Maurstad stated I would suggest that climate change impacts every part of our count as for example, 98% of counties have had a significant flood event. And so, I think it's across the nation. I can certainly take back and I don't have right in front of me what the participation rate is in your area. We certainly could find it, but I know the regional office in Chicago has a good idea of where those areas are and have a strategy for trying to address bringing them into the program.

Rep. Edmond Jordan (LA) stated I'm really just trying to get some understanding because I've heard you say several times that we need to get more taxpayers into the program and as you're aware in my state, Louisiana, we've had some issues with those Risk Rating 2.0 maps and we're challenging those maps because it's led to a 234% increase in the rates. So, I guess in a state like Louisiana and Mississippi and others where we have some of the largest percentage of people living in poverty, you're giving us a 234% increase, but yet you're saying you want more people to participate in the program. I can't reconcile that, especially in a state where we have limited access to carriers and homeowners insurance has risen by over 63% as well. And so we have a lot of people on Citizens who is the issuer of last resort. Make me understand how you're making that request to somebody like me who has to go home and say, “Okay, we want you to participate although the rate has increased by over 200%”

Mr. Maurstad stated first of all there needs to be a distinction between our new pricing methodology and the community flood insurance studies that determine where and how that community needs to be regulated. So, our pricing methodology utilizes those maps, but also utilizes a whole lot of other information. So, there aren't any Risk Rating 2.0. maps. Secondly, part of the benefit that we believe of the new pricing methodology is we for the first time have been able to show people what the full risk rate is for their specific property. Not somebody else's, but theirs. And that information we believe is helpful for them to understand what their risk is. If you're a current policyholder, you don't get a 234% increase. If you're a current policyholder your policy can only increase 18% a year, not 63% or any other number. And unlike previously, that 18% glide path ends when your property reaches its full risk rate. So right now, roughly 30% of our policyholders are paying full risk rate. And so, the risk premium stays level. We'll have by year five about 50% of our policyholders will be at that full risk rate. Year ten about 90%. So unlike in the past where premiums were going up every year and would have continued to go up every year the new program sets a limit or sets a cap. So, I want to make two distinctions. One, if you're a new policyholder, you pay full risk rate. No longer do you come into the program discounted or subsidized. If you're a current policy holder, your policy can only increase 18% a year.

Rep. Jordan stated that I get that and I understand for the current people but you're asking new taxpayers to come in and so for the ones who are currently there, I get the 18%. But if you're asking me to go back and say that we want new taxpayers to come in and participate in the program and they're paying that full rate then that’s difficult. Mr. Maurstad stated first of all, my taxpayer comment was to try to illustrate that the revenue that we received from the policyholders can't alone support the program. So, we need federal taxpayer supports as it's a federally backed program. Relative to the new policyholders having to pay their full risk rate, we believe more information is better. But most importantly, that's why it's critical that we have support for the affordability plan that

we've put in place. That is a means tested premium assistance program and our proposal is to start at a 120% of average mean income. As your income goes down, your percentage of your support would go up. It's been in the President's budget the last three years and a key to the issue that you're talking about is having that affordability plan adopted.

MENTAL HEALTH PARTIY AND THE AFFORDABLE CARE ACT (ACA) – WHY IS THERE STILL A GAP?

Rep. Rachel Roberts (KY) stated that I'm very proud to sponsor this model law dealing with mental health parity. It contains a number of provisions that I believe are very important and worthy of our discussion time here. We had a great session focusing on mental healthcare at our last meeting in July and since that time, a lot of you reached out to me and gave feedback on that hearing and we really want to keep this conversation moving ahead and work towards NCOIL adopting some model policy around these issues. The conversation initially started with a bill that I've been sponsoring in Kentucky which requires insurance coverage for an annual mental health wellness exam performed by a mental health professional. While I'm very passionate about that specific issue, this also seems to be an opportunity to broaden the conversation and to focus on other mental healthcare and behavioral issues. As a reminder, that conversation we had in July was really the first behavioral health conversation NCOIL's had in quite some time, or perhaps ever, so I want to stress that this bill that's in your book today is really a starting point. The cake is not baked here. We have just opened the pantry to figure out what the ingredients are that we have to work with. And I'm very open to conversations around this and additions to this and co-sponsorship for this. So, as you can see on the first draft of the Model on page 352 of your binders, the annual mental health examination provision is on page 359. That's the original starting point of this. The other provisions are based on existing state law and deal with issues such as medical necessity determinations and substance use disorder benefits. Specifically, establishing standards of care for substance use disorder care, coverage parity, access to medications and treatments and removing some of the preauthorization step barriers to those methods of care and emergency care benefits. The conversation today is meant to be a brief introduction and to frame some of these issues and hopefully we can further develop this model throughout the year. I encourage anyone with interest to please reach out to me as we continue these conversations.

Jim Broyles, Ph.D., Director of Professional Affairs at the Ohio Psychological Association (OPA), thanked the Committee for the opportunity to speak and stated that my role is to work with our member psychologists primarily focusing on insurance issues. So, part of what I do is I hear from our member psychologists about any kind of concerns or issues they have in working with the insurance companies which is the vast majority of our members. I also interact with my colleagues at the American Psychological Association (APA) who have a very similar role. And I interact with other behavioral health professionals here in Ohio, The Social Workers Association, the Counselors Association and the Psychiatrist's Association. I guess most importantly, what I'm saying is I hope that you will hear my comments as being pretty representative of behavioral health professionals. I was, by the way, very encouraged to hear this conversation about the ERISA issue which I also think is a really important issue that we're facing too in a similar way. So, in general, we have a very favorable reaction to this model legislation. We feel like it is a very much needed next step in creating parity requirements for the

insurance industry. What I want to do is I just want to go through some of the legislation and highlight some of the areas that we feel can be very helpful for us in facing and dealing with some of the problems that we encounter. But in general, I guess what I ask you to do is just be mindful of the idea that there is some very important access to care issues at stake in providing behavioral health coverage to our population. And in some cases, the access to care barriers can be there as a result of policies made by insurance organizations. More and more, behavioral health providers are leaving panels, and when I talk to them and ask them about their reason for that, we do regular surveys, they state that it's due to administrative burden, poor coverage frustration and just general hassles associated with policies that come from the insurance organizations. And we feel like this piece of legislation addresses many of those.
So, I'll go through and just sort of highlight some of the areas that we feel like are very helpful pieces of this legislation. So, in section one, under the definition of “generally accepted standards of mental health and substance use disorder care” - a nice definition but finding the generally accepted standards is easier said than done. But I will say that in many cases, those standards of care many providers feel like their perspective and their understanding of what is the right standard of care is not always heard. And so, the ending of this definition includes 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 from nonprofit healthcare provider professional associations and specialty societies. So, that you can see there in that piece of the legislation that actually requires our voice to be heard in creating these standards of care. And we think that could be very helpful. Under the definitions again the “medically necessary treatment of mental health or substance use disorder” - the topic of medical necessity is a very much hot topic among behavioral health providers. I think probably among all even physical health providers too. The definition of medical necessity is far away from being clear to us about how insurance organizations define that and how they apply that. And most of us are feeling like some of that is not always right up front for us. Requiring the use of standards, criteria and guidelines created by nonprofit professional organizations such as the APA, a very respected association, allows us again to have a very much needed voice in the creation of these definitions or the standards that are used.

Section two, “ensuring mental health and substance use disorder medical necessity determinations follow generally accepted standards of care” - in that section there under (b) it states an insurer shall not limit benefits or coverage for chronic or pervasive mental health substance use disorders to short term or acute treatment at any level of placement. So, what we find sometimes is that insurance coverage for a condition can be limited if acute symptoms are not currently present and what we know to be true is that many chronic conditions or pervasive conditions can often still be present, encouraging the reemergence of more difficulties later on. But if those acute symptoms are not present then access to insurance coverage can be denied. Section 2(d), that ends with all denials and appeals shall be reviewed by a professional with the same level of education and experience of the provider requesting the authorization. I can tell you that in many cases, denials can occur and we have no idea about this decision making process or the level of training or experience for the individual who's making that decision so that can be a very helpful portion. Section 2(f), conducting the utilization review of all covered healthcare 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. Again, the very same reasoning there. It seems very important to us. So, in other words, this gives us a voice in creating or defining the standards that are being used by the insurance company.

Section 2(h) addresses a really important problem that many behavioral health practices are having right now. It talks about forbidding of rescinding or modifying authorizations for services rendered for any reason, particularly if it is later determined after the services are provided the insurer makes a subsequent determination that it did not make an accurate determination of the insurance or policyholder's eligibility. So, I want to describe to you a circumstance that is not uncommonly faced by behavioral health practices. So behavioral health services can be rendered to an individual and treatment can be successful. And then a year later or two years later depending on the circumstance, an insurance organization can say, "Hey, we found out that we weren't really covering that person or we shouldn't give you that authorization." And at that point funds can be reclaimed from the individual provider and that can amount to hundreds or even thousands of dollars. And the important point in all of this to consider is this - most behavioral health practitioners right now are operating from their own private practice. These are small businesses. They cannot withstand what we call a claw back. They cannot withstand a claw back that amounts to hundreds or even thousands of dollars. It imposes a really important financial burden on them. Section 2(j) talks about actually applying real penalties for violations of the law and we find that in some cases there is not always the consequence that is needed for violations of the law so that's really important for us too.

In Section 3, ensuring coverage of mental health and substance use disorder benefits are at parity with medical and surgical benefits - under (a)(2) it talks about evaluating each complaint to determine whether a parity violation occurred. So, I'm asking you to keep in mind that provider complaints or their client complaints, their patient complaints are very often the only avenue that we have that allows us to bring an important issue to the attention of an enforcement agency. So, having that enforcement agency be required to look at not only what's going on with this individual complaint but also whether or not this is a parity violation can be hugely helpful. Section 5, mental health or substance use disorder emergency care benefits - we're just very much in favor of that. That just seems very clear to us. Section 6, coverage of mental health wellness examinations. The one question that I that about this, and Rep. Roberts and I had talked about this very briefly, is that we have a little bit of concern about that 45 minute time frame. And Rep. Roberts said that it's a parallel to a law in Colorado. And so, we're understanding that. Our concern with that is that it feels a little bit more like a practice guideline. We don't usually see those kinds of time limits happening in the law. So, we're just bringing that up. And I suggested that maybe we have it up to 45 minutes to make sure that that's not being misinterpreted by an insurance organization. So, I hope you're hearing that in general, we are in favor of this legislation and I'm open to questions.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Hackett and seconded by Rep. Lehman, the Committee adjourned at 11:00 a.m.

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

National Council of Insurance Legislators (NCOIL)

Mental Health Parity Model Act

Sponsored by Rep. Rachel Roberts (KY)

Draft as of October 17, 2023. To be discussed during the Joint State-Federal Relations & International Insurance Issues Committee on April 12, 2024.

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.

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

National Council of Insurance Legislators (NCOIL)

Resolution Reaffirming Support for the U.S. State-Based System of Insurance Regulation in Response to Growing Federal Encroachment

To be discussed and considered during the Joint State-Federal Relations & International Insurance Issues Committee on April 12, 2024.

****Sponsored by Rep. Tom Oliverson, M.D. (TX), NCOIL President, and Asw. Pam Hunter (NY), NCOIL Vice President.***

WHEREAS, the U.S. state-based system of insurance regulation has effectively protected consumers and helped create the largest, most competitive and innovative insurance market in the world; and

WHEREAS, Congress has continually affirmed the primacy of state-based insurance regulation, including the McCarran-Ferguson Act in 1945 and most recently in the Dodd-Frank Act of 2010; and

WHEREAS, despite this success and affirmation, there has been a growing trend in recent years at the federal agency level of encroaching on the longstanding framework of the state-based insurance regulatory system; and

WHEREAS, this encroachment is extremely troubling and poses a threat to the state-based system of insurance regulation, and with it the stability and success the state system has produced; and,

WHEREAS, this threat is illustrated by actions such as:

- the return of the U.S. Department of Labor (DOL)'s proposed fiduciary rule despite an essentially identical rule being vacated by the United States Court of Appeals for the Fifth Circuit;
- the Federal Trade Commission's (FTC) proposed rules regarding service contracts and non-compete agreements;
- the Internal Revenue Service's (IRS) proposed rule regarding captive insurers;

- the tri-agency proposed rule regarding short-term, limited duration insurance; independent, non-coordinated excepted benefits coverage; level-funded plan arrangements; and tax treatment of certain accident and health insurance;
- certain activities within the Federal Insurance Office (FIO); and
- the growing unintended reach of the Employee Retirement Income Security Act of 1974 (ERISA), acting as a critical barrier for states seeking to enact meaningful healthcare reforms; and

NOW, THEREFORE, BE IT RESOLVED, that NCOIL reaffirms its unqualified support for the U.S. state-based insurance regulatory structure; and

NOW, THEREFORE, BE IT FURTHER RESOLVED, that NCOIL will continue to monitor and push back on any and all attempts by the federal government to infringe upon the state-based system of insurance regulation; and

BE IT FINALLY RESOLVED, that a copy of this resolution will be distributed to the Senate Majority Leader, the Senate Minority Leader, the Speaker of the House, the House Minority Leader, the Senate Banking Committee Chair, the Senate Banking Committee Ranking Member, the House Financial Services Committee Chair, the House Financial Services Committee Ranking Member, federal and state insurance legislators and regulators, the Federal Insurance Office, the Federal Trade Commission, the Internal Revenue Service, the Department of Health & Human Services, the Department of Labor, the Department of the Treasury, and other interested parties.

NCOIL – NAIC DIALOGUE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
NCOIL – NAIC DIALOGUE COMMITTEE
2023 NCOIL ANNUAL MEETING – COLUMBUS, OHIO
NOVEMBER 17, 2023
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) NCOIL – NAIC Dialogue Committee met at The Renaissance Columbus Downtown Hotel in Columbus, Ohio on Friday, November 17, 2023 at 10:45 a.m.

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

Other members of the Committee present were:

Rep. Matt Lehman (IN)
Rep. Michael Sarge Pollock (KY)
Rep. Brenda Carter (MI)
Sen. Lana Theis (MI)
Sen. Paul Utke (MN)
Rep. Nelly Nicol (MT)
Sen. Shawn Vedaa (ND)
Asw. Pam Hunter (NY)
Sen. Bob Hackett (OH)
Rep. Brian Lampton (OH)
Del. Steve Westfall (WV)

Other legislators present were:

Sen. Larry Walker (GA)
Rep. Brian Lohse (IA)
Rep. Rachel Roberts (KY)
Rep. Jane Pringle (ME)
Rep. Mike McFall (MI)
Rep. Helena Scott (MI)
Rep. Stephanie Young (MI)
Sen. Walter Michel (MS)
Sen. Joseph Thomas (MS)
Rep. Bob Titus (MO)
Asm. Ken Blankenbush (NY)
Asm. Jarett Gandolfo (NY)
Rep. Tim Barhorst (OH)
Sen. Bill DeMora (OH)
Sen. George Lang (OH)
Rep. Bob Peterson (OH)
Rep. Sharon Ray (OH)
Rep. Forrest Bennett (OK)
Rep. Ellyn Hefner (OK)

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 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 Del. Westfall and seconded by Sen. Bob Hackett (OH), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 21, 2023 meeting.

INTRODUCTORY REMARKS

Rep. Ferguson stated that before we get started, I really want to say how much we appreciate the NAIC and the Commissioners for participating with us. I've said before that it's really a symbiotic relationship between legislation and regulation and we really so appreciate this relationship and I'm glad we've been able to strengthen that over the years.

Oklahoma Commissioner Glen Mulready thanked Rep. Ferguson for this opportunity to have this exchange. I 100% echo your comments. I have often overlooked when I come back to NCOIL because I just think of NCOIL and I see people like Rep. Ferguson and Rep. Matt Lehman (IN), NCOIL Immediate Past President, and Commissioner Tom Considine, NCOIL CEO, but I forget some of the new people that may be here and things have not always gone as well with our two organizations as they have now. I don't think they've ever been better and so thank you for that. That takes some work to build and work on that relationship and that's just a little bit of history but I also just wanted to congratulate you, Rep. Ferguson, as you wrap up your year as NCOIL President. It's been a great year for NCOIL. Congratulations as you wrap up. I also want to bring apologies from Rhode Island Superintendent Beth Dwyer and Ohio Commissioner Judi French. They were both with us at the breakfast but had to leave. And also, Idaho Director Dean Cameron who typically is at the NCOIL conferences with me and just a couple of days ago he was asked by his Governor to take over their largest state agency, The Department of Health and Welfare, on an interim basis. He still is Director of the insurance department but he apologizes as well for not being able to be here. And one final thing is we have with us today Louisiana Commissioner Jim Donelon and for those of you who don't know he previously served in the legislature in Louisiana for 19 years. He has served this space extremely well. And just another general comment about NAIC and NCOIL. I do think when we come to these and when we have our legislative members coming to our meeting in just a matter of a couple of weeks in Orlando and working together collaboratively as we have been makes us both better. So, thank you for the opportunity.

Rep. Ferguson then asked all the participating Commissioners to introduce themselves and note whether they are elected or appointed as she just learned that not all are appointed: Kentucky Commissioner Sharon Clark (appointed); Louisiana Commissioner (elected); Oklahoma Commissioner Glen Mulready (elected); Maryland Commissioner Kathleen Birrane (appointed).

RECAP OF NCOIL D.C. FLY-IN

Rep. Ferguson stated that for the newer members we started this dialogue with the Commissioners several years ago because we do have so many issues in common and we try strive to be on the same page and think about issues and the state-based control of insurance. Last month several of us from NCOIL went to D.C. for a fly-in and we discussed numerous issues with our Members of Congress and staff. I think it was a very successful meeting and I think most of the Members I talked to were for state-based

control of insurance. We talked about the reintroduction of the Prohibit Auto Insurance Discrimination (PAID) Act which seeks to prohibit auto insurers from using certain factors in underwriting such as education level and marital status. Also, we talked about preserving state regulation of healthcare with possibly some waivers or amendments to the Employee Retirement Income and Security Act of 1974 (ERISA). I think there is some precedent for that as I said yesterday with other federal programs we have waivers for Medicaid and Medicare and the Affordable Care Act (ACA) and I think certainly the Arkansas pharmacy benefits manager (PBM) law and the NCOIL PBM Model Law that eventually went to the Supreme Court in the Rutledge decision which said that states do have the opportunity to regulate actors in industries that are adjacent to and have a cost impact on ERISA plans. So, I think there is some penetration into that ERISA law and we really are advocating for waivers to that program to allow more state control, particularly of self insured plans that only have employees in our state that they would have to abide by all the state laws that we all fought so hard to protect consumers. Another issue was enacting a long term reauthorization of the National Flood Insurance Program (NFIP). I live on the Mississippi River so I certainly have concerns about that. Overall, the fly-in was a real success. We also looked at the state-based regulation of insurance of a little bit of what we talked about yesterday regarding The Department of Labor's (DOL) fiduciary rule that was overturned, but the DOL is reintroducing it. During our last dialogue in July, we spoke about your fly-in which was held in April, and do you have any questions or comments in regard to those things that we talked about at our fly-in or did you have different concerns at you're fly-in?

Cmsr. Mulready stated that as you noted, our fly-in was in April and we discussed some of the same things such as NFIP reauthorization but something on the top of our agenda that we talked about at breakfast as well was Medicare Advantage and we are really pushing hard to our delegation. We sent letters from the NAIC really to grant the States additional authority with Medicare Advantage. The problem that we see every year around this time and post enrollments is we get the calls, we get the consumer complaints that they've enrolled in a plan and it turns out there's not the providers there that they thought they were. And we have no authority to do anything to help our own Oklahoma consumers. And so we would like to have some more authority in that space. I chuckled when the response we got from them this summer was that they had noticed all their complaints were down and my comment to that was, “yeah talk to me at open enrollment. It's in the middle of summertime. Nobody's complaining right now. We're not just prior to enrollment, we're not post enrollment.” So that's something big. And then I think you touched on it but the PBM piece as well there’s been a lot of activity there at the federal level. Numerous states, probably close to 40 now have placed that under the insurance department, that compliance and enforcement and licensing mechanisms for PBMs. And we have our own case actually PCMA v. Mulready which is on appeal in the Tenth Circuit. And that was a setback for us on that ERISA issue, a substantial setback versus the Rutledge case. So that's on appeal at the Tenth Circuit, and if that falls through, that will probably end up at the Supreme Court as well. One other thing where I think we're all on the same page is the tri-agency rule proposal regarding short term limited duration (STLD) plans. Our letters went from the NAIC with that as well. For the most part all we focused on is that this is a state decision. Each state should be able to decide so it shouldn't come down from the federal side of things. So, we'll see where that shakes out but that was the position we took and talked a lot about that. Rep. Ferguson stated that we have a lot of concern about the federal position on those as well.

UPDATE ON DRAFT NAIC CONSUMER PRIVACY PROTECTION MODEL LAW

Rep. Ferguson stated that the next thing we wanted to talk about was the NAIC Consumer Privacy Protection Model Law. The NAIC is working to amend some of its existing models with the end result being a new NAIC Consumer Privacy Protection Model Law. The proposed amendments are on page 189 in your book. We understand that the draft model has been met with some significant concerns. Can you provide us with an update on what the next steps are? And why do you think the model's been met with so much concern?

Cmsr. Birrane stated that let me first say that the H committee, which is the parent committee that the Privacy Protection Working Group sits under met yesterday and we did two things relevant to that Model Law. The first thing that we did was we extended the time period through the end of 2024 for consideration and for drafting to occur. The second thing that we did was we received comments from industry about changing the charge slightly to allow more flexibility around what the final product will be - will it truly be a complete rewrite, or will it be an update? We accepted those comments in order to provide for that additional flexibility. I'm going to start at the end instead of the beginning because I think that probably is maybe ultimately more germane to what your concerns are and that is we have pressed not a stop button, put a pause button. Because there have been lots of comments and lots of meetings to try to really work through the various issues related to privacy in general. So, there's the big question and issue of privacy regulation in general. There's what's happening internationally. There's what's happening nationally. There are the existing state laws that exist. So, from a big picture perspective, what are those issues? And then a second consideration is then of all those issues what is really appropriate for a model law that regulates the insurance industry? And then the next piece is so what does that mean then for our modernization of the model laws that were enacted a very long time ago? One right after the passage of Gramm-Leach-Bliley. The other right after the passage of the Health Insurance Portability and Accountability (HIPAA) Act. One of which has been broadly adopted, the other which has been adopted almost nowhere.

So, the objective here is to say, the drafting group did a lot of work. They made a very good faith effort to put out a very broad model that has created a lot of controversy and a lot of comments. They have been working diligently through those comments and the request of the H Committee now to that working group is that they pause and take all of the comments that have been received to date and they integrate them into a version 2.0. That version 2.0 is not going to be completed until the beginning of the year. When it is completed, the goal is not to expose it for further comment. The goal is to bring the Commissioners together and have a discussion around where that 2.0 model currently sits. So, with the benefit of insight and thought and comment from industry, with the benefit of insight, thought and comment from this body, and from other legislators, we now need to sit at the table as Commissioners and really hash this out. What is the right direction? Are we pleased? Do we think that 2.0 is in the right place? Or do we need to pivot one place or another? That is a conversation that will be happening in the first quarter of 2024. And what I anticipate is that out of that Commissioner and senior staff level conversations around the right approach and the right direction, and an effort to build true consensus among the members, we will at that point be ready to announce I'm going to optimistically say at our spring national meeting what that direction is going to

look like. But what I can assure you is that as you know the NAIC tries to work from consensus, tries to work from the middle ground to accommodate the thoughts and concerns, and the needs of all of our states and where we go from here will be reflective of that.

Rep. Matt Lehman (IN), NCOIL Immediate Past President, stated that I appreciate those comments and I appreciate what the NAIC is doing on this. I like the idea of more of an update because as we talked earlier, there's a lot of language in there about mail and things that were relevant in the 1990s so it's time to update that stuff. I think one suggestion I'd put out is you mentioned the team you kind of have working around this and at parallel to that there are the legislative bodies working on data privacy as well. And I think we all share one common theme and that is we don't really trust the federal government to take over all that data, especially with insurance. So I would ask that you would just maybe keep us at the table or this kind of dialogue works fantastic but I also think in your planning maybe reach out to legislators such as myself as I ran the bill in Indiana and other states have done that so it's important to see how that is going to work parallel with what you're doing or is it going to run into some conflict of what you're doing so that we can cut that off at the pass. Cmsr. Birrane stated that I think that's an excellent suggestion and thank you for making it. And, what we can do is coordinate once we kind of get to that. 2.0 and we sort of have our initial discussions of how do we bring you into those discussions before we go out with something that's fully public.

UPDATE ON NAIC'S DEVELOPMENT OF MODEL BULLETIN ON ISSUES RELATING TO ARTIFICIAL INTELLIGENCE AND THE INSURANCE INDUSTRY

Rep. Ferguson stated that we addressed in a general session yesterday the impact of artificial intelligence related to the insurance industry. And as you know, we had a comment letter to the NAIC because we have concerns about some non-statutory terms in your AI bulletin. So can you comment on your bulletin and what the next steps are in further developing that and maybe removing that non statutory language?

Cmsr. Birrane stated let me talk a little bit about the process if that's okay first for those who didn't have the benefit of that yesterday. So, we all know that artificial intelligence is playing a huge role in how everybody does business these days and that includes insurance companies. And there's a lot to be gained. A lot of efficiency. A lot of consumer benefit to be gained. But there's also the potential for consumer harm. And so like any other methodology and like any other tool it has to be used within guidelines. All of our legislatures have passed significant legislation over the years that regulates the insurance industry, that regulates what it does and how it does it, and what it's allowed to consider, and what it's not allowed to consider. So, throughout the entire premium calculation or rate underwriting and rating processes through the claims processes there is substantial legislation on all of our books that guide that process. The NAIC made the determination that we do need to have a U.S. regulatory framework for the use of artificial intelligence by the insurance industry. We spent about a four or five month intensive period of providing foundational education to all of our Commissioners at the Commissioner level to make sure that we had a common ground of understanding vocabulary. We brought in experts, we brought in professors, we brought in folks that do this on a day-to-day basis to provide that foundational education and then coming out of that really understanding the basics and understanding sort of what the pros are, what the concerns are, and what drives those risks? We then met in

a very lengthy session in New Hampshire at the end of 2022 and had roundtables where we sat together and said, “Okay, what’s the deal?” So, the questions that each group was asked were do we want to make a statement? When? What should be its form? Should it be prescriptive or principal based? And how should it address third party vendors? And what came out of that was an amazing level of consistency and consensus. Literally every working group, very few people didn’t have exactly the same views. So, one we needed to speak. Two, we needed to do it now. Three, we decided that the most appropriate approach was a regulatory bulletin that provided guidance and expectations for how to use these tools given the legislative frameworks that already exist and already govern and set standards or industry behavior.

We had robust discussion about whether it was appropriate to do a model law or a model regulation at this point. And the decision to do the model bulletin was driven by first of all we felt we had the statutory underpinnings to be able to provide that guidance, number one. And number two, we felt that in terms of time and speed that the bulletin was the most efficient way to go. That does not preclude us from in the future if it makes sense to go to another effort to look at model laws or model regulations. But in that time, in that moment, it made the most sense to us to move with the bulletin. So that's what we did. And then we also decided that it would be principles based. It would flow from the principles that were published and voted on in 2020 and that it would focus on primarily governance and risk management. And that with third parties we were not going to try to regulate third parties through this process, but we would hold licensees responsible for the data that they use and the models that they use from third parties. Our drafting efforts, which have been again, very highly collaborative, very broad participation across all the states with over 20 states involved in the drafting process resulted in a draft that was circulated in July. We accepted comments, we came back out again with a new draft in October and we're still looking at the definitions. We appreciate the comments with respect to some definitions. We purposefully avoided wording and certain definitions that aren't defined in statute. And frankly, we avoided defining terms like unfair discrimination, recognizing that some states have specifically adopted definitions in statute. Other states have, well their courts, have done that. Where we chose to include defined terms for us were along the lines of what you would expect the department to do if these are less legal terminology. So, for example, you'll see the use of the term an adverse consumer consequence. So, we're trying to focus on in this bulletin what we are most concerned about our AI systems that have the potential to create an adverse consumer consequence.

And so those are words that we're just trying to define. They're not in statute anywhere, but that's because statutes are really broad and here we're saying okay for this bulletin we're just focused on this activity. We talk about things like proportionality. So, where our bulletin says to companies we know that a great big, huge global company, multinational, that writes, $100 billion worth of business a year is really different than one of your mono line one state workers comp carrier that writes $100 million in premium a year. So their staffing, their needs, what they do are going to be really different. So, part of what the bulletin does is it presents the idea of proportionality and not just in terms of the robustness, but also in terms of telling companies what we want you to do and want you to focus on and your processes should be commensurate with the risk of harm to consumers. So we use that term risk of consumer harm that if you’ve got something that’s really going to hurt a consumer like pricing decisions, you need to be more robust than maybe thinking about what your chat box says. So those are the kinds

of things that are words that we're using that we are defining. If there are other specific terms that are still left in the bulletin, I know we haven't received your next comment letter, we are happy to consider those. But the goal has not really been to try to override statutes. It's tried to focus on more practical terminology that you wouldn't normally see defined in statute in any event.

Rep. Brenda Carter (MI) stated that I would like to know with artificial intelligence, have you considered it's impact on rate making and the possible discriminatory factors with rate making? Cmsr. Birrane replied absolutely and that is a huge driver of this exercise. I think it's one of the main drivers. We have to be careful to make sure that we don't limit it to that because claims administration is a huge issue as well. You know, quote unquote “fraud detection” is a huge issue as well and whose claims are considered fraudulent. And frankly, marketing practices. So, who's worthy of insurance in the first place? And then the underwriting standards. So, you're absolutely correct that that is a main driver. We do have very robust systems in place in the world of insurance that deal with the standards around discrimination. I refer to it as discrimination with a little D and discrimination with a big D. So, insurance discrimination with a little D is this idea that if you're going to charge Mary a rate that's different than Joe it has to be based on something that's different between the two of them that relates to their risk. That's the term of unfair discrimination. And then there's big D which is are your practices such that they are discriminating against protected classes, most of which are identified in statute? And the concern that exists is that sometimes it is difficult to be able to assess what those impacts and outcomes are. It is not impossible - Washington D.C. is embarked upon an analytical exercise in a market conduct exam to look at this attribute in the context of auto rating. Maryland just issued orders relating to practices that we were very concerned about in terms of the potential for redlining in this day and age. So, I can assure you that is a large driver of the work that the NAIC does. The NAIC has a group within its C Committee and its Casualty Actuarial and Statistical Task Force that looks at large predictive models, particularly for large companies, and there are actuaries in that group.

Sen. Larry Walker (GA) stated that I've been in the insurance business long enough to remember the controversy surrounding financial responsibility as part of an underwriting process and the carriers were able to demonstrate that there was an actuarial basis to use that. And so, it's widely accepted. My concern on this AI stuff for underwriting is it seems to be a lot of black box proprietary factors going into that. And there will be tension I think between the Georgia Insurance Commissioner and the carriers with regard to transparency on that. And I wonder if your bulletin or you all discussed transparency and what factors go into that decision? I've got a new homeowners carrier that all we do is put in the address, the name and the date of birth of the prospect and they provide a homeowner rate but they decline a huge percentage of our submissions and we have no idea why and they don't tell you why. Cmsr. Birrane stated that the bulletin doesn't do deep dives into transparency. The bulletin is focused very much on the development of and use of AI from the standpoint of governance and risk management. It repeats the principles that companies need to move toward transparency but what it doesn't do and please understand that this is not the last word, this is an incremental process, and what you're talking about is what are the directives that should be placed on insurers in terms of what is the level of detail that they should be providing to consumers beyond letting them know that there is an AI system in play? What is the level of detail that should be available to consumers and to their

representatives as brokers in terms of what's driving their particular denial, etc. That work is still being discussed at the NAIC. That is a next step. The bulletin does have a statement in it that reiterates what was in our principles about the need to have explain-ability and transparency but it does not go into specifics with respect to that and that is an area where I think states are still evolving in terms of what they think the right approach is for their state.

Sen. Walker stated that first of all I always like having an unfair advantage anytime I can. But my concern is for the consumer and really for the insurance market I guess in general in Georgia is if you've got a carrier that has built a better mousetrap, so to speak, and comes in and more or less takes the cream of the crop or cherry picks but isn't sharing in the wider population of risk and then the other carriers are going to have to be inverted and are adversely impacted by that. As an insurance commissioner, is that a concern you would share? Cmsr. Birrane stated that it's always a concern, absolutely. But that's why we exist. I do have optics into every carriers underwriting standards. I do have optics into all of their rating plans and all of their rating factors because that's what we do. We receive their rating factors. We review their rating factors. Some states are prior approval, Maryland is not. But we do evaluate all of those rating standards. And what happens with us is that when we have brokers like yourself or consumers that are saying what's going on here, we do investigate that. I'm in the middle of a large market conduct exam exactly on that issue. So, we are concerned and the typical concern is making sure that those underwriting standards meet the statutory guidelines, that they are not unfairly discriminatory and making sure that carriers write everything they have a rate for and they don't say, “Well, I have really broad underwriting standards and really great rates but I'm going to cherry pick what I want out of that because I'm not going to write everybody that qualifies.” So you are absolutely correct in that and having those concerns and that those are the concerns of the Department. We use the laws that already exist and the tools that already exist to address those considerations I would say literally on a daily basis.

Rep. Lehman stated that you hit the same concern I had when we did the NCOIL transparency model which we then passed in Indiana last session and I can get you the language. But it basically creates that disclosure to the consumer from the carrier as to what were the largest factors going into that rate. I can give that information offline.

Rep. Ferguson stated that in the interest of time we need to move on but I will comment the non statutory word “bias” is one of our major concerns in the bulletin.

FOLLOW-UP DISCUSSION ON ACTIVITIES OF NAIC’S SECURITIES VALUATION OFFICE (SVO)

Rep. Ferguson stated that we talked about a little bit about this at the breakfast and I know there's a little controversy about it from yesterday - the SVO and their retroactive look at valuation. Can you comment on your process and why the SVO exists and when you decide to retroactively look at the rating.

Cmsr. Donelon stated that I’ll hit a few points that I think are relevant to that discussion. Relying on credit rating agencies is an efficient way to review insurer investments. Not company solvency. But increasingly, we regulators have become concerned by the quality of ratings for certain classes of certain tranches of investments and have noted

significant discrepancies between rating agencies for the same investment. Since capital charges are directly linked to these ratings, there's troubling potential for rating shopping by some insurers to avoid having to hold more capital. I myself in my state of Louisiana have twice engaged with the SVO on behalf of investments that were on the books for top of the line very old, over 100 year old life insurer in one case. And another in the property & casualty area that had downgrades on part of their investments and asked me to intercede which I did with the SVO and we worked it out frankly I don't know to what end whether they succeeded or not. But that is the only experience I've had in 18 years with the SVO and I consider it to have been positive and their role to be important. That rate shopping issue I think is not really relevant to the discussion that we're having but I can understand why the issue has been put forth by some of you and we are committed to working in collaboration with you to resolve those issues. You'll recall during the 2007, 2008 financial crisis that blind reliance by regulators on credit ratings in part contributed to overlooking a growing subprime mortgage crisis. Not in the insurance arena, but in the banking arena. And while Dodd-Frank required many federal regulators to take steps to reduce their reliance on such ratings, no such holistic changes have been made in state insurance regulation. In discussion this morning at breakfast the concern that has been expressed by industry for the fees being charged for the services at the SVO specifically for appeal processes that may be necessitated, we are taking that back to NAIC and we'll discuss with our internal folks the need for number one, if they are being charged additional fees for appeals which I doubt based on my experience, but if they are, the need for that which I doubt also. So, with those things said, as a result of the concerns I mentioned, a proposal was drafted by the SVO that would grant it a limited amount of discretion to review and challenge for NAIC solvency regulatory purposes only rating agency assessments of investment risk. And the proposal was exposed for public comment in May with a July deadline which is approaching. With the SVO'S proposal it's also important to note that a state insurance regulator, just like the SVO, would be able to initiate a review of a rating designation under our proposal.

Sen. Lana Theis (MI) stated that I would respectfully like to ask that you reconsider this. My issue is not just with the fees associated with it but the way that the oversight would have to work. So if a company that was going to be invested in got downgraded, their ability to go back to their rating company and say here's the reason why we think that's incorrect, that's significant. And they have an ability then to have a back and forth and that makes sense. But if their choice is to go to the regulator who regulates them there's no open discussion there. So that is a huge problem for me. It's like the fox watching the hen house. And please forgive the reference, but there no freedom of communication back and forth. So, that's a major issue for me as well as the fees you are already effectively regulating. And I understand the concerns but the references that you're listing right now go back 15 years and this is a quantifiable measurement. You can look at the people who are currently doing the ratings and you can see whether or not they're rating beyond the solvency of the industry that they're looking at or the business that they're looking at. So I want to push back on where it is you're heading for this and I would hope that the other legislators here would do the same.

Cmsr. Birrane asked for a point of clarification - are you referring to the credit rating of the company or the credit rating of the investments? Sen. Theis stated that I am concerned generally about the SVO oversight altogether and how it interacts with the company. Cmsr. Birrane stated that this particular exercise that we've been addressing,

and I'll certainly take those comments back, have been very much focused on the rating of individual investments and types of investments which obviously ultimately can have an impact on the overall credit rating of the company itself. But the primary exercise is around what is the appropriate charge on a particular investment and how does the NAIC determine that for purposes of what is allowed to be considered in statutory accounting as available capital so that when consumers make claims the money is there to pay them. Sen. Theis stated that I absolutely agree that we need to be concerned about the claims and whether or not the money is there to pay them. And we can get into all kinds of other discussions about what you consider to be valid investments and what the reasoning is behind the strength of an investment which is another discussion we're going to have later I think. But I just want to caution because of the lack of ability for a defense in what the outcome is of the ratings or what the determination is of the ratings and the complexity and the people we had speak were absolute experts on a very minute portion of review of value and the SVO will not have that level of complexity. Cmsr. Birrane stated that I appreciate that and in my years at DLA Piper I certainly worked on collateralized debt obligation (CDO) and collateralized loan obligation (CLO) investment part of things so I do very much appreciate your comments. And just for awareness, there is a new draft that is coming out that is specifically targeted at looking at that appeal and input process so I think we'll have the opportunity to review those new sections and get your feedback on those once they're out there.

Sen. Bob Hackett (OH) stated that I was the one that actually defended you yesterday and after the fact a number of people criticized me and I didn't change my views. I was an investment advisor. I went through '07 and '08 crisis and I saw the mistakes and was not happy with New York. And a lot of things, if I could see it a lot of other people could see it so I don't mind having another set of eyes. The problem that came on this scenario is a lot of these people thought you were overstepping your bounds, not just for the excessive fees but were they trying to actually come in and be a rating agency yourself? And so that's when you have to go back and talk to them. I don't mind having another set of eyes involved, etc. But we need to have the expertise which I think there is good expertise with the Department of Insurance. But the concern is maybe you overstepped and gone a little too far and I'm curious to see what you say about that.

Cmsr. Donelon stated that unfortunately, in my home state of Louisiana, we've had more than our share of insolvencies over the years and we rely on the model laws that have been in place since the 1990s which were part of the accreditation process. That's core to how we operate on a national basis state by state. And the model laws are focused on individual rules relative to individual investments, not the rating of the company. And I stand to be corrected by Cmsr. Birrane but we'll certainly take your concerns back and consider the fee structure and the appeal process and the transparency of the whole process from what we've learned here with you yesterday and today. But we to my knowledge, and I defer to my colleagues, we don't want to compete with AM Best and Demotech and the other rating agencies. And what I've heard in the hallway here is that Demotech, for one, is not concerned about us encroaching on what they do. That's not their concern. And frankly, it shouldn't be because we don't want that. We don't want to do that. So, your points are well taken and we'll take them back. But it's really statutory requirements for the evaluation and the acceptance of different categories of investments that companies put on their books for their ability to pay their claims and we are evaluating those investments of vehicles on an individual basis, not on a company wide basis.

Cmsr. Mulready stated that we received 17 comments on this which includes 45 pages and that will be part of the review at our national meeting in Orlando. Sen. Hackett stated that the only point I wanted to make is I understand the insolvencies you've had but there are other factors that led to the insolvencies. And you know that. And I know that. And there are factors that people thought you would never face on those type of claims. So, it was more than just the investments that caused the insolvency concern. In Ohio, we don't have the problem that you had down there and I ask people the question how much do you think our fund puts in to run the department of insurance? The answer is zero - everything is paid for by the private industry and premium tax dollars so there is not one dime put in by the state of Ohio because that's just the way the system runs in Ohio. Cmsr. Donelon stated that it runs the same way in my state. Sen. Hackett stated that so it's not just the investments that caused insolvency in Florida and other states. Cmsr. Donelon replied, absolutely.

Rep. Nelly Nicol (MT) stated that my question is more of a point. The appeals that get put forth are putting the companies instantly on defense so it's something that they have to argue against and as the regulator you're the one that already has the upper hand to the insurance companies. So, maybe just take that into consideration. And also, take under consideration that in every state these appeals processes aren't always on the up and up. And so, in specific states, you might have different issues with the appeals process. And beyond that, we're also looking at these things are documents that are being put in the company filings and the rating companies are going to be looking at all of that. So, maybe you're not giving them a poor rating or have anything to do with the rating. I understand that. But this does affect the company and their bottom line when you write these things down and put it in permanent record.

Cmsr. Donelon stated no question about it and I for one is a legislator was very supportive of imposing, and it's in place and it's been part of my burden in the 18 years I've been Commissioner - when I took action that companies challenged, we have now outside of my authority, a division of administrative law that oversees the department of environmental quality, and myself and the state revenue department. All of us regulators and state agencies are subject to that expedited oversight in Louisiana, by not judicial, not the court system, but by the Division of Administrative Law. I supported that. I continue to support it even though I've had my issues with it over the years. There's no such avenue available to us on a state by state basis for oversight of regulators. The courts, we don't want to go there and I don't think the companies want to go there. So, to the extent that we can under our state deferring to the domiciliary state for regulation of solvency as our accreditation system has mandated, to the extent that we can make it transparent, more user friendly, less expensive, like you have brought to our attention here in these two days, I and I think my colleagues are all in support of doing that. This has been completely off of my radar until now when I came to Columbus. I had that one investment product at a large international life insurance company and it got resolved without me even knowing how the resolution ended up to the satisfaction of the company or not. And I had another from when I was president from a different state, that also got resolved without me knowing what the outcome was. So, it hasn't been brought to my attention in 18 years as an issue until now. But certainly, these are legitimate questions of cost, transparency, appeal process, etc. and we'll take your message back and address it at the NAIC level.

DISCUSSION ON NAIC'S DATA CALL RELATING TO PROPERTY INSURANCE MARKET

Rep. Ferguson stated that we'll move on to the next topic, a discussion of the NAIC data call relating to property insurance market. We saw the NAIC's announcement of its plan to issue a nationwide data call to help state insurance regulators better understand property markets, coverages and protection gaps in light of increasing climate risk, reinsurance cost, and inflationary pressures. We're also aware of the recent announcement by the federal insurance office (FIO) of its plan to also issue a similar data call. Starting on page 191 in your binders, you can see both the NAIC and the FIO's announcement of their recent data calls. The description of FIO's data call does seem very similar to the NAIC data call and it's our understanding that there was communication between the two of you regarding whether or not the FIO data call would be duplicative. Can you describe to us what those conversations were like and how the NAIC views FIO's data call. I'd also like to note that with this data call from FIO and with other federal actions such as the DOL's fiduciary rule and as we talked about earlier the STLD rules, there do seem to be significant threats from the federal government to intrude on the state based system of insurance regulation. It might be worth considering our respective organizations working together on some sort of joint comment letter to push back on this activity all together since we do represent the legislative and the regulatory authority for state based systems.

Cmsr. Mulready stated that I'd like to talk a little bit and then get back on track on just on what's happening with homeowners' coverage. Every single one of you at this table, every legislator is or regulator will receive phone calls from your constituents about rate increases on their homeowner's policy. I can guarantee it. I've received numerous of them. So, let me just talk a little bit about that. And I'm from Oklahoma and I like to say we're a weather state and that impacts us even more so but it is happening across the country and just quickly just like I tell my legislators at home here's what's happening - number one, we have catastrophic storms. We are having the frequency and severity greatly increasing. So, we're just seeing more and more of these catastrophic storms. In April in Oklahoma we had a tornado. That's probably approaching a $1 billion claim. We had one public school, a high school that that claim alone is $30 million for a public high school in Shawnee, Oklahoma. So, we're seeing more and more of those in severity and frequency. We also have an issue in the reinsurance world as you stated. And the reinsurance association folks are here and they can talk to you about the $200 billion of capital that left the reinsurance market just due to changing interest rates and other potential investments and other things happening in our economy. Well, that does nothing but drive up costs for the reinsurance. And the third is just inflation and inflationary pressures that are happening. I experienced this personally. Just this last week we had our own roof claim. My wife was going to send off that final check and she pulled out of her file a proposal and it was for $20,000 and she said, "Is this what I send off for the roof?" And I said "No that's the proposal from one and a half years ago, almost to the day." A year and a half ago, the same roofer who replaced our roof a year and half later, it was $26,000. That's a 30% increase in a one and a half year period just due to inflationary trends.

So, that's what we're seeing. And now I'll get back on track. Arkansas Commissioner Alan McClain is the Chair of the NAIC's C Committee and he wanted to be here but had something come up and he wanted me to apologize that he couldn't be here. But we are

in the midst of doing a data call to develop that data trying to identify coverage and protection gaps, also focused a lot on availability and affordability. I think it's important to note that within Oklahoma we have certain storms and I specifically mentioned Shawnee but you can have very concentrated differentials within a state within the geographic area. So, we'll be focusing on that. And really just helping our regulators better understand the marketplace with that. Now we focus on solvency and we know what's happening with that and other filings but the availability and affordability, it's a little bit tougher for us to keep our finger on the pulse. And so that's really what this effort is about so we can better understand that. You mentioned FIO and their data call. I would argue that there was engagement with us. We received a letter requesting that we provide this data to them. It was a very unreasonable time period and it could not be met. I can tell you that our state, we sent back a letter saying we are happy to work on this but number one, we don't collect that data at that level at this time. And we could get it to you but we can't do it in 30 days. And I forget what the exact timeframe was but it was not a reasonable timeframe. So, I don't believe there was reasonable engagement at all with FIO. And we have pushed back on that and I think you are right to identify it as a significant threat of federal overreach. And so we, the NAIC, are doing our own data call. We are going to gather, analyze and then utilize that data for each unique market. I think what we envision is more of an ongoing collection of data as opposed to a one-time thing. But it would be more of an ongoing thing that we could continue to update and give each of us a better insight into our own markets. So, that would be more of a long term, but what we will be collecting is down to zip code level data, premiums, policies, claims, losses, limits deductibles, non-renewals and coverage types. And that data request format has not been finalized. They are working on that and hopefully we'll finalize that here in about two weeks at our national meeting. And your idea of a joint letter, I can't speak for the NAIC, but I can speak for myself, I would highly encourage that. I think that adding that weight to the two organizations pushing back on that is very helpful.

Rep. Ferguson asked if the primary function of the FIO is to collect data? What would you say is their primary function? Cmsr. Mulready stated I think that's a great question. What is your primary function? Why do you exist? I think the original idea of FIO was more on the international level representing the U.S. maybe at a federal level. But I think there are a lot of people that question what is that role and I think there is movement to sort of justify that at that position of that role like what we're seeing here with this data call.

DISCUSSION ON NAIC'S UPDATED CANNABIS INSURANCE WHITE PAPER

Rep. Ferguson stated that we'll move on to an always interesting topic, cannabis. I know Ohio just passed their recreational marijuana law, but here we'll talk particularly cannabis as it relates to insurance. The NAIC recently issued a white paper to serve as a regulatory guide for understanding the market for cannabis insurance. It's obviously very topical. Can you provide a brief summary of the white paper findings and what we should be aware of as legislators?

Cmsr. Clark stated that in Kentucky this is a quick learning experience because we just recently passed our medical marijuana law so we have been scrambling to find what was the insurance impact? I didn't really think about it until I got a desperate call from our agency that will be overseeing this product. And we had a very thorough discussion

on what their insurance needs are going to be because in the legislation there is a requirement for liability insurance. So, that takes me on this journey of learning more about cannabis. But in 2019 the first paper came out and it was just really looking at some of the major obstacles and where we were at that time and what a difference four years makes because we're now I think it's up to 38 states that allow medicinal marijuana plus three territories. And then there's 24 states that allow recreational. So, the insurance aspect of it. When my agency contacted me, they were saying we have to have liability insurance from that seed to the dispensary aspect of it. And then there's different components like in Kentucky it's greenhouse-only growing so that makes a little bit of difference in the liability coverage of what is needed in the limits. So, we did our homework and made recommendations to them. Then it becomes the availability issue - are there insurance companies out there that are going to write this coverage? And right now it's primarily in the not admitted surplus lines market. We did in Kentucky just in the last six weeks have a company apply that is going to be looking about limited insurance coverage. They're not going to do the seed to the dispensary but they're a little segment, and it is an issue out there that's going to be challenging.

I can't blame the insurance companies for not wanting to step up. You have all types of interstate laws you have and are they going to be accused of criminalization processes? So really what we need to happen, most of you all have heard about The Secure and Fair Enforcement Regulation Banking Act (SAFER) law that is in Congress that protects and allows for banking institutions to deal with this. However, there is another piece of legislation with Senator Menendez in Congress. It's called the Clarifying Law Around Insurance of Marijuana Act (CLAIM). And what that Act is going to do is it's going to allow insurance companies to provide that coverage for any aspect of the operation in a state that has legalized marijuana without having any type of penalties. And it can be done on a state by state basis. California has passed legislation to protect the industry. But the easiest thing would be to have a national law on it. So it's something we're all facing and there's still concerns. But again, federal action would be the swiftest remedy.

Cmsr. Mulready stated that in Oklahoma we did, I think it was 2018, pass through initiative petition something related to marijuana that did not come through the legislature. And that caused a lot of problems because it wasn't well written, and fees were set extremely low and it has caused a lot of problems. And I know many of you have heard this week a lot about Oklahoma and the Medical Marijuana Authority (MMA). They have had their hands full. We have over 2,500 dispensaries, over 5,000 growers. It has really become a big issue. This past year in our legislature, I think it was SB-913. They passed a requirement for a $50,000 surety bond so that's been the newest developments in this industry. We have had meetings and some conversations with some captives to come up with additional solutions outside of surplus lines so there's some potential captive opportunities there for that industry as well. I will say also I think it was a week ago today our Attorney General's organized crime unit came in and seized 72,000 pounds of illegal marijuana in the state of Oklahoma and they gathered that all and weighed that and burned it so.

Asw. Pam Hunter (NY), NCOIL Treasurer, stated that I just have a quick question consistent with the SAFER Act and you mentioning a similar piece of legislation. Would the NAIC consider taking a proactive stance and petitioning the federal government to declassify marijuana to reduce it from schedule one? It seems as we've been having this conversation relative to inflation and the market will not be able to sustain, especially

with the servicers and the providers keep asking for rate increases. That's what's happening in New York and we see people who are uninsured, underinsured, people driving without insurance just because they are getting tapped with increases. And with cannabis, we have a large illicit market because the way we did it was just wrong and we messed it up really bad. But is there a way that the NAIC would take a strong stance on declassification? Because it seems to me if we did declassify it that would open up banking for this emerging business that they literally are keeping tens of millions of dollars in cash in people's homes because they can't bank it. And this is real. This is actually happening. And that would loosen up and help with the insurance market as well, insuring it's just like any other agricultural product.

Cmsr. Clark stated that I don't know how much influence we would have on that aspect of it because of course marijuana goes back to the Richard Nixon days with the Controlled Substance Act that was passed at that point. I think I saw some recent polls for 80% of Americans were in favor of medicinal cannabis. And it was dropped off a little bit I think to 60%. The quickest way rather than us getting outside our guardrails and outside our lane I think is for the CLAIM Act and the SAFER Act to pass and that might answer the question. If they opened up that drug laws we can get into all kinds of questions and it would be a much slower process so I think the CLAIM Act and the SAFER Act are the fastest way to get there.

Cmsr. Mulready stated to Asw. Hunter that we'll bring that back, but I think that might be a little bit of a step outside of our lane for many of our members to get behind addressing the banking issue, as opposed to insurance.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Hackett and seconded by Del. Steve Westfall (WV), the Committee adjourned at 12:00 p.m.

LIFE INSURANCE & FINANCIAL PLANNING COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
LIFE INSURANCE & FINANCIAL PLANNING COMMITTEE
2023 NCOIL ANNUAL MEETING – COLUMBUS, OHIO
NOVEMBER 16, 2023
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Life Insurance & Financial Planning Committee met at The Renaissance Columbus Downtown Hotel in Columbus, Ohio on Thursday, November 16, 2023 at 3:15 p.m.

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

Other members of the Committee present were:

Rep. Deborah Ferguson, DDS (AR)
Sen. Walter Michel (MS)
Sen. Joseph Thomas (MS)
Sen. Jerry Klein (ND)
Sen. Shawn Vedaa (ND)
Asm. Ken Blankenbush (NY)
Asw. Pam Hunter (NY)
Rep. Tim Barhorst (OH)
Sen. Bob Hackett (OH)
Sen. George Lang (OH)
Rep. Ellyn Hefner (OK)
Rep. Tom Oliverson, M.D. (TX)
Del. Steve Westfall (WV)

Other legislators present were:

Sen. Larry Walker (GA)
Rep. Brian Lohse (IA)
Rep. Chad Aull (KY)
Rep. Jane Pringle (ME)
Rep. Helena Scott (MI)
Sen. Lana Theis (MI)
Rep. Stephanie Young (MI)
Sen. Paul Utke (MN)
Rep. Bob Titus (MO)
Sen. Pam Helming (NY)
Asm. David Weprin (NY)

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. Bob Hackett (OH), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Sen. Klein and seconded by Del. Steve Westfall (WV), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 21, 2023 meeting.

UPDATE ON NCOIL LIFE INSURANCE IS A PROMISE FOR LIFE MODEL ACT

Rep. Anderson stated that we will start today with an update on the NCOIL Life Insurance is a Promise for Life Model Act. This will be a very brief update as 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 114 in your binders and on the website and app. Sen. Holdman did ask me to report to everyone that since he was not able to be here today and since there has still been significant regulatory developments 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 deciding what's the next step to take with this model. It may end up being that such regulatory activity reaches a level that makes the model unnecessary and states that are interested in responding to this issue can utilize the resolution that NCOIL adopted on this issue as a guidance. We did have a couple of speakers scheduled to make brief comments but in light of some last minute scheduling changes and the model being held they have withdrawn requests to speak. So, if there are any questions on this issue, please reach out to Sen. Holdman, myself or the NCOIL staff.

DISCUSSION ON THE RETURN OF THE U.S. DEPARTMENT OF LABOR (DOL) FIDUCIARY RULE

Rep. Anderson stated that next on our agenda is a discussion on the return of the U.S. DOL fiduciary rule. As many of you know, the DOL has been working on this rule for nearly a decade and despite a prior version being vacated by the courts the DOL is back at it again with a second bite at the apple. In your binder on page 117, is a resolution I sponsored that was adopted at our last meeting which opposes the return of this rule. And on page 119 is a similar resolution that was adopted back in 2016. Lastly, on page 121 is a statement from NCOIL CEO, Cmsr. Tom Considine, regarding the DOL's latest action. As you can see from both resolutions and the statement the main issue here 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 insurance legislative and regulatory structure, tens of millions of Americans have been able to receive sound retirement assistance, products and services from financial professionals who have consistently served the best interests of the consumers.

Allison Itami, Principal at Groom Law Group, thanked the Committee for the opportunity to speak and stated that the DOL is racing through a rulemaking effort in the next weeks that will shape the behavior of insurance companies and insurance agents that's currently under your regulation in a profound way. The DOL is reviving its 2016 rulemaking to capture more sales activity both providing itself with the ability to prevent a company from doing business for a full 10 years. The activity that was highlighted in the rollout was the sale of annuities portrayed as containing junk fees. This rulemaking explicitly rejects your efforts to regulate using a suitability best interest standard for annuities sold to retirement investors as falling short of the protection that DOL wishes to provide. I'm a principal at Groom Law Group. It's a boutique law firm focusing on employee benefits including health and retirement plans that are often covered by federal law, the Employee Retirement Income Security Act of 1974 (ERISA). Groom attorneys have been focused on ERISA for as long as ERISA has been around and that's coming up on 50 years. For much of that time, the provision of investment advice with respect to retirement plans has been governed by the five part test regulation. The

proposed rulemaking at issue today is another attempt to redesign the regulation and its implementing exemptions. This is the third such attempt since 2010. I personally devoted thousands of hours on advocacy and compliance, worked back in 2015 through 2018 during the last DOL proposal and finalization. This was the proposal that was vacated by the Fifth Circuit Court of Appeals in 2018. Why is this rulemaking so important? This rulemaking is so important because ERISA is a statute of prohibitions. It starts from a place of no, no actions can be taken without permission. That means no services can be provided and very few sales can occur without complying with the conditions of a prohibited transaction exemption. Failure to comply with an exemption can result in having to part with profits and it might impose penalties and it will also impose excise taxation. These are all very serious consequences.

Why is this rule so important to you? Although it is framed as protection from junk fees and regulatory arbitrage, the proposal, in my opinion, is at heart the DOL's inability to take a win. The 2016 rulemaking truly did shift the retirement industry and the financial professionals that work in it. The rulemaking kicked off, or at least preceded consumer protection efforts from others like the Securities and Exchange (SEC) and from states. These consumer protection efforts have included Regulation Best Interest and the adoption by the states of the National Association of Insurance Commissioners (NAIC) Model 275. Several states have also imposed fiduciary standards on state regulated financial professionals. The disclosures that retirement investors now receive have become more fulsome. The efforts to mitigate conflicts have also increased. Under these consumer protection efforts, the standards of care require some formulation of providing a recommendation that takes into account the recipients needs without placing the financial interests of the financial professional first. For a rulemaking that was vacated before it truly took hold it's pretty remarkable the impact that it has had. Rather than allowing these new efforts to establish and flourish the DOL has taken direct aim at the states. The DOL is of the belief that regulatory arbitrage occurs where investment advice providers can use more favorable rules in one market to circumvent less favorable rules elsewhere. When they use elsewhere here they mean avoiding the DOL regulation to be regulated at the state level. The DOL states that state regulated annuities are covered by state regulations that potentially hold those selling such insurance products to a lower standard. The DOL views Model 275 as lacking because they view it as a suitability standard rather than a fiduciary one. Because the DOL does not believe that the state adopted standards of insurance regulation are good enough they feel it justifies federal regulation in this area.

The regulation first broadens the definition of fiduciary investment advice to capture most activities by financial professionals when the recipient is a retirement plan participant or individual retirement account (IRA). Next, the DOL once again uses its exemptions to impose standards of care upon entities and transaction types that Congress did not. Further, if stating that state standards were too low and imposing standards upon IRAs that Congress admitted wasn't enough, the exemption also reserves an unbelievable amount of discretion to the DOL in a manner that could be business ending. The DOL has proposed to condition exemptive relief upon remaining eligible. Ineligibility is found based upon affiliate convictions, including when a foreign affiliate is convicted in areas that are completely unrelated to providing investment advice or management. DOL has also reserved for itself the ability to discretionarily revoke eligibility based upon a pattern of behavior such as the failure to file excise tax returns. Given DOL’s stated goal of forcing everybody to use a single exemption, the loss of that single exemption could

result in the inability to conduct business with retirement investors for a full ten years for both small shops and multinational institutions. The fewer providers that are in this space, the less likely it is for consumers to have access to the provider of their choice and the growing possibility that prices will increase as compliance becomes more complex. In my opinion providers are willing and able to comply with an appropriate standard of care but the DOL's vision for an appropriate standard of care tramples upon where other regulators have already recently acted. It imposes compliance costs in the form of disclosures that DOL itself does not believe enhanced protection.

Confusion over the ability to tout your own services as a sales effort rather than being fiduciary advice has caused many to shy away from advising upon retirement assets even while advising or managing that same person's non retirement assets. The rulemaking's scant nod to ERISA's savings clause, which is meant to carve out from federal preemption state laws that regulate insurance, banking and securities is inadequate because this rulemaking is intended to push state regulators out of the field because they elected to impose a standard of care that the DOL does not approve of. DOL's bid to "level the playing field" has been to set the field beyond the reach of state regulators based on unconvincing worries that no other regulator is able to protect retirement consumers as well as it can. It states that it uniquely among regulators can impose uniform standards for the provision of investment advice to retirement investors. As mentioned in your resolutions that the Chair just referenced from earlier this year, that protection goes to such an extreme that it limited services in the 2016 go round and it may well do so again. Given ERISA's starting point of prohibition, providing a recommendation that is indeed in the consumer's best interest is not good enough. You still need to comply with all the bells and whistles of the exemption conditions. Meeting all those add-ons is costly and failure with respect to those add-ons can result in the inability to conduct business even while meeting a best interest standard of care. Forcing so many relationships into DOL's regulatory field is not necessary given the efforts of other regulatory bodies to act in these spaces including your efforts with Model 275. Usurping your regulatory authority based on no evidence or experience with the newly adopted and implemented model 275 appears unjustified and like regulation for the sake of regulation given all the widespread changes that have occurred in the financial services industry in the past decade.

Brian Graff, CEO of the American Retirement Association (ARA), thanked the Committee for the opportunity to speak and stated that let me start by agreeing with Ms. Itami with respect to what we felt was an absolutely outrageous and inappropriate attack on one particular insurance product by the White House when the regulation was issued, namely fixed index annuities. We published an editorial several days after that attack criticizing quite vociferously the unfair and frankly flawed attack on fixed index annuities because they are perfectly appropriate and sound products and investment options for retiring investors frankly benefiting millions of those investors throughout the country. And so I want to make sure that's on the record and we've been consistent with this that we want everyone to understand how we feel about the way that the regulation was rolled out, that it was inappropriate. And certainly, we believe and support the idea that products like fixed index annuities have an important role to play in the retirement investor marketplace. That being said, there is one aspect of the current regulatory regime that we as an organization have concern about and that has to do with retirement plans that are sponsored by employers. Let me explain. For 140 million American workers, the gateway to investing in the first place is in the workplace. That's how most

Americans save, invest in the market, build wealth and hopefully generational wealth. As an organization, we have been continuously working to expand coverage of workplace retirement plans because they are the gateway to building that equity and starting to save. American workers are 15 times more likely to save when they're covered by a workplace plan then on their own in an IRA. Retirement plans in the workplace work. Problem is, there's still 40% of the American workforce, roughly 65 million American workers, who don't have access to a plan at work and it's particularly acute and problematic for communities of color where predominantly many of them work for smaller businesses, family owned businesses. And the racial wealth gap when it comes to retirement savings remains significant. 50% of black Americans, 62% of Hispanic Americans, have no retirement savings. Compared to about 35% of white Americans. We believe that gap is absolutely unacceptable.

So, expanding coverage to workplace plans is critically important. You might be asking yourself why am I talking about this and what does this have to do with the fiduciary rule? Well, the one thing that the NAIC model rule doesn't apply to, the one thing that the SEC best interest rule doesn't apply to is the advice given to an employer with respect to their workplace retirement plan that they're offering to their employees. And that is why we have a concern with the current regulatory regime and that is the element of this rule that we think is worth considering. The reason this is so important is because the person and by the way this rule with respect to the fact that Regulation best interest doesn't apply to workplace retirement plans or the NAIC model is because advice given to a small business owner is considered institutional advice even if that small business owner has two employees and has no sophistication when it comes to investments. So, basically what we're saying is that there is no current regulatory regime when it comes to workplace retirement plans in many cases and in particular, when it comes to the selling of a retirement plan to a small business owner. We, along with many of you in states, have been working very hard to address this coverage problem. There are now 14 states that require employers above a certain size to have some type of workplace plan. We've worked with many of you on that legislation. We just recently worked with Congress to enact numerous provisions to incentivize and make it easier for small businesses to have workplace retirement plans. I think we all share the goal of having some coverage in the workplace so that working Americans can save. The problem is there are no investor protections in many cases for those small business owners and that's the focus of our emphasis with respect to this rule.

Leah Walters, Senior Vice President of State Relations at the American Council of Life Insurers (ACLI), thanked the Committee for the opportunity to speak and stated that first, I want to thank Cmsr. Considine for the statement on the DOL's proposal. And we agree with you. The proposed rule is unnecessary and burdensome to the many consumers it seeks to protect. And we also agree that it 100% undermines the state based regulatory system of insurance. And this encroachment by the federal government should not go unnoticed. As you just heard, a lot has happened since 2016. The SEC has a best interest regulation. The NAIC has adopted amendments to model 275 and 40 states have adopted the NAIC best interest language. And for those who know about NAIC models, that's not an easy feat in two to three years - 40 states and its growing. We also have six states with pending activity and we think Utah will be number 41 on December 3rd. So, we want to thank all of you for the work in your states that you've done getting this accomplished. But this federal trend of staff completely ignoring the state based insurance regulation system should not go unnoticed. This is the second such

encroachment in one year. In July, there was a tri-agency action of the Department of Health and Human Services, DOL and Treasury, they proposed a rule preempting state authority on short term limited duration insurance (STLDI) and supplemental products. Both NCOIL and the NAIC issued letters of opposition on such encroachment and we agree with you as we think the state based system is where the regulation of insurance products should continue. We heard a lot from Ms. Itami about what the rule itself does and we believe it's a significant setback for retirement savers. We believe that public policy should provide all Americans with the option for financial security and that should happen through choices, not limitations on their financial security. Conflating legitimate retiring costs with junk fees we believe was the scare tactic to push regulation that will hurt Americans. The other thing is traditional pensions are no longer the norm. So, guaranteed income through annuities let's people create their own pensions and that's why annuity ownership is up. And just a couple more facts - the median household income among annuity owners is $76,000 a year. The median household income is $63,000 a year. So, you see who's buying annuities, middle income. And fiduciaries generally typically charge ongoing fees and impose account minimums that moderate income savers just cannot afford so we think this would be a huge hit to the middle market. So again, we want to thank NCOIL and the NAIC for leadership on this. We think you're already protecting consumers against conflicts of interest. These 40 states represent 76% of U.S. consumers with this enhanced best interest of care. and we think that's exactly where it belongs, in the states.

HOLD THAT RATING: DISCUSSION ON ACTIVITIES OF NAIC'S SECURITIES VALUATION OFFICE (SVO)

Last on the agenda is a discussion on the activities of the NAIC'S SVO. This discussion deals with a proposal from the NAIC'S SVO that generally speaking, would provide them with the authority to overrule the determination of rating agencies that rate certain types of securities. The proposal has generated a significant amount of controversy. There are a slew of questions about potential issues with the proposal that can be said to fall into three buckets. Number one, due process. Number two, unintended consequences. Number three, misguided financial incentives for the SVO. So that is just for your background. This has also garnered attention at the federal level. A letter was sent to the NAIC by several U.S. House Members raising concerns. You can see that letter on the website and the app along with NAIC's response.

The Honorable Beth Dwyer, Director of the Rhode Island Department of Business Regulation, thanked the Committee for the opportunity to speak and stated that I will try to get through this pretty quickly although it is a very complicated subject. So, what is the issue? The issue is that insurers are investing in newer products, not your typical bonds. They're not as easily understood as we have seen in the past. So, the NAIC had a number of working groups under the financial condition committee looking at various issues with these type of investments. As you know, one of our main focuses, if not our main focus as state insurance regulators is the solvency of companies and we have to understand what they are investing in in order to have an understanding of whether or not the companies are solvent. So, we started hearing comments as I believe you did as well from various people involved in investments and insurers that it seemed like our approach was scattershot, maybe not coordinated. And so, what we did was we put out what we are calling the framework for insurer investments which you have on the screen here. What we did was draft a framework that I'm going to go through the seven points

of our initial draft and we hope that each of these points shows that these issues are being coordinated at the Commissioner level. They are not being directed by NAIC staff. The comments that we are hearing are being addressed. For instance, due process - I think you're going to see even more when we come to our next version of the draft on various ways to give due process to insurers who have these investments.

But let me run through if I could what that framework is going to look like. The purpose is not an intent to compete with credit rating providers or to become a credit rating provider. Our intent is to understand the ratings and establish a clear procedure on how we would adjust a rating on a particular investment if we believe that that rating was not properly assessing risk. So, what we're trying to get to is the appropriate financial charge based on the risk of the investment. We are committed to a clear procedure with levels of appeals and we are committed to adding levels of appeal that are not currently in our process. Our intent is to continue to rely on credit rating providers but to make sure that reliance is well informed. A number of people within state insurance departments have called our current reliance on credit rating providers blind reliance and from a financial regulator point of view that is scary. We want to understand what the investment is and we want to have the appropriate charge for that investment. So, the first proposal is to reduce or eliminate blind reliance on credit rating providers but retain overall utilization of those providers with the implementation of a due diligence framework. That framework has yet to be drafted. We do have some investment professionals within the states that are going to draft procedures and that will be out for public comment. I actually included at the very end here the last bullet, a quote from the framework which says, “inefficient and impractical for the SVO to effectively replicate the capabilities of credit rating providers on a large scale and would not provide incremental benefit if the output substantially similar. Rather, the SVO should focus primarily on holistic due diligence around credit rating provider usage.” What that means is we intend to continue to rely on credit rating providers, unless we see some indicia that that particular investment is getting an inappropriate charge in our financial framework.

The second proposal is to retain the ability within the SVO to provide individual credit assessment and utilize regulatory discretion when needed under well documented and governed parameters. This is a backstop. Most credit ratings are going to be accepted. The newer and more exotic ones, if that's the right word, and probably isn't the right word, those are the ones that we're going to be focusing on. The ones that we feel like we're not getting the right charge for. We're not going to be focusing on all of them. I've also heard some criticism that the SVO in and of itself wants to create itself as a competitor to credit rating providers and I do want all of you to know the SVO is part of the NAIC. The people that work there are NAIC employees. What they do and how they do it is directed by the Commissioners so it doesn't matter how much money comes in, they don't have the free discretion to spend whatever they want or add employees or anything like that. That all has to be approved by the Commissioners. There is no intent by the Commissioners to compete with credit rating providers. What we use the SVO for is to inform Commissioners on very complicated investments and how we should look at those investments in evaluating the financial solvency of an insurance company. The third proposal is to enhance the SVO risk analysis capabilities. So, this is to assist Commissioners on understanding risk analysis. It's not directly associated with any credit rating provider. But this would cost money and the NAIC would have to approve the money in order for us to do this. But it's something that we think could be very valuable to individual states in doing their own analysis. The fourth proposal is to

enhance the structured asset modeling capabilities focusing less on individual designation production and more on credit rating provider due diligence and validation. Again, we're going to have to draft procedures on this but what we're trying to do is set up procedures for credit rating providers so that we can have more faith in the ratings that we receive from them. The fifth proposal is to build out a broad policy advisory function at the SVO that can consider and recommend future policy changes to regulators. So, we are not investment experts, we are insurance regulators. But we do need to understand and be able to take into account the securities that our insurers are investing in. The sixth proposal is an investment working group under the E Committee. We currently have something called the Valuation of Securities Task Force. The proposal is to make a smaller group, very specifically focused on investments to advise the Commissioners on various policies.

And the final proposal is to rename the SVO and the Valuation of Securities Task Force to better recognize the responsibilities of the groups. We also have an issue with the Valuation of Securities Task force in that there's just too many members. I'm sure you've all been members of committees when there's so many people you can't get anything done. So, we're looking at the committees and the task force we have in this area to see if reduction in size might assist us in getting more done. So, the conclusion is that these proposals are designed to provide regulators with the tools that we need to properly value investments. The goal is equal capital for equal risk. As financial regulators were attempting to assess the appropriate capital and avoid regulatory arbitrage. There is no attempt to compete with credit rating providers. We are the recipients of the ratings and we're evaluating them for our own use, not putting them out for somebody else's use. The NAIC has established a public process to consider this so the framework is out for comment. We've received comments from I believe 17 different carriers. I would, by the way, strongly suggest that anybody who is interested in this file comments either orally or written. It makes it very difficult when we hear comments outside of what we have in the process. It's very difficult to address those comments if the people who are interested don't file comments. We will have a meeting at the NAIC meeting in Orlando where each of the 17 that have filed written comments will be allowed to supplement those comments orally. We will then take back all of the comments and come up with a second version of the framework hopefully addressing most of the issues that commenters bring up.

Caitlin Colvin, Senior Managing Director, Business Development at Kroll Bond Rating Agency (KBRA), thanked the Committee for the opportunity to speak and stated that I'm happy to give the credit rating agency perspective on some of the work streams going on within the NAIC. For those of you that aren't familiar, KBRA was founded in 2010. We have over 500 employees, over 68,000 ratings representing over $3.3 trillion in debt issuance. We are the largest post crisis founded rating agency. And we rate all asset classes. We are a nationally recognized statistical rating organization (NRSRO) in all asset class and we'll talk about that in a little bit but what I want to start off by saying is we were very happy to see the E Committee's framework that was released before the summer national meeting. We think there's a lot of really interesting and helpful guideposts in that framework. And most importantly, I think it's important to say we are very supportive of additional rating agency diligence. We're happy to talk about our process and speaking from KBRA's perspective, of course, we're happy to talk about our process, our methodologies, how our teams arrive at certain ratings. We're happy to do case studies on certain transactions and talk about asset classes. We think rating

agencies broadly actually are very well positioned to opine on credit given that is our sole reason for existing. And we as rating agencies, and again speaking specifically for KBRA, we work really hard at cultivating sector expertise and we really believe we are the experts in particular in certain classes that may potentially be more challenging and take a little bit longer to understand. But we think it's really important to staff our credit analysts with the right people to dive into those credits and we don't take that lightly. It can take us months to turn around a rating and come to a rating that we think is the appropriate rating for that security. I'm just speaking from experience. I'm an aircraft finance lawyer by trade. I was initially hired by KBRA to actually rate aircraft finance transactions and I was able to build a team and pass along knowledge that we think is really helpful in the ratings that we have outstanding in that asset class.

We really understand collateral. We really understand structure and we think it's really helpful to the market and the write ups we provide to insurance companies that are purchasing that kind of paper. That's just one example. We also believe that you don't really want your podiatrist doing brain surgery. So we have a subject matter expertise in each asset class that we do. I think in contrast to the SVO, and I think in what Dir. Dwyer was saying they are a very helpful organization and they're helpful staff to the Valuation of Securities Task Force but they are tasked with reviewing a great many securities. We have the staff and expertise we think to sort of be best in class in credit ratings. So, we're happy to shed light on how we do that and we look forward to engaging in further dialogue and in fact the Valuation of Securities Task Force passed along a list of questions to each credit rating provider about our processes, about our regulations, about our methodologies. And we did provide responses to those and very much look forward to dialoguing with regulators on those. We think that's going to shed a lot of light on how diligent these processes are and how much the insurance companies actually rely on the write ups that we do. And in contrast, not only do we provide the write up in conjunction with the rating itself, we also do extensive research across asset classes where we believe, banks in particular, there's a void. So, sector expertise is helpful. I do just want to take a minute or two to focus on the federal regulation over NRSRO's. We are an approved rating agency. We are regulated by the SEC. We are also regulated in Europe by European Securities and Markets Authority (ESMA), and the Financial Conduct Authority (FCA) and in particular U.S. federal regulation require us to be extremely transparent in what we're doing. It requires us to have published methodologies. It requires us to back test when we're changing methodologies. It requires us to say how many ratings would be impacted when we make those changes. I think things like that are really helpful, particularly when it comes to the NAIC. I think Standard & Poor's (S&P) for example just produced its insurance rating risk based capital (RBC) rating methodology today. It was required to list which companies would be impacted by or potentially impacted by that methodology. That kind of transparency is really helpful.

And I think as we start working through the discretionary proposal that Rep. Anderson spoke about at the beginning, we think it's really important that that transparency exists because it is required by rating agencies and we think that can be very helpful in that process. And as Dir. Dwyer said the discretionary proposal it was re-released and it'll be seemingly on the agenda at the national meeting. And as was alluded to at the beginning by Rep. Anderson as well, it garnered a significant amount of attention, the initial draft. My reading of the second draft and some comments I received is that there are certain additional transparencies built in but I very much look forward to

understanding a little bit better what the SVO is required to bring in front of regulators, particularly state regulators, where you have insurance companies across states. How's that going to be worked out? And I'm very much looking forward to understanding the controls that the Commissioners are looking to put in place in light of the E Committee framework but I think we'll be hearing a lot more of that after the national meeting in December.

Ms. Walters stated that the ACLI and its member companies appreciate and support this new holistic approach that the NAIC is looking at. As we know, the regulation of insurer investments continues to evolve daily so it makes sense for this coordinated approach. While each of the projects are led by knowledgeable subject matters and there's some overlap in membership between the working groups, we think it might also make sense to maybe create a more smaller group of knowledgeable regulators that have a clear sight into all of the groups so that they can see the big picture and the interconnected projects and perhaps could provide an additional layer of leadership and guidance if necessary.

Sen. Lana Theis (MI) stated that this is an extraordinarily important issue. I have some generalized questions regarding the statements that there was a blind reliance and they weren't appropriately assessing risk and wanting people to be well informed. Who considers the risk inappropriate and based on what factor? What are you looking at to consider it appropriate? Because they have measurable quantifiable success rates and you weren't referring to those. Dir. Dwyer stated that this is only on some by the way. So the vast majority of ratings are accepted by the NAIC and the charge is given. There's various indicia on some and it's usually private credit. It won't be something that you'd use, it's not something you or I would buy. This is private credit. One of the things we're going to put into our procedures is what indicia it would be that would lead us to consider whether to take one step further and look closer at the investment. So some of the things I've heard and I do not obviously day-to-day look at investments myself, but some of the things I've heard are a credit rated at A where the underlying assets might be C and you wonder why the A is given. So, you look a little further into whether that was the appropriate valuation. That's the kind of thing we're talking about.

Sen. Theis asked are you seeing insolvency such that you feel like you need to do this? Dir. Dwyer stated we're not seeing insolvency but our job is to make sure that the insolvencies don't occur. Newer investments are starting to come into the market. They are not a huge percentage of the market yet but we don't usually wait until there is an insolvency to do something that we're concerned about. Sen. Theis stated that I understand what you're saying, but it sounds like you have a regulator overseeing something that's saying we're going to agree with you as long as we agree with you and then we're going to tell you it's not correct and you're going to have to go back and then that's going to be a pretty chilling effect on our rating agencies in how they're going to be able to approach the rating and what they're going to consider and what remedies they might have. So, I have concerns about the NAIC here and the regulator organization being the one that makes the determination as to whether or not these rating factors are accurate. It doesn't seem like it's going to be an independent approach. It's basically as long as you say what we think, then we agree and you're good. But if we disagree there's going to be a major problem. Dir. Dwyer stated that's kind of what we do every day. So, you might have an insurer file a reserve with you, and this doesn't have anything to do with investments, but you'll file a reserve with us, our domestic

companies, and we will take a look at it with a consulting actuary or an actuary that's on staff and say, “we don't agree with you.” And we go back and forth with the insurer. That would kind of be the same thing here, except that you have the involvement of credit rating providers which you wouldn't in the reserve type situation.

Sen. Theis stated that it is an expansion of what it is that you do. It's not what you do every day. This is an expansion, correct? Dir. Dwyer stated no, it's not an expansion. Every day we do look at the investments of insurers and give them an appropriate charge. The issue is the investments are changing. These are newer investments, they're not, buying a corporate bond. If you buy a corporate bond, it's pretty easy. You bought the bond, the bond is rated A or B, we give an appropriate charge for this. These are newer investments. They're not corporate bonds. They are more complicated and we feel we need to understand the rating that's given and why it's given to give the appropriate charge. We also have an issue between companies. So, if there are certain companies investing in these newer investments and they're getting an inappropriate charge for that, there’s a competitive advantage over companies that are still investing in bonds. So, we're also looking at that. We look to make sure that whatever financial charge we're giving is the appropriate charge for that investment.

Rep. Tom Oliverson, M.D. (TX) stated that my understanding is that you have these NRSRO's which are all regulated by the SEC. The private sector is essentially already fulfilling this responsibility but now we have the organization that is not regulated by the SEC which is responsible for taking those recommendations and basically taking action with the insurance companies doing business in their states and sort of I'm going to take your business from you and I'm going to do it myself. My question is, are you going to charge for this? Does the SVO charge for these services that they're providing? Dir. Dwyer stated that they do charge for some services and we are going to look at what they're charging and how they charge but we are the customer. So, when a bond is rated by an NRSRO, we are the customer of that. So we're looking at the solvency of the insurance company. The rating organization is rating that bond and then we're looking at that rating and making sure that we agree with it. Right now, a lot of what we do is simply blind reliance on that SEC regulated provider. The problem is the SEC is not responsible for the solvency of insurance companies. If we see an investment that we do not feel is getting the appropriate charge, that can affect the solvency of the insurance company which is what our responsibility is.

Rep. Oliverson stated that it just seems to me like this is an unmitigated terrible conflict of interest for the NAIC to get into this business. And then I could see in a very short period of time that essentially this becomes the only company doing this business cause the NAIC stops using everybody else and essentially says, “we're just going to do this in house. And by the way, we're making a lot of money by doing it.” I really have a bad feeling about this and I hope that you all will go back to the drawing board on multiple proposals here. I have serious questions about the appeals process and the lack of transparency. And if you're an insurance company and you disagree with the SVO, you're essentially appealing to the umpire that threw you out of the game. There is no alternative mechanism for dispute resolution. And if you come in heavy-handed as an insurance company because you object to the ratings now you're not only picking a fight with the SVO, you're picking a fight with the NAIC who essentially holds all the cards in your future ability to do business. I think this is an unbelievably bad conflict of interest and I can assure you that we are going to continue to stay very aggressively engaged

with you on this if you all continue down this path to make sure that we're not doing irreparable damage to the free market in this process by essentially reducing the number of NSRSO's down to one which is the SVO. Dir. Dwyer stated that I can tell you that is absolutely not the intent of the Commissioners at all. We have absolutely no intent to replace credit rating providers. In fact, in order for us to do our own ratings of all of the investments and insurance companies we'd have to be larger than S&P and we have no intent to do that.

Sen. Bob Hackett (OH) stated to Rep. Oliverson that we rarely disagree but I disagree with you profusely here. I like the rating agencies but the rating agencies aren't perfect and I'll give you an example. Look at mortgage-backed bonds – in 2008 and 2009 they were rated a lot better than they should have been rated but they were rated based on the details and the data of risk that they were given. And so, I don't mind this because our Department of Insurance has to make sure that companies are strong and we have to look at them even stronger than in addition to the ratings alone. So, they're going to listen to the rating agencies, but they're going to make the rating agencies really back things up if there are questions. Sen. Hackett asked Ms. Colvin how KBRA rated the mortgage-backed bonds in 2009 because I know how Moody's rated them and how S&P rated them. Ms. Colvin stated that KBRA was founded in 2010 so we didn't rate them. Sen. Hackett stated that's probably why KBRA was started, because of the criticism of Moody's and other rating agencies. Ms. Colvin stated that's exactly right. Rep. Oliverson stated then it should be done at cost - don't turn it into a profit center. If you're turning it into a profit center, then it becomes a monopoly.

ADJOURNMENT

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

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

National Council of Insurance Legislators (NCOIL)

Model Unclaimed Life Insurance Benefits Act

***Updated version adopted by the NCOIL Executive Committee on November 23, 2014. Model originally adopted by the Executive Committee on November 20, 2011*.**
Readopted by the NCOIL Life Insurance & Financial Planning Committee on March 16, 2019 and the NCOIL Executive Committee on March 17, 2019

To be considered for re-adoption during the Life Insurance & Financial Planning Committee's meeting on April 12, 2024.

Section 1. Short Title

This Act shall be known as the Unclaimed Life Insurance Benefits Act.

Section 2. Purpose

This Act shall require recognition of the escheat or unclaimed property statutes of the adopting state and require the complete and proper disclosure, transparency, and accountability relating to any method of payment for life insurance death benefits regulated by the state's insurance department.

Section 3. Definitions

A. "Contract" means an annuity contract. The term "Contract" shall not include an annuity used to fund an employment-based retirement plan or program where (1) the insurer does not perform the Record Keeping Services or (2) the insurer is not committed by terms of the annuity contract to pay death benefits to the beneficiaries of specific plan participants.

B. "Death Master File" means the United States Social Security Administration's Death Master File or any other database or service that is at least as comprehensive as the United States Social Security Administration's Death Master File for determining that a person has reportedly died.

C. "Death Master File Match" means a search of the Death Master File that results in a match of the social security number or the name and date of birth of an insured, annuity owner, or retained asset account holder.

D. “Knowledge of Death” shall mean (a) receipt of an original or valid copy of a certified death certificate or (b) a Death Master File Match validated by the Insurer in accordance with Section 4(A)(1)(a).

E. “Policy” means any policy or certificate of life insurance that provides a death benefit. The term “Policy” shall not include (i) any policy or certificate of life insurance that provides a death benefit under an employee benefit plan (a) subject to The Employee Retirement Income Security Act of 1974 [29 USC 1002], as periodically amended, or (b) under any Federal employee benefit program, or (ii) any policy or certificate of life insurance that is used to fund a preneed funeral contract or prearrangement, or (iii) any policy or certificate of credit life or accidental death insurance, or (iv) any policy issued to a group master policyholder for which the insurer does not provide Record Keeping services.

F. “Record Keeping Services” means those circumstances under which the Insurer has agreed with a group Policy or Contract customer to be responsible for obtaining, maintaining and administering in its own or its agents' systems information about each individual insured under an Insured’s group insurance contract (or a line of coverage thereunder), at least the following information: (1) Social Security number or name and date of birth, and (2) beneficiary designation information, (3) coverage eligibility, (4) benefit amount, and (5) premium payment status.

G. “Retained Asset Account” means any mechanism whereby the settlement of proceeds payable under a Policy or Contract is accomplished by the insurer or an entity acting on behalf of the insurer depositing the proceeds into an account with check or draft writing privileges, where those proceeds are retained by the insurer or its agent, pursuant to a supplementary contract not involving annuity benefits other than death benefits.

Drafting note: All other terms used in this Act shall be interpreted in a manner consistent with the definitions used in [Insert State Insurance Code].

Section 4. Insurer Conduct

A. An insurer shall perform a comparison of its insureds’ in-force Policies, Contracts, and Retained Asset Accounts against a Death Master File, on at least a semi-annual basis, by using the full Death Master File once and thereafter using the Death Master File update files for future comparisons to identify potential matches of its insureds. For those potential matches identified as a result of a Death Master File Match, the insurer shall:

1. within ninety (90) days of a Death Master File Match:

    a. complete a good faith effort, which shall be documented by the insurer, to confirm the death of the insured or retained asset account holder against other available records and information;

b. determine whether benefits are due in accordance with the applicable policy or contract; and if benefits are due in accordance with the applicable policy or contract:

i. use good faith efforts, which shall be documented by the insurer, to locate the beneficiary or beneficiaries; and

ii. provide the appropriate claims forms or instructions to the beneficiary or beneficiaries to make a claim including the need to provide an official death certificate, if applicable under the policy, contract.

2. With respect to group life insurance, insurers are required to confirm the possible death of an insured when the insurers maintain at least the following information of those covered under a policy or certificate: (1) Social Security number or name and date of birth, and (2) beneficiary designation information, (3) coverage eligibility, (4) benefit amount, and (5) premium payment status.

3. Every insurer shall implement procedures to account for:

a. common nicknames, initials used in lieu of a first or middle name, use of a middle name, compound first and middle names, and interchanged first and middle names;

b. compound last names, maiden or married names, and hyphens, blank spaces or apostrophes in last names;

c. transposition of the "month" and "date" portions of the date of birth; and

d. incomplete social security number

4. To the extent permitted by law, the insurer may disclose minimum necessary personal information about the insured or beneficiary to a person who the insurer reasonably believes may be able to assist the insurer locate the beneficiary or a person otherwise entitled to payment of the claims proceeds.

B. An Insurer or its service provider shall not charge any beneficiary or other authorized representative for any fees or costs associated with a Death Master File Search or verification of a Death Master File Match conducted pursuant to this section.

C. The benefits from a Policy, Contract or a Retained Asset Account, plus any applicable accrued contractual interest shall first be payable to the designated beneficiaries or owners and in the event said beneficiaries or owners can not be found, shall escheat to the state as unclaimed property pursuant to [Cite state statute for escheat or unclaimed life insurance benefits]. Interest payable under [cite insurance code statutory interest law]

shall not be payable as unclaimed property under [cite state statute for escheat of unclaimed life insurance benefits].

Drafting note: Some states' insurance commissioners may want to develop an informational notice that apprises beneficiaries of their rights to the payment of interest on the benefits or proceeds of a life insurance policy or retained asset account. The written notice should be provided by a life insurer to a beneficiary prior to or concurrent with the payment of any life insurance proceeds or the settlement of any life insurance claim, where applicable.

D. An insurer shall notify the [Insert the state agency for unclaimed property] upon the expiration of the statutory time period for escheat that:

1. a Policy or Contract beneficiary or Retained Asset Account holder has not submitted a claim with the insurer; and

2. the insurer has complied with subsection A of this Section and has been unable, after good faith efforts documented by the insurer, to contact the Retained Asset Account holder, beneficiary or beneficiaries

E. Upon such notice, an insurer shall immediately submit the unclaimed Policy or Contract benefits or unclaimed Retained Asset Accounts, plus any applicable accrued interest, to the [Insert the state agency for unclaimed property].

F. Failure to meet any requirement of this section with such frequency as to constitute a general business practice is a violation of [Insert State Unfair Trade Practices Statute]. Nothing herein shall be construed to create or imply a private cause of action for a violation of this Section.

Drafting note: Some states' Unfair Trade Practices statutes specify that an act must be shown to be a "pattern" or "general business practice" in order to constitute a violation of that statute. In those instances, care should be taken in the adoption of this model to ensure consistency across those two statutes.

Section 6. Effective Date

This Act shall take effect no less than one year after the date signed into law.

Drafting note: To address other concerns with transparency and accountability in life insurer procedures relating to treatment of retained asset accounts, please refer to the NCOIL Beneficiaries' Bill of Rights, which requires extensive written disclosures to consumer and insurer reporting.

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

NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

LIFE SETTLEMENTS MODEL ACT

Readopted by the NCOIL Life Insurance & Financial Planning Committee on March 16, 2019 and the NCOIL Executive Committee on March 17, 2019
Readopted by the NCOIL Executive Committee on March 9, 2014
Adopted by the NCOIL Executive Committee on November 16, 2007
Amended by the NCOIL Life Insurance & Financial Planning Committee on November 15, 2007
Amended by the Executive Committee on July 16, 2004
Adopted by the Executive Committee on November 17, 2000.

****To be considered for re-adoption during the Life Insurance & Financial Planning Committee's meeting on April 12, 2024.***

****Proposed amendments submitted for discussion by the Life Insurance Settlement Association (LISA).***

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[DRAFTING NOTE: “It is an essential public policy objective to protect consumers against stranger- originated life insurance (STOLI). STOLI is a practice or plan to initiate a life insurance policy for the benefit of a third party investor who, at the time of policy origination, has no insurable interest in the insured. STOLI practices include but are not limited to cases in which life insurance is purchased with resources or guarantees from or through a person, or entity, who, at the time of policy inception, could not lawfully initiate the policy themselves, and where, at the time of inception, there is an arrangement or agreement, whether verbal or written, to directly or indirectly transfer the ownership of the policy and/or the policy benefits to a third party. Trusts, that are created to give the appearance of insurable interest, and are used to initiate policies for investors, violate insurable interest laws and the prohibition against wagering on life. STOLI arrangements do not include those practices set forth in Section 2L(2) of this Act.

Trusts that are created to give the appearance of insurable interest and are used to manufacture policies for investors are illegal STOLI schemes. As the United States Supreme Court held, a person with insurable interest cannot lend that insurable interest “as a cloak to what is in its inception a wager.” Grigsby v.Russell, 222 U.S. 149 (1911).

Therefore, states should consider adopting an amendment to their insurable interest laws, if necessary, to provide additional protection against trust-initiated STOLI and other schemes involving a cloak, as follows:

‘In accordance with Grigsby v. Russell, 222 U.S. 149, it shall be a violation of insurable interest for any person or entity without insurable interest to provide or arrange for the funding ultimately used to pay premiums, or the majority of premiums, on a life insurance policy, and, at policy inception have an arrangement for such person or entity to have an ownership interest in the majority of the death benefit of that life insurance policy.’”]

Section 1. Short Title

Sections 1 through 18 of this Act may be cited as the ‘Life Settlements Act.’

Section 2. Definitions

A. ‘Advertisement’ means any written, electronic or printed communication or any communication by means of recorded telephone messages or transmitted on radio, television, the Internet or similar communications media, including film strips, motion pictures and videos, published, disseminated, circulated or placed before the public, directly or indirectly, for the purpose of creating an interest in or inducing a Person to purchase or sell, assign, devise, bequest or transfer the death benefit or ownership of a life insurance policy or an interest in a life insurance policy pursuant to a Life Settlement Contract.

B. ‘Broker’ means a Person who, on behalf of an Owner and for a fee, commission or other valuable consideration, offers or attempts to negotiate Life Settlement Contracts

between an Owner and Providers. A Broker represents only the Owner and owes a fiduciary duty to the Owner to act according to the Owner's instructions, and in the best interest of the Owner, notwithstanding the manner in which the Broker is compensated. A Broker does not include an attorney, certified public accountant or financial planner retained in the type of practice customarily performed in their professional capacity to represent the Owner whose compensation is not paid directly or indirectly by the Provider or any other person, except the Owner.

C. 'Business of life settlements' means an activity involved in, but not limited to, offering to enter into, soliciting, negotiating, procuring, effectuating, monitoring, or tracking, of Life Settlement Contracts.

D. 'Chronically ill' means:

1. being unable to perform at least two (2) activities of daily living (i.e., eating, toileting, transferring, bathing, dressing or continence);

2. requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment; or

3. having a level of disability similar to that described in Paragraph (1) as determined by the United States Secretary of Health and Human Services.

E. 'Commissioner' means the Commissioner or Superintendent of the Department of Insurance.

F. 'Financing Entity' means an underwriter, placement agent, lender, purchaser of securities, purchaser of a policy or certificate from a Provider, credit enhancer, or any entity that has a direct ownership in a policy or certificate that is the subject of a Life Settlement Contract, but:

1. whose principal activity related to the transaction is providing funds to effect the Life Settlement Contract or purchase of one or more policies; and

2. who has an agreement in writing with one or more Providers to finance the acquisition of Life Settlement Contracts. 'Financing Entity' does not include a non-accredited investor or Purchaser.

G. 'Financing Transaction' means a transaction in which a licensed Provider obtains financing from a Financing Entity including, without limitation, any secured or unsecured financing, any securitization transaction, or any securities offering which either is registered or exempt from registration under federal and state securities law.

H. 'Fraudulent Life Settlement Act' includes:

1. Acts or omissions committed by any person who, knowingly and with intent to defraud, for the purpose of depriving another of property or for pecuniary gain, commits, or permits its employees or its agents to engage in acts including, but not limited to:

(a) Presenting, causing to be presented or preparing with knowledge and belief that it will be presented to or by a Provider, Premium Finance lender, Broker, insurer, insurance producer or any other person, false material information, or concealing material information, as part of, in support of, or concerning a fact material to one or more of the following:

(i) An application for the issuance of a Life Settlement Contract or insurance policy;

(ii) The underwriting of a Life Settlement Contract or insurance policy;

(iii) A claim for payment or benefit pursuant to a Life Settlement Contract or insurance policy;

(iv) Premiums paid on an insurance policy;

(v) Payments and changes in ownership or beneficiary made in accordance with the terms of a Life Settlement Contract or insurance policy;

(vi) The reinstatement or conversion of an insurance policy;

(vii) In the solicitation, offer to enter into, or effectuation of a Life Settlement Contract, or insurance policy;

(viii) The issuance of written evidence of Life Settlement Contracts or insurance;

(ix) Any application for or the existence of or any payments related to a loan secured directly or indirectly by any interest in a life insurance policy; or

(x) Enter into any practice or plan which involves STOLI.

(b) Failing to disclose to the insurer where the request for such disclosure has been asked for by the insurer that the prospective insured has undergone a life expectancy evaluation by any person or entity other than the insurer or its authorized representatives in connection with the issuance of the policy.

(c) Employing any device, scheme, or artifice to defraud in the business of life settlements.

(d) In the solicitation, application or issuance of a life insurance policy, employing any device, scheme or artifice in violation of state insurable interest laws.

2. In the furtherance of a fraud or to prevent the detection of a fraud any person commits or permits its employees or its agents to;

(a) Remove, conceal, alter, destroy or sequester from the Commissioner the assets or records of a licensee or other person engaged in the business of life settlements;

(b) Misrepresent or conceal the financial condition of a licensee, financing entity, insurer or other person;

(c) Transact the business of life settlements in violation of laws requiring a license, certificate of authority or other legal authority for the transaction of the business of life settlements;

(d) File with the Commissioner or the chief insurance regulatory official of another jurisdiction a document containing false information or otherwise concealing information about a material fact from the Commissioner;

(e) Engage in embezzlement, theft, misappropriation or conversion of monies, funds, premiums, credits or other property of a Provider, insurer, insured, owner, insurance, policy owner or any other person engaged in the business of life settlements or insurance;

(f) Knowingly and with intent to defraud, enter into, broker, or otherwise deal in a Life Settlement Contract, the subject of which is a life insurance policy that was obtained by presenting false information concerning any fact material to the policy or by concealing, for the purpose of misleading another, information concerning any fact material to the policy, where the owner or the owner's agent intended to defraud the policy's issuer;

(g) Attempt to commit, assist, aid or abet in the commission of, or conspiracy to commit the acts or omissions specified in this subsection; or

(h) Misrepresent the state of residence of an owner to be a state or jurisdiction that does not have a law substantially similar to this Act for the purpose of evading or avoiding the provisions of this Act.

I. ‘Insured’ means the person covered under the policy being considered for sale in a Life Settlement Contract.

J. ‘Life expectancy’ means the arithmetic mean of the number of months the Insured under the life insurance policy to be settled can be expected to live as determined by a life expectancy company considering medical records and appropriate experiential data.

K. ‘Life insurance producer’ means any person licensed in this state as a resident or nonresident insurance producer who has received qualification or authority for life insurance coverage or a life line of coverage pursuant to [insert reference to applicable producer licensing statute, with specific reference to a life insurance or equivalent line of authority].

L. ‘Life Settlement Contract’ means a written agreement entered into between a Provider and an Owner, establishing the terms under which compensation or any thing of value will be paid, which compensation or thing of value is less than the expected death benefit of the insurance policy or certificate, in return for the owner’s assignment, transfer, sale, devise or bequest of the death benefit or any portion of an insurance policy or certificate of insurance for compensation, provided, however, that the minimum value for a Life Settlement Contract shall be greater than a cash surrender value or accelerated death benefit available at the time of an application for a Life Settlement Contract. “Life Settlement Contract” also includes the transfer for compensation or value of ownership or beneficial interest in a trust or other entity that owns such policy if the trust or other entity was formed or availed of for the principal purpose of acquiring one or more life insurance contracts, which life insurance contract insures the life of a person residing in this State.

1. ‘Life Settlement Contract’ also includes

(a) a written agreement for a loan or other lending transaction, secured primarily by an individual or group life insurance policy; or

(b) a premium finance loan made for a policy on or before the date of issuance of the policy where:

(i.) The loan proceeds are not used solely to pay premiums for the policy and any costs or expenses incurred by the lender or the borrower in connection with the financing; or

(ii.) The Owner receives on the date of the premium finance loan a guarantee of the future life settlement value of the policy; or

(iii.) The Owner agrees on the date of the premium finance loan to sell the policy or any portion of its death benefit on any date following the issuance of the policy.

2. ‘Life Settlement Contract’ does not include:

(a) A policy loan by a life insurance company pursuant to the terms of the life insurance policy or accelerated death provisions contained in the life insurance policy, whether issued with the original policy or as a rider;

(b) A premium finance loan, as defined herein, or any loan made by a bank or other licensed financial institution, provided that neither default on such loan nor the transfer of the policy in connection with such default is pursuant to an agreement or understanding with any other person for the purpose of evading regulation under this Act;

(c) A collateral assignment of a life insurance policy by an owner;

(d) A loan made by a lender that does not violate [insert reference to state’s insurance premium finance law], provided such loan is not described in Paragraph (1) above, and is not otherwise within the definition of Life Settlement Contract;

(e) An agreement where all the parties [i] are closely related to the insured by blood or law or [ii] have a lawful substantial economic interest in the continued life, heath and bodily safety of the person insured, or are trusts established primarily for the benefit of such parties;

(f) Any designation, consent or agreement by an insured who is an employee of an employer in connection with the purchase by the employer, or trust established by the employer, of life insurance on the life of the employee;

(g) A bona fide business succession planning arrangement:

(i.) Between one or more shareholders in a corporation or between a corporation and one or more of its shareholders or one or more trust established by its shareholders;

(ii.) Between one or more partners in a partnership or between a partnership and one or more of its partners or one or more trust established by its partners; or

(iii.) Between one or more members in a limited liability company or between a limited liability company and one or more of its members or one or more trust established by its members;

(h) An agreement entered into by a service recipient, or a trust established by the service recipient, and a service provider, or a trust established by

the service provider, who performs significant services for the service recipient's trade or business; or

(i) Any other contract, transaction or arrangement from the definition of Life Settlement Contract that the Commissioner determines is not of the type intended to be regulated by this Act.

M. 'Net death benefit" means the amount of the life insurance policy or certificate to be settled less any outstanding debts or liens.

N. 'Owner' means the owner of a life insurance policy or a certificate holder under a group policy, with or without a terminal illness, who enters or seeks to enter into a Life Settlement Contract. For the purposes of this article, an Owner shall not be limited to an Owner of a life insurance policy or a certificate holder under a group policy that insures the life of an individual with a terminal or chronic illness or condition except where specifically addressed. The term 'Owner' does not include:

1. any Provider or other licensee under this Act;

2. a qualified institutional buyer as defined in Rule 144A of the federal Securities Act of 1933, as amended;

3. a financing entity;

4. a special purpose entity; or

5. a related provider trust.

O. 'Patient identifying information' means an insured's address, telephone number, facsimile number, electronic mail address, photograph or likeness, employer, employment status, social security number, or any other information that is likely to lead to the identification of the insured.

P. 'Policy' means an individual or group policy, group certificate, contract or arrangement of life insurance owned by a resident of this state, regardless of whether delivered or issued for delivery in this state.

Q. 'Premium Finance Loan' is a loan made primarily for the purposes of making premium payments on a life insurance policy, which loan is secured by an interest in such life insurance policy.

R. 'Person' means any natural person or legal entity, including but not limited to, a partnership, Limited Liability Company, association, trust or corporation.

S. 'Provider' means a Person, other than an Owner, who enters into or effectuates a Life Settlement Contract with an Owner, A Provider does not include:

1. any bank, savings bank, savings and loan association, credit union;

2. a licensed lending institution or creditor or secured party pursuant to a Premium Finance Loan agreement which takes an assignment of a life insurance policy or certificate issued pursuant to a group life insurance policy as collateral for a loan;
3. the insurer of a life insurance policy or rider to the extent of providing accelerated death benefits or riders under [refer to law or regulation implementing or accelerated death benefits provision] or cash surrender value;

4. any natural Person who enters into or effectuates no more than one agreement in a calendar year for the transfer of a life insurance policy or certificate issued pursuant to a group life insurance policy, for compensation or anything of value less than the expected death benefit payable under the policy;

5. a Purchaser;

6. any authorized or eligible insurer that provides stop loss coverage to a provider; purchaser, financing entity, special purpose entity, or related provider trust;

7. a Financing Entity;

8. a Special Purpose Entity;

9. a Related Provider Trust;

10. a Broker; or

11. an accredited investor or qualified institutional buyer as defined in respectively in regulation D, rule 501 or rule 144A of the federal securities act of 1933, as amended, who purchases a life settlement policy from a Provider.

T. 'Purchased Policy' means a policy or group certificate that has been acquired by a Provider pursuant to a Life Settlement Contract.

U. 'Purchaser' means a Person who pays compensation or anything of value as consideration for a beneficial interest in a trust which is vested with, or for the assignment, transfer or sale of, an ownership or other interest in a life insurance policy or a certificate issued pursuant to a group life insurance policy which has been the subject of a Life Settlement Contract.

V. 'Related Provider Trust' means a titling trust or other trust established by a licensed Provider or a Financing Entity for the sole purpose of holding the ownership or beneficial interest in purchased policies in connection with a Financing Transaction. In order to qualify as a Related Provider Trust, the trust must have a written agreement with the licensed Provider under which the licensed Provider is responsible for ensuring

compliance with all statutory and regulatory requirements and under which the trust agrees to make all records and files relating to life settlement transactions available to the Department of Insurance as if those records and files were maintained directly by the licensed Provider.

W. 'Settled policy' means a life insurance policy or certificate that has been acquired by a Provider pursuant to a Life Settlement Contract.

X. 'Special Purpose Entity' means a corporation, partnership, trust, limited liability company, or other legal entity formed solely to provide either directly or indirectly access to institutional capital markets:

1. for a financing entity or provider; or

(a) in connection with a transaction in which the securities in the special purpose entity are acquired by the owner or by a "qualified institutional buyer" as defined in Rule 144 promulgated under The Securities Act of 1933, as amended; or

(b) the securities pay a fixed rate of return commensurate with established asset- backed institutional capital markets.

Y. 'Stranger-Originated Life Insurance' or 'STOLI' is a practice or plan to initiate a life insurance policy for the benefit of a third party investor who, at the time of policy origination, has no insurable interest in the insured. STOLI practices include but are not limited to cases in which life insurance is purchased with resources or guarantees from or through a person, or entity, who, at the time of policy inception, could not lawfully initiate the policy himself or itself, and where, at the time of inception, there is an arrangement or agreement, whether verbal or written, to directly or indirectly transfer the ownership of the policy and/or the policy benefits to a third party. Trusts, that are created to give the appearance of insurable interest, and are used to initiate policies for investors, violate insurable interest laws and the prohibition against wagering on life. STOLI arrangements do not include those practices set forth in Section 2L(2) of this Act.

Z. 'Terminally Ill' means having an illness or sickness that can reasonably be expected to result in death in twenty-four (24) months or less.

Section 3. Licensing Requirements

A. No Person, wherever located, shall act as a Provider or Broker with an Owner or multiple Owners who is a resident of this state, without first having obtained a license from the Commissioner. If there is more than one owner on a single policy and the owners are residents of different states, the Life Settlement Contract shall be governed by the law of the state in which the owner having the largest percentage ownership resides or, if the owners hold equal ownership, the state of residence of one owner agreed upon in writing by all owners.

B. Application for a Provider, or Broker, license shall be made to the Commissioner by the applicant on a form prescribed by the Commissioner, and the application shall be accompanied by a fee in an amount established by the Commissioner, provided, however, that the license and renewal fees for a Provider license shall be reasonable and that the license and renewal fees for a Broker license shall not exceed those established for an insurance producer, as such fees are otherwise provided for in this chapter.

C. A life insurance producer who has been duly licensed as a resident insurance producer with a life line of authority in this state or his or her home state for at least one year and is licensed as a nonresident producer in this state shall be deemed to meet the licensing requirements of this section and shall be permitted to operate as a Broker.

D. Not later than thirty (30) days from the first day of operating as a Broker, the life insurance producer shall notify the Commissioner that he or she is acting as a Broker on a form prescribed by the Commissioner, and shall pay any applicable fee to be determined by the Commissioner. Notification shall include an acknowledgement by the life insurance producer that he or she will operate as a Broker in accordance with this Act.

E. The insurer that issued the policy that is the subject of a Life Settlement Contract shall not be responsible for any act or omission of a Broker or Provider or Purchaser arising out of or in connection with the life settlement transaction, unless the insurer receives compensation for the placement of a Life Settlement Contract from the Provider or Purchaser or Broker in connection with the Life Settlement Contract.

F. A person licensed as an attorney, certified public accountant or financial planner accredited by a nationally recognized accreditation agency, who is retained to represent the Owner, whose compensation is not paid directly or indirectly by the Provider or Purchaser, may negotiate Life Settlement Contracts on behalf of the Owner without having to obtain a license as a Broker.

G. Licenses may be renewed every [INSERT NUMBER OF YEARS] on the anniversary date upon payment of the periodic renewal fee. As specified by subsection B of this section, the renewal fee for a Provider shall not exceed a reasonable fee. Failure to pay the fee within the terms prescribed shall result in the automatic revocation of the license requiring periodic renewal.

H. The term of a Provider license shall be equal to that of a domestic stock life insurance company and the term of a Broker license shall be equal to that of an insurance producer license. Licenses requiring periodic renewal may be renewed on their anniversary date upon payment of the periodic renewal fee as specified in subsection B of this section. Failure to pay the fees on or before the renewal date shall result in expiration of the license.

I. The applicant shall provide such information as the Commissioner may require on forms prepared by the Commissioner. The Commissioner shall have authority, at any

time, to require such applicant to fully disclose the identity of its stockholders (except stockholders owning fewer than ten percent of the shares of an applicant whose shares are publicly traded), partners, officers and employees, and the Commissioner may, in the exercise of the Commissioner's sole discretion, refuse to issue such a license in the name of any Person if not satisfied that any officer, employee,
stockholder or partner thereof who may materially influence the applicant's conduct meets the standards of Sections 1 to 14 of this Act.

J. A license issued to a partnership, corporation or other entity authorizes all members, officers and designated employees to act as a licensee under the license, if those Persons are named in the application and any supplements to the application.

K. Upon the filing of an application and the payment of the license fee, the Commissioner shall make an investigation of each applicant and may issue a license if the Commissioner finds that the applicant:

1. if a Provider, has provided a detailed plan of operation;

2. is competent and trustworthy and intends to transact its business in good faith;

3. has a good business reputation and has had experience, training or education so as to be qualified in the business for which the license is applied;

4. if the applicant is a legal entity, is formed or organized pursuant to the laws of this state or is a foreign legal entity authorized to transact business in this state, or provides a certificate of good standing from the state of its domicile; and

5. has provided to the Commissioner an anti-fraud plan that meets the requirements of section 13 of this Act and includes:

(a) a description of the procedures for detecting and investigating possible fraudulent acts and procedures for resolving material inconsistencies between medical records and insurance applications;

(b) a description of the procedures for reporting fraudulent insurance acts to the Commissioner;

(c) a description of the plan for anti-fraud education and training of its underwriters and other personnel; and

(d) a written description or chart outlining the arrangement of the anti-fraud personnel who are responsible for the investigation and reporting of possible fraudulent insurance acts and investigating unresolved material inconsistencies between medical records and insurance applications.

L. The Commissioner shall not issue any license to any nonresident applicant, unless a written designation of an agent for service of process is filed and maintained with the Commissioner or unless the applicant has filed with the Commissioner the applicant's written irrevocable consent that any action against the applicant may be commenced against the applicant by service of process on the Commissioner. M. Each licensee shall file with the Commissioner on or before the first day of March of each year an annual statement containing such information as the Commissioner by rule may prescribe.

N. A Provider may not use any Person to perform the functions of a Broker as defined in this Act unless the Person holds a current, valid license as a Broker, and as provided in this Section.

O. A Broker may not use any Person to perform the functions of a Provider as defined in this Act unless such Person holds a current, valid license as a Provider, and as provided in this Section.

P. A Provider, or Broker shall provide to the Commissioner new or revised information about officers, ten percent or more stockholders, partners, directors, members or designated employees within thirty days of the change.

Q. An individual licensed as a Broker shall complete on a biennial basis fifteen (15) hours of training related to life settlements and life settlement transactions, as required by the Commissioner; provided, however, that a life insurance producer who is operating as a Broker pursuant to this Section shall not be subject to the requirements of this subsection. Any person failing to meet the requirements of this subsection shall be subject to the penalties imposed by the Commissioner.

Section 4. License Suspension, Revocation or Refusal to Renew

A. The Commissioner may suspend, revoke or refuse to renew the license of any licensee if the Commissioner finds that:

1. there was any material misrepresentation in the application for the license;

2. the licensee or any officer, partner, member or director has been guilty of fraudulent or dishonest practices, is subject to a final administrative action or is otherwise shown to be untrustworthy or incompetent to act as a licensee;

3. the Provider demonstrates a pattern of unreasonably withholding payments to policy Owners;

4. the licensee no longer meets the requirements for initial licensure;

5. the licensee or any officer, partner, member or director has been convicted of a felony, or of any misdemeanor of which criminal fraud is an element; or the licensee has pleaded guilty or nolo contendere with respect to any felony or any

misdemeanor of which criminal fraud or moral turpitude is an element, regardless whether a judgment of conviction has been entered by the court;

6. the Provider has entered into any Life Settlement Contract that has not been approved pursuant to the Act;

7. the Provider has failed to honor contractual obligations set out in a Life Settlement Contract;

8. the Provider has assigned, transferred or pledged a settled policy to a person other than a Provider licensed in this state, a purchaser, an accredited investor or qualified institutional buyer as defined respectively in Regulation D, Rule 501 or Rule 144A of the Federal Securities Act of 1933, as amended, financing entity, special purpose entity, or related provider trust; or

9. the licensee or any officer, partner, member or key management personnel has violated any of the provisions of this Act.

B. Before the Commissioner denies a license application or suspends, revokes or refuses to renew the license of any licensee under this Act, the Commissioner shall conduct a hearing in accordance with this state's laws governing administrative hearings.

Section 5. Contract Requirements

A. No Person may use any form of Life Settlement Contract in this state unless it has been filed with and approved, if required, by the Commissioner in a manner that conforms with the filing procedures and any time restrictions or deeming provisions, if any, for life insurance forms, policies and contracts.

B. No insurer may, as a condition of responding to a request for verification of coverage or in connection with the transfer of a policy pursuant to a Life Settlement Contract, require that the Owner, Insured, Provider or Broker sign any form, disclosure, consent, waiver or acknowledgment that has not been expressly approved by the Commissioner for use in connection with Life Settlement Contracts in this state.

C. A Person shall not use a Life Settlement Contract form or provide to an Owner a disclosure statement form in this state unless first filed with and approved by the Commissioner. The Commissioner shall disapprove a Life Settlement Contract form or disclosure statement form if, in the Commissioner’s opinion, the contract or provisions contained therein fail to meet the requirements of Sections 8, 9, 11 and 15B of this Act or are unreasonable, contrary to the interests of the public, or otherwise misleading or unfair to the Owner. At the Commissioner’s discretion, the Commissioner may require the submission of advertising material.

Section 6. Reporting Requirements and Privacy

A. For any policy settled within five (5) years of policy issuance, each Provider shall file with the Commissioner on or before March 1 of each year an annual statement containing such information as the Commissioner may prescribe by regulation. In addition to any other requirements, the annual statement shall specify the total number, aggregate face amount and life settlement proceeds of policies settled during the immediately preceding calendar year, together with a breakdown of the information by policy issue year. The annual statement shall also include the names of the insurance companies whose policies have been settled and the Brokers that have settled said policies.

1. Such information shall be limited to only those transactions where the ~~Insured~~Owner is a resident of this state and shall not include individual transaction data regarding the business of life settlements or information that there is a reasonable basis to believe could be used to identify the Owner or the Insured.

2. Every Provider that willfully fails to file an annual statement as required in this section, or willfully fails to reply within thirty days to a written inquiry by the Commissioner in connection therewith, shall, in addition to other penalties provided by this chapter, be subject, upon due notice and opportunity to be heard, to a penalty of up to two hundred fifty dollars per day of delay, not to exceed twenty-five thousand dollars in the aggregate, for each such failure.

B. Except as otherwise allowed or required by law, a Provider, Broker, insurance company, insurance producer, information bureau, rating agency or company, or any other person with actual knowledge of an insured's identity, shall not disclose the identity of an insured or information that there is a reasonable basis to believe could be used to identify the insured or the insured's financial or medical information to any other person unless the disclosure:

1. is necessary to effect a Life Settlement Contract between the owner and a Provider and the owner and insured have provided prior written consent to the disclosure;

2. is necessary to effectuate the sale of Life Settlement Contracts, or interests therein, as investments, provided the sale is conducted in accordance with applicable state and federal securities law and provided further that the Owner and the insured have both provided prior written consent to the disclosure;

3. is provided in response to an investigation or examination by the Commissioner or any other governmental officer or agency or pursuant to the requirements of Section 13;

4. is a term or condition to the transfer of a policy by one Provider to another Provider, in which case the receiving Provider shall be required to comply with the confidentiality requirements of Section 6B;

5. is necessary to allow the Provider or Broker or their authorized representatives to make contacts for the purpose of determining health status. For the purposes of this section, the term "authorized representative" shall not include any person who has or may have any financial interest in the settlement contract other than a Provider, licensed Broker, financing entity, related provider trust or special purpose entity; further, a Provider or Broker shall require its authorized representative to agree in writing to adhere to the privacy provisions of this Act; or

6. is required to purchase stop loss coverage.

[Drafting Note: In implementing this section, states should keep in mind privacy considerations of insureds. However, the language needs to be broad enough to allow licensed entities to notify Commissioners of unlicensed activity and for insurers to make necessary disclosures to insurers and in similar situations.]

C. Non-public personal information solicited or obtained in connection with a proposed or actual life settlement contract shall be subject to the provisions applicable to financial institutions under the federal Gramm Leach Bliley Act, P.L. 106-102 (1999), and all other state and federal laws relating to confidentiality of non-public personal information.

Section 7. Examination

[Drafting Note: NCOIL has established a Model Act for the examination of insurers. This Model should be applied to settlement companies. Where practicable, examination should be detailed in a rule adopted by the Commissioner under the authority of this law.]

A. The Commissioner may, when the Commissioner deems it reasonably necessary to protect the interests of the public, examine the business and affairs of any licensee or applicant for a license. The Commissioner may order any licensee or applicant to produce any records, books, files or other information reasonably necessary to ascertain whether such licensee or applicant is acting or has acted in violation of the law or otherwise contrary to the interests of the public. The expenses incurred in conducting any examination shall be paid by the licensee or applicant.

B. In lieu of an examination under this Act of any foreign or alien licensee licensed in this state, the Commissioner may, at the Commissioner’s discretion, accept an examination report on the licensee as prepared by the Commissioner for the licensee’s state of domicile or port-of-entry state.

C. Names of and individual identification data, or for all Owners and insureds shall be considered private and confidential information and shall not be disclosed by the Commissioner unless required by law.

D. Records of all consummated transactions and Life Settlement Contracts shall be maintained by the Provider for three years after the death of the insured and shall be available to the Commissioner for inspection during reasonable business hours.

E. Conduct of Examinations

1. Upon determining that an examination should be conducted, the Commissioner shall Issue an examination warrant appointing one or more examiners to perform the examination and instructing them as to the scope of the examination. In conducting the examination, the examiner shall use methods common to the examination of any life settlement licensee and should use those guidelines and procedures set forth in an examiners' handbook adopted by a national organization.

2. Every licensee or person from whom information is sought, its officers, directors and agents shall provide to the examiners timely, convenient and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents, assets and computer or other recordings relating to the property, assets, business and affairs of the licensee being examined. The officers, directors, employees and agents of the licensee or person shall facilitate the examination and aid in the examination so far as it is in their power to do so. The refusal of a licensee, by its officers, directors, employees or agents, to submit to examination or to comply with any reasonable written request of the Commissioner shall be grounds for suspension or refusal of, or nonrenewal of any license or authority held by the licensee to engage in the life settlement business or other business subject to the Commissioner's jurisdiction. Any proceedings for suspension, revocation or refusal of any license or authority shall be conducted pursuant to Section [insert reference to cease and desist statute or other law having a post-order hearing mechanism].

3. The Commissioner shall have the power to issue subpoenas, to administer oaths and to examine under oath any person as to any matter pertinent to the examination. Upon the failure or refusal of a person to obey a subpoena, the Commissioner may petition a court of competent jurisdiction, and upon proper showing, the Court may enter an order compelling the witness to appear and testify or produce documentary evidence.

4. When making an examination under this Act, the Commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants or other professionals and specialists as examiners, the reasonable cost of which shall be borne by the licensee that is the subject of the examination.

5. Nothing contained in this Act shall be construed to limit the Commissioner's authority to terminate or suspend an examination in order to pursue other legal or regulatory action pursuant to the insurance laws of this state. Findings of fact and

conclusions made pursuant to any examination shall be prima facie evidence in any legal or regulatory action.

6. Nothing contained in this Act shall be construed to limit the Commissioner's authority to use and, if appropriate, to make public any final or preliminary examination report, any examiner or licensee work papers or other documents, or any other information discovered or developed during the course of any examination in the furtherance of any legal or regulatory action which the Commissioner may, in his or her sole discretion, deem appropriate.

[Drafting Note: In many states examination work papers remain confidential. The previous paragraph should be adjusted to conform to state statute and practice.]

F. Examination Reports

1. Examination reports shall be comprised of only facts appearing upon the books, from the testimony of its officers or agents or other persons examined concerning its affairs, and such conclusions and recommendations as the examiners find reasonably warranted from the facts.

2. No later than sixty (60) days following completion of the examination, the examiner in charge shall file with the Commissioner a verified written report of examination under oath. Upon receipt of the verified report, the Commissioner shall transmit the report to the licensee examined, together with a notice that shall afford the licensee examined a reasonable opportunity of not more than thirty (30) days to make a written submission or rebuttal with respect to any matters contained in the examination report and which shall become part of the report or to request a hearing on any matter in dispute.

3. In the event the Commissioner determines that regulatory action is appropriate as a result of an examination, the Commissioner may initiate any proceedings or actions provided by law.

G. Confidentiality of Examination Information

1. Names and individual identification data for all owners, purchasers, and insureds shall be considered private and confidential information and shall not be disclosed by the Commissioner, unless the disclosure is to another regulator or is required by law.

2. Except as otherwise provided in this Act, all examination reports, working papers, recorded information, documents and copies thereof produced by, obtained by or disclosed to the Commissioner or any other person in the course of an examination made under this Act, or in the course of analysis or investigation by the Commissioner of the financial condition or market conduct of a licensee shall be confidential by law and privileged, shall not be subject to [INSERT

OPEN RECORDS, FREEDOM OF INFORMATION, SUNSHINE OR OTHER APPROPRIATE PHRASE] shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. The Commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as part of the Commissioner's official duties. The licensee being examined may have access to all documents used to make the report.

H. Conflict of Interest

1. An examiner may not be appointed by the Commissioner if the examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any person subject to examination under this Act. This section shall not be construed to automatically preclude an examiner from being:

(a) an owner;

(b) an insured in a Life Settlement Contract or insurance policy; or

(c) a beneficiary in an insurance policy that is proposed for a Life Settlement Contract.

2. Notwithstanding the requirements of this clause, the Commissioner may retain from time to time, on an individual basis, qualified actuaries, certified public accountants, or other similar individuals who are independently practicing their professions, even though these persons may from time to time be similarly employed or retained by persons subject to examination under this Act.

I. Immunity from Liability

1. No cause of action shall arise nor shall any liability be imposed against the Commissioner, the Commissioner's authorized representatives or any examiner appointed by the Commissioner for any statements made or conduct performed in good faith while carrying out the provisions of this Act.

2. No cause of action shall arise, nor shall any liability be imposed against any person for the act of communicating or delivering information or data to the Commissioner or the Commissioner's authorized representative or examiner pursuant to an examination made under this Act, if the act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive. This paragraph does not abrogate or modify in any way any common law or statutory privilege or immunity heretofore enjoyed by any person identified in Paragraph (1).

3. A person identified in Paragraph (1) or (2) shall be entitled to an award of attorney's fees and costs if he or she is the prevailing party in a civil cause of action for libel, slander or any other relevant tort arising out of activities in carrying out the provisions of this Act and the party bringing the action was not substantially justified in doing so. For purposes of this section a proceeding is "substantially justified" if it had a reasonable basis in law or fact at the time that it was initiated.

J. Investigative Authority of the Commissioner

1. The Commissioner may investigate suspected Fraudulent Life Settlement Acts and persons engaged in the business of life settlements.

K. Cost of Examinations

[Drafting Note: The Insurance Department may have a funding mechanism for examinations and it should be inserted in this section and be consistent with other examination expenses.]

Section 8. Advertising

A. A broker, or provider licensed pursuant to this act may conduct or participate in advertisements within this state. Such advertisements shall comply with all advertising and marketing laws [statutory cite] or rules and regulations promulgated by the Commissioner that are applicable to life insurers or to brokers, and providers licensed pursuant to this act.

B. Advertisements shall be accurate, truthful and not misleading in fact or by implication.

C. No person or trust shall:

1. directly or indirectly, market, advertise, solicit or otherwise promote the purchase of a policy for the sole purpose of or with an emphasis on settling the policy; or

2. use the words “free”, “no cost” or words of similar import in the marketing, advertising, soliciting or otherwise promoting of the purchase of a policy.

Section 9. Disclosures to Owners

A. The Provider shall provide in writing, in a separate document that is signed by the Owner and Provider, the following information to the Owner no later than the date the Life Settlement Contract is signed by all parties:

1. the fact that possible alternatives to Life Settlement Contracts exist, including, but not limited to, accelerated benefits offered by the issuer of the life insurance policy;

2. the fact that some or all of the proceeds of a Life Settlement Contract may be taxable and that assistance should be sought from a professional tax advisor;

3. the fact that the proceeds from a Life Settlement Contract could be subject to the claims of creditors;

4. the fact that receipt of proceeds from a Life Settlement Contract may adversely affect the recipients' eligibility for public assistance or other government benefits or entitlements and that advice should be obtained from the appropriate agencies;

5. the fact that the Owner has a right to terminate a Life Settlement Contract within fifteen (15) days of the date it is executed by all parties and the Owner has received the disclosures contained herein. Rescission, if exercised by the Owner, is effective only if both notice of the rescission is given, and the Owner repays all proceeds and any premiums, loans, and loan interest paid on account of the Provider within the rescission period. If the insured dies during the rescission period, the Contract shall be deemed to have been rescinded subject to repayment by the Owner or the Owner's estate of all proceeds and any premiums, loans, and loan interest to the Provider;

6. the fact that proceeds will be sent to the Owner within three (3) business days after the Provider has received the insurer or group administrator's acknowledgement that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated in accordance with the terms of the Life Settlement Contract;

7. the fact that entering into a Life Settlement Contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy or certificate of a group policy to be forfeited by the Owner and that assistance should be sought from a professional financial advisor;

8. the amount and method of calculating the compensation paid or to be paid to the Broker, or any other person acting for the Owner in connection with the transaction, wherein the term compensation includes anything of value paid or given;

9. the date by which the funds will be available to the Owner and the transmitter of the funds;

10. the fact that the Commissioner shall require delivery of a Buyer's Guide or a similar consumer advisory package in the form prescribed by the Commissioner to Owners during the solicitation process;

11. the disclosure document shall contain the following language: “all medical, financial or personal information solicited or obtained by a Provider or Broker about an insured, including the insured’s identity or the identity of family members, a spouse or a significant other may be disclosed as necessary to effect the Life Settlement Contract between the owner and provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every two years;

12. the fact that the Commissioner shall require Providers and Brokers to print separate signed fraud warnings on their applications and on their Life Settlement Contracts is as follows: “Any person who knowingly presents false information in an application for insurance or Life Settlement Contract is guilty of a crime and may be subject to fines and confinement in prison.”

13. the fact that the insured may be contacted by either the Provider or broker or its authorized representative for the purpose of determining the insured’s health status or to verify the insured's address. This contact is limited to once every three (3) months if the insured has a life expectancy of more than one year, and no more than once per month if the insured has a life expectancy of one year or less;

14. the affiliation, if any, between the Provider and the issuer of the insurance policy to be settled;

15. that a Broker represents exclusively the Owner, and not the insurer or the Provider or any other person, and owes a fiduciary duty to the Owner, including a duty to act according to the Owner’s instructions and in the best interest of the Owner;

16. the document shall include the name, address and telephone number of the Provider;

17. the name, business address, and telephone number of the independent third party escrow agent, and the fact that the owner may inspect or receive copies of the relevant escrow or trust agreements or documents;

18. the fact that a change of ownership could in the future limit the insured’s ability to purchase future insurance on the insured’s life because there is a limit to how much coverage insurers will issue on one life;

B. The written disclosures shall be conspicuously displayed in any Life Settlement Contract furnished to the Owner by a Provider including any affiliations or contractual arrangements between the Provider and the Broker. C. A Broker shall provide the Owner and the Provider with at least the following disclosures no later than the date the Life

Settlement Contract is signed by all parties. The disclosures shall be conspicuously displayed in the Life Settlement Contract or in a separate document signed by the Owner and provide the following information:

(1) The name, business address and telephone number of the Broker;

(2) A full, complete and accurate description of all the offers, counter-offers, acceptances and rejections relating to the proposed Life Settlement Contract;

(3) A written disclosure of any affiliations or contractual arrangements between the Broker and any person making an offer in connection with the proposed Life Settlement Contracts;

(4) The name of each Broker who receives compensation and the amount of compensation received by that broker, which compensation includes anything of value paid or given to the Broker in connection with the life settlement contract;

(5) A complete reconciliation of the gross offer or bid by the Provider to the net amount of proceeds or value to be received by the Owner. For the purpose of this section, gross offer or bid shall mean the total amount or value offered by the Provider for the purchase of one or more life insurance policies, inclusive of commissions and fees; and

(6) The failure to provide the disclosures or rights described in this Section 9 shall be deemed an Unfair Trade Practice pursuant to Section 17. Section 10. Disclosure to Insurer

[Drafting Note: The provisions in this Section pertaining to premium finance arrangements and disclosures may be inserted into a state's premium finance law. If so, it is recommended that the disclosures be made to the borrower and/or insured by a lender which takes the policy as collateral for a premium finance loan.]

A. Without limiting the ability of an insurer from assessing the insurability of a policy applicant and determining whether or not to issue the policy, and in addition to other questions an insurance carrier may lawfully pose to a life insurance applicant, insurance carriers may inquire in the application for insurance whether the proposed owner intends to pay premiums with the assistance of financing from a lender that will use the policy as collateral to support the financing.

1. If, as described in Section 2L, the loan provides funds which can be used for a purpose other than paying for the premiums, costs, and expenses associated with obtaining and maintaining the life insurance policy and loan, the application shall be rejected as a violation of the Prohibited Practices in Section 13 of this Act.

2. If the financing does not violate Section 13 in this manner, the insurance carrier:

(a) may make disclosures, including but not limited to such as the following, to the applicant and the insured, either on the application or an amendment to the application to be completed no later than the delivery of the policy: “If you have entered into a loan arrangement where the policy is used as collateral, and the policy does change ownership at some point in the future in satisfaction of the loan, the following may be true:

(i.) a change of ownership could lead to a stranger owning an interest in the insured’s life;

(ii.) a change of ownership could in the future limit your ability to purchase future insurance on the insured’s life because there is a limit to how much coverage insurers will issue on one life;

(iii.) should there be a change of ownership and you wish to obtain more insurance coverage on the insured’s life in the future, the insured’s higher issue age, a change in health status, and/or other factors may reduce the ability to obtain coverage and/or may result in significantly higher premiums;

(iv.) you should consult a professional advisor, since a change in ownership in satisfaction of the loan may result in tax consequences to the owner, depending on the structure of the loan;” and

(b) may require certifications, such as the following, from the applicant and/or the insured:

(i) I have not entered into any agreement or arrangement providing for the future sale of this life insurance policy;

(ii) My loan arrangement for this policy provides funds sufficient to pay for some or all of the premiums, costs, and expenses associated with obtaining and maintaining my life insurance policy, but I have not entered into any agreement by which I am to receive consideration in exchange for procuring this policy; and

(iii) the borrower has an insurable interest in the insured.”

Section 11. General Rules

A. A Provider entering into a Life Settlement Contract with any Owner of a policy, wherein the insured is terminally or chronically ill, shall first obtain:

1. if the Owner is the insured, a written statement from a licensed attending physician that the Owner is of sound mind and under no constraint or undue influence to enter into a settlement contract; and

2. a document in which the insured consents to the release of his medical records to a Provider, settlement broker, or insurance producer and, if the policy was issued less than two years from the date of application for a settlement contract, to the insurance company that issued the policy.

B. The insurer shall respond to a request for verification of coverage or policy illustration submitted by a Provider, settlement broker, or life insurance producer not later than ~~thirty~~ twenty-one (21) calendar days of the date the request is received. The insurer shall accept an original or facsimile or electronically delivered copy of such request for verification of coverage or policy illustration and any accompanying authorization signed by the owner. The request for verification of coverage must be made on a form approved by the Commissioner. The insurer shall complete and issue the verification of coverage or indicate in which respects it is unable to respond. In its response to a verification of coverage, the insurer shall indicate whether, based on the medical evidence and documents provided, the insurer intends to pursue an investigation at this time regarding the validity of the insurance contract.

C. Before or at the time of execution of the settlement contract, the Provider shall obtain a witnessed document in which the Owner consents to the settlement contract, represents that the Owner has a full and complete understanding of the settlement contract, that the Owner has a full and complete understanding of the benefits of the policy, acknowledges that the Owner is entering into the settlement contract freely and voluntarily, and, for persons with a terminal or chronic illness or condition, acknowledges that the insured has a terminal or chronic illness and that the terminal or chronic illness or condition was diagnosed after the policy was issued.

D. Upon receipt of a properly completed request for change of ownership or beneficiary of a policy, the insurer shall respond in writing within twenty-one (21) calendar days with written acknowledgement confirming that the change has been effected or specifying the reasons why the requested change cannot be processed. The insurer shall not unreasonably delay effecting change of ownership or beneficiary with any Life Settlement Contract lawfully entered into in this state or with a resident of this state. The insurer shall, upon request by the owner or the owner's authorized representative, send confirmation of change of ownership or beneficiary via facsimile or electronic mail.

E. If a settlement broker or life insurance producer performs any of these activities required of the Provider, the Provider is deemed to have fulfilled the requirements of this section.

F. If a Broker performs those verification of coverage activities required of the Provider, the provider is deemed to have fulfilled the requirements of section 9A.

G. Within twenty (20) days after an owner executes the Life Settlement Contract, the Provider shall give written notice to the insurer that issued that insurance policy that the policy has become subject to a Life Settlement Contract. The notice shall be accompanied by the documents required by Section 11~~0~~ A. (2).

H. All medical information solicited or obtained by any licensee shall be subject to the applicable provision of state law relating to confidentiality of medical information, if not otherwise provided in this Act.

I. All Life Settlement Contracts entered into in this state shall provide that the Owner may rescind the Contract on or before fifteen (15) days after the date it is executed by all parties thereto. Rescission, if exercised by the Owner, is effective only if both notice of the rescission is given, and the Owner repays all proceeds and any premiums, loans, and loan interest paid on account of the Provider within the rescission period. If the insured dies during the rescission period, the Contract shall be deemed to have been rescinded subject to repayment by the Owner or the Owner's estate of all proceeds and any premiums, loans, and loan interest to the Provider.

J. Within three business days after receipt from the Owner of documents to effect the transfer of the insurance policy, the Provider shall pay the proceeds of the settlement to an escrow or trust account managed by a trustee or escrow agent in a state or federally chartered financial institution pending acknowledgement of the transfer by the issuer of the policy. The trustee or escrow agent shall be required to transfer the proceeds due to the Owner within three business days of acknowledgement of the transfer from the insurer.

K. Failure to tender the Life Settlement Contract proceeds to the Owner by the date disclosed to the Owner renders the Contract voidable by the Owner for lack of consideration until the time the proceeds are tendered to and accepted by the Owner. A failure to give written notice of the right of rescission hereunder shall toll the right of rescission until thirty days after the written notice of the right of rescission has been given.

L. Any fee paid by a Provider, party, individual, or an Owner to a Broker in exchange for services provided to the Owner pertaining to a Life Settlement Contract shall be computed as a percentage of the offer obtained, not the face value of the policy. Nothing in this Section shall be construed as prohibiting a Broker from reducing such Broker's fee below this percentage if the Broker so chooses.

M. The Broker shall disclose to the Owner anything of value paid or given to a Broker, which relate to a Life Settlement Contract.

N. No person at any time prior to, or at the time of, the application for, or issuance of, a policy, or during a two-year period commencing with the date of issuance of the policy, shall enter into a Life Settlement regardless of the date the compensation is to be provided and regardless of the date the assignment, transfer, sale, devise, bequest or

surrender of the policy is to occur. This prohibition shall not apply if the Owner certifies to the Provider that:

1. the policy was issued upon the Owner's exercise of conversion rights arising out of a group or individual policy, provided the total of the time covered under the conversion policy plus the time covered under the prior policy is at least twenty-four months. The time covered under a group policy must be calculated without regard to a change in insurance carriers, provided the coverage has been continuous and under the same group sponsorship; or

2. the Owner submits independent evidence to the Provider that one or more of the following conditions have been met within the two-year period:

(a) the Owner or insured is terminally or chronically ill;

(b) the Owner or insured disposes of his ownership interests in a closely held corporation, pursuant to the terms of a buyout or other similar agreement in effect at the time the insurance policy was initially issued;
(c) the Owner's spouse dies;

(d) the Owner divorces his or her spouse;

(e) the Owner retires from full-time employment;

(f) the Owner becomes physically or mentally disabled and a physician determines that the disability prevents the Owner from maintaining full-time employment; or

(g) a final order, judgment or decree is entered by a court of competent jurisdiction, on the application of a creditor of the Owner, adjudicating the Owner bankrupt or insolvent, or approving a petition seeking reorganization of the Owner or appointing a receiver, trustee or liquidator to all or a substantial part of the Owner's assets;

3. Copies of the independent evidence required by Section 11.N(2) shall be submitted to the insurer when the Provider submits a request to the insurer for verification of coverage. The copies shall be accompanied by a letter of attestation from the Provider that the copies are true and correct copies of the documents received by the Provider. Nothing in this Section shall prohibit an insurer from exercising its right to contest the validity of any policy;

4. If the Provider submits to the insurer a copy of independent evidence provided for in item (2)(a) when the Provider submits a request to the insurer to effect the transfer of the policy to the Provider, the copy is deemed to establish that the settlement contract satisfies the requirements of this section.

O. The insurer shall respond to policy service requests, including but not limited to requests for policy loans, within twenty-one (21) calendar days of the date the request is received.

Section 12. Authority to Promulgate Regulations; Conflict of Laws

A. The Commissioner may:

1. promulgate regulations implementing Sections 1 to 18 of this Act and regulating the activities and relationships of Providers, Brokers, insurers and their agents, subject to statutory limitations on administrative rule making.

[Drafting Note: Fees need not be mentioned if the fee is set by statute.]

B. Conflict of Laws.

1. If there is more than one Owner on a single policy, and the Owners are residents of different states, the Life Settlement Contract shall be governed by the law of the state in which the Owner having the largest percentage ownership resides or, if the Owners hold equal ownership, the state of residence of one Owner agreed upon in writing by all of the Owners. The law of the state of the Insured shall govern in the event that equal Owners fail to agree in writing upon a state of residence for jurisdictional purposes.

2. A Provider from this state who enters into a Life Settlement Contract with an Owner who is a resident of another state that has enacted statutes or adopted regulations governing Life Settlement Contracts, shall be governed in the effectuation of that Life Settlement Contract by the statutes and regulations of the Owner's state of residence. If the state in which the Owner is a resident has not enacted statutes or regulations governing Life Settlement Contracts, the Provider shall give the Owner notice that neither state regulates the transaction upon which he or she is entering. For transactions in those states, however, the Provider is to maintain all records required if the transactions were executed in the state of residence. The forms used in those states need not be approved by the Department.

3. If there is a conflict in the laws that apply to an Owner and a Purchaser in any individual transaction, the laws of the state that apply to the Owner shall take precedence and the Provider shall comply with those laws.

Section 13. Prohibited Practices

A. IT IS UNLAWFUL FOR ANY PERSON TO:

1. enter into a Life Settlement Contract if such Person knows or reasonably should have known that the life insurance policy was obtained by means of a false, deceptive or misleading application for such policy;

2. engage in any transaction, practice or course of business if such Person knows or reasonably should have known that the intent was to avoid the notice requirements of this Section;

3. engage in any fraudulent act or practice in connection with any transaction relating to any settlement involving an Owner who is a resident of this state;

4. issue, solicit, market or otherwise promote the purchase of an insurance policy for the purpose of or with an emphasis on settling the policy;

5. enter into a premium finance agreement with any person or agency, or any person affiliated with such person or agency, pursuant to which such person shall receive any proceeds, fees or other consideration, directly or indirectly, from the policy or owner of the policy or any other person with respect to the premium finance agreement or any settlement contract or other transaction related to such policy that are in addition to the amounts required to pay the principal, interest and service charges related to policy premiums pursuant to the premium finance agreement or subsequent sale of such agreement; provided, further, that any payments, charges, fees or other amounts in
addition to the amounts required to pay the principal, interest and service charges related to policy premiums paid under the premium finance agreement shall be remitted to the original owner of the policy or to his or her estate if he or she is not living at the time of the determination of the overpayment;

6. with respect to any settlement contract or insurance policy and a Broker, knowingly solicit an offer from, effectuate a life settlement contract with or make a sale to any Provider, financing entity or related provider trust that is controlling, controlled by, or under common control with such Broker;

7. with respect to any Life Settlement Contract or insurance policy and a Provider, knowingly enter into a Life Settlement Contract with a Owner, if, in connection with such Life Settlement Contract, anything of value will be paid to a Broker that is controlling, controlled by, or under common control with such Provider or the financing entity or related Provider trust that is involved in such settlement contract;

8. with respect to a Provider, enter into a Life Settlement Contract unless the life settlement promotional, advertising and marketing materials, as may be prescribed by regulation, have been filed with the Commissioner. In no event shall any marketing materials expressly reference that the insurance is “free” for any period of time. The inclusion of any reference in the marketing materials that

would cause an Owner to reasonably believe that the insurance is free for any period of time shall be considered a violation of this Act; or

9. with respect to any life insurance producer, insurance company, Broker, or Provider make any statement or representation to the applicant or policyholder in connection with the sale or financing of a life insurance policy to the effect that the insurance is free or without cost to the policyholder for any period of time unless provided in the policy.

10. with respect to an insurer, prohibit a life insurance producer or broker from disclosing to a client the availability of a life settlement contract. No insurer shall include any provision in a life insurance policy that prohibits lawful assignment of such policy.

11. with respect to an insurer, deny legal effect, validity or enforceability of any signature, contract or other record relating to a life settlement transaction solely because it is in electronic form.

12. with respect to an insurer, deny legal effect, validity or enforceability of any third-party authorization executed by an Owner or Insured.

B. A violation of Section 13 shall be deemed a Fraudulent Life Settlement Act.

Section 14. Fraud Prevention and Control

A. Fraudulent Life Settlement Acts, Interference and Participation of Convicted Felons Prohibited.

1. A person shall not commit a Fraudulent Life Settlement Act.

2. A person shall not knowingly and intentionally interfere with the enforcement of the provisions of this Act or investigations of suspected or actual violations of this Act.

3. A person in the business of life settlements shall not knowingly or intentionally permit any person convicted of a felony involving dishonesty or breach of trust to participate in the business of life settlements.

B. Fraud Warning Required

1. Life Settlement Contracts and applications for Life Settlement Contracts, regardless of the form of transmission, shall contain the following statement or a substantially similar statement: “Any person who knowingly presents false information in an application for insurance or Life Settlement Contract is guilty of a crime and may be subject to fines and confinement in prison.”

2. The lack of a statement as required in Paragraph (1) of this subsection does not constitute a defense in any prosecution for a Fraudulent Life Settlement Act.

C. Mandatory Reporting of Fraudulent Life Settlement Acts

1. Any person engaged in the business of life settlements having knowledge or a reasonable belief that a Fraudulent Life Settlement Act is being, will be or has been committed shall provide to the Commissioner the information required by, and in a manner prescribed by, the Commissioner.

2. Any other person having knowledge or a reasonable belief that a Fraudulent Life Settlement Act is being, will be or has been committed may provide to the Commissioner the information required by, and in a manner prescribed by, the Commissioner.

D. Immunity from Liability

1. No civil liability shall be imposed on and no cause of action shall arise from a person's furnishing information concerning suspected, anticipated or completed Fraudulent Life Settlement Acts or suspected or completed fraudulent insurance acts, if the information is provided to or received from:

(a) the Commissioner or the Commissioner's employees, agents or representatives;

(b) federal, state or local law enforcement or regulatory officials or their employees, agents or representatives;

(c) a person involved in the prevention and detection of Fraudulent Life Settlement Acts or that person's agents, employees or representatives;

(d) any regulatory body or their employees, agents or representatives, overseeing life insurance, life settlements, securities or investment fraud;

(e) the life insurer that issued the life insurance policy covering the life of the insured; or

(f) the licensee and any agents, employees or representatives.

2. Paragraph (1) of this subsection shall not apply to statements made with actual malice. In an action brought against a person for filing a report or furnishing other information concerning a Fraudulent Life Settlement Act or a fraudulent insurance act, the party bringing the action shall plead specifically any allegation that Paragraph (1) does not apply because the person filing the report or furnishing the information did so with actual malice.

3. A person identified in Paragraph (1) shall be entitled to an award of attorney's fees and costs if he or she is the prevailing party in a civil cause of action for libel, slander or any other relevant tort arising out of activities in carrying out the provisions of this Act and the party bringing the action was not substantially justified in doing so. For purposes of this section a proceeding is "substantially justified" if it had a reasonable basis in law or fact at the time that it was initiated.

4. This section does not abrogate or modify common law or statutory privileges or immunities enjoyed by a person described in Paragraph (1).

E. Confidentiality

1. The documents and evidence provided pursuant to Subsection D of this section or obtained by the Commissioner in an investigation of suspected or actual Fraudulent Life Settlement Acts shall be privileged and confidential and shall not be a public record and shall not be subject to discovery or subpoena in a civil or criminal action.

2. Paragraph (1) of this subsection does not prohibit release by the Commissioner of documents and evidence obtained in an investigation of suspected or actual Fraudulent Life Settlement Acts:

(a) in administrative or judicial proceedings to enforce laws administered by the Commissioner;

(b) to federal, state or local law enforcement or regulatory agencies, to an organization established for the purpose of detecting and preventing Fraudulent Life Settlement Acts or to the NAIC; or

(c) at the discretion of the Commissioner, to a person in the business of life settlements that is aggrieved by a Fraudulent Life Settlement Act.

3. Release of documents and evidence under Paragraph (2) of this subsection does not abrogate or modify the privilege granted in Paragraph (1).

F. Other Law Enforcement or Regulatory Authority. This Act shall not:

1. preempt the authority or relieve the duty of other law enforcement or regulatory agencies to investigate, examine and prosecute suspected violations of law;

2. preempt, supersede, or limit any provision of any state securities law or any rule, order, or notice issued thereunder;

3. prevent or prohibit a person from disclosing voluntarily information concerning life settlement fraud to a law enforcement or regulatory agency other than the insurance department; or

4. limit the powers granted elsewhere by the laws of this state to the Commissioner or an insurance fraud unit to investigate and examine possible violations of law and to take appropriate action against wrongdoers.

G. Life Settlement Antifraud Initiatives.

1. Providers and Brokers shall have in place antifraud initiatives reasonably calculated to detect, prosecute and prevent Fraudulent Life Settlement Acts. At the discretion of the Commissioner, the Commissioner may order, or a licensee may request and the Commissioner may grant, such modifications of the following required initiatives as necessary to ensure an effective antifraud program. The modifications may be more or less restrictive than the required initiatives so long as the modifications may reasonably be expected to accomplish the purpose of this section. Antifraud initiatives shall include:

2. Fraud investigators, who may be Provider or Broker employees or independent contractors; and

3. An antifraud plan, which shall be submitted to the Commissioner. The antifraud plan shall include, but not be limited to:

(a) a description of the procedures for detecting and investigating possible Fraudulent Life Settlement Acts and procedures for resolving material inconsistencies between medical records and insurance applications;

(b) a description of the procedures for reporting possible Fraudulent Life Settlement Acts to the Commissioner;

(c) a description of the plan for antifraud education and training of underwriters and other personnel; and

(d) a description or chart outlining the organizational arrangement of the antifraud personnel who are responsible for the investigation and reporting of possible Fraudulent Life Settlement Acts and investigating unresolved material inconsistencies between medical records and insurance applications.

4. Antifraud plans submitted to the Commissioner shall be privileged and confidential and shall not be a public record and shall not be subject to discovery or subpoena in a civil or criminal action.

Section 15. Injunctions; Civil Remedies; Cease and Desist

A. In addition to the penalties and other enforcement provisions of this Act, if any Person violates this Act or any rule implementing this Act, the Commissioner may seek an

injunction in a court of competent jurisdiction in the county where the Person resides or has a principal place of business and may apply for temporary and permanent orders that the Commissioner determines necessary to restrain the Person from further committing the violation.

B. Any Person damaged by the acts of another Person in violation of this Act or any rule or regulation implementing this Act, may bring a civil action for damages against the Person committing the violation in a court of competent jurisdiction.

C. The Commissioner may issue a cease and desist order upon a Person who violates any provision of this part, any rule or order adopted by the Commissioner, or any written agreement entered into with the Commissioner, in accordance with this State's Act governing administrative procedures.

D. When the Commissioner finds that such an action presents an immediate danger to the public and requires an immediate final order, he may issue an emergency cease and desist order reciting with particularity the facts underlying such findings. The emergency cease and desist order is effective immediately upon service of a copy of the order on the respondent and remains effective for 90 days. If the department begins non-emergency cease and desist proceedings under paragraph A, the emergency cease and desist order remains effective, absent an order by an appellate court of competent jurisdiction pursuant to [cite the state's administrative procedure Act]. In the event of a willful violation of this Act, the trial court may award statutory damages in addition to actual damages in an additional amount up to three times the actual damage award. The provisions of this Act may not be waived by agreement. No choice of law provision may be utilized to prevent the application of this Act to any settlement in which a party to the settlement is a resident of this state.

Section 16. Penalties

A. It is a violation of this Act for any Person, Provider, Broker, or any other party related to the business of life settlements, to commit a Fraudulent Life Settlement Act.

B. For criminal liability purposes, a person that commits a Fraudulent Life Settlement Act is guilty of committing insurance fraud and shall be subject to additional penalties under [insert State statute regarding insurance fraud].

C. The Commissioner shall be empowered to levy a civil penalty not exceeding [insert appropriate State fine] and the amount of the claim for each violation upon any person, including those persons and their employees licensed pursuant to this Act, who is found to have committed a Fraudulent Life Settlement Act or violated any other provision of this Act.

D. The license of a person licensed under this Act that commits a Fraudulent Life Settlement Act shall be revoked for a period of at least [insert appropriate State penalty].

Section 17. Unfair Trade Practices

A violation of Sections 1 to 16 of this Act shall be considered an unfair trade practice pursuant to state law and subject to the penalties provided by state law.

Section 18. Effective Date

A. A Provider lawfully transacting business in this state prior to the effective date of this Act may continue to do so pending approval or disapproval of that person's application for a license as long as the application is filed with the Commissioner not later than 30 days after publication by the Commissioner of an application form and instructions for licensure of Providers. If the publication of the application form and instructions is prior to the effective date of this chapter, then the filing of the application shall not be later than 30 days after the effective date of this Act. During the time that such an application is pending with the Commissioner, the applicant may use any form of Life Settlement Contract that has been filed with the Commissioner pending approval thereof, provided that such form is otherwise in compliance with the provisions of this Act. Any person transacting business in this state under this provision shall be obligated to comply with all other requirements of this Act.

B. A person who has lawfully negotiated Life Settlement Contracts between any Owner residing in this state and one or more Providers for at least one year immediately prior to the effective date of this Act may continue to do so pending approval or disapproval of that person's application for a license as long as the application is filed with the Commissioner not later than 30 days after publication by the Commissioner of an application form and instructions for licensure of Brokers. If the publication of the application form and instructions is prior to the effective date of this chapter, then the filing of the application shall not be later than 30 days after the effective date of this Act. Any person transacting business in this state under this provision shall be obligated to comply with all other requirements of this Act.

PROPERTY & CASUALTY INSURANCE COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
PROPERTY & CASUALTY INSURANCE COMMITTEE
2023 NCOIL ANNUAL MEETING – COLUMBUS, OHIO
NOVEMBER 17, 2023
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Property & Casualty Insurance Committee met at The Renaissance Columbus Downtown Hotel in Columbus, Ohio on Friday, November 17, 2023 at 3:15 p.m.

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

Other members of the Committee present were:

Rep. Brian Lohse (IA)
Rep. Matt Lehman (IN)
Rep. Michael Meredith (KY)
Rep. Michael Sarge Pollock (KY)
Rep. Rachel Roberts (KY)
Rep. Cherlynn Stevenson (KY)
Rep. Brenda Carter (MI)
Sen. Lana Theis (MI)
Sen. Paul Utke (MN)
Sen. Walter Michel (MS)
Rep. Nelly Nicol (MT)
Sen. Jerry Klein (ND)
Sen. Shawn Vedaa (ND)
Asm. Ken Blankenbush (NY)
Asm. Erik Dilan (NY)
Asm. Jarett Gandolfo (NY)
Sen. Bob Hackett (OH)
Rep. Brian Lampton (OH)
Sen. George Lang (OH)
Rep. Forrest Bennett (OK)
Rep. Carl Anderson (SC)
Rep. Jim Dunnigan (UT)
Del. Steve Westfall (WV)

Other legislators present were:

Rep. Deborah Ferguson, DDS (AR)
Sen. Dan McConchie (IL)
Rep. Helena Scott (MI)
Rep. Stephanie Young (MI)
Rep. Bob Titus (MO)
Rep. Tim Barhorst (OH)
Rep. Ellyn Hefner (OK)

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. Carl Anderson (SC), 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. Brenda Carter (MI) and seconded by Sen. Bob Hackett (OH), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 22, 2023 meeting and the minutes of the Committee's September 22, 2023 interim Zoom meeting.

CONTINUED DISCUSSION ON NCOIL CATALYTIC CONVERTER THEFT PREVENTION MODEL ACT

Rep. Jordan stated that first on our agenda is a continued discussion of the NCOIL Catalytic Converter Theft Prevention Model Act, a model which I'm co-sponsoring with my good friend Rep. Tom Oliverson, M.D. (TX), NCOIL Vice President. You can view that model on page 289 of your binders and on the website and the app. We've been discussing this model since our spring meeting in March, and while we have been having some productive discussions there have been some concerns raised by some that this model is somewhat outside the scope of the committee's normal work. I understand it can be argued that there is a downstream insurance consequence to stolen catalytic converters but I think you can say that about anything that's stolen and this model kind of deals with some criminal provisions. Accordingly, after we hear from our speakers today I'd like to hear any thoughts or comments from my colleagues as to whether they believe that this committee should keep on pursuing development of this model into next year.

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 NICB is a non-profit organization that works with member insurance companies and state and local law enforcement to detect, prevent and deter insurance crimes. And today I'll just be following up with our presentations that we made over the spring and summer meetings with some additional information and a quick update. So again, we're talking about catalytic converters. These are the exhaust emission control devices underneath your vehicles that since 2019 we've seen a surge in thefts of these devices, largely due to the rising prices of precious metals that make up these devices, Rhodium, Platinum and Palladium. And since 2020, we've seen an explosion of thefts where we had 16,000 in 2020 and that rose to over 50,000 in 2021. And then we saw another spike in 2022 with up to 64,000 catalytic converter thefts. And this coincides with the prices of these precious metals peaking in 2021. So, I'm just going to dive right into the impact to the industry and I believe there's a direct impact and that direct impact is high costs. Specifically, the cost associated with replacing these stolen catalytic converters on automobiles as well as the repair costs for incidental damage done. Thieves are not exactly surgeons when they're ripping these catalytic converters off from your vehicles. They're not precise. They often cause a lot of damage that doesn't just equate to a $200 or $300 catalytic converter being sold on the secondary market. It could result in thousands of dollars in repairs to that vehicle. So, let's take an example. So, there's one insurance company that paid for almost $4.5 million in catalytic converter claims in 2019. So, this is the start of the crisis in 2019. Now we fast forward to 2021 they paid out $73 million. That's a massive jump. And then if we fast forward again to 2022, that spikes again to $112 million. That is, once again, a direct impact on the bottom line of the industry.

Now of course, there's a consumer impact as well. The financial impact due to repair costs and economic losses. As well as a public safety impact and riding around in a

damaged vehicle as well as the risk of injury or death from being at the wrong place at the wrong time and stumbling into an active catalytic converter theft. In fact, there's no more famous case I'd argue than the off duty, Harris County Sheriff's deputy who lost his life as he was murdered by three thieves who were trying to steal his catalytic converter from his vehicle. So since then, states have been overwhelming in their response to tackle this crisis. As you can see since 2020, we've seen a significant amount of legislation introduced with it peaking in 2022 with 123 bills introduced. As of today in 2023 we have 99 bills that have been introduced and 25 of them enacted. But what I really want to focus on is this map. And what this map really shows is the variation that we get across states. So, we have states that have enacted some comprehensive legislation that have tackled a number of provisions from establishing catalytic converter theft as a crime. Record keeping requirements, buyer and seller limitations. But then we have other states that have taken a more incremental approach and maybe adopted one or two of these provisions. So again, there's a lot of variation. And the solution to this, in my opinion, is through this model legislation that we have on the table to establish a model that will establish those tools for states to use to help combat catalytic converter thefts and the impact that it has not only on consumers, but on the insurance industry. And so, this model contains the following provisions, criminal statutes yes, that's just a part of it. There's also buyer limitations. For example, making sure that transactions involved in used attached catalytic converters are taking place at fixed business locations. There are seller restrictions, such as ensuring that sellers are only licensed and regulated entities that would come across these devices over the normal course of their business.

And then finally, a voluntary state vehicle identification number (VIN) etching grant program. And what I mean by that is aftermarket voluntary programs where I can take in my vehicle to a local Police Department or another eligible entity, have them etch a serial number or VIN number or some sort of marking which will then be used as a deterrent against these criminals. Because it's much harder to sell a catalytic converter if there's a tracking number on it or if there's a serial number that law enforcement can use to track these devices. And this grant program is designed to provide these local jurisdictions with some funding in order to hold these VIN etching events and it is funded entirely on enforcement actions such as fines for non-compliance with state catalytic converter laws. Now, I'm going to wrap up this presentation by focusing on two success stories. In June 2022, Hawaii enacted Senate Bill 2279, this was their catalytic converter theft bill. As of halfway through 2023, the Honolulu Police Department reported 119 catalytic converter thefts and you can compare that to 1,600 in 2022 and 2,000 in 2021. It made a difference. And now if we look at it from the insurer perspective, State Farm recently announced a drastic reduction in catalytic converter theft claims and the money that they paid out as a result of these claims. In the first six months of 2022 State Farm paid out $50 million over 23,500 thousand catalytic converter theft claims. During that same span, the first six months of 2023, that number decreased to just over $40 million over 14,500 claims. And they directly attributed this significant decrease to state legislation, law enforcement efforts, media coverage which is shining a light on the issue. And declining metals prices. And I think what this is indicative of is that state legislation is making a difference. It's having a positive impact in tackling this crisis and we shouldn't be taking our foot off the gas. We should move forward with model legislation that'll give the states the tools that they need to enact legislation that they don't already have on the books in order to help fight this crisis and continue to drive down theft rates.

And yes, it's true that metal prices are declining. They've been declining since the end of 2021. But that's just temporary. Markets are cyclical. Prices are low today, but they'll be high tomorrow. And the incentive to steal these catalytic converters will be there. The incentive to potentially even attack consumers to drive up these catalytic converter theft claims for insurers, that will all be there. And so this model not only will help tackle the issue today but it will provide the tools and the guardrails necessary to tackle the issue in the future as well.

Todd Foreman, Director of Law Enforcement Outreach at the Institute of Scrap Recycling Industries (ISRI), thanked the Committee for the opportunity to speak and stated that ISRI is a trade association for recyclers. We have about 1,600 member companies in the U.S. As I represent them, we like to help draft legislation. We like to help get the legislation out there because it is important to us to make sure that the recyclers aren't buying stolen materials and that the materials aren't being stolen as well since in buying the materials they're sometimes victims of the crime. I retired as a chief of police about two years ago when I came to work for ISRI. So, I've been working within the theft area of catalytic converters and other things since my career started. Mr. DeCampos is exactly right, the prices were about $300 at the height of the crimes in terms of the average price for a catalytic converter. At this point, the average price is about $100 per catalytic converter. That means there's highs and lows above but the price is greatly reduced. The prices of the metals in them are still above the price of gold. Rhodium is the most valuable of the three. These strategic metals are strategic for the U.S. to keep in the U.S. and are used many ways and they're listed as strategic metals by the federal government. We would like to continue to work with this organization to help with the model legislation because we believe it's important. Now, I don't think we need to make a new bill because as you saw every state except for one has legislation on catalytic converters. So, the legislation is already there but they all don't meet the standards that we're looking for. They all don't help stop the theft. Some of them are better than others as Mr. DeCampos was stating. Some areas have slowed down the thefts as Hawaii has and there's some other states that have really good laws like Tennessee, North Carolina, and South Carolina. We work with those States but they still need some work to meet the standards. The model has the standards in it that we're looking for. We need to limit who's able to sell them. We need to limit who's able to send them through the mail. Those type of things. So, I support you continuing to work on this.

Rep. Matt Lehman (IN), NCOIL Immediate Past President, stated that with regard to whether the Committee should continue to proceed, with all due respect to what I'm hearing here and I don't disagree with anything said – what I'm looking at is NCOIL as an institution is getting into an area of the criminal code and what do we do with people who steal things. And I look back to think if we've ever done anything in that vein and the answer is no, that's not really what we do. And when you said there's already legislation there, it just needs to be changed and tweaked, I guess I would encourage us to go back to our states because I kind of looked at this and thought if this bill was brought in Indiana I don't think it would go through the insurance committee. It would go to courts or criminal code. And so I just don't want to kind of get outside of our lane of being focused on insurance. And I know that's a big issue right now because of the theft but I just think it's an issue that I'm glad has been brought forth and I thank you for the information and I will go back to Indiana and see how strong our laws are on some of

this because I do agree on maybe enhancing some of those things when it comes to the etching. But I don't know that it's necessarily an issue for an NCOIL model law.

Rep. Brenda Carter (MI) stated along those same lines, I do want to know if there are other considerations that you may have since this does not fall under the purview of Department of Insurance and Financial Services for the state of Michigan. And also, what kind of benefits would there be for our fraud investigation unit since this is something that could help us curb fraud in our state? Mr. DeCampos stated that the benefits to your fraud bureaus is ultimately by having these deterrents and guardrails in place, it provides paper trails for your fraud bureaus as well as your local law enforcement jurisdictions in order to track down either criminal organizations or those opportunistic individual thieves that are trying to sell these converters. And that's really the crux of it is to provide the assistance to your law enforcement entities or to your investigative authorities to be able to hopefully recover those devices. Or if not, then to at least tackle the criminal elements that are perpetrating these crimes which ultimately the impact is not just on the consumer but also on the insurance industry as well. So this definitely falls under the purview of your fraud bureaus who are indeed being forced to deal with this issue due to the sheer amount of theft impacting auto claims associated with catalytic converters.

Rep. Carter stated going back to the model itself, how would this benefit states that don't have this model in place? In other words, I'm agreeing to the fact that this does not fall under the purview of the Department of Insurance and Financial Services and there is a program in Lansing, Michigan right now where we're working in collaboration with you and others, so I just want to just make sure that we are covering all bases here and getting every opportunity to curb this epidemic. Mr. Foreman stated that all the states would benefit from the model legislation because it gives the points that we need to really have in the laws. If we don't have those points in the laws it doesn't benefit law enforcement. One of the big things that I've been pushing through ISRI is possession of the detached catalytic converters. Not everybody should have possession of an detached catalytic converter unless they have proof of ownership or they're licensed to be in the business. And that's where the challenge is we want that in the law so that we can have the right people having possession and it helps law enforcement because while I was working through the years we could stop the car with 10 catalytic converters in the car and we weren't able to attach it to anything else and we couldn't do anything to them because there were no laws about having that possession. Mr. DeCampos stated that Mr. Foreman brought up a really good point during his presentation and what we're talking about here is creating basic standards that all states can look up to in order to shore up their laws addressing this issue. And right now there's gaps when we look at all 50 states. Not all state statutes are living up to these standards. And what a model can do is establish what those standards are and then allow states to pick and choose to amend their statutes in order to get up to that level needed to actually create the deterrent necessary in order to deter criminals and have the regulation necessary to regulate these devices. I really think that's a big take away when it comes to this issue. Yes, criminal penalties, I understand reservations around that. But that's just a small part of it. We need to look at it holistically in the form of standards that states can look to.

Del. Steve Westfall (WV) stated that I think we need to continue this model. I've been an insurance agent for 43 years and used to deal with a lot of theft of a lot of things in West

Virginia. Now we're dealing with stealing catalytic converters. We do have legislation in force, but it's not deterring the theft. So, I think we need to do this. I think it'll help insurance rates. They do a lot of damage when you take them off and you then have a big expense. I'm for this model and I plan to run some version of this in West Virginia next year.

Rep. Jordan stated that I certainly agree on this just for the purposes of discussion but I share some of the same concerns as Reps. Carter and Lehman from the perspective of I'm not sure how this differs from arson or really just any regular auto theft. I think the legislation itself has purpose and it's well intentioned but it really doesn't fall under the purview of the insurance committee. I think in most states this would probably fall under some criminal justice or some similar committee. So I think that really is the real question of where it belongs. Does it belong here at NCOIL dealing with insurance? Or does it really go into the realm of criminal justice in one of those committees? So I just don't know if we want to open Pandora's box.

Rep. Michael Sarge Pollock (KY) stated that we passed a law back in 2017 in Kentucky on this and I think more importantly this model is bringing attention to what's going on with our insurance companies. And then also part of it is just a sense of support more or less if we stand behind with some type of model. I'm like Del. Westfall in that we're looking at doing some things to upgrade the law we passed in 2017 in Kentucky and I think the model is important to show support.

Rep. Brian Lampton (OH) stated that I have a true story that occurred in my district to show that this is a big problem. I have a friend who owns a store and the thieves were coming in through the bike path. They cut a hole in the fence. They were carrying backpacks full of catalytic converters that they cut out of several motor homes that were stored there. And the sheriff told him the only thing he could do was get them for criminal trespassing even though they had three or four catalytic converters in their possession. So I think that's why this is important as we want standards developed. Everybody knows a stolen car is a theft and there's laws for it. We need to define this and get this set up so that having 10 catalytic converters on you is a criminal offense. And I also know that having an NCOIL model will greatly assist any of us who are trying to pass legislation in our respective states as it gives it more power and more position. But you're right that it won't be in the insurance committees. It will be in a criminal justice or that type of committee. But I think this is something we definitely should pursue as it will benefit both our insurers and our constituents.

Rep. Jordan stated that this will be something that we will discuss during our interim meeting before the Spring Meeting in April in order to decide whether we want to continue to move forward or not[1].

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

[1] John Ashenfelter, Associate General Counsel at State Farm, and Jon Schnautz, Assistant VP of State Affairs at the National Association of Mutual Insurance Companies (NAMIC), each submitted witness slips in support of the continued development of the Model.

Rep. Jim Dunnigan (UT) stated that as I noted during our interim meeting in September, I'm very interested in developing policy for states to follow that would incentivize homeowners and renters to take steps to strengthen their residences from natural disasters. In my home state of Utah, we've been dealing with some really horrific wildfires over the last couple of years so I'm very interested in public policy that ultimately aims to strengthen homes and neighborhoods. One of the challenges I find in my state is people don't want to make many changes to their structure, but they want their fire insurance policy to cover it at preferred rates when they live in a mountainous area. It's challenging. So, initially we started with amendments to the existing NCOIL building code model that were modeled after the Oklahoma law that would require the insurers to offer a premium discount if certain stands were met in regard to strengthening homes. And you can see that language on page 250 if you're interested. However, as I studied it more, I was not convinced that it would really move the needle so I'm withdrawing those amendments and looking to develop something new and I'll give you an example. Let's say that you're considering to replace a roof that's going to cost $20,000 or $30,000 and your fire insurance is $4,000 a year. They give you a 10% discount. You'll save $400, but that's probably not going to motivate you to put on a $20,000 roof. So, today I'm looking forward to hearing from our invited speaker from Louisiana to learn about what they've done and see if it's something that NCOIL should consider. I'm very committed to this overall issue of strengthening homes from natural disasters and encourage and invite comments and submission of policy suggestions.

Tom Travis, Deputy Commissioner of the Office of Policy, Innovation & Research at the Louisiana Department of Insurance, thanked the Committee for the opportunity to speak about our program. It's just gotten underway. We have kind of an origin story in Alabama. They have their Strengthen Alabama Homes program, which we borrowed heavily from to design our program, and to do our regulation, and set our grant amount. And we've consulted with them a lot on their processes and the forms they use. Also there, we've talked to their IT people at the University of Alabama, and we developed our IT system from that. There are also other states that have mitigation programs. South Carolina has legislation very similar to Alabama. And then of course there is the Fortified Home Program and Fortified Roof in particular, which our grant program uses or is based on from the Insurance Institute for Business and Home Safety (IBHS). And they've developed a comprehensive wind mitigation. They're now working on wildfire mitigation. They've created a wildfire designation program which I think is being rolled out in California right now. And of course, Smart Home America which is a non-profit and it's kind of an advocacy group that's sponsored by IBHS. And we've worked with them heavily in developing our processes. Our statute provides for grants to retrofit existing homes with Fortified roofs to the IBHS Fortified Roof standard which is a fairly comprehensive technical standard. And once you get that you will get discounts that the insurance companies have to file with us according to our statute. Also, the program requires that the homeowner have a homestead exemption. This is like Alabama. We are then able to verify that it's a primary residence. We've had a lot of people have rental properties they're trying to get into the program and this keeps it just to the primary residents and it's something we can legally verify as we can go to the assessor and Tax Commission records online and verify that very quickly. For our regulation, the grantees are required to have residential insurance, that can be a homeowners policy, a dwelling policy or a similar type of policy. But it must have wind coverage. A lot of our people have Citizens, our residual market, wind only policies or wind and hail only policies and that qualifies as well.

We also require flood insurance for those that are in a special flood hazard area. And it's a first to apply basis. We have an online system and we open it up and you have to be on line, and you have to get in and you fill out the application and if you're not in that first 500 or 1,000 or whatever number we set, then once it fills up you're not allowed to complete the application. And we do that for a variety of reasons. One is so we don't have a lot of personal information of people that we're not going to be giving grants to. And also, we have evaluators in the program and these are people who are IBHS approved. They're usually people who are building inspectors. I have one on our list who is an architect. Some of them are claims adjusters. There's one claims adjusting firm that has a nationwide relationship with IBHS and they're the people who start the process and work through it. They've determined if the building is able to be upgraded to the standard as there are various technical requirements that they have to meet. They have to go through IBHS hurricane training and high wind and hail training so that they know what the different standards are for the different zones. If you're on the coast, you have the hurricane standard that you have to meet and if you're farther north, you meet the high wind and hail. And then we have ethics rules in our regulation for the evaluators. And the primary thing there is that you can't be an evaluator and be a contractor or a roofer in the program and the same is true for the contractors. And that prevents someone from going and evaluating someone's business and then another contractor who's also an evaluator, evaluating that person's business. So, it keeps people from developing too close a relationship and that was something that Alabama had added to their regulation last year before we did our regulation.

And then of course you have the roofers and contractors and they have to complete the hurricane and high wind and hail certificates from IBHS. There's a roofer certificate and then a professional certificate which is a general contractor. Most of the people we have are registered with us as roofers and have the roofer license or registration with the contractor board. And the next requirement is license or registration. And then of course they must have certain insurance coverage and I think it's $1 million of commercial general liability (CGL) coverage and they must have workers comp coverage. And that's a requirement that IBHS has for the people on the IBHS approved list. And as I said earlier, they have the same ethics rules as the evaluators. And then our grant application process is online only. So you get on and you have to do everything online and some people have a little difficulty with it but once you hit the apply button and get in the application it's very simple so it's not very difficult to get past that once you get in. The process is homeowner driven. We do have a list of approved evaluators and approved contractors but we don't tell the homeowners that you must use this contractor or this evaluator. And so they have to every step of the way make the decisions and we try to keep a light touch on those decisions. It's overseen by our staff. We have a three or four people administrative staff who review the applications for completeness and make sure that they meet all the requirements. We check the insurance documents and make sure everything is straight. And we check the homestead exemptions and the flood zones. And we have pre-inspection or pre-site inspection reports from the evaluators which is how we determine their eligibility to move forward that they have a home that has an adequate foundation and it's in good repair. That's reviewed by our staff. For lessons learned, there's an internal administration burden. It does take time to go through all this, and we're in the middle of doing a total of 3,000 grants in just a few months. Alabama has been doing 1,000 grants a year and they're spaced out a little bit further. But we were given a lot of money and we wanted to

get people in the program and start doing roofs before the next hurricane season or have them completed before the next hurricane season.

So, that's something that if you're thinking about doing one of these programs you have to think about the internal administration. We can validate homestead exemptions and flood zones online but when you review insurance documents that takes time because you have to get them uploaded from the policyholders and the homeowners and then you have to go through them. And if you're not familiar with reviewing insurance documents it can take a little time as they vary from company to company. So making sure that they have wind coverage is sometimes a little difficult. You have to start reading the fine print. And the learning curves are steep for everyone, myself included. I'm not a contractor, I'm a lawyer by trade. And the administrative staff they don't really have much, if any, contracting background. A couple of them have actually gone through some of the online training though and have learned a great deal and it's a pretty impressive body of knowledge they've absorbed. And as we work through this we're learning a great deal. We also have a contractor and evaluator workforce, many of whom are fairly new to the process. Even though they've completed the certificates and met the IBHS approval requirements, some of them have done a few roofs and there's some of them have who maybe have done one or two and maybe hadn't even done one yet. So, we do provide a fair amount of oversight through our pre-inspection, pre-site inspection process and then we have a bid review process that we adopted from Alabama. We have a standard bid sheet for the contractors and part of that is to make sure that they are addressing the issues that have been raised by the evaluators. And so, they're all kind of learning how to do that and this afternoon we had a Zoom meeting and our people get online with IBHS and our contractors and roofers or evaluators and they ask questions like "how do I deal with this problem?" We have a lot of peculiarities of construction and so that's one of the things that we've been dealing with and our staff is new to construction terminology and the administrative requirements but they've learned pretty fast.

And then of course every area of the country has peculiarities of construction - an example being a dry stack foundation. That's people who have bricks or blocks that are stacked up without any mortar or cement between the bricks. And that's what they have the house on. You can't put a Fortified roof on a house that is likely to get blown over. They won't certify it. And then there are certain things like in the New Orleans area they have something called a ridge tile and it's something I'd never noticed but if you drive through New Orleans, you'll see a lot of houses that have tiles along the ridges of a shingle roof and they won't certify those as Fortified. People who have those have to have them taken off because IBHS hasn't figured out a way to test and certify a ridge tile. But those in other areas of the country I'm sure have their own peculiar construction issues and that's the kind of thing you have to watch out for. And we've benefited from a relationship with IBHS and Smart Home America and they've been very involved in Louisiana for the last several years. They've been pushing this in the building trade groups in the New Orleans area and with the insurance groups even before we were doing this grant program. And so they laid the groundwork. And we have a large workforce of contractors who've been approved. We have 111 contractors that have met all the approval requirements and we have 30 or so evaluators and the evaluators have their own workforce that goes out and does the legwork for them. But to compare, Alabama's been doing this for several years and they have 15 evaluators and they have about 30 contractors. I talked with an Alabama contractor this afternoon who wants to

sign up for our program as well. So we have managed to get a lot of people. So, as we're moving them through there's plenty of competition out there to keep the prices down on the roofs. And it has had an effect on the bids that have been coming in. Anyway, these groups have supported developing our process and our forms. The pre-site inspections and the bid sheet, we borrowed heavily from Alabama but we have changed both of them to address the issues that are peculiar to Louisiana. And like I said, this afternoon we had our office hour type meeting and it's a question and answer session and we put out information to the participants. We also have a dedicated IBHS e-mail for questions after our program so if someone's participating in our program, they can use that e-mail address and it goes into a priority mailbox at IBHS and they get a fairly speedy response, usually within a day.

For recommendations for those who might want to establish a program like this, the first is to establish the relationships with IBHS and Smart Home America as they have lots of resources including demonstrations at their site. They've done visits for Alabama legislators and I got to go to one of those along with the Rep. Jordan and another members of our insurance committee and some of our staff. And we got to learn about the Alabama program in depth and we also got to see a lot of other research and the testing that goes into the various Fortified roof elements. They have a farm out there where they age shingles - they've been out there for years and they'll bring a panel of them in there and they'll have an ice gun and they'll shoot hail balls at it and steel balls. They do all kinds of things like that to test that. They have a wind tunnel for testing the ability to withstand high winds. And we've established relationships with other state mitigation programs, particularly the Alabama program, but we've talked to people in the other programs as well and we got a lot of knowledge there and learned from some of their mistakes. One is that, and Alabama continues to do it with their applications, they open up at midnight to take applications. We were told older people don't stay up that late and for a lot of people it's not convenient. So, we open at noon so that more people can be up and at their computers and won't sleep through the application period. Also, you need to work with the various construction and housing and insurance sectors within the state. That includes groups like our Uniform Construction Code Council but also the home builders and the various insurance agent groups. Also, you need to identify the resources that are required. Fiscally, you have to figure out how you're going to fund the operating of this if you're going to sustain it long term because it's going to require people and administrative expense. Also grant funding - Alabama has a dedicated fee, I believe it's on their insurance producers, and that goes into a fund and that's how they manage their grants. We have a fund, but we do not have a dedicated funding source. We got a $20 million appropriation this year, along with another $10 million that's appropriated from the money that we collect for our fees and revert to the general fund and we're allowed to keep $10 million of that or up to $10 million of that for the grant program. So, we'll have about $30 million, which at $10,000 a grant is 3,000 grants. You're going to have to think about personnel. You need to think about job descriptions and whether they should be employees or contractors and what skill sets you would need. Also, you need to think about the IT support because you need to start planning that early and we spent almost a year working on our IT system and there's still a lot we would like to add to it and things that we've learned since launching the program that we would like to add.

Communicating is also very important. There's a lot of misinformation that gets spread about the program so it's important to communicate with the evaluators and contractors.

And one of the things that surprised me is the number of contractors who signed up after we launched the program. There's 111 we have approved now but when we started on October 2nd we were somewhere in the 40s or low 50s and a lot of those are people who've applied since then. And I'm not sure why they were waiting because we were hoping to receive applications for several weeks or months before the program. Also, communicating with the public is important. A lot of people don't necessarily understand what the program consists of. Some people just think it's that the government is going to come in and give them a free roof. But they do have to pay the fees for evaluators or any permits and that evaluator fee can be $500 up to $700. Also, it's important that they understand that they pay the excess cost of construction. So, you get $10,000 and some of these roofs are $15,000 or $20,000 and they have to be able to pay that. Also, communicating with other stakeholder groups is important like insurance broker groups letting them know what's going on, and also with the insurance companies and other trade associations. And then anticipate is another recommendation. There are always going to be problems. Mike Tyson says everyone has a plan until they get punched in the mouth. And I have been punched in the mouth. There are so many things that I did not anticipate and so you just have to think about every step of the way what could happen and try to figure it out. And we thought we built a lot of stuff into our system and into our processes to deal with that but there's always going to be a problem with somebody has a special situation or complaint. So being able to have your program have the resources to be able to respond to those problems in those special situations is important.

Rep. Cherlynn Stevenson (KY) asked how many contractors are participating in the program and what has buy-in been like from them? Mr. Travis stated that we have 111 as of two days ago that were approved. I've still got another 40 applications and I would say eight or ten of those just have a few things they need to get done. So, that's a lot of contractors. So, it's a huge workforce. And like I said, the Alabama program has been very geographically limited until a year or two ago. They were just in Baldwin and Mobile counties, but they've moved north and they're actually in Jefferson County around Birmingham but they still only have like 30 contractors but the ones who are in it are very enthusiastic. Every time I talk to them, they think it's a great program and they want to come to Louisiana and do the same thing.

Rep. Jordan stated that before we move on to our next topic, there are some technical changes to the NCOIL Building Codes Model Act that are wholly separate from the premium discount amendments that are also sponsored by Rep. Dunnigan. These amendments are found on page 258 in your binders and as you can see they are very technical in nature and really just serve to bring the model up to date in terms of references within the model. Hearing no questions or comments, upon a Motion made by Rep. Lehman and seconded by Rep. Pollock, the Committee voted without objection to re-adopt the Model with the amendments.

Rep. Jordan thanked everyone and stated that the Model with the amendments will be presented to the Executive Committee for final ratification on Saturday[2].

[2] The following submitted witness slips in support of re-adoption of the Model with the amendments: John Ashenfelter, Associate General Counsel at State Farm; Jon Schnautz, Assistant VP of State Affairs at the National Association of Mutual Insurance Companies (NAMIC); and Paul Martin, VP of State Relations at the Reinsurance Association of America (RAA).

CONTINUED DISCUSSION ON NCOIL PUBLIC ADJUSTER PROFESSIONAL STANDARDS REFORM MODEL ACT

Rep. Michael Meredith (KY) stated that for those of you all who were at the Minneapolis meeting, we introduced this Model there and had a very robust discussion. This model is based off what we adopted in Kentucky during our last legislative session following the severe floods and tornadoes that we had in the state. And I think we're getting pretty close to what I think is a good piece of consumer protection legislation with this model act. If we can get everybody's schedules to align, I would like to actually have an interim meeting of the committee before the April meeting in Nashville so that we can have a committee vote on this model. But from today's perspective as far as the discussion goes, like I said we had a very robust discussion about it back in July in Minneapolis and I think there are really two things still being discussed back and forth and those are around the conflict of interest provisions and the fee cap provisions that are in the model. So, I hope that's what we will discuss today as we go on. I do want to recognize we do have our Commissioner of Insurance, Sharon Clark, in the room from Kentucky. She has done great work in implementing what we did in our state. So, I want to recognize her and her team for their work that they did on our bill while we're here. But again, I would like to move on into the discussion about fee caps and conflict of interest. From my perspective, I think both of those things are very important and need to remain in the model from a consumer protection standpoint.

Jon Schnautz, Assistant VP of State Affairs at the National Association of Mutual Insurance Companies (NAMIC), thanked the Committee for the opportunity to speak and thanked Rep. Meredith and the co-sponsors, Rep. Lehman and Del Westfall, for their work on this. We are here in support of the model today with some additional clarification if we can find agreement on it. When we spoke to the model back in Minneapolis, we were generally supportive of NCOIL having the model here but had some very important clarifications we thought needed to be made. Those clarifications have been made. I can go through them if the committee would like, but otherwise I will spare you. But our goal was to have something that every state could take back and use to strengthen its protections of consumers in these particular areas. We don't think this model is perfect. If we were writing it, we would add some other things to it but we do think it has reached a point where it can serve the function that a good model can and should and the perfect should not be the enemy of the good. We think it should move forward as soon as the Committee is ready to do that. I do want to say a couple of quick things just to add a little to what I've said so far. One of the things I want to note is most of the provisions that have been added since the summer meeting are based on provisions that already exist in Texas law and they have existed in Texas law for 20 years. So, when you hear anyone talk about the possible implications of having these in the model, that's not really a hypothetical thing, because they have been on the books for Texas for 20 years and we know what the impacts are and we can assess those fairly well. The final thing I would just mention to the committee. I don't remember if this came up during the earlier discussion. I do want to make NCOIL aware that the National Association of Insurance Commissioners (NAIC) is moving forward with its own set of amendments to its Public Adjuster Model Act. The two are a little different. They focus on some different things but they're generally pretty well aligned. But one point that I would make is one of the proposed changes to the NAIC model that we think is very positive is taking the existing fee cap language which has been optional in the model

and making it a real non optional provision of the model that matches exactly with what Rep. Meredith has done in his model. And we think it's a good change.

Mr. DeCampos thanked the Committee for the opportunity to speak and stated that NICB strongly supports the model due to the important consumer protection provisions that are within it. For example, public adjusters will be prohibited from engaging in activities that could be construed as a conflict of interest, and from having a financial stake in business entities that obtained business in connection with an insurance claim. These consumer protections will help deter unscrupulous public adjusters from engaging in deceitful and fraudulent business practices. For example, signing up consumers for services that they do not need, that they never asked for, and in some cases, have no knowledge that they even occurred. Such as signing up consumers for additional subcontractor work or even signing them up with a law firm without their knowledge. As the committee continues its consideration of this model law, NICB strongly urges the committee to ensure that these critical consumer protections remain unchanged and in place because they are there specifically to help consumers from some of this predatory behavior.

Cole Klein, President of the American Association of Public Insurance Adjusters (AAPIA), thanked the Committee for the opportunity to speak and stated that AAPIA is a national association that represents members all across the country that service policyholders with average and smaller size losses. We did submit some drafting notes to the model and if anybody has questions about those you can feel free to ask me. They were pertaining to the drafting note that followed the fee cap language and we suggested that it be optional and with corrective language regarding some of the states having higher and lower caps. And with the wording of the contract section near the end of the model, we suggested language which is similar to Pennsylvania's regarding home improvement contractors. We also had a question regarding the section that says a public adjuster may charge a reasonable fee that does not exceed inclusive of all compensation the public adjuster is paid on a claim. Specifically, we question what "inclusive of all compensation" and whether that includes expenses incurred by the public adjuster on the insurer's behalf to be reimbursed back to the public adjuster.

Del. Westfall stated that I like the current model we have. I think it is getting better. I was hoping for a vote today, but I'm anxious to hear if we possibly could vote on this during an interim meeting sometime between now and April. I'd also like to ask that I be added as a co-sponsor of the Model as I plan to run some version of this in West Virginia in January. Rep. Meredith replied yes to Del. Westfall being added as a co-sponsor.

Rep. Lehman thanked Rep. Meredith and stated that we've had quite a few conversations and we passed a similar bill in Indiana. We did not address the fee caps and I think that's something we can have further discussion on. But I do think what's overarching all of this is this is a good model because it really is a consumer protection model. And I hope we can get this to a place where we get something out so that we can get it to our legislatures as soon as possible.

Rep. Jordan stated that many of you are aware that we've had something similar to this in Louisiana. I still have some issues with it as presented. I do believe that some of the language still, as it relates to Louisiana, encroaches on the unauthorized practice of law. We have addressed some of the contingency fee issues. We do not allow for that. But

again, I think as Mr. Schnautz said, I'm certainly not going to let the perfect be the enemy of the good. Those issues that we have in Louisiana, I think we can continue to fight those in Louisiana and for the other states, if it's a model that's acceptable by the majority of the group, then I think we move forward with that. But I would just note my objections that I have for the record[3].

CONSIDERATION OF PROPOSED AMENDMENTS TO NCOIL DELIVERY NETWORK COMPANY (DNC) INSURANCE MODEL ACT

Rep. Jordan stated that last on our agenda is the consideration of proposed amendments to the NCOIL Delivery Network Company (DNC) Insurance Model Act, sponsored by Del. Westfall and Rep. Pollock. We discussed these amendments during our interim meeting in September and they really serve as clean up amendments. I'll now recognize Brad Nail, of Converge Public Strategies, who led the interested persons discussion group on this Model last year, and this, year, and he can briefly summarize the amendments.

Mr. Nail thanked the Committee for the opportunity to speak and stated that this committee in 2022 considered and ultimately adopted the model for DNC insurance. Bills were introduced and passed in North Dakota and in Indiana with some changes to the minimum limit requirements and they were introduced in a handful of other states. Through those legislative activities some of the stakeholders saw some minor amendments that could make improvements to the model language in advance of future introductions in their states. So those changes are technical or clarifying in nature based on that experience and feedback. And Mr. Chairman, the materials are in your meeting materials and it's all fairly self-explanatory, but obviously I'm happy to answer specific questions anybody has on any of these amendments.

Hearing no further questions or comments, upon a Motion made by Sen. Paul Utke (MN), and seconded by Rep. Carter, the Committee voted without objection by way of a voice vote to adopt the amendments.

Rep. Jordan thanked everyone and stated that the amendments will be presented to the Executive Committee for final ratification on Saturday[4].

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Utke and seconded by Rep. Lehman, the Committee adjourned at 5:00 p.m.

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[3] John Ashenfelter, Associate General Counsel at State Farm, and Anne Marie Franklin, Gov't Affairs Manager at the Kentucky Farm Bureau, each submitted witness slips in support of the continued development of the Model.

[4] Jon Schnautz, Assistant VP of State Affairs at the National Association of Mutual Insurance Companies (NAMIC) submitted a witness slip in support of the amendments.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
PROPERTY & CASUALTY INSURANCE COMMITTEE
INTERIM COMMITTEE MEETING – FEBRUARY 2, 2024
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Property & Casualty Insurance Committee held an interim meeting via Zoom on Friday, February 2, 2024 at 2:00 P.M. (EST)

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

Other members of the Committee present were:

Rep. Cara Pavalock-D'Amato (CT)
Sen. Larry Walker (GA)
Rep. Matt Lehman (IN)
Rep. Mike Meredith (KY)
Rep. Rachel Roberts (KY)
Rep. Edmond Jordan (LA)
Rep. David LeBoeuf (MA)
Rep. Brenda Carter (MI)
Rep. Nelly Nicol (MT)
Sen. Bob Hackett (OH)
Sen. George Lang (OH)
Rep. Tom Oliverson, M.D. (TX)
Rep. Jim Dunnigan (UT)
Del. Steve Westfall (WV)

Other legislators present were:

Rep. Ethan Cha (MN)
Rep. Bob Titus (MO)
Asm. Jake Blumencranz (NY)
Rep. Elyn Hefner (OK)

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 Rep. Matt Lehman (IN) and seconded by Del. Steve Westfall (WV), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

INTRODUCTORY REMARKS: CHAIR BENNETT

Rep. Bennett thanked everyone for joining this meeting today. I'd like to begin by saying that I'm honored to Chair this Committee this year and I look forward to building upon the great work that Rep. Edmond Jordan (LA), NCOIL Secretary, did last year as Chair. This Committee promises to again be extremely busy throughout the year, and I'm ready to hit the ground running starting with this meeting today. We have two Model Laws on today's agenda, one of which we will be voting on. For the other Model, we will be discussing which direction to take going forward.

CONTINUED DISCUSSION AND CONSIDERATION OF NCOIL PUBLIC ADJUSTER PROFESSIONAL STANDARDS REFORM MODEL ACT

Rep. Bennett stated that a lot of work has gone into developing this Model, and the latest version was distributed and posted on the website earlier this week. I'll first turn things over to the sponsor of the Model, Rep. Mike Meredith (KY).

Rep. Meredith thanked the co-sponsors of the Model, Rep. Lehman and Del. Westfall, and thanked NCOIL for taking up this very important issue. We've had very productive discussions on this Model going back to last Summer, and I appreciate everyone's engagement and comments. As a reminder, this is based on what we adopted in Kentucky last year, and when we started working on this, the focus was: consumer protection, transparency, and preventing conflicts of interest. I'm not in any way trying to prohibit public adjusters from conducting their business – I'm just trying to ensure that consumers are protected to the best extent possible.

As you can see by looking at the latest version of the Model, we've made a lot of progress from where we first started, and I thank Committee members, insurers and public adjusters for their feedback. I know a lot of comments have been made on the fee cap provisions in Section 7 of the Model. And what I have in there now is 15% for non-catastrophic claims and 10% for catastrophic claims. That is where we ended up in Kentucky as well. I'm not necessarily opposed to lower caps. Some states do have lower caps, which is why I included the drafting note about how this Model is not meant to interfere with those states. But I think for a Model Law, the numbers you see before you are a good starting point and states can debate whether they want to go lower than that. And we need to make sure insureds are not losing too much of their proceeds in the process and having to come up with that much more out of pocket or borrow the money to make the repairs needed.

I'm happy to take any questions when the discussion opens up but before I stop, I just want to note that I think adopting this Model is a great sign for NCOIL and serves as great guidance to legislatures, and I know some are already considering the Model. So having this Model out there is very beneficial and showcases NCOIL as a leader in this space. I'll stop there and just thank everyone for all of their work on this.

Cole Kline, President of the American Association for Public Insurance Adjusters (AAPIA), thanked the Committee for all of its work on the Model. We feel strongly that the fee cap provisions take away choice from policyholders and it severely restricts policyholders with average size losses from being able to retain professional, licensed assistance on their claims. These are policyholders with claims of $25,000 or less and we would like to see those fee caps raised to provide choice for policyholders.

Jon Schnautz, Assistance Vice President of State Affairs at the National Association of Mutual Insurance Companies (NAMIC) thanked the Committee for all of its work along with the sponsors and co-sponsors of the Model. The Model is not perfect and no Model ever is but we do think a lot of improvement has been made and we are here today in support of the Model and ask that the Committee vote in support of it, particularly because at this point in the year a lot of states are in session and the blessing of NCOIL would allow the Model to be deployed more around the country. Since it was raised, I will speak very briefly to the fee cap provisions - we do think it's an important part of the

Model. I would note that many states including my home state of Texas have fee caps. Texas has had a 10% across the board fee cap for 20 years and I went back and looked at the legislative history on that and there has been no bill filed to raise that cap since 2011 and I think that speaks to the fact that it doesn't restrict the ability of people to hire public adjusters. Last time I checked we have 1,500 licensed public adjusters in the state. The other point I would make is the percentage is a percentage of the entire claims settlement, it is not a percentage of what the public adjuster is getting the policyholder on top of what the insurer is already not contesting.

Del. Westfall stated that I'm very pleased that the Committee is considering this Model today as it has already passed out of the WV Banking & Insurance Committee and we made some minor modifications as some of it was already in WV code. I think it's a good consumer protection Model and I'm glad to hear that TX had 10% caps across the board for 20 years and it hasn't been touched and in WV we're looking at 10% across the board as well. We currently in WV have 10% for catastrophic claims but unlimited for other losses and I think that's where the problem is. It's happening in the eastern panhandle in WV coming across from MD and PA, it's not happening in other places but I think it will. I support this Model and encourage adoption.

Rep. Lehman stated that I support the Model and in Indiana we passed a similar law but in Indiana we don't have fee caps. I think what we really wanted to do was focus on transparency and we wanted to make sure we had some very bright lines as to what the public adjuster's role was and what an insured's role was as the lines were getting blurred. We saw insureds losing their right to file a complaint and losing their right to file a claim and there are bad actors in every industry but we just wanted to make sure that it brought some clarity to what their role is and I think, as Rep. Meredith said at the beginning, we didn't want to necessarily eliminate the industry but we did need to put some pretty strong parameters around them. I do think the issue of fee caps merits a discussion but I will end with what my philosophy at NCOIL has always been – we're all going to be different back in our states. NCOIL's role is to build the strong foundation to put a piece of legislation that I can take back to my state and I can put the windows in and other things but each state needs to know this is what has been vetted through a process with multiple stakeholders and this Model has gone through that process and I support the Model being adopted.

Rep. Bennett stated that two years ago my childhood home caught fire and my parents were beside themselves and I wasn't well versed about public adjusters and they used one and I was skeptical at first but at least in my parents case it was a big help. That said, I understand concerns about things like fee caps and that's the great thing about model legislation - we are setting an example and states can take it back and I think in OK we're going to be running some version of this at some point. I appreciate the work that has been done on this with all types of different stakeholders.

Hearing no further questions or comments, upon a Motion made by Del. Westfall and seconded by Rep. Lehman, the Committee voted without objection via a voice vote to adopt the Model. Rep. Bennett thanked everyone and stated that the Model will now be placed on the Executive Committee's agenda at the Spring Meeting in Nashville for final ratification.

CONTINUED DISCUSSION ON NCOIL CATALYTIC CONVERTER THEFT PREVENTION MODEL ACT

Rep. Bennett stated that the next item on our agenda is a continued discussion on the NCOIL Catalytic Converter Theft Prevention Model Act (Model). We've been discussing this issue since our Spring Meeting of last year, and during the Committee's last meeting in November, there was a discussion surrounding whether this Model is somewhat outside the scope of the Committee's normal work. It was stated that while it certainly can be argued that there is a downstream insurance consequence to stolen catalytic converters, you can really say that about anything that's stolen. And also, this issue really gets into the territory of a state's criminal code, and therefore the Model would likely not be presented to a state's insurance committee. To that end, some have called for the Model to be withdrawn and instead have the Committee adopt a Resolution encouraging states to enact stricter laws governing catalytic converter theft.

I do note that since the Committee's last meeting in November, an amended version of the Model has been submitted by the National Insurance Crime Bureau (NICB) in consultation with other interested stakeholders that aims to make the Model more insurance-centric. That Model has been distributed and is posted on the website. The amendments are in the form of two added sections: one would require the designated Department to begin a study on the economic impact of catalytic converter thefts on the insurance industry. A report and recommendations for legislative action would then be submitted to the Governor and legislative leadership. The other section would require the Department to establish a catalytic converter theft task force for the prevention, reduction, and investigation of catalytic converter theft. The task force would have the authority, subject to authorization and appropriation, to establish a grant program for the provision of funds to state and local agencies to provide grants to do a number of things aimed at preventing and reducing catalytic converter theft.

So that's what has been presented to this Committee. Today, I'd like to hear from both legislators and interested parties as to what direction they would like to take: either continue development of the Model Law, with the new provisions; or develop a Resolution.

Rep. Tom Oliverson, M.D. (TX), NCOIL President and sponsor of the Model, stated that I understand the sentiments that perhaps the Model wouldn't necessarily go through an insurance committee but the reality is that this is a significant cost driver for a lot of our property & casualty insurers and policyholders within this space. It is not a victimless crime and I think it is one of those crimes that we do a great service to the industry as an organization by just reminding everybody and taking a position and saying this needs more attention. It doesn't take that long to steal a catalytic converter and it ends up costing a fair amount of money to replace and a fair amount of time and it's taking people's cars off the road. In Texas, our legislation that concerns catalytic converter theft was named after a Harris County deputy who was shot to death by confronting these thieves that are undoubtedly organized crime participants. It's a significant cost to the industry and I think we have a situation where there is an obvious stressor to the property & casualty marketplace that we can point to and recognize, whether it's crime related or not really shouldn't be a factor in whether or not we take a position on it because we are in the business of ensuring stability in the state based system of insurance and making sure our constituents have access to affordable policies and if this

is a significant factor in disrupting that then I think we owe it to the people of our states to take a position on it. I'm strongly in favor of the Model and will push for it and I look forward to seeing it adopted.

Rep. Edmond Jordan (LA), NCOIL Secretary and sponsor of the Model, stated that I think the Model itself has purpose and it's well intentioned but it really doesn't fall under the purview of state insurance committees so while I obviously support the overall issue as I'm sponsoring the Model, I think that a Resolution is the best path forward here. I think that's an "everybody wins" scenario as NCOIL is still taking a position and offering guidance to states, but the organization isn't getting into the position of producing Models that are outside the scope of insurance committees.

Eric DeCampos, Director of Gov't Affairs at NICB, thanked the Committee for the opportunity to speak and stated that the language submitted by NICB is an initial attempt to address some of the Committee's concerns regarding whether the Model is related enough to insurance. I do want to reiterate a point I made at the November meeting which is that the Model will set a precedent to address a key concern within the insurance industry and is within the scope of this Committee's consideration. It can be argued that this Model falls under the purview of other non-traditional Models that have been adopted by this Committee such as the Model Act Regarding Auto Airbag Fraud and the Consumer Protection Towing Model Act which were both recently re-adopted in 2023 and are often considered in judicial and transportation committees in states. Given the precedent set by this Committee through the adoption of those Models we respectfully request that the Committee consider continued development of the Model with potentially voting on it in Nashville.

Brad Nail, on behalf of Enterprise Mobility, thanked the Committee and the sponsors for their work on this Model. All told, Enterprise and its subsidiaries have a fleet of over 2.3 million vehicles making it the largest fleet owner in the world so we feel the effects of catalytic converter theft at a large scale. I thought it might help the Committee to hear some real data on the impact of this crime from a perspective of an insured or in our case a self-insured victim. From January, 2023 to January, 2024 we had approximately 3,000 catalytic converter theft losses for a total of over $8.5 million. And if anything those numbers are low because not all catalytic converter thefts get categorized in a way that makes them easily identifiable in claims systems so that is a low end estimate. So as one company with over $8.5 million in unrecoverable losses to our bottom line we would like to see the law reflect the scope and impact of the criminal operations engaged in these thefts. The data from NICB shows that thefts are still on the rise. Of the top states for thefts, almost all lack a statute making catalytic converter theft a crime meaning they are relying on their general theft or larceny statutes. And we have seen statutes in some states that specifically address catalytic converter theft result in fewer incidents so I think there is value in putting the statutory spotlight on this issue. North Carolina is a good example of a state that established felony penalties for catalytic converter theft in 2021 and saw an immediate decrease after enactment. As to the appropriate role for NCOIL on this issue, there is precedent for this Committee to adopt model laws addressing criminal liability for certain actions. The Distracted Driving Model Act includes misdemeanor criminal penalties and the Model Anti-runners Fraud Bill included felony penalties. Insurance and anti-fraud efforts and special investigation units frequently deal with criminal activity and we think this issue is analogous to other

legislative anti-fraud efforts. So given our experience we urge the Committee to pursue model legislation that will have an impact in deterring this crime.

Todd Foreman, Director of Law Enforcement Outreach at the Institute of Scrap Recycling Industries (ISRI) thanked the Committee and stated that all states expect for WY have laws related to catalytic converters. They are different in various ways and as was mentioned earlier TX and NC have some good laws with felonies for possession and VA has that as well. What we would ask is to make this a point where the Model would be included in current laws instead of creating a new law because it could make it more confusing for law enforcement and industry. So we would ask that you continue work but there are some edits to add to incorporate into current law if they already exist.

Jorge Conforme, on behalf of LKQ Corp., thanked the Committee and stated that he is here wearing LKQ's automotive recycler hat. As part of the established process, LKQ acquires vehicles from insurance companies at insurance auctions and these vehicles come with attached catalytic converters. In reviewing the Model language we wanted to raise the question of whether or not a scrap motor vehicle would include a vehicle that is acquired for purposes of dismantling or recycling. We also wanted to discuss "covered activity." Companies like LKQ don't purchase catalytic converters. The only ones we acquire are ones that come with the vehicle and then we do detach and we don't sell them to the public, we send them to a remanufacturer facility. So I just wanted to ensure that legal, proper industries like automotive dismantling and recycling are covered under "covered activity" and that scrap motor vehicles does include motor vehicles acquired for purposes for recycling an dismantling.

Del. Westfall stated that I took this Model and tried to incorporate it in current WV law and we came up with something and it got a few people's attention. It didn't get sent to the insurance committee, it was sent to the judiciary committee and we discussed and held it for this year hoping that we could deal with it and finish it at NCOIL. This theft is a problem across the entire country and with the Model I think we have a better chance of passing good legislation in the states and incorporating it into current codes. I think we should move forward with this Model and this is a big problem in WV. Rep. Benett noted that catalytic converter bills usually don't go through the insurance committee in OK either.

Rep. David LeBoeuf (MA) stated that I may be missing some context since I wasn't at the Committee's November meeting but looking at the Model, it's a great Model and the real sticking points that I see are sections 5 and 6 because it's prescriptive on the offenses. Section 5 automatically categorizes this as a felony and in MA, a hit and run, first time driving under the influence (DUI), and assault and battery are misdemeanors so I wonder if there is a way to find a happy medium where you focus on the processes in the other elements of the bill and maybe have some attachment or statement explaining the logic of the need for some type of progressive offense because I can see where you have provisions like the Model you can have criminal justice advocates come against it if it's an automatic felony and then it also gets into the 17 year old that's at the bottom of the chain, should they be treated the same as someone who is leading the ring.

Rep. Lehman stated that I've been around NCOIL a long time and we've danced on this line before in terms of a criminal act versus an insurance act and I'm in favor of doing

this and we should discuss it more in April and I'd be curious to know which Committee this would go to in states across the country. In Indiana, the majority of this would fall in the criminal code and would go to that committee but I do think there are parts of this that do touch insurance so we may end up with a situation where it's in the insurance committee or reassigned there so I think because of that we should continue the conversation and then make a decision. I do think it's a hugely important issue and a problem we need to continue to address.
Rep. Bennett stated that there will be a robust conversation in April and I'll be following up with staff and the sponsors to discuss what we plan to do and we'll be revisiting this in April.

Jeff Klein stated that I don't really have a dog in this fight as I'm representing the American Bankers Association (ABA) but frequently the National Association of Insurance Commissioners (NAIC) includes dating notes in models and given the comments today about the necessity for this model, perhaps a drafting note could bridge gaps in giving states discretion to assign the module to insurance committees as opposed to other committees.

Rep. Bennett thanked everyone for their comments and stated that he looks forward to continuing the discussion in April.

ADJOURNMENT

Hearing no further business, upon a Motion made by Rep. Lehman and seconded by Del. Westfall, the Committee adjourned at 3:00 p.m.

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

National Council of Insurance Legislators (NCOIL)

Catalytic Converter Theft Prevention Model Act

Draft as of June 20, 2023. To be discussed during the Property & Casualty Insurance Committee on April 13, 2024.

Rep. Tom Oliverson, M.D. (TX) – NCOIL President; Rep. Edmond Jordan (LA), NCOIL Secretary --- 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, Unit 106
Belmar, NJ 07719
732-201-4133
CHIEF EXECUTIVE OFFICER: Thomas B. Considine

National Council of Insurance Legislators (NCOIL)

Resolution in Support of Strengthening State Laws to Prevent Catalytic Converter Theft

To be discussed during the Property & Casualty Insurance Committee on April 13, 2024

****Sponsored by Rep. Edmond Jordan (LA) – NCOIL Secretary***

WHEREAS, throughout the past several years, states across the country have experienced a surge in the theft of catalytic converters; and

WHEREAS, in total, the nation experienced more than 64,000 catalytic converter thefts in 2022 alone; and

WHEREAS, thefts of catalytic converters have proven to have a significant harmful impact to consumers, with thefts causing:

- violation of personal property rights and a sense of community safety;
- disruption of daily life;
- loss of personal vehicles during the lengthy repair process; and
- in extreme cases, the loss of life to both consumers and law enforcement agents.

WHEREAS, thefts of catalytic converts have also proven to have a detrimental impact on both insureds and insurers with increased catalytic converter thefts leading to increased claims paid and increased premiums; and

WHEREAS, in response to this crisis, state legislatures have taken action by enacting different types of laws with varying degrees of success; and

WHEREAS, based upon the experiences in states across the country, there should be certain provisions which all state catalytic converter laws should have, such as:

- creating new criminal statutes for catalytic converter theft that classify both the theft of and receipt of stolen catalytic converters as a felony, with the penalties attendant thereto;

- setting forth limitations for purchasers of catalytic converters, such as establishing recordkeeping requirements, requiring all purchases to take place at a fixed business address, and verifying a seller's authorization to trade in catalytic converters;
- setting forth limitations for sellers of catalytic converters, such as permitting only certain registered or licensed entities to sell catalytic converters; establishing certain verification requirements for sellers; requiring sellers to provide certain identifying documentation; prohibiting cash transactions; prohibiting any transactions outside the house of 9:00 p.m. – 6:00 a.m.; and
- establishing a vehicle identification number (VIN) stamping grant program to be carried out by a designated state agency; and

NOW, THEREFORE, BE IT RESOLVED, that NCOIL encourages states to examine their current statutory code and take steps to implement the abovementioned provisions in an effort to help stop and prevent ongoing thefts of catalytic converters; and

BE IT FINALLY RESOLVED, that a copy of this resolution will be distributed to State Legislative Leadership, and the Chairs of Committees with jurisdiction over insurance, and over criminal matters in each legislative chamber in each state.

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

National Council of Insurance Legislators (NCOIL)

Strengthen Homes Program Model Act

Sponsored by Rep. Jim Dunnigan (UT)
Co-sponsored by Rep. Matthew Gambill (GA)

Draft as of March 13, 2024. To be introduced and discussed by the NCOIL Property & Casualty Insurance Committee on April 13, 2024.

Table of Contents

Section 1. Title

This Act shall be referred to as the "[State] Strengthen Homes Program Model Act."

Section 2. Purpose

The purpose of this Act is to promote the strengthening of homes in order to protect against severe weather.

Section 3. Grant Program

(A) The [State] Strengthen Homes Program is hereby created within the Department of Insurance. The Commissioner of Insurance, as program administrator, may make financial grants to retrofit roofs of insurable property, as defined in Section 4(C)(9) of this Act, with a homestead exemption to resist loss due to hurricane, tornado, or other catastrophic windstorm events and to meet or exceed the "fortified roof" standard of the Insurance Institute for Business and Home Safety. The commissioner shall promulgate rules governing eligibility requirements for grants and the administration of the program.

(B) In order to receive a grant pursuant to this Section, the grantee shall do all of the following:

(1) Obtain all permits required by law or ordinance for construction.

(2) Arrange and pay for inspections required by law or ordinance and the terms of the grant, which shall include inspection pursuant to Section 4(C)(3) of this Act.

(3) Comply with applicable building codes.

(4) Maintain records as required by Section 4(C)(4) and (5) of this Act and the terms of the grant.

(C) The name of a recipient of a grant received pursuant to this Section, the amount of the grant, and the municipal address of the retrofitted insurable property shall be a public record.

(D) There is hereby established in the state treasury as a special fund the [State] Strengthen Homes Program Fund, hereafter referred to in this Section as the "fund". Monies appropriated or transferred to the fund shall be deposited by the state treasurer after compliance with the provisions of xxxxxxx of the Constitution of [State]. Monies in the fund shall be invested in the same manner as monies in the state general fund, and any interest earned on monies in the fund shall be credited to the fund. All unexpended and unencumbered monies in the fund at the end of the fiscal year shall remain in the fund. Monies in the fund shall be used to provide grants pursuant to this Section.

(E) This Section does not create any of the following:

(1) An entitlement for property owners to receive funding to inspect or retrofit residential property.

(2) An obligation for the state to appropriate funding to inspect or retrofit residential property.

(F) The provisions of this Section shall terminate and have no effect beginning at twelve o'clock midnight on xxxxxxxx.

Section 4. Premium Discount or Insurance Rate Reduction

(A) Any insurer required to submit rates and rating plans to the commissioner shall provide an actuarially justified discount, credit, rate differential, adjustment in deductible, or any other adjustment to reduce the insurance premium to insureds who build or retrofit a structure to comply with the requirements of the [State Building Code] or the fortified home or fortified commercial standards created by the Insurance Institute for Business and Home Safety.

(B) Any insurer required to submit rates and rating plans to the commissioner shall provide an actuarially justified discount, credit, rate differential, adjustment in deductible, or any other adjustment to reduce the insurance premium to insureds who install mitigation improvements or retrofit their property utilizing construction techniques demonstrated to reduce the amount of loss from a windstorm or hurricane. The mitigation improvements or construction techniques shall include but not be limited to roof deck attachments; secondary water barriers; roof coverings; brace gable ends; construction techniques which enhance or reinforce roof strength; roof-covering performance; roof-to-wall strength, wall-to-floor-to-foundation strength; opening protection; and window, door, and skylight strength.

(C) (1) All insurers required to submit rating plans to the commissioner shall provide an actuarially justified discount, credit, rate differential, adjustment in deductible, or any other adjustment to reduce the insurance premium charged to any insured who builds or retrofits a structure to comply with the requirements of the fortified home and fortified commercial standards created by the Insurance Institute for Business and Home Safety.

(2) To obtain a credit or discount provided in this Subsection, an insurable property located in this state shall be certified as constructed in accordance with the fortified home or fortified commercial standards provided by the Insurance Institute for Business and Home Safety.

(3) An insurable property shall be certified as in conformance with the fortified home or fortified commercial standards only after inspection and certification by an Insurance Institute for Business and Home Safety certified inspector.

(4) An owner of insurable property claiming a credit or discount shall maintain and provide certification records and construction records, including certification of compliance with the Insurance Institute for Business and Home Safety standards, for which the owner seeks a discount. Such documents may include but are not limited to receipts for contractors, receipts for materials, and records from local building officials.

(5) An owner of insurable property claiming a credit or discount shall maintain the Insurance Institute for Business and Home Safety certification documents, which shall be considered evidence of compliance with the fortified home or fortified commercial standards. The certification shall be presented to the insurer or potential insurer of a property owner before the adjustment becomes effective for the insurable property along with any other necessary records.

(6) The credit or discount shall apply only to policies that provide wind coverage and may apply to the portion of the premium for wind coverage or to the total premium, if the insurer does not separate out the premium for wind coverage in the rate filing. The adjustment shall apply exclusively to the premium designated for the improved insurable property. The adjustment is not required to be in

addition to other mitigation adjustments provided by the insurer and shall be in lieu of those other adjustments, including those in place prior to xxxxxxxx, if they are deemed to be duplicated.

(7) The records required by this Subsection shall be subject to audit by the commissioner.

(8) Nothing in this Section shall prohibit insurers from offering additional adjustments in deductible, other credit rate differentials, or a combination thereof. These adjustments shall be available under the terms specified in this Section to any owner who builds or locates a new insurable property in this state to resist loss due to hurricane, tornado, or other catastrophic windstorm events.

(9) For the purposes of this Subsection, insurable property includes residential property, commercial property, modular homes, and manufactured homes that may be retrofitted.

D. The commissioner of insurance, in consultation with the State Uniform Construction Code Council, shall promulgate rules and regulations in accordance with the Administrative Procedure Act to implement the provisions of this Section. The rules and regulations may include but not be limited to the following:

(1) Provisions defining and delineating the criteria for discounts, credits, rate differentials, adjustments in deductibles, or any other adjustments to reduce the insurance premium and how such discounts, credits, rate differentials, adjustments in deductibles, or any other adjustments are computed in determining their application in each premium quoted.

(2) Those items necessary for an insurer to compute or otherwise determine the actuarially justified amount of any premium rate reduction, discount, credit, rate differential, reduction in deductible, or other adjustment available to an insured.

(3) Provisions establishing the inspection and certification requirements for insureds who comply with the provisions of this Section.

(4) Recordkeeping requirements for insurers.

Section 5. Effective Date

This Act shall take effect xxxxxxx.

FINANCIAL SERVICES & MULTI-LINES ISSUES COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
FINANCIAL SERVICES & MULTI-LINES ISSUES COMMITTEE
2023 NCOIL ANNUAL MEETING – COLUMBUS, OHIO
NOVEMBER 17, 2023
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Financial Services & Multi-Lines Issues Committee met at The Renaissance Columbus Downtown Hotel in Columbus, Ohio on Friday, November 17, 2023 at 9:00 a.m.

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

Other members of the Committee present were:

Rep. Matt Lehman (IN)
Rep. Edmond Jordan (LA)
Rep. Brenda Carter (MI)
Rep. Mike McFall (MI)
Sen. Paul Utke (MN)
Rep. Nelly Nicol (MT)
Sen. Jerry Klein (ND)
Sen. Shawn Vedaa (ND)
Asm. Ken Blankenbush (NY)
Asm. Jarett Gandolfo (NY)
Sen. Pamela Helming (NY)
Asw. Pam Hunter (NY)
Rep. Tim Barhorst (OH)
Sen. Bob Hackett (OH)
Rep. Brian Lampton (OH)
Sen. George Lang (OH)
Rep. Jim Dunnigan (UT)
Del. Steve Westfall (WV)

Other legislators present were:

Rep. Deborah Ferguson, DDS (AR)
Rep. Brian Lohse (IA)
Rep. Chad Aull (KY)
Rep. Michael Sarge Pollock (KY)
Rep. Cherlynn Stevenson (KY)
Rep. Helena Scott (MI)
Sen. Lana Theis (MI)
Rep. Stephanie Young (MI)
Rep. Bob Titus (MO)
Sen. Joseph Thomas (MS)
Sen. Bill DeMora (OH)
Rep. Bob Peterson (OH)
Rep. Sharon Ray (OH)
Rep. Ellyn Hefner (OK)
Rep. Carl Anderson (SC)

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. Edmond Jordan (LA) 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. Brenda Carter (MI), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 20, 2023 meeting and the minutes of the Committee's September 29, 2023 interim Zoom meeting.

CONSIDERATION OF PROPOSED AMENDMENTS TO NCOIL INSURANCE E-COMMERCE MODEL ACT

Rep. Bennett stated that we will start today with consideration of proposed amendments to the NCOIL Insurance E-Commerce Model Act (Model) which you can find on pages 158 to 160 in the binders and they are on the website and app as well. We've been discussing the amendments since our Spring meeting in March and it seems like we're now in a position to vote on this. Before we go any further, I'll turn things over to the sponsor of the amendments, Louisiana Representative Edmond Jordan.

Rep. Jordan thanked everyone who's been working on this Model and been providing feedback. In 2020 I sponsored the underlying Model that we're discussing today that set forth provisions on how certain insurance documents can be delivered to policyholders electronically. And since then, almost every state has adopted that Model in some form. I'm proud to sponsor these amendments to the Model which generally mirror laws that several states have enacted, including in my home state of Louisiana, that permit health plan sponsors to consent on behalf of covered persons for e-delivery of certain health plan notices and disclosures. Importantly, these laws preserve a person's ability to opt back into paper delivery if they so choose and there is an attestation clause and process involved that requires confirmation that employees routinely use electronic communications during the normal course of their employment. So, I'd like to thank all the interested parties that have worked with me on this throughout the year to get this to a place to where everyone is satisfied. And ultimately the version before you today has more consumer protections and safeguards in place than when it was first introduced in March. I'm very confident that this is a solid piece of policy and should be approved by this Committee and considered by other states who have yet to adopt it.

Molly Zito, Deputy General Counsel of Regulatory Affairs at UnitedHealthcare, thanked the Committee for the opportunity to speak and thanked Rep. Jordan for introducing this amendment and also Wes Bissett and his members at the Independent Insurance Agents & Brokers of America (IIABA) for working with us on it. I completely agree with Rep. Jordan that the amended language is an upgrade from what was introduced in March. I think it helps employers and employees. It allows the employers to default their employees into electronic delivery of the health insurance documents but it also gives the employees an opportunity to understand what they're receiving electronically as well as an opportunity to opt out. So I just wanted to say thank you again and we hope that the members of the Committee can support this amendment. Mr. Bissett, Senior Counsel at the IIABA, thanked the Committee and stated that I don't have much to say as I think Rep. Jordan said it all in terms of substance. I want to thank him for his

leadership on this issue, not just in this version, but going back to 2020. It's been a very successful Model. I think with these amendments it's almost like version 2.0 and it allows states to build upon what they have in place already. I appreciate Ms. Zito's willingness to work with us on some of this language as well and would urge the Committee to take action on it today.

Hearing no questions or comments, upon a Motion made by Sen. Klein and seconded by Sen. Bob Hackett (OH), the Committee voted without objection to adopt the amendments by way of a voice vote. Rep. Bennett stated that the amendments will be presented to the Executive Committee for final ratification on Saturday.

EARNED WAGE ACCESS: EARLY PAYDAY OR PAYDAY LOAN?

Rep. Bennett stated that next on the agenda is a discussion relating to earned wage access providers. Essentially, these providers grant workers access to wages that have already been earned before they've hit their bank accounts. A few states have taken action and enacted laws with licensing and other provisions. And as the title of the topic indicates, one of the main issues here is whether these products should be categorized as a loan. And you can view the laws that Missouri and Nevada have passed on this on the website and the app. Today we'll hear from different perspectives on this issue and depending on how the discussion goes it's possible we could start developing a Model Law next year.

Ben LaRocco, Senior Director of Gov't Relations at EarnIn, thanked the Committee for the opportunity to speak and stated that first I'll tell you a little bit about EarnIn. Earned wage access allows you to access your pay early. We had about 1.8 million Americans use the EarnIn app last year to use this service. So, there's quite a large demand for this product. It's grown a lot. We grew about 30% last year and as we grow, it's attracted interest from legislators and regulators who are struggling to think about how to consider this product. So, once you have earned wages, and we're all working right now and we're theoretically earning money - that money is legally ours. But our employers get to hang on to it until payday because payroll is complicated. There's wage and hour laws and other things that make more flexible pay schedules very difficult. And so we've sort of settled on a two or four week pay cycle. Earned wage access providers allow workers to access that money on their own schedules. Home Depot is one of our corporate partners, so in the break room at Home Depot there's a sheet that says, "if you work today, download this app and you can get paid today." We estimate wages based on a number of different factors and pay those out at the workers request. Again this is only at the workers request if they want to do it. And there's a few different models. We work directly with consumers, so anybody can download our app. Others work directly with employers but the legislation sort of treats these products very similarly.

So what are the benefits of this? It allows a better connection between work and reward. If you're a bartender or a server and you need some extra money you can just go and pick up an extra shift and you go home with that cash. If you're a warehouse worker or a retail worker and the boss says, "Hey, can you pick up this shift?" - you might not get that pay for two or three weeks. And so the ability to say, "Yes, I'll pick up that shift" and then download those funds at the end of the day can really provide positive incentives for both workers and employers. It's access to your own money, similar to an ATM. And the way the business model works is it's a premium service. So, all providers offer a

free mechanism to access their funds. So, the way EarnIn works is if you access your funds over ACH that takes generally one to three business days in order to get those funds. There's no cost to that. If you want it immediately, there's a charge of between $1.99 and $3.99. If something goes wrong and you can't pay us back, there's no recourse so there's no reporting to a credit Bureau. There's no late fees or interest. So if somebody accesses $100 of their pay and for some reason we don't get paid back, six months later they would still not owe us more than that original $100. And I think one thing that's important is there's no selling of data. Data is always a very lively topic in state legislative circles but the way we operate and the data frameworks that we operate under are very different than companies like Google or Facebook so there's no monetization of data in any way. So, I talked a little bit about how we make money. It's that expedited fee. EarnIn also askes for voluntary tips. So, if we say, “Hey, if you like the service give us a couple bucks.” The average tip is less than $2 and less than half of our transactions have a tip. So, on average, we're making $4 to $5 per transaction. And just to reiterate, we don't make money when something goes wrong. So, there's no late fees, no penalties, etc. We only make money when our customers succeed. We don't make any money when they fail. Which is great for aligning incentives.

So why are we here talking to you about regulation? So, as this industry has grown, we don't really fit into any legislative frameworks. We believe there are characteristics of a loan but the fact that it's non-recourse and there's no finance charges, we feel like that's not a great bucket for us. There's some characteristics of money transmission and some characteristics of payroll. So rather than trying to force us in any one of those buckets, we think it's important to create a purposeful framework which is what Nevada and Missouri have done. And as a company, we're funded by venture capital. Our investors want more certainty and we want more certainty in our ability to serve customers, and our business partners like Home Depot and other companies want more certainty that this benefit that they provide their employees will be around for a long time. I think there's also a lot of other reasons around compliance and other things where having a more definitive framework makes sense. So just on the screen now, there's how earned wage access looks compared to what other people would be using if earned wage access was not around. Typically, what our customers tell us is the two main alternatives are overdrafts or late fees on bills. So, we think that both from an upfront cost standpoint and what happens when something goes wrong standpoint, earned wage access is quite a bit more friendly compared to a lot of our competitors or the other things that our customers would have access to. So, there are a couple of legal considerations. We've been around for around 10 years. There hasn't been a ton of scrutiny on this industry until the last couple of years. We talked a little bit about why we think it's not a loan. There have been a couple of statements about why. The Nevada Attorney General put out an advisory opinion saying that we're not subject to the Arizona lending laws. The Biden Administration has put out some guidance saying we're not subject to tax laws for on demand pay arrangements which is a little different than earned wage access but a common parlance for the two.

So, getting into sort of the regulation of earned wage access specifically. Government action really started in roughly 2017. The Consumer Financial Protection Bureau (CFPB) under Richard Cordray, who was appointed by President Obama, put out a payday rule which was meant to regulate the payday loan industry. There was a carve out for earned wage access providers that basically said, “if your service is non-recourse, if it doesn't charge any mandatory fees, then you're not subject to the payday

loan rule and you guys are something different." The first state bills were introduced in 2019. The industry was pretty fractured and those bills I think left a lot to be desired. So, we've been working since that time to get the industry and a lot of folks on board to come together with what we've seen today. In 2021, California signed Memorandums of Agreement with a bunch of companies sort of laying out a framework for the product. And in 2023, about 14 states have introduced some version of a bill. Those are the states that it's been introduced. It's a little different in each state. We're hopeful that the version that Missouri and Nevada passed will be what other states consider. Nevada is a supermajority Democrat state and our sponsor was the Senate Majority Leader. And Missouri a very red state and very similar laws passed in both states so we hope that it's not a partisan issue. And then at some point, the federal government is likely to act on this issue but based on recent conversations that would really only apply to federal law. As you know, a lot of financial services and insurance issues have some purview that's federal and some purview that's state so on the federal bill, there wouldn't be any preemption.

So what's in the bill? It provides clear definitions of what an earn wage access provider is. It creates a new category, so saying there's some components of the lending law, some components of money transmission, some components of payroll. And all of these combine to create this new framework. It explicitly defines what non-recourse is. It requires that free option to differentiate it. And it requires a lot of very robust and transparent disclosures. One thing that's new for this is if an earned wage access provider debits bank accounts. So EarnIn, we can get paid back in a couple different ways. One of those is an ACH debit. If we caused an overdraft because we debited the wrong day, we would have to look - and we do this already - but in the law we would have to reimburse that overdraft. It allows for capture of costs - if regulators are incurring costs to regulate us, they can capture those costs. And it can include data sharing with regulators. We share data with California. Some other state regulators want that data, some don't.

Andrew Kushner, Policy Counsel at the Center for Responsible Lending (CRL), thanked the Committee for the opportunity to speak and stated that CRL is a nonpartisan, nonprofit advocacy organization that works nationwide, you know, both at the federal level and in various states combating predatory lending practices like payday loans and other credit products. I'm excited to speak to you all about earned wage advance. I think my colleague, Ben, talked about this a little bit but there really are two very different types of earned wage advance. And on their side they say access and we say advance and I'll have a slide about why there's slightly different terminology in a second. And I've got the direct to consumer company over here on my left and the employee integrated company here on my right. I think one main difference that I just want to highlight is typically, with the employer integrated product, there's repayment through payroll deduction. So, the money comes to the earned wage advance provider directly from the employer. In the direct to consumer product, that repayment is actually coming from the bank account of the user. So, the money transfers from the employer to the user, and then it's recouped from the user to the lender. And so in that context there's the potential for overdraft fees and other types of problems that you don't see with the employer integrated model. And these are examples of companies that offer these employer integrated products. I think EarnIn may really be the one direct to consumer product. There's some other logos on the screen, there of companies that offer other types of sort of "non-recourse direct to consumer loans" but don't proport to make those

loans based on earned wages. Companies like Dave, Brigit, and MoneyLion - we call those FinTech cash advance providers rather than earned wage access providers. But like EarnIn, they're not integrated in an employer's time keeping system which is a key difference in our view.

And so, this is why we tend to think of these products as loans and as advances because it's the case that in neither of the models that we're talking about here today do consumers actually receive or access their earned wages. In the first instance in the employer integrated model, the money, the advance, which is in red on the screen is actually coming from the lender to the consumer. The next step in the process is that the employer through payroll deduction repays the lender on payday. And then this transaction is settled or completed with the consumer receiving less on payday. In the direct to consumer model, there actually is no connection between the employer and the earned wage advance lender. The advance is directly from the lender to the consumer. On payday the employee receives their entire pay and then the transaction is settled with the lender debiting from the employee's bank account to finish the transaction. And so that's why we think of these products as loans. There are a receipt of money not from the employer in most cases but from a third party that is ultimately repaid. We heard a little bit earlier about non-recourse and I think it's important to understand what non-recourse means in this context. Non-recourse doesn't mean that the consumer has not agreed to repay what they receive from the earned wage advance provider. It simply means that provider's debt collection strategies do not include suing a user for an unpaid debt, selling that unpaid debt to a debt collector, and reporting to credit agencies. And the reason why, in our view, companies don't use these strategies is that they simply do not make sense with their business model and a little bit later I'll show some data about these sort of average size of transactions but the average earned wage advance is something like $85. And I think we can all understand it doesn't make sense to initiate a claim in small claims court for an unpaid $85 advance. The cost of trying to recoup that isn't worth it. But these providers do have other ways of collecting on these loans, including a payroll deduction which is almost always going to be repaid because the employer integrated providers have access to real time, time and attendance data. They know the money exists. The money is coming directly from the employer. There's kind of no question of repayment there or debiting a bank account in the case of direct to consumer lenders. And we know from litigation involving some of these companies that if the transaction is not repaid upon the first attempt to recollect that the providers will re-present that transaction in some cases multiple times which can incur overdraft fees for users.

One of the main ways that the direct to consumer and other Fintech cash advance providers make money is through tips which from our perspective is a little bit strange. This is not the case like when you're in a coffee shop and you're tipping a service industry worker who performs a service for you. This is just functionally money that goes up to the company for providing the service and in our view it's clearly a finance charge and a cost that should be considered in evaluating the product. So, these lenders use, in our view, kind of pressure tactics to induce users to tip. Like a sort of sad looking person saying, "Looks like we didn't get a tip last time." Or sort of suggesting that a tip kind of benefits the community or in some way supports other users of the product. We think the company should just call these charges, fees or finance charges. We've learned a lot about the product in the last year mostly thanks to the California Department of Financial Protection and Innovation (DFPI) Memorandum of

Understanding with earned wage advance providers. And what we learned was quite striking. Consumers use these products a lot. The DFPI found that on average people take out nine of these advances a quarter. So that's 36 times a year. The DFPI also found on the average across the entire industry, the annual percentage rate (APR) is over 330% for both the companies that solicit tips and those that do not solicit tips. That's squarely in payday territory and when you also look at the frequency of use this is when it becomes very concerning for advocates like us. Most users tip. It's like something like in 74% of transactions where a tip was solicited the user did tip. And while there is a theoretical free way to get these advances without paying to sort of expedite fees you see that in the vast majority of cases people are paying these fees. And they need to pay these fees because they need the money now. I mean, that's the whole point of the product. So, it isn't surprising. And so, from our perspective, what these products are, are nothing more than an agreement to receive money now and pay it back in the future, usually with an additional cost to be paid to the lender. And I think in every other context that's credit. You receive money from a third party and you pay it back in the future. We think of that as credit. And I think kind of pulling back the frame here a little bit I think you all as legislators have an opportunity to really think about how to solve the underlying problems that I think are leading people to use these products. From our perspective, financial innovation cannot solve a structural issue which is that people just don't make enough money to get by. But if you have a structural deficit between expenses and earnings like by borrowing against your future pay, you're never going to close that gap. And so the underlying problems are much more difficult to solve but creating a carve out for these types of products isn't actually going to get anyone any closer to sort of paying their rent on a long-term basis.

So, a little bit about the legal landscape. I think we've heard about this a little bit. In 2020, the CFPB exempted a very narrow class of these providers from the federal Truth in Lending Act (TILA). The key criterion in this guidance is that the employee makes no payment voluntary or otherwise. So, no tip or no expedite fee whatsoever. The CFPB has said those are not credit products under federal law. And we have seen industry kind of use this guidance in state legislative fights saying that the industry is exempt more generally from TILA but that's simply not the case. We've also heard a little bit about the bills. As mentioned, the legislation did pass in Missouri and in Nevada. There are bills still pending in a number of states. And then legislation did fail in Texas and Virginia last year. I just want to say a quick word about Missouri and Nevada. Missouri and Nevada essentially do not regulate payday loans. They don't have any sort of rate caps on payday loans and they have some of the most lax laws and highest interest rates on payday loans in the country. And so I would say we think the Missouri and Nevada model is a bad model but it's particularly a bad model in a state that has decided to outlaw expensive short term small dollar credit. And so, if you're seeing that model touted, I think you can say we do things differently in Illinois or in Georgia or in Montana, for example. So just to wrap up, we, along with the National Consumer Law Center, have put out a joint guidance on state earned wage advance regulation the upshot of which is that we think these products should be regulated as the credit products they are. The QR code on the screen will take you to that joint guidance if you want to take a look. We also in that report point to specific consumer protections that advocates think and need to be the case for these products to be safely regulated outside the credit system. And those protections are very different than what is in the bills that industry is trying to move at the state level. I mentioned this a little bit earlier from the non-recourse standpoint - we don't think that it makes sense that no provider sends their claims of

unpaid debts to small claims court. It just doesn't make sense from a financial model. So, from our perspective, the industry coming in and saying, “we need this consumer protection law that prevents us from doing something that we don't already do” is sort of like the cable company saying, “we want to be exempt from consumer protection law but ban us from putting a boot on your car if you don't pay back the cable bill.” That's not a tactic they use. And so, we don't think the consumer protections in those bills are particularly meaningful and any bill that does specifically regulate earned wage advance should have protections like these on the screen.

Ryan Naples, Director of Public Policy at DailyPay, thanked the Committee for the opportunity to speak and stated that DailyPay is an employer integrated earned wage access provider. We were founded in 2015. We like to start when we talk about earned wage access to discuss how this is really solving for a frequency of pay issue. This is not solving for income insufficiency which is a much more intersectional and much more complicated problem to solve. We were started because when people worked in small businesses and they were about $100 short they were able to go to the general manager of the store or an owner of a store and say, “I need $100 before payday.” And that $100 could be physically taken out of the cash register and then put back. And as big box stores started proliferating and Target is our largest customer at the moment, the general managers at Target couldn't do that. And they would try to. And so a request for proposal (RFP) was drafted both by Target and by Walmart in order to solve this problem using a financial technology. So, this is essentially the financial technology equivalent of being able to go and take money out of the cash register for an employee. We are an employer integrated earn wage access provider. So, we signed a contract with businesses. We then take about four to six weeks to integrate with their payroll on time attendance system. At that point, we are kind of like inside the computer, if you will, and anyone who has a job with the employers that we sign up with has the ability to actually download our app. People can then see how much they make throughout the workday. This is an entirely optional service. Our platform updates four times a day with data. Everyone is eligible if they work for a provider we have contract with. About 36% of employees actually end up downloading the app. If someone does want to take access to the money that they already earned, they do have to earn it first. So, you can't access anything that's in the future. We get a lot of complaints that they can't access anything over the amount that they work on the first day, and that’s because you have to work in order to access anything.
About 50% of people on our platform do not ever access their wages. They just really like the platform to look to see how much they make throughout the day and throughout the day period. There is also on our platform a one to one financial counseling and coaching service available through the Coordinated Assistance Network which is a nonprofit that's based in Florida. They also do a lot of work on mental health counseling and coaching and do referrals to that too because financial stress also leads to a lot of mental health stress. We did actually get them from a larger consumer group. If someone does decide to access their wages it's typically about $100. We continue to track how much someone makes throughout the remainder of the pay period. Because we're integrated with time and attendance, we don't have to really even ask the employer. And then on regular payday the paycheck goes in the normal course to the employee however they normally set it up just less whatever they've already accessed. People have three options on our platform to move their money. There is the standard delivery which is essentially like Venmo. So, to be honest, it's exactly like Venmo, except we also have a debit card so people can transfer their wages for no cost if they

can wait one to three business days and expedited delivery fee is $2.99 to $3.99. Employers have the option to pay for this for their employees and so that's why there is a range. It's entirely based on what employers want to be contributing towards the service. During the pandemic this was a big employee recruitment and employee retention tool. We don't have any other fees. We don't ask for tips and there's also no membership fees or subscription fees. It is a flat one-time transaction fee, more similar to an ATM fee really than an installment payment because it's $3.49 which is extremely low. Nationally, we have about 1.4 million users. Our average transfer amount is $108.00. The number of employers we have access to that we have signed up with continues to grow. Target and Hilton and Dick's Sporting Goods and Krogers are our largest partners. UnitedHealth just signed up.

We do research about every year to see what is the financial health impact on our users. In 2021 we worked with an economist who previously was at the CFPB. Then she was in the private sector. Now she's back at the CFPB. She was not there in 2020 when the federal guidance letter was issued that talked about how earned wage access is not actually credit if we're not charging people anything. There was a footnote to that note about as long as there's no charge. The footnote says nominal processing fees are likely sufficient for compliance with the guidance. But they didn't actually define what a nominal processing fee is. So, that's definitely part of the reason why I think we're so active legislatively and regulatorily is because there's not a lot of clarity. Because who's ever heard of saying here's a footnote and we're not going to define anything. So the people that we've spoken to who've used our service previously were paying bills late. Again, we're solving really for the frequency of pay problem - we can't solve for the income insufficiency problem. About 20% of people were taking out payday loans. About 40% of people were overdrawing their bank accounts. And over half of people were paying bills late. And of course there are costs with that. So, what we saw was that after people had access to DailyPay they were able to no longer use payday loans and 88% of them credited this to DailyPay. And the same with overdrawn bank accounts. A high percentage of people who previously had done a lot of really expensive things just did not have to do them anymore because they had access to the wages they already earned and they didn't also have to take on any debt.

So again, we're not solving for income insufficiency, but we are saving people money if they're using much more expensive financial strategies. And so these are conservative estimates of how much we saved with people if they were previously in payday loan debt or over drafting their bank account regularly. We do have a small average transfer amount of about $100. So even though people have access to their whole paycheck they almost never access more than about 40% of it. California does have everybody's data. Our data is different than what was in their report. We don't see people using it as frequently per month as California does. And the large majority of people are doing fewer than 10 times per month. Our average per person is less than once a week which obviously means very little but really we're seeing people most often do about one transfer on the first Friday of a two Friday pay period if that makes sense. Most people want to get paid every week or need access to money every week. And in terms of people who are high frequency users, we do not have any high frequency users that are high frequency users for longer than a month and the people who are high frequency users for two months is much smaller. And there are no such thing as high frequency users really on our platform for three months. And people often don't stay using DailyPay, and this I think shows that people use access to these services really when

they need it. The majority of people are not using this for longer than three months to a year. It is true that we do not consider ourselves a credit product. I think credit laws are defined in different states. We are active in all 50 states. Jamming us into the credit bucket let's say like in Wisconsin where loans can charge for unpaid debits or they can charge a whole bunch of fees – there are a lot of things that can happen to people who take out money that is not good for them. And we're really helping people escape those practices. And I also should say the bills in the states that were passed, they do have earned wage access specific consumer protections around tips and other things like that, that the credit laws obviously are silent on.

Rep. Deborah Ferguson, DDS (AR), NCOIL President, stated that the reason so many states are looking at regulating this is because there's been a lot of predatory practices in the industry. As NCOIL perhaps looks at developing a Model Law, I know there was criticism of the Nevada law because it didn't define it as a loan. Can you address whether it's a loan or a credit? How are those being defined across different bills being considered in different States and what's your opinion on that? Mr. Naples stated that we don't do any underwriting. We don't do any credit checks. There's a one-time flat fee. It's not based on credit worthiness. There's not an installment agreement. Every state is going to be different but we don't send any uncollected funds to debt collection - that's because we're employer integrated. When we don't get paid back or made whole it's because an employer to be honest has gone out of business mostly and not made payroll and the employee doesn't have to pay us back for that. We don't go after the employee. So, there are a whole host of reasons why we are different from a credit product and, if we were forced into the lending law bucket depending on the state, there would be really negative consequences for consumers but also for our own businesses and this service would go away. And in terms of the number of complaints that are received on this there are not a lot and I wouldn't say that this industry has been characterized by as predatory but all of our bills passed with wide bipartisan majorities and I think we're very collaborative like in the state of Nevada our negotiating partner was the Nevada Legal Aid Society and in New York we talk regularly with the Legal Aid Society of New York as well. So this is an industry that is very mission driven and collaborative.

Mr. Kushner stated that I think structurally, these products are loans just simply because it's an agreement to receive money from a third-party company, not your employer - not directly from your employer, but a third-party company and to pay that back. And so we think really in all States and at the federal level, you know that triangular relationship that I put up on the screen that's just a quintessential loan and a credit product. I didn't mention and I probably should have, Maryland and Connecticut and California are all at various stages of a regulatory process that defines these products as loans. And so it is true that there's some variation of the definition of a loan under state law that does differ to some degree state by state but there are states that have taken up kind of the opposite track and trying to regulate these products as loans. I think the danger with these bills the industry is pushing is that they say they're not loans and they have no regulation whatsoever of what providers can charge. They do have to have a free option. I admit that. But there's no usury cap or fee cap and so kind of theoretically the sky is the limit in that regard. And from our perspective, the number one most important thing about our credit regulations is the usury cap - regulating the amount that consumers can be charged to access credit. That's what's important from our perspective. I sort of disagree with Mr. Naples that there's nothing about being a lender

that requires you to use debt collection strategies - that's a choice. It really just means in most states although not in Nevada and Missouri that there's a cap on what you can charge and that's a massively important consumer protection that is missing from these bills.

Mr. Naples stated that California has an exception - their regulatory proposal is for credit but we can all get an exception from needing a lending license if we do a couple of things. And that does not include a fee cap. It includes just kind of existing the way we already are. Connecticut did put out regulations saying that we were a loan but then they pushed back the compliance date from October 1st to January 1st. And we've been talking to the regulator about working on a bill together with the legislature. And Maryland did put out guidance and they did not ask us to get a lending license. So it's definitely in flux.

Mr. LaRocco stated that in Nevada, we literally worked on the Nevada bill for three years. We listened to dozens of people - Attorneys General, consumer advocates, banking regulators - not only in Nevada, but across the country and they put in feedback on that bill and it did pass almost unanimously. I think there were three votes against it. A lot of time and effort went into that to make sure that the appropriate protections were in there for both providers and operators. Connecticut, California, Maryland - none of those were legislation. Those were all regulatory either guidance or rulemaking. And again, California exempts us from the lending law as long as we register under a separate law in California. I'm going to give you an example: I give you $100 and you pay me back $100 plus $4. That's how ATMs work. When you go to the ATM, you take out $100 - that's not your $100. The ATM company pays you $100 and then they get paid back from your bank later. That's how the interoperability of our financial system works. So, just to say will you give me money and agree to repay it later is a loan - that's just not how our financial service works when you actually get down to the details. The final thing I want to talk about is the usury cap situation and I think the free option provides very important competitive benefits where not only do we have to compete with each other but we have to compete with ourselves. So, anything that somebody asks you to pay has to be a good enough value that somebody wants to opt into it and it has to be more valuable than the free option. So, one of the reasons why payday loans get a bad name - there is a very important need that is being served and that's why this industry is growing – is they have a lot of things that require payment that are very bad that are not present in our product. So, I think that's a very important distinction that the competition that is inherent in the product is very consumer friendly and long lasting. We've all been operating for 10 years and there's robust competition. Our fees are still low in the absence of regulation so it's hard for me to see how having legislation would cause our fees to increase for some other reason.

Mr. Naples stated that there's a lot of top down pressure on companies like ours, especially ones that are new and industries that are small. And so it's true that there are companies like the buy now pay later company Affirm that will get a lending license and continue to do all the great things for consumers like it's credit invisible. It's non-recourse. All the fees stay really low. But Affirm is a $5 billion dollar company and in a different ball game essentially than all of our other companies that are much more affected or impacted by the demands of our funders. I do think that there is a lot that we actually agree on even though it sounds like we agree on nothing in terms of no one really is opposed to a fee cap. And our fees are really so low. It's really always a

question of what do you set it at? And in Nevada there is a six year sunset and there is robust reporting required so that if a fee cap is actually necessary or a frequency cap the regulator can set it based on the data of what everybody is actually charging because there's really never going to be a fee cap lower than like $3.50. But if it's $5, the way that businesses work is folks will raise their fees to whatever the cap is going to allow for. And so if there's going to be a cap it needs to be based on something other than just picking a number out of a hat. And I do think it's impactful to think about how California has everybody's data. They've had it for two years and the regulations they've put out includes no caps and no frequency caps. In fact, they actually did have a requirement that we follow California's own small dollar loan transaction fee cap which is higher than what most people charge and they took it out because it would have caused companies to raise their prices. So, I do think we all actually agree on a fee cap, it just depends on what it is. Mr. Kushner noted that California said nothing about why they removed the fee cap from the regulatory package. The idea that they said it was because companies would go to that level is inaccurate. The exemption from state credit law under California is for a maximum of four years under the regulatory package so this is not like an all time thing.

Rep. Ferguson asked do you have any idea where the CFPB is leaning on this? I know they've not really addressed regulation, but do any of you have any idea where they might be leaning? Mr. Kushner stated that we both talked a little bit about the 2020 guidance that basically says if you don't charge a fee you're exempt from TILA. I think for me that implies the converse that if you do charge a fee or there's any money received by the lender that you should be subjected to TILA. I have no inside intel that the CFPB is leaning in that direction. It seems to me implied from the 2020 opinion. I won't proport to have any inside knowledge except that as I think both of us discussed there have been some news reports that the CFPB is in the process of creating additional guidance on these products which I think should be released in 2024. There is federal legislation pushed by the industry to basically stop that effort in its tracks but we expect the guidance in the future. Mr. LaRocco stated that I would say we actually partially agree on that one. We think that guidance probably will come out from the CFPB in early 2024. We also have no idea what that will say. I think a couple of things to consider as state representatives. One, any guidance that comes out will be non-binding. It'll just be an advisory opinion. Second, what is in the purview of federal law is very different than what's in the purview of state law. So things like state credit laws and usury caps and those kinds of things are not in the purview of the federal government. So the CFPB, really any guidance that comes out of them would not really affect state laws specifically.

Asw. Pam Hunter (NY), NCOIL Treasurer, stated that I chair the banking committee in New York, so I know a little bit about this and I feel like the conversation not just today, but just in this space is that we're normalizing being nickeled and dimed every single day. Every one of us has a phone right now with us that we could make transactions with like Venmo or Zelle and there's a fee if you want your money early. The bottom line is really we’re talking about financial literacy and also low wages and I don't necessarily know if this is the place or space that we're ever going to fix either one of those but it seems to me that if, and I'm not touting this as a great example, but I know this to be a fact that an employer could do this themselves. They could pay their employees every day. And one of the employers in my area, a large global employer we all know, actually offers this option that the person could get paid daily. And many times when we're

having this daily pay conversation, it is for people who are on the margins, who need their money today. In the examples that I received in my district is I need to get paid every day because I am literally homeless and I need this money to pay for the hotel I stay in everyday. So what happens when we get in a situation where you're fronting this money from your employer every day and payday comes and you're down 40%? This is not a sustainable model for people to live in. So, I guess my challenge is because this is not going away and I'm not trying to over regulate market, I want to make sure that our consumers are protected and that normalizing $4 on $100 is not where we need to be. But how can we move forward so that these consumers who are on the margins are not going to be preyed upon and can be protected. How do we make employers do daily pay for their employees? I work today. I earned my pay today. Why can't I get my pay today? How do we work that out? Also, we are assuming that everyone lives in this traditional bank space and they do not. I have a phone, I have an app. I'm getting direct deposit fronted to my phone. It's all electronic transactions. So what happens when I lose my job or I stop my direct deposit going to your app based system? And I'm fronted money from you and then I just walk away from it. And I've had conversations with some of these organizations and they've given me different answers. So, it's ripe for all sides to have issues and I think it really needs to be vetted a bit better for protections for consumers and also not being predatory. But there are bigger problems relative to this whole banking space and really it does come down to financial literacy and low wages. But if someone can answer for me my question that would be great - why can't I work today and get my money that day.

Mr. LaRocco stated that we know of two employers that provide this on their own, Walmart and Amazon. They each have more than 1 million employees. Even very sophisticated employers like Target and Home Depot can't do this on their own. And they looked at third parties. It's very difficult for a lot of reasons. Wage and hour laws are very complicated. I think there are a lot of companies that would love to do it. But it's just too complicated and they can't. I think there may be something else that could be done on that but the fact is that right now it's very difficult for employers and we don't know exactly why because we're not in their position. But they have chosen to look to third parties. Just the quick point on what happens if you change your bank account - if you use EarnIn and you change your bank account, literally thousands of people do that with EarnIn a year, nothing happens to them. They use their bank account, they change their account, they don't pay us back. They just don't get to use EarnIn anymore until they pay us back and that's just a fact of dealing with the business. We've done more than 250 million transactions. When you do that many transactions, a certain number of people are not going to pay you back. It's built into our business model. So there's basically nothing else that's done.

Mr. Naples stated that from what we see from the data from our app is, despite our name of DailyPay, no one is using us every single day. And I think that the importance of these licensing laws is that they do require robust reporting so that regulators actually know how people are really behaving on this app. And we're the two largest probably in the country and we're actively engaging constantly with regulators. We think that transparency is important. And what we see is that people use platform when they need it for a discrete period of time and then they don't use it again. And we do not see the regular reliance that would really be extremely problematic. And I do think that in terms of having employers also cover the cost of these transactions again is something that we invested in and pushed for. There was a provider that tried to only work with employers

that did that, a competitor of ours, and they essentially went out of business. Their technology was bought by Walmart because they were Walmart's provider that doesn't charge people if you get their NEO app. So, this is a space that's in flux but wants to be regulated for these reasons.

Rep. Stephanie Young (MI) stated that in Michigan we have an issue with our payday loans. We have been fighting to regulate how much they're able to charge. They call them fees. When we look at the interest, it can be up to 300% interest on these loans and we're looking at how we can do that. But it's back to what Asw. Hunter said - it has to do with low wages. And we find people get caught up in these cycles. How do you get out if you start with early loans or early pay and then by the end of your two week period when you're supposed to get paid now you're 40% less or you're 50% less. I know it's all so tricky. But I do have a specific question. There was a slide and I want to be certain I understood this slide where you had the percentages of the companies how they run their payroll. So, there are companies that run it monthly, biweekly, or weekly and then, of course, there's daily pay. And I'm wondering do you all have data on the people who are on each of these types of pay cycles and how many of those people actually use these products? Because it seems to me that the folks that are on that monthly pay, which I am adamantly opposed to but I don't run these businesses, would be using these types of products more because it takes them longer to get access to the money that they've already earned. And I'm just curious to know, does that data exist? Have you all collected it?

Mr. Naples stated that we don't have that data. I think we do hear, though, that the people that are paid monthly use it, anecdotally, more frequently. I know in Washington. DC, the U.S. House of Representatives' staff is all paid monthly and so when we'll be in meetings they are the people that actually have heard of earned wage access because they themselves are using it because their paycheck is only once a month. Mr. LaRocco stated just two quick anecdotes. We have over 100 congressional staffers that use EarnIn. And I would also say we've met two state representatives in the last couple of weeks that both used EarnIn and I thought that was very interesting in our conversations. Mr. Kushner stated that I don't know either and it's a very good question but I do think your concerns are spot on that in a way the use of these products can sort of generate their own demand because there's less available on payday. And really quickly I just wanted to say in response to the previous question, people ask us all the time what's the solution here? I think ideally employers would just provide this as a benefit for free. And I think some do shoulder that cost for their providers. I think it's a major disincentive for that to happen to allow these bills to pass that effectively carve these products out from state credit laws and allow the cost to be put onto the worker. I think that's the wrong approach. Mr. LaRocco stated that if anybody in your states have connection with researchers or something like that I think it actually would be interesting. We do have operations in all 50 states so we absolutely could do some research like that so it could be an interesting collaboration.

Rep. Jim Dunnigan (UT) stated that on DailyPay, you had three formulas of fees. The standard delivery, there's no fee. You can have instant gratification if they use your debit card right? Mr. Naples replied, yes, for no fee. Rep. Dunnigan stated then on the third one, it's instant, but there's maybe up to a $3.50 fee. I'm interested to know of each of those what percentage of your customers use those? Mr. Naples stated it's about 70% are doing the instant with for the $3.49. Rep. Dunnigan asked why don't they use your

free card? What's the downside to using your free card and getting it? Mr. Naples stated they need to put their direct deposit on the debit card so they need to use it more regularly so they have to be comfortable using the card more regularly. Rep. Dunnigan asked who determines the fee up to $3.49? Mr. Naples stated our standard instant fee is $3.49 across our whole platform and then the employers, well ask them how much if they're willing to cover the fee for their employees or how much of it. Rep. Dunnigan asked so what do the employers receive from this? Do they get a cut? Do they get anything? Mr. Naples stated they don't get anything. It helps with employee retention and reduces times for recruitment and reduces employee absenteeism because so much of the app is just visibly showing people how much they can make and how much they're making. Mr. LaRocco stated that's actually one thing that's in the bill. There's a prohibition against any revenue share or anything like that so it doesn't incentivize employers to push somebody to one particular service that might have higher fees. Rep. Dunnigan stated and to clarify, you said that Walmart's offering the daily pay. Do they charge their employees a fee for that service? Mr. Naples stated they have a NEO bank called One, and so Walmart employees download One and use One as their bank. Then they can get earned wage access for no cost. And Amazon, we believe, does it themselves on their own platform but we're actually not really sure. But they're the only ones that are offering it themselves. They're obviously very well capitalized.

PRESENTATION ON INFLATION'S IMPACT ON THE INSURANCE MARKETPLACE

Douglas Ruml, Assistant Professor, Finance Program Director at the Ohio Dominican University, Division of Business, thanked the Committee for the opportunity to speak and stated that I was asked by the Institutes Griffith Foundation to speak today and to that end I was also asked to say that I'm going to keep my comments and contributions to today's program unbiased and purely educational so there's no political slant to anything I'm going to say. And I'm going to talk about inflation in the area basically of insurance. There's four different measures of inflation that I'm going to talk about. There's general inflation, there's claims cost inflation which would also includes social inflation, another new term maybe for some of us. There's wage inflation. That's the one I won't spend a lot of time on. And there's also interest rates. So, we'll talk about these four things fairly briefly. And I've got my first slide and you can see the lines there. I want to call your attention to the green one that's in the middle of this slide. And that is the inflation with when you take out the energy and food and things that are very volatile. So that's the type of inflation that they call core inflation and that's the thing that gets reported by the government every month. And we just had the last months, year on year just came out. So, this slide is actually a little bit old because this is the September numbers and in fact the October numbers were down one half of 1% which doesn't sound like much, but people are really excited about it and the stock markets went bananas for a couple of days.

So that's where that's at but we have to drill down in this because even if it went down a little bit it's up very high compared to what's considered normal. So, it has been around 5%. It's been as high as 9.x% and normal is considered 2% or less. So, in the last few years, there's been a high level of inflation. So even if it's gone down a little bit or if it's flattened recently, it's still at a higher level than it was three or four years ago. We've been through an awful lot with that. On the right side of this slide I also give you a definition of what inflation is. So, really, inflation means that you can't buy as much with your money this year as you could have bought with the same amount of money in

previous years. That's really what inflation means. You don't see it. You're still getting the money but you're just not able to buy as much. We think about that as the prices have gone up but another way of looking at it is that our money doesn't go as far and so that's sort of the problem that people have to face with this. And one of the things that insurers have to do when that's the case because they have expenses as well and those expenses include people that are policyholders that have had accidents or damage to their homes or you know they're going to the doctor. Those people have to stretch their dollars out and the insurance companies are saying, "Well, we have to take care of their needs and pay for that house that we said we would replace the value of." And so, insurers are saying, "We're paying more than we thought when we did the mathematical models 10 years ago on this particular person. And so, we're going to have to charge them more in the future." So, that's kind of where that gets scary.

Let's talk a little bit about another chart and you can see the line going up and down. If you'll notice over on the left side, there's kind of a gray area where it was going up and then it went way down. And that was the Great Recession right there. So, the inflation rate, again this is the core, every 12 months, year on year. It went quite a bit down during the recession. That's what happens when companies and businesses organizations don't have a lot of money. There's not a lot of money working in the economy. It tends to make the interest rates go lower. So, that's what happened then but if you look it's kind of hovered around the middle and then in the last couple of years over on the right side you'll see it spiked up quite a bit and the level it's kind of bounced around it since then is still higher than that average was from before. So, this is again general inflation, inflation in the economy so that's the overall inflation and the first type of inflation that we were going to talk about. Let's talk about the second kind of inflation, which has to do with insurance and this is claims cost inflation. Sometimes people ask, "why did my insurance rate go up this year? Why are my rates going up? Why are they higher than they were before?" And I've put five bullet points here that have to do with some of those issues. The first one is housing material and labor costs have gone up. So, somebody has damage to their home. They need to get it fixed. They find out those costs have gone up. So, in the general economy those costs may have gone up over three years, maybe 15%. But specifically to the housing market, they went up around 45% so in some areas it's really expensive. You see that a lot with construction. You see it also with anything related to microchips which unfortunately was automobiles so you had a big issue with that as there was a shortage of microchips.

Thirdly, there was just general auto repair and labor costs going up. Again, getting your car fixed. When people are not buying new cars, they're using their old car for longer and they need to be repaired more often and you get sticker shock when you go into get it fixed because the cost is going up by a considerable amount. We also have healthcare trending upwards. So, healthcare costs, labor and other things that have tended to cause that to go up. And then finally, supply chain issues. So, especially in the aftermath of the pandemic, we had a lot of issues with just not being able to get stuff to where it needs to be. Let's talk a little bit about social inflation because this is a terminology that has to do really with a lot of time with legal costs. So quite often when we're talking about social inflation, we're talking about these five things. The first is that juries, the attitudes of people sitting in juries tend to have changed and now they feel more likely to say, "well, there's a tort case that I'm seeing and we think that this entity that's being sued is a big one and so, they can afford it." And so there tends to be inflation with especially noneconomic damages. That's just the nature of the beast.

Secondly, third party litigation funding - this is a new thing. It's for law firms to be able to get funding and allow them, if their plaintiffs, to pursue cases for a longer period of time and mass growth torts would be a primary issue with that. Number three is additional capital. So, additional capital is there because they're making more money, law firms are able to spend more on legal advertising and so that tends to cause more lawsuits to bubble up in the economy. Number four, social sentiment. Trust in institutions has declined. So, people tend to just think that companies or other institutions should be held more accountable for things. So that's again related a little bit to the juries but just the fact that everybody sort of agrees with that in society. And then finally, expanding legal concepts. So, there's a lot of work that's been done that has to do with what you're liable for which wouldn't have been the case two or three or four or five years before. But now you are liable and so a lot of the times companies and their insurers have to get their arms around what those future costs were going to be and now the future's arrived and we have more costs with that sort of stuff.

This is the one I don't want to spend a lot of time on, it's wage inflation. We've touched about it already with medical, with auto repair, and with other companies but it also affects insurance companies. So, they're a service provider and a lot of their expense is actually wages. So, let's talk about the fourth and final thing - interest rates. So, the Federal Reserve, they try to stop rising inflation like what's going on right now or what has been going on and one of the things they do, one of the major tools in their arsenal, is to be able to raise rates. And what that means is that it costs you or I or any entity a company to borrow money. It costs more to do that. And so, when the rates are raised that tends to ripple through the whole economy where you have things costing more. It costs also more for insurance companies to raise capital in the market when they go out and they say, "well, we want to issue a bond." Maybe four years ago, that bond would have paid a bondholder 3% or 4%. Today it might pay them 6% to 8% or 10%. So they have to pay a lot more to borrow money from people. Now, I mentioned briefly at the beginning that currently we have disinflation which is it's seems like it's stabilized. We'll see how that lasts. That line was going down. That's a good thing but it's still at a higher level than it was before all this started.
Rep. Matt Lehman (IN), NCOIL Immediate Past President, stated that in the space of social inflation, when you talk about increasing of larger sums awarded in that, are we seeing a percentage there? Are those up 10% or 20% or 50% an award? Is there a tangible number that you can cite that those are up? Prof. Ruml stated that yes - at least with third party litigation. Westfleet Advisors which is a brokerage firm, they're findings were that this one particular area of third party litigation grew by 44% between 2019 and 2020. Rep. Lehman stated ok so the funding mechanism has increased 44%. The jury awards, the jury who gave him $1 million now they're giving him $4 million - is it that kind of a shift? Prof. Ruml stated I don't have the data recently. I know it was going up fairly steadily and it was greater than the level of inflation.

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

Rep. Bennett stated that last on our agenda is a consideration of a resolution in support of establishing national standards and procedures for the reporting and payment of premium taxes as a result of direct procurement. You can view the resolution on page 166 in your binders and it's on the website and app. Rep. Tom Oliverson, M.D. (TX),

NCOIL Vice President, is sponsoring the resolution but he had to leave first thing this morning to get back to Texas for a special session. Before I go any further I just want to note we have been discussing this issue since our March meeting and as you can see by the amount of edits to the resolution before you there has been a tremendous effort to listen to suggested feedback and make the appropriate changes. So, it seems to me that given the heavy amount of changes that we've made any further suggested changes made in opposition to this issue are made by those that don't want the resolution at all. And as I said during our last meeting what we're dealing with here is simply creating a mechanism by which states can collect unpaid tax revenue. That seems like an issue that everyone can agree on no matter what you think and who you represent and no matter what side of the aisle you're on.

Bill Bryan, Director of Providence Insurance Partners, LLC, thanked the Committee for the opportunity to speak and stated that I really don't have much to add. We have been before the committee several times on this issue and as you mentioned in your comments, the reason for that repeated appearance has been to address the concerns that were raised by some people about the original version of the resolution. And it's been steadily sort of reduced and whittled down to what really is kind of a minimal addressing of just this very specific narrow provision to ask that there be clarification on the methodology of paying premium tax. It's not inventing anything. It's not adding anything. It's not changing anything. It's just asking for some standardization and clarification of that process by the states.

Rep. Lehman stated that as Rep. Bennett noted, this is very narrowly tailored and it's really focusing on the taxes that are due. And I think we'd all agree that it's always better to collect taxes that are owed and taxes that are due than it is to create new taxes. So, all this simply does is put that mechanism in place. Also, I know there's been some opposition to this but I think with the edits, we're not even addressing the industries that have had concerns. And as legislators, we don't put our thumb on the scale of competition so I think this is a good resolution and I would ask for its favorable adoption.

Upon a Motion made by Rep. Lehman and seconded by Sen. Hackett, the Committee voted without objection by way of a voice vote to adopt the Resolution. Rep. Bennett stated that the Resolution will be presented to the Executive Committee for final ratification on Saturday.

ADJOURNMENT

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

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

National Council of Insurance Legislators (NCOIL)

Transparency in Third Party Litigation Financing Model Act

Sponsored by Rep. Matt Lehman (IN)

Draft as of March 13, 2024. To be discussed by the NCOIL Financial Services & Multi-Lines Issues Committee on April 13, 2024.

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Section 1. Title

This Act shall be known and cited as the "[State] Transparency in Third Party Litigation Financing Act."

Section 2. Purpose

In an effort to promote consumer protections related to third party litigation funding transactions, this Act establishes that such transactions must be subject to state regulation and sets forth requirements regarding disclosure, registration, funding company and attorney responsibilities and limitations, violations, and other items.

Section 3. Definitions

As used in this Act, the following terms shall have the following meanings:

1. "Advertise" means publishing or disseminating any written, oral, electronic or printed communication or any communication by means of recorded telephone messages or transmitted or broadcast on radio, television, the internet or similar communications media, including audio recordings, film strips, motion pictures and videos, published, disseminated, circulated or placed before the public, directly or indirectly, for the purpose of inducing a consumer to enter into a consumer litigation funding.

2. "Charges" means the amount of money to be paid to the consumer litigation funding company by or on behalf of the consumer, above the funded amount provided by or on behalf of the company to a consumer pursuant to this Act. Charges include all administrative, origination, underwriting or other fees, including interest, no matter how denominated. Such charges shall not exceed the maximum annual percentage rate as provided for in Title 10, United States Code, section 987(b). Any contract which exceeds such rate shall be considered usurious as defined by [insert citation to state usury law].

3. "Commercial litigation financier" means a person that enters into, or offers to enter into, a commercial litigation financing agreement with a plaintiff in a civil proceeding. The term does not include a nonprofit organization.

4. "Commercial litigation financing agreement" means a nonrecourse agreement that a commercial litigation financier enters into, or offers to enter into, to provide funding to support a plaintiff or the plaintiff's attorney in prosecuting the civil proceeding, if the repayment of the funded amount is:

(a) required only if the plaintiff prevails in the civil proceeding; and

(b) sourced entirely from the proceeds of the civil proceeding, whether the proceeds result from a judgment, a settlement, or some other resolution.

The term does not include a consumer litigation funding transaction, an agreement between an attorney and a client for the attorney to provide legal services on a contingency fee basis or to advance the client's legal costs, a health insurance plan or agreement, a repayment agreement of a financial institution if repayment is not contingent upon the outcome of the civil proceeding, a funding agreement to a nonprofit organization that represents a client on a pro bono basis, or an agreement of an assigned claim to prosecute an environmental contamination matter.

5. “Foreign country of concern” includes the following:

(a) A foreign government listed in 15 CFR 7.4.

(b) A country designated as a threat to critical infrastructure by the governor under [insert citation to state law].

6. “Foreign entity of concern” means a partnership, association corporation, organization, or other combination of persons:

(a) organized or incorporated in a foreign country of concern;

(b) owned or controlled by the government, a political subdivision, or a political party of a foreign country of concern;

(c) that has a principal place of business in a foreign country of concern; or

(d) that is owned, organized, or controlled by or affiliated with a foreign organization that has been:

(i) placed on the federal Office of Foreign Assets Control specially designated nationals and blocked persons list (“SDN List”); or

(ii) designated by the United States Secretary of State as a foreign terrorist organization.

7. "Consumer litigation funding" means a non-recourse transaction in which a consumer litigation funding company purchases and a consumer assigns to the company a contingent right to receive an amount of the potential proceeds of a settlement, judgment, award, or verdict obtained in the consumer's legal claim.

8. "Consumer litigation funding company" or "company" means a person or entity that enters into a consumer litigation funding contract of no more than xxxxxxx dollars with a consumer. This term shall not include:

(a) an immediate family member of the consumer;

(b) a bank, lender, financing entity, or other special purpose entity:

(i) that provides financing to a consumer litigation funding company; or

(ii) to which a consumer litigation funding company grants a security interest or transfers any rights or interest in a consumer litigation funding; or

(c) an attorney or accountant who provides services to a consumer.

9. "Consumer" means a natural person who has a pending legal claim and who resides or is domiciled in [State].

10. "Funded amount" means the amount of monies provided to, or on behalf of, the consumer in the consumer litigation funding. "Funded amount" excludes charges.

11. "Funding date" means the date on which the funded amount is transferred to the consumer by the consumer litigation funding company either by personal delivery or via wire, ACH or other electronic means or mailed by insured, certified or registered United States mail.

12. "Immediate family member" means a parent; sibling; child by blood, adoption, or marriage; spouse; grandparent; or grandchild.

13. "Legal claim" means a bona fide civil claim or cause of action.

14. "Resolution date" means the date the funded amount, plus the agreed upon charges, are delivered to the consumer litigation funding company by the consumer, the consumer's attorney or otherwise.

Section 4. Contract Requirements; Right of Rescission

1. All consumer litigation funding contracts shall meet the following requirements:

(a) a contract shall be written in a clear and coherent manner using words with common, everyday meanings to enable the average consumer who makes a reasonable effort under ordinary circumstances to read and understand the terms of the contract without having to obtain the assistance of a professional;

(b) the contract shall be completely filled in when presented to the consumer for signature;

(c) the contract shall contain, in twelve point bold type font, a right of rescission, allowing the consumer to cancel the contract without penalty or further obligation if, within ten business days after the funding date, the consumer returns to the consumer litigation funding company the full amount of the disbursed funds;

(d) the contract shall contain the initials of the consumer on each page;

(e) a statement that there are no fees or charges to be paid by the consumer other than what is disclosed on the disclosure form;

(f) in the event the consumer seeks more than one litigation funding contract from the same company, a disclosure providing the cumulative amount due from the

consumer for all transactions, including charges under all contracts, if repayment is made any time after the contracts are executed;

(g) a statement of the maximum amount the consumer may be obligated to pay under the contract other than in a case of material breach, fraud or misrepresentation by or on behalf of the consumer; and

(h) clear and conspicuous detail of how charges, including any applicable fees, are incurred or accrued.

2. The contract shall contain a written acknowledgement by the attorney retained by the consumer in the legal claim that attests to the following:

(a) the attorney has reviewed the mandatory disclosures in Section 7 of this Act with the consumer;

(b) the attorney is being paid on a contingency basis pursuant to a written fee agreement;

(c) all proceeds of the legal claim will be disbursed via either the trust account of the attorney or a settlement fund established to receive the proceeds of the legal claim on behalf of the consumer;

(d) the attorney is obligated to disburse funds from the legal claim and take any other steps to ensure that the terms of the litigation funding contract are fulfilled;

(e) the attorney has not received a referral fee or other consideration from the consumer litigation funding company in connection with the consumer litigation funding, nor will the attorney receive such fee or other consideration in the future; and

(f) the attorney in the legal claim has provided no tax, public or private benefit planning, or financial advice regarding this transaction.

3. In the event that the acknowledgement required pursuant to paragraph (c) of subdivision two of this section is not completed by the attorney or firm retained by the consumer in the legal claim, the contract shall be null and void. The contract shall remain valid and enforceable in the event the consumer terminates the initial attorney and/or retains a new attorney with respect to the legal claim.

4. Notwithstanding [insert citation to State law governing prepayment penalties within usury section], no prepayment penalties or fees shall be charged or collected on consumer litigation funding. A prepayment penalty on consumer litigation funding shall be unenforceable.

Section 5. Prohibitions and Charge Limitations

1. Consumer litigation funding companies shall be prohibited from:

(a) paying or offering to pay commissions, referral fees, or other forms of consideration to any attorney, law firm, medical provider, chiropractor or physical therapist or any of their employees for referring a consumer to the company;

(b) accepting any commissions, referral fees, rebates or other forms of consideration from an attorney, law firm, medical provider, chiropractor or physical therapist or any of their employees;

(c) intentionally advertising materially false or misleading information regarding its products or services;

(d) referring, in furtherance of an initial legal funding, a customer or potential customer to a specific attorney, law firm, medical provider, chiropractor or physical therapist or any of their employees; provided, however, if a customer needs legal representation, the company may refer the customer to a local or state bar association referral service;

(e) knowingly providing funding to a consumer who has previously assigned and/or sold a portion of the consumer's right to proceeds from his or her legal claim without first making payment to and/or purchasing a prior unsatisfied consumer litigation funding company's entire funded amount and contracted charges, unless a lesser amount is otherwise agreed to in writing by the consumer litigation funding companies, except that multiple companies may agree to contemporaneously provide funding to a consumer provided that the consumer and the consumer's attorney consent to the arrangement in writing;

(f) having any influence, receiving any right to, or making, any decisions with respect to the conduct of the underlying legal claim or any settlement or resolution thereof. The right to make such decisions shall remain solely with the consumer and the attorney in the legal claim;

(g) attempting to obtain a waiver of any remedy or right by the consumer, including but not limited to the right to trial by jury; and

(h) knowingly paying or offering to pay for court costs, filing fees or attorney's fees either during or after the resolution of the legal claim, using funds from the consumer litigation funding transaction.

2. An attorney or law firm retained by the consumer in the legal claim shall not have a financial interest in the consumer litigation funding company offering consumer litigation funding to that consumer.

3. Any attorney who has referred the consumer to his or her retained attorney shall not have a financial interest in the consumer litigation funding company offering consumer litigation funding to that consumer.

4. The attorney may only disclose privileged information to the consumer litigation funding company with the written consent of the consumer.

Section 6. Contracted Amounts

The contracted amount to be paid to the consumer litigation funding company shall be a predetermined amount based upon intervals of time from the funding date through the resolution date, and shall not be determined as a percentage of the recovery from the legal claim.

Section 7. Disclosures

1. In a civil proceeding in which a plaintiff enters into a consumer litigation funding contract, the contents of the consumer litigation funding contract are subject to discovery under the [State] Rules of Trial Procedure by a party other than the plaintiff, or an insurer that has a duty to defend another party in the civil proceeding.

2. In a civil proceeding in which a plaintiff enters into a consumer litigation funding contract, the plaintiff or the plaintiff's attorney shall provide to each of the other parties in the civil proceeding, and each insurer that has a duty to defend another party in the civil proceeding, written notice that the plaintiff has entered into a consumer litigation funding contract.

3. A plaintiff or the plaintiff's attorney shall provide the written notice required by subsection 2. Within a reasonable time after the date on which the consumer litigation funding contract was executed.

4. All consumer litigation funding contracts shall contain the disclosures specified in this section, which shall constitute material terms of the contract. Unless otherwise specified, such disclosures shall be typed in at least twelve point bold type font and be placed clearly and conspicuously within the contract, as follows:

(a) On the front page under appropriate headings, language specifying:

(i) the funded amount to be paid to the consumer by the consumer litigation funding company;

(ii) an itemization of one-time charges;

(iii) the maximum total amount to be assigned by the consumer to the company, including the funded amount and all charges; and

(iv) a payment schedule to include the funded amount and charges, listing all dates and the amount due at the end of each one hundred eighty day period from the funding date, until the date the maximum amount due to the company pursuant to the contract is paid.

5. Pursuant to the provisions set forth in this section, within the body of the contract: "Consumer's right to cancellation: you may cancel this contract without penalty or further obligation within ten business days after the funding date if you return to the consumer litigation funding company the full amount of the disbursed funds."

6. The consumer litigation funding company shall have no role in deciding whether, when and how much the legal claim is settled for, however, the consumer and consumer's attorney must notify the company of the outcome of the legal claim by settlement or adjudication prior to the resolution date. The company may seek updated information about the status of the legal claim but in no event shall the company interfere with the independent professional judgement of the attorney in the handling of the legal claim or any settlement thereof.

7. Within the body of the contract, in all capital letters in at least twelve point bold type font contained within a box: "THE FUNDED AMOUNT AND AGREED UPON CHARGES SHALL BE PAID ONLY FROM THE PROCEEDS OF YOUR LEGAL CLAIM, AND SHALL BE PAID ONLY TO THE EXTENT THAT THERE ARE AVAILABLE PROCEEDS FROM YOUR LEGAL CLAIM. YOU WILL NOT OWE (INSERT NAME OF THE CONSUMER LITIGATION FUNDING COMPANY) ANYTHING IF THERE ARE NO PROCEEDS FROM YOUR LEGAL CLAIM, UNLESS YOU HAVE VIOLATED ANY MATERIAL TERM OF THIS CONTRACT OR YOU HAVE COMMITTED FRAUD AGAINST (INSERT NAME OF CONSUMER LITIGATION FUNDING COMPANY)."

8. Located immediately above the place on the contract where the consumer's signature is required, in twelve point bold type font: "Do not sign this contract before you read it completely. Do not sign this contract if it contains any blank spaces. You are entitled to a completely filled-in copy of the contract before you sign this contract. You should obtain the advice of any attorney. Depending on the circumstances, you may want to consult a tax, public or private benefits planning, or financial professional. You acknowledge that your attorney in the legal claim has provided no tax, public or private benefit planning, or financial advice regarding this transaction. You further acknowledge that your attorney has explained the terms and conditions of the consumer litigation funding contract."

9. A copy of the executed contract shall promptly be delivered to the attorney for the consumer.

Section 8. Violations

1. Any consumer litigation funding company found in willful violation of any provision of this article in a specific funding case:

(a) waives its right to recover both the funded amount and any and all charges, as defined in Section 3 of this Act, in that particular case; and

(b) shall be liable for a civil penalty of not more than xxxxxxxxx dollars for each violation, which shall accrue to the [State] and may be recovered in a civil action brought by the attorney general.

2. Nothing in this Act shall be construed to restrict the exercise of powers or the performance of the duties of the [State] attorney general, which he or she is authorized to exercise or perform by law

Section 9. Assignability; Liens

1. The contingent right to receive an amount of the potential proceeds of a legal claim is assignable by a consumer.

2. Only attorney's liens related to the legal claim which is the subject of the consumer litigation funding or medicare or other statutory liens related to the legal claim shall take priority over any lien of the consumer litigation funding company

Section 10. Effect of Communication on Privileges

All communication between the consumer's attorney in the legal claim and the consumer legal funding company as it pertains to the consumer legal funding shall fall within the scope of the attorney client privilege, including, without limitation, the work-product doctrine.

Section 11. Registration

1. Unless a consumer litigation funding company has first registered with the [State] pursuant to this Act, the company may not engage in the business of consumer litigation funding in this state.

2. An applicant's registration must be filed in the manner prescribed by the secretary of state and must contain all the information required by the department of state to make an evaluation of the character and fitness of the applicant company. The initial application must be accompanied by a xxxxxxx dollar fee. A renewal registration must include a xxxxxxxx dollar fee. A registration must be renewed every two years and expires on the thirtieth of September.

3. A certificate of registration may not be issued unless the department of state, upon investigation, finds that the character and fitness of the applicant company, and of the officers and directors thereof, are such as to warrant belief that the business will be operated honestly and fairly within the purposes of this Act.

4. Every registrant shall also, at the time of filing such application, file with the department of state, if the department of state so requires, a bond satisfactory to the department of state in an amount not to exceed xxxxxxx dollars. In lieu of the bond at the option of the registrant, the registrant may post an irrevocable letter of credit. The terms of the bond must run concurrent with the period of time during which the registration will be in effect. The bond must provide that the registrant will faithfully conform to and abide by the provisions of this Act and to all rules lawfully made by the administrator under this act and to any such person or persons any and all amounts of money that may become due or owing to the state or to such person or persons from the registrant under and by virtue of this Act during the period for which the bond is given.

5. Upon written request, the applicant shall be entitled to a hearing on the question of the applicant's qualifications for registration if:

(a) the department of state has notified the applicant in writing that the application has been denied, or

(b) the department of state has not issued a registration within sixty days after the application for the registration was filed.

6. A request for a hearing may not be made more than fifteen days after the department has mailed a written notice to the applicant that the application has been denied and stating in substance the department of state's findings supporting denial of the application.

7. Notwithstanding the prior approval requirement of subdivision one of this section, a consumer litigation funding company that registered with the department of state between the effective date of this article or when the department of state has made applications available to the public, whichever is later, and one hundred eighty days thereafter may engage in consumer litigation funding while the company's registration is pending approval with the department of state. All funding agreements entered into prior to the effective date of this Act are not subject to the terms of this Act.

8. No consumer litigation funding company may use any form of consumer litigation funding contract in this state unless it has been filed with the department of state in accordance with the filing procedures set forth by the secretary of state.

9. The secretary of state is hereby authorized to adopt rules and regulations to implement the provisions of this section as needed.

Section 12. Reporting

1. Each consumer litigation funding company that engages in business in the state shall submit a report to the department of state no later than the thirty-first of January of each year specifying:

(a) number of consumer litigation fundings by the company;

(b) summation of funded amounts in dollar figure; and

(c) annual percentage charged to each consumer where repayment was made.

2. The department of state shall make such information available to the public, in a manner which maintains the confidentiality of the name of each company and consumer, no later than ninety days after the reports are submitted.

Section 13. Commercial Litigation Funding Prohibitions

A commercial litigation financier may not provide funding to a commercial litigation financing agreement that is directly or indirectly financed by a foreign entity of concern.

Section 14. Commercial Litigation Disclosure Prohibitions

A party may not disclose or share any documents or information subject to a court order to seal or protect that is received in the course of the civil proceeding with a commercial litigation financier.

Section 15. Commercial Litigation Conduct Prohibitions

A commercial litigation financier may not make any decision, have any influence, or direct the plaintiff or the plaintiff's attorney with respect to the conduct of the underlying civil proceeding or any settlement or resolution of the civil proceeding, or make any decision with respect to the conduct of the underlying civil proceeding or any settlement or resolution of the civil proceeding. The right to make these decisions remains solely with the plaintiff and the plaintiff's attorney in the civil proceeding.

Section 16. Disclosure of Commercial Litigation Financing Agreement

1. In a civil proceeding in which a plaintiff enters into a commercial litigation financing agreement, the contents of the commercial litigation financing agreement are subject to discovery under the [State] Rules of Trial Procedure by a party other than the plaintiff, or an insurer that has a duty to defend another party in the civil proceeding.

2. In a civil proceeding in which a plaintiff enters into a commercial litigation financing agreement, the plaintiff or the plaintiff’s attorney shall provide to each of the other parties in the civil proceeding, and each insurer that has a duty to defend another party in the civil proceeding, written notice that the plaintiff has entered into a commercial litigation financing agreement.

3. A plaintiff or the plaintiff’s attorney shall provide the written notice required by subsection 2. Within a reasonable time after the date on which the commercial litigation financing agreement was executed.

Section 17. Severability

If any provision of this Act is, for any reason, declared unconstitutional or invalid, in whole or in part, by any court of competent jurisdiction, such portion shall be deemed severable, and such unconstitutionality or invalidity shall not affect the validity of the remaining portions of this Act, which remaining portions shall continue in full force and effect.

Section 18. Rules

The xxxx shall have authority to promulgate rules necessary to effectuate the purposes of this Act.

Section 19. Effective Date

This Act shall take effect xxxx days after it shall have become a law; provided, however, it shall not apply or in any way affect or invalidate any consumer or commercial litigation funding previously effectuated prior to the effective date of this Act.

The following will be discussed and referenced throughout the agenda topic "Discussion on NCOIL Earned Wage Access Model Law." A first draft of the Model will be distributed following the Spring Meeting.

Nevada SB 290

New York S916B

HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
INTERIM COMMITTEE MEETING – JANUARY 26, 2024
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee held an interim meeting via Zoom on Friday, January 26, 2024 at 2:00 P.M. (EST)

Representative Jim Dunnigan of Utah, Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Deborah Ferguson, DDS (AR)
Rep. Dafna Michaelson Jenet (CO)
Rep. Tammy Nuccio (CT)
Rep. Rod Furniss (ID)
Rep. Rita Mayfield (IL)
Rep. Rachel Roberts (KY)
Rep. Brenda Carter (MI)
Sen. Paul Utke (MN)
Sen. Pam Helming (NY)
Asw. Pam Hunter (NY)
Asm. David Weprin (NY)
Sen. Bob Hackett (OH)
Sen. George Lang (OH)
Del. Steve Westfall (WV)

Other legislators present were:

Rep. Brian Lohse (IA)
Rep. Bridget Kosierowski (PA)
Rep. Kyle Mullins (PA)
Del. Walter Hall (WV)

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 Treasurer, the Committee voted without objection by way of a voice vote to waive the quorum requirement.

INTRODUCTORY REMARKS: CHAIR DUNNIGAN

Rep. Dunnigan thanked everyone for joining the meeting and stated that it's great to Chair NCOIL's first official meeting of 2024. We have only one item on today's agenda, but it's an item that is ready for a vote after a year of vigorous and healthy debate. And that item is the NCOIL Medical Loss Ratios for Dental (DLR) Health Care Services Model Act (Model).

CONTINUED DISCUSSION AND CONSIDERATION OF NCOIL DLR MODEL

Rep. Dunnigan stated that a lot of work has gone into developing this Model and the Model underwent significant changes since it was first introduced last year. The latest version of the Model was distributed and is posted on the website. And importantly, the latest version is supported by representatives from both sides as indicated by the joint statement of support from the National Association of Dental Plans (NADP) and the American Dental Association (ADA) that was also distributed and posted. Rep. Dunnigan stated that he wanted to stop there so as to not take any more time away from the sponsor of the Model, Del. Steve Westfall (WV). As a reminder, in addition to being sponsor of the Model, Del. Westfall Chaired this Committee last year so he deserves a lot of credit for overseeing everything that led us to this point.

Del. Westfall thanked everyone for their hard work on this Model. It's always great when a compromise can be reached with the end result being a good piece of public policy. And I want to stress that there was significant compromise from both sides on this issue. If you look at where the Model first started and look at where it is now – it really is a striking transformation. And I have to say I really learned a lot throughout this process and I'm glad we took some extra time to further discuss the issue. Back in November I was prepared to vote on the prior version of the Model, but I'm glad we didn't as now we get the best of both worlds. We have a Model that I believe is superior to what we had been discussing, and it's supported by representatives of both dentists and dental plans.

In terms of the substance of the Model, we ended up with what has been described as a "Colorado plus" version. And that means the Model doesn't simply require a specific DLR percentage for all dental plans. Rather, it requires dental plans to report DLR information to the Commissioner which the Commissioner then aggregates for each market segment. The Commissioner then calculates an average DLR for each market segment and identifies as "outliers" any dental plans that fall outside a certain scope of that average DLR. The Commissioner is then authorized to take enforcement actions against those "outliers", including ordering them to issue rebates. And then if a carrier remains an "outlier" for 2 consecutive years, that carrier is then subject to a minimum DLR percentage as determined by the Commissioner via rules. I'll stop there and just thank everyone again for all of their work on this. I'm going to introduce this version in West Virginia and I encourage my colleagues to do the same in their states as I believe this is a good piece of public policy.

Owen Urech, Director of State Gov't Affairs at NADP thanked the Committee for the opportunity to speak and stated that the compromise language in front of you today represents an important step forward in the policy discussions on DLR issues and I want to thank Del. Westfall, NCOIL staff, the ADA, and NADP membership for all their hard work in delivering this language to the Committee. In short, this Model establishes a data driven approach to DLR regulation which determines statistical outlier plans and directs Commissioners to remediate those plans which are outside those norms. For plans that are outside those norms for multiple years the Commissioner will set a loss ratio based on market average for the outlier dental plans to meet. NADP believes this represents a practical and thoughtful compromise between plans and providers which we hope will be considered by policymakers. Going forward we hope this is part of a continuing dialogue in dental coverage and oral health which is constructed towards the mutual goals of improving American's oral health.

Rep. Tammy Nuccio (CT), Vice Chair of the Committee, stated that I read the Model and I just want to be sure that we're not establishing a DLR but rather a reporting timeline where departments will calculate what the DLR is and calculate an average of what they are seeing and then anybody outside the average will be given guidelines to come within the average, is that ultimately what we are saying? Cmsr. Tom Considine, NCOIL CEO, stated that it's not automatic that they will come within the average, rather the Commissioner has authority to take enforcement or remedial action including rebates that would then bring them into the average, but its not automatic. Rep. Nuccio stated that so we're really just collecting information now, not establishing a loss ratio. Cmsr. Considine stated that its something between the two – collecting information and empowering the Commissioner to take action if she believes it's warranted.

Rep. Rita Mayfield (IL), co-sponsor of the Model, stated that you mentioned rebates - how does that trickle down to the patient? Cmsr. Considine stated that on the Affordable Care Act (ACA) side, the rebate goes to the customer and I believe that is the same approach in the Model. Mr. Urech stated that is correct and the Model was intentionally written that way.

Sen. Hackett stated that I just want to thank Del. Westfall and the NCOIL staff for all the great work. I was a critic at first about this but a solution was developed that we all can support. Thanks for working this out.

Hearing no further questions or comments, upon a Motion made by Rep. Mayfield and seconded by Asw. Pam Hunter (NY), NCOIL Vice President, the Committed voted without objection via a voice vote to adopt the Model. Rep. Dunnigan thanked everyone and stated that the Model will now be placed on the Executive Committee's agenda at the Spring Meeting in Nashville for final ratification.

ADJOURNMENT

Hearing no further business, upon a Motion made by Del. Westfall and seconded by Asw. Hunter, the Committee adjourned at 2:30 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
2023 NCOIL ANNUAL MEETING – COLUMBUS, OHIO
NOVEMBER 16, 2023
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee met at The Renaissance Columbus Downtown Hotel in Columbus, Ohio on Thursday, November 16, 2023 at 10:00 a.m.

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

Other members of the Committee present were:

Rep. Deborah Ferguson, DDS (AR)
Rep. Matt Lehman (IN)
Rep. Rachel Roberts (KY)
Rep. Cherlynn Stevenson (KY)
Rep. Brenda Carter (MI)
Rep. Mike McFall (MI)
Sen. Lana Theis (MI)
Sen. Paul Utke (MN)
Rep. Nelly Nicol (MT)
Sen. Jerry Klein (ND)
Sen. Shawn Vedaa (ND)
Asm. Erik Dilan (NY)
Asw. Pam Hunter (NY)
Asm. Jarett Gandolfo (NY)
Sen. Pam Helming (NY)
Asm. David Weprin (NY)
Rep. Tim Barhorst (OH)
Sen. Bob Hackett (OH)
Rep. Brian Lampton (OH)
Sen. George Lang (OH)
Rep. Ellyn Hefner (OK)
Rep. Carl Anderson (SC)
Rep. Tom Oliverson, M.D. (TX)

Other legislators present were:

Sen. Larry Walker (GA)
Rep. Brian Lohse (IA)
Rep. Chad Aull (KY)
Rep. Michael Meredith (KY)
Rep. Michael Sarge Pollock (KY)
Rep. Jane Pringle (ME)
Rep. Helena Scott (MI)
Rep. Stephanie Young (MI)
Rep. Bob Titus (MO)
Sen. Walter Michel (MS)
Asm. Ken Blankenbush (NY)
Rep. Bob Peterson (OH)
Rep. Sharon Ray (OH)
Rep. Forrest Bennett (OK)

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 Rep. Tom Oliverson, M.D. (TX), NCOIL Vice President, the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Carl Anderson (SC), and seconded by Rep. Oliverson, the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 20, 2023 meeting and the minutes of the Committee's October 6, 2023 interim Zoom meeting.

DRUG SHORTAGES AND SUPPLY QUESTIONS: A POLICY AND DATA OVERVIEW

Andrew Barnhill, Head of Public Policy at IQVIA, thanked the Committee for the opportunity to speak and stated that I appreciate the opportunity to kick things off today with a topic of general interest to many of us as legislators and across the health sector as a whole and that is drug shortages. IQVIA is the world's largest clinical research organization. We're also a very large healthcare data organization and so the focus of my conversation this morning for a few minutes will be looking at prescription data and giving you some observations about trends related to drug shortages. Shortages have been an ongoing issue in the U.S. healthcare system for more than a decade and it really is something that matters to all players across the ecosystem. One of the ways and data sources that we want to take a look at this morning is the National Prescription Audit (NPA) which IQVIA conducts and it's the industry standard source of all national prescription activity for pharmaceutical products. It measures the demand for those products, including dispensed pharmaceuticals to consumers across three unique channels. And that's retail, mail service and long-term care pharmacies. And IQVIA as part of this process collects new and refilled prescription data daily that represents over 92% of all outpatient prescription activity in the U.S. So, a lot of these observations are coming from that data set. As of the most recent audit, earlier this fall, there are 132 molecules in the U.S. market with an active shortage and those impact a range of therapeutic areas everything from pain and anesthesia to oncology to central nervous system and infectious disease and diabetes drugs as well. Over the past five and a half years, three times as many new molecule shortages have occurred as have been resolved with those shortages typically lasting more than a year or so. So, that fact right there is really what's leading to a lot of the discussion and concern if you will, surrounding perceived shortages and actual shortages in the U.S. today.

I want to sort of demystify a little bit about what's going on with some of these shortages. First of all, they tend to be in generics, about 84% of them are generic products and they tend to also be injectable drugs. 67% of molecules on shortage today come from injectables and are more frequently multi source products. And this is a big difference from even back a decade ago where you were largely talking about single source products. The market of the shortage concerns largely remains concentrated in a few suppliers which really impacts the ability to readily resolve those shortages when you know one or two leading suppliers is affected. But there are several categories that I think you've probably seen in your research or in news reporting that I want to hit on this morning to give us a closer look at what's going on. One is in the oncology space. So, although oncology shortages have really only impacted a small share of overall volume, the inspection driven disruptions in some market exits have led to significant shortages in older chemotherapeutics and particularly platinum based ones. So, in effect, treatment for some cancer patients has been quite impacted and might be delayed by some of these chemotherapy shortages. And this is why the oncology concerns have really drawn our attention recently. There have also been some mental health molecules that have been on shortage since 2018. So, that's not a new thing with some

classes of drugs in the mental health space that have been showing a sharp increase in shortage largely due to demand in the past five years. Another that you've probably heard about a bit recently have been anesthesia drugs as anesthetic shortages have been persistent since 2017, driven by a lidocaine shortage. But this is something that has continued, particularly as these medicines became utilized by patients of COVID-19 who were hospitalized. That resulted in some shocks to the supply chain that drove up the volumes substantially during that time and have continued as a shortage to date.

Two other categories, one in the antibacterial space. We certainly had a number of public health measures during COVID-19 that disrupted the normal seasonal pattern of bacterial infections, particularly in children, and we've started to see a return in late 2022. And certainly now in 2023, a return to those normal historic infection levels. And so, as a result, we saw a shortage in pediatric particularly the oral liquids antibacterials as the pandemic at the same time was resulting in this unpredictable demand. We've also seen that some of these shortages can lead to concerns about antimicrobial resistance (AMR). So, we want to keep a close eye on this issue with antibacterials as we move along because there is more than just domestic concern here. There's potentially some significant global concerns about antibacterials. The final category is one you're probably hearing arguably the most about in the press right now, which is GLP-1's. So, the GLP-1 agonists are a novel mechanism and this illustrates to us since we're hearing about shortages, that shortages can also affect new drugs prior to the patents expiring. So, it's not just something that you're going to see on generics or those that have been on the market for a long time. But this is a little bit of a different issue and I want to explain the difference here for a moment. So, the first GLP-1 agonist for treatment of type 2 diabetes launched in 2005. However, the attention surrounding this class of drugs really spiked since the launch of Ozempic in 2018 and then the subsequent launch of Wegovy as a treatment for obesity outside of just diabetes in 2021. So, since that launch, Wegovy new prescriptions are up 181% for diabetes, GLP-1 indications, and 257% for obesity GLP-'s in just this very short period of time. So, Wegovy, Ozempic, Trulicity, Mounjaro, all the ones currently on market are experiencing shortages from sort of a different set of reasons as new patients are demanding access across diabetes and obesity. And we see an outpacing of supply potentially causing difficulties in filling prescriptions for patients already on therapies. And what you're seeing is a lot of pharmacy hunting taking place with individuals trying to find those products and going out of their normal neighborhoods or local pharmacies in order to get them. So that's a little bit different than the true shortage issues that we're mentioning earlier, such as in the oncology drugs and in the anesthesia drugs.

But the GLP-1's have shown significant progress for people living both with diabetes and obesity. That's more than doubled since the end of 2020, driven by new patients across those categories. And so this surge is showing us that we are potentially going to see as new innovative medicines come on market that some of the initial levels of shortage might become a recurring issue in our pharmacy ecosystem that we have to wrestle with as time goes on. But final takeaways for us and this group today I think are one that shortages have different causes depending on the market dynamics that are at play and they require a different set of solutions - a variety of solutions and participation from all the stakeholders in the healthcare ecosystem including legislators to resolve and prevent future shortages from occurring. But we should also think about the shortage environment as one that's requiring a careful balancing of patient access with availability, making certain that we can collectively do everything we can as partners in the

healthcare ecosystem to eliminate barriers to patient access even in the midst of shortage concerns. So hopefully that provides you an overview about some of the different aspects we're seeing in the shortage landscape and might even elicit more questions for you as time goes on.

AMAZON'S ENTRY INTO THE U.S. HEALTHCARE MARKETPLACE

Tanvi Patel, Director & General Manager of Partner Services at Amazon Pharmacy, thanked the Committee for the opportunity to speak and stated that I'm excited to come here and share what we at Amazon have been up to in our health services space and answer any questions you might have. So, Amazon Health Services, which encompasses Amazon Pharmacy, Amazon Clinic and now One Medical also, is relatively new but our vision is very clear. They are just much like what we do in all of Amazon we're very customer obsessed. We're focused on the customer. Working backwards. A lot of invention. A lot of iteration, a lot of learning. And then investment in the right places to ensure that our patients that are coming to Amazon for their healthcare can trust Amazon for that healthcare whether it be primary care services through One Medical, digital health services through Amazon Clinic or getting their medications and staying healthy through Amazon Pharmacy. So, I wanted to share a little bit about what we've been working on and the progress we've made to date and then really what our objectives and goals are in this industry and then open it up to any questions you might have. Back in 2018, which is probably when our healthcare journey started with the acquisition of PillPack. PillPack is a service that does compliance packaging for medications for patients that are multi chronic that may have two, three or more medications and they need packets to make sure that they're taking them when they need to take them several times a day, potentially, and which medications, including potentially even over the counter medications they may be taking with that. In 2020 we built Amazon Pharmacy on top of PillPack, which is a multi service, full service pharmacy, which serves home delivery of pharmacy, whether it be acute medications, if you need an antibiotic today. In several geographies we're delivering same day or early the next day. Or if it's your chronic medications for maintenance management which many in the industry have been using potentially for a long time. Getting faster and faster allows us to really serve with convenience where there may be pharmacy deserts and accessibility and affordability of those medications.

And then we launched Amazon Care. Many of you might have heard of that. We learned from what Amazon Care was in terms of how patients were looking to Amazon for that convenient digital healthcare and then we iterated on that and turned it into Amazon Clinic last year. Amazon Clinic is leaning into what Amazon does well in terms of meeting customers where they have needs with providers who can provide those needs. It's a marketplace for digital health. So, it serves about 36 or 37 different chronic conditions. It allows patients to come to Amazon, answer a few questions and then matches them with a third-party digital health provider who can help take care of those medical needs for them and then go on to prescribe or point them in another direction to make sure that they're continuing to stay healthy. One Medical was acquired in March of this year, which is a member based primary health service provider. We have about 200 locations across 28 geographies and growing. Just this year or just last week in fact, we launched a $9 a month for One Medical membership for prime members and about $199 a year otherwise. So, all of these combined really allow us to serve our patients and our customers to get care, find care and then stay healthy. The goals that we have in this

space are really around price transparency, ensuring that customers know what they may be paying before they get into it, and affordability and accessibility. So, I wanted to speak a little bit more deeply just about what we're doing in pharmacies specifically to these goals. A couple programs that we've launched recently, we launched Rx Pass earlier this year. Rx Pass is $5 a month for prime members and we have about 60 to 65 formularies on the list of generic medications that are available to the members of Rx Pass, unlimited on that list but the formulary is created such that it covers medications that 150 million Americans take today.

This has been a very great program especially for Americans who are either underinsured or uninsured to make sure that they have the continuity of care on these commonly used generic medications. If they change an employer, if they are not employed but they know that they can continue to get the medications they need to stay healthy in those case. Another program that we launched is Rx Coupon. We work directly with manufacturers for manufacturers sponsored coupons to bring down the price of very popular medications that customers and patients need to stay healthy. For example, diabetes monitors, or insulin down to $35. So, we continue to work with many of our manufacturer partners for these. And as Mr. Barnhill mentioned, GLPs are another one. We're definitely trying to bring down the price of GLP's as they're dispensed on Amazon to make sure that our patients can get the better affordable prices. Another way that we are thinking about the way folks buy medications in this country is with price transparency. So, when a customer goes to Amazon to buy their medications and they enroll with Amazon Pharmacy or they're working with their physician to say I would like my medications to be sent to me through Amazon Pharmacy whether it be today, tomorrow or two days from now - they are able to see upfront what that pricing may be. So, we're leaning into technology where we can to estimate the price of a medication that that member may pay through their insurance provider. We work with most major insurance providers to make sure that we're serving the majority of the country or we might have a price program. We have a Prime Rx program where many generics are 80% off price and then a lot of brands are 40% off. And then we have the coupon programs in Rx Pass. So, we're able to expose that pricing to the customers so that they are aware of what they may be paying ahead of time. As we're thinking about more and more what we can do in this industry, we're working with health systems providers. We're starting with One Medical understanding what are those customer pain points at that point of care to see how we could help influence the industry to make sure that our Americans continue to stay healthy and get the medications that they need.

Sen. Jerry Klein (ND) stated that this may go back to Mr. Barnhill because one of the things we hear about the shortages is we're depending on foreign imports. Are we as a country getting behind that and figuring out that we don't want to depend on our foreign, some would suggest adversaries, for this basic product that many people are needing? My daughter is a pharmacist and is suggesting that it's a battle to keep up with the prescriptions because they continually are running in short supply. So you talked about shortages. I'm more interested in solutions and how you perceive the industry moving forward. Ms. Patel stated that from a pharmacy standpoint, we work directly with the wholesalers and manufacturers here in the U.S. or elsewhere to make sure that we're getting the right selection of medications for patients. I do agree that we do run into shortages and it is something that we also are trying to influence in terms of are there ways to ensure that the customers who need them are receiving pricing at the right

time? Mr. Barnhill stated that I'll also add to your point about some questioning sources of products as well. I think most manufacturers are spending a lot of time and effort right now to diversify their sources of their products and where their manufacturing takes place. And there's certainly a willingness to adapt and I think if you look at where manufacturers are basing a lot of their operations and importing now you've seen some trends shift over the past two to three years so I think we'll continue to see some progress there.

DISCUSSION AND CONSIDERATION 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 next on our agenda is the consideration of a resolution dealing with health savings accounts (HSAs). We will be voting on the resolution today. You may recall that we briefly discussed the resolution during our July meeting and this deals with a very straightforward issue regarding HSAs. You can view the resolution on the website and on the app and your brochure on page 56. I'll recognize Sen. Klein, the sponsor of the resolution, for brief remarks.

Sen. Klein stated that as mentioned, the resolution is very straightforward. It's just meant to encourage an amendment in state law that would ensure that when certain types of laws are passed, we aren't inadvertently causing people to lose their access to their HSAs. Our state has already enacted this type of carve out and the idea is this resolution would help encourage more states to do so. There is a technical amendment to the resolution that has been distributed that I and all interested parties involved agree to. I encourage the committee to support this resolution.

Kevin McKechnie, Executive Director of the HSA Council at the American Bankers Association (ABA), thanked Sen. Klein and the Committee for considering the resolution and thanked the co-sponsors, Rep. Tom Oliverson, M.D. (TX), NCOIL Vice President; Sen. Beverly Gossage (KS), and Rep. Rachel Roberts (KY), Vice Chair of the Committee. As Sen. Klein described, the resolution in front of you is designed to sit in your state's insurance code and ensure that benefit mandates managed in the insured marketplace which you manage in your state, coordinate with federal internal revenue service (IRS) rules which you don't manage. And that challenge has to be addressed at some point. Just to give you a brief survey of the field. There are somewhere around 45 different bills in the U.S. Congress addressing HSAs. There are something on the order of 750 bills that would impact HSAs across all U.S. state jurisdictions and that field means we have to monitor all of those bills to make sure that they don't propose health benefit mandates that would be in conflict of federal rules. And we do that to protect the people insured by state managed HSA qualified insurance. And that number of people is large and growing. We insure about one in three working Americans. The ABA represents about 95% of all the HSAs in the U.S. This is tens of millions of people and I can't tell you exactly how many of those Americans are in insured plans versus Employee Retirement and Income Security Act of 1974 (ERISA) plans. We know that in smaller states that number tends to be higher. We know that in the larger states it tends to be lower. We have individual examples in many of your states where a benefit mandate was passed that did not have coordination. And probably a lot of you felt the hand of your State Bankers Association as they reached out to try to coordinate and

solve that problem. Which is to say not to oppose. First of all, you're right to manage insurance within your state laws any way you wish. And second of all, not to oppose any of the benefit mandates that you may consider meaningful. Our only purpose is to figure out exactly how HSA rules managed at the IRS can coordinate with your state insurance code. And as Sen. Klein pointed out, eight states have already done that and they are Arkansas, Kentucky, North Dakota, Oregon, Pennsylvania, Rhode Island, Texas, and Utah. And what we're suggesting is this is very good legislative structure and it protects the millions of people that rely on insured health plans in your states.

Hearing no questions or comments, upon a Motion made by Rep. Roberts and seconded by Sen. Bob Hackett (OH), the Committee voted without objection by way of a voice vote to adopt the resolution with the technical amendment. Del. Westfall thanked everyone and stated that the resolution will be the presented to the Executive Committee of final ratification on Saturday.

CONTINUED DISCUSSION OF NCOIL MEDICAL LOSS RATIOS FOR DENTAL (DLR) HEALTH CARE SERVICES PLANS MODEL ACT

Del. Westfall stated that last on our agenda is a discussion on the NCOIL Dental Loss Ratio (DLR) Model Act (Model). We are not voting on the Model today. I wanted to vote on it today but we are not and the intention is to have some remarks from interested parties and legislators today and then have an interim Zoom meeting of the Committee sometime in January to vote on some version of the Model legislation so that we will have something going forward as a lot of us have a session starting in January and February. So it's important that we can have some kind of Model to use for next year's legislative year.

Chad Olson, Director of State Gov't Affairs at the American Dental Association (ADA), thanked the Committee for the opportunity to speak and stated that I'm so pleased that we have continued this discussion. Thank you to Del. Westfall for pushing the discussion forward. I think the great news is that we've got I think some language on the table and in discussion that we can move forward on where the parties were very far apart. Rep. Deborah Ferguson, DDS (AR), NCOIL President, said in her opening remarks the best thing about NCOIL is dealing with a tough issue and then bringing it together and balancing the needs of the insurers against consumers. And I think this is an issue that is very pro patient. We continue to argue that a DLR will set up the plans to be more valuable if the DLR is established. It will be more valuable to the consumers purchasing the plans and that I think is the end goal - dental plans that work for the patients and give them coverage that they need.

Owen Urech, Director of Gov't Relations for the National Association of Dental Plans (NADP), thanked the Committee for the opportunity to speak and stated that I want to echo that we look forward to continuing the conversation on the Model. I know there's been a lot of back and forth in consideration of different options. As we stated in the summer meeting in Minneapolis, we've seen a lot of success in the regulatory framework that was developed based on the language that passed in Colorado. That would create a reporting and outlier remediation structure for DLR so that your regulators in your state can have a holistic look at a dental plan and the value that it presents and also use loss ratio in that consideration but looking broadly at the value of the plan and how people are utilizing it and moving forward from there so that we have a consideration of what

that looks like. So that is our position is that we think Colorado is extremely workable policy but we are happy to continue the conversation and also think that there's a lot of areas where we can have discussions and build a more positive direction on this language.

Asw. Pam Hunter (NY), NCOIL Treasurer, stated that we've been having this conversation for a year and it seemed like we were going along at a good clip and then we kind of got off track and then we were going along again and I was a little exasperated the other day because the amount of calls and texts and emails that I've gotten about this has been crazy. But I think that we need to wheel it back here and bring it back and really identify if it's the Colorado model or the Massachusetts model. The percentage model is obviously a concern. Plans moving out of the state because of the percentages obviously, we don't want employers leaving. We don't want people to not have coverage. This assessment model, which sounds great and we're talking about looking and review and remediation later - that doesn't necessarily solve any of the dentist problems with getting increased rates until after an assessment. I'm still trying to figure out how we are helping the consumers with access to care and maybe this is not even the conversation about that. But it seems like dental care is important and equal to healthcare and we minimize how important dental care is. I would like if we could just get back to the basics of what is the problem that we're trying to solve with this model and then how do we move forward. And I know you've had many conversations and we had an interim meeting. The interim meeting produced a different version of the model, and then there's subsequent issues after that. So, I'm hopeful that there will be other legislators to speak up but I feel like we've gone down this rabbit hole for a year and we're back to kicking it down to another meeting which is fine because we want to make sure we have the best model possible but those are the concerns I have. I don't want plans leaving states. I am concerned that this Colorado version seems like a great compromise but again, that doesn't help with increased rates for the dentists. And we can't have all things for all people, of course but I'm worried about consumers not getting the access to care that they need and out of pocket money that they're paying for dental. And it's Medicare reenrollment time and I don't know how many commercials you see every five minutes on TV about you can get dental care and the only dental care you're getting is a fillings and cleanings and one exam per year. I feel like that bigger conversation actually needs to be had in addition to this. So, I just went a long way in saying I think that we need to just get back to basics with this legislation and see what is the problem we're trying to solve. And we can't be all things to everyone and I'm very concerned about employers leaving and consumers not having access to care and obviously the dentist getting the reimbursement that they deserve.

Rep. Matt Lehman (IN), NCOIL Immediate Past President, stated that similar to what Asw. Hunter said, we seem to be going around and around on this issue and I know when we were in Minneapolis I raised this point but when we talk about medical loss ratio (MLR) I guess I go back and think when that term was used during the whole Affordable Care Act debate it was, if you have MLR it's going to help the consumer. It's going to put more money into the pocket of the providers, etc. Because we're limiting what the carriers can hold and pushing everything else out. The problem I saw in the healthcare side was we went from having probably 15 companies that would write health insurance to two. And now they have just become behemoths in the industry. So how do we make sure that we're not putting our finger on the scale of the market and I don’t know how many members you have in your health plans - are there 22 companies that’ll

provide dental coverage? Or is there eight or two? And so the MLR is going to have an impact on those members, which the end result is we do want to put quote unquote "more money back into the pockets of the consumers" and the people providing the services. But that balance concerns me as to what happens if that MLR as it has done in the medical world forces out the competition.

Mr. Olson stated that I think that the view of the ADA is that the competition right now between dental plans is predicated only on providing a low rate quote to employers. And that is not the benefit of the end users, the patients. Competing around the true value of the plan's MLR is one way to get there. To Asw. Hunter's point, I think where we're heading is giving some flexibility saying to set an MLR and each state would be able to determine what it should properly be to balance some of the things you're talking about, Rep. Lehman, without saying, it has to be this. And that's why we're open to a discussion about percentages being determined by the state instead of necessarily being mandated. And I think that would address some of your concerns as well, Asw. Hunter. So that's I think kind of where the conversation is going on the compromise side from our view. Again, one more last thing with the focus on competition, benefiting patients at the end of the day and not just employer prices. That has resulted among the industry in a race to the bottom. If you're only point of competition is to keep the rates low for employers, you're not providing a good benefit and that's why dental benefit coverage is different.

Mr. Urech stated that to offer a little bit different perspective, I think where there's some opportunities for us to have some alignment is to say, if regulators through this process, through language that we can develop at NCOIL or based off of what other models have been proposed, can look at all of the value that a dental plan is bringing to somebody that you have loss ratio as part of that conversation that's important. But we are also extremely concerned about what the impact is going to be on competition. We've seen what's happening in Massachusetts, and they haven't even finalized the regulations there yet. We have five plans already at this point leaving the small group market. And I think speaking to a little bit of what Mr. Olson said, it is true that when dental plans are quoting a price to an employer, when they are bringing those benefit options to them those employers are dealing with their narrow budgets and trying to provide dental coverage to their employees to make sure that they can get the care that they need. And ultimately, we want to have a conversation about value. But also we know that from just the studies that have been done and from the market experience that people are extremely price sensitive on their dental benefits and we want to make sure that's protected. We want to make sure that the premiums stay at a place where people can afford them and that moving forward people are able to utilize the care that they need. I think that's the ultimate goal for both of us is that people get the dental coverage or get the dental treatment that they need and they can stay healthy. Oral health is incredibly critical to overall health as Asw. Hunter said earlier.

Rep. Ferguson stated that as a person who's all about compromise, I think for us to get to a reasonable model bill maybe both of you have to be unhappy at some point. I mean, obviously the dentists want a Massachusetts model where you're actually putting in DLR percentages. The dental plans don't want any percentages put in the bill. I would like to see you get together and both agree to be unhappy and that the compromise that we've looked at is not only reporting like Colorado does but to also after a three-year period look at all that for the states themselves to decide what those DLR

percentages are. That will give states time to look at the data. It will give them time to look at what other outcomes have been in different states that have already passed legislation. I just don't understand why that wouldn't be a reasonable compromise for both of you. I know neither of you will be happy. You're not getting everything you want, and you have to go back to your membership and say I compromised and this is our model bill. But as we said, NCOIL is all about state regulation and by allowing the DLR to be set by the states I think that's a very reasonable compromise. Mr. Urech stated we are absolutely open to compromise and discussion on this issue. And I know that there's a lot of room between NADP and the ADA on a lot of these issues but I think we've made progress and we're happy to continue talking about that and I know getting into the nitty gritty of those details is one of the things that we're going to need to do.

Sen. George Lang (OH) stated that Asw. Hunter asked a great question - what is the problem we're trying to solve? And is it a problem created by legislators or is it a market driven problem? And I think it's fair that we consider the impact on consumers. I think it's incumbent upon us to do that but it is equally incumbent upon us to consider the impact on the industry. And I don't want to do anything that is going to harm the industry. The more we try to turn the industry into a commodity, and that may not be a fair analogy, but the more we try to do it, the more we're going to drive out innovation. The more we're going to drive out competition. And I'm worried about the unintended consequence of driving prices ultimately higher if in fact that occurs. And I'm also concerned about the fact as Rep. Ferguson pointed out, this only impacts companies that are regulated by the state, not those that fall under ERISA. And are we in fact going to put small employers at a huge disadvantage if the states are regulating in a way that the plans that fall under ERISA, the self-funded plans, the large employers are not. And what is the long term negative impact this is going to have on the industry? And how may that translate into a negative impact on the consumer? I'd appreciate that perspective from the dental plans on that.

Mr. Urech stated that building off some of the things that we've said already, we want to make sure that anything that is passed through NCOIL is looking at the value of a dental plan holistically in the activities that it's doing. We've talked a lot about Colorado at this meeting and also at the previous meetings. I think our endpoint is if we're creating a model that is showing the demonstration of value, that loss ratio is not the end all be all in that conversation that is going to be had with regulators, with legislators. So, I know there's a lot more dialogue to go on that but I think that's one of our priorities is to make sure that's part of the conversation.

Mr. Olson thanked Sen. Lang for bringing it back to Asw. Hunter's key question which is what's the end goal? I think the end goal is to create an environment where the plans are serving the consumers more than the employers only. And you asked what's the situation? Why is this occurring? I would go back to my earlier analysis that competition is not resulting in a good benefit to the consumers. Right now the plans, as I've said before, have had a $1,000 to $1,500 annual maximum and then the consumer pays out of their own pocket. And that has not changed since the 1980s. That is what competition has produced. So, I think that as Mr. Urech said, there's a lot of options. What DLR does is it forces the conversation to be more about how do we provide value for patients? And then the last thing I'll say about plans leaving Massachusetts. The history of the ACA shows that while plans may have some initial changes to their structures, etc. and considerations on whether they can continue to pursue a market,

we've also seen that they've been successful, the major medical plans under the auspices of an MLR. I know the industry on the dental side pretty well. I know it's peopled by smart people and I know that they can innovate. And there was an article that wrote about Guardian I think leaving a certain segment of the small group in Massachusetts. In that same article there was another plan saying, “We're ready to take up the slack.” And I think that's the beauty of the industry as you talked about innovation. Once a good floor is set that is going to get to the benefit of consumers, I'm confident the plans will respond in kind.

Mr. Urech stated just a quick note on the ACA, I think something that's worthwhile to point out is that when the ACA passed MLR requirements for medical plans that was a barometer for the other reforms that were done in the ACA which were the essential health benefits (EHB) and the employer mandate which expanded the scope of medical coverage and drastically changed that market. And then the loss ratio was kind of one of the parameters that the regulators were using to look at the effects and the requirements and the compliance from the medical plans. That's one of the reasons that the loss ratio was included within the ACA was to measure those others. I think as we've discussed in some of these other meetings, dental still is a voluntary benefit and it is something that there's lots of price sensitivity. You don't have that same requirement for complete and full coverage and that drives the market factors for why people are buying dental coverage and what employers are looking for in them. I'll just share one last thing about Massachusetts - we're concerned that, yes, there may be one plan that hasn't entered the market yet in Massachusetts that may be looking at it, but five plans leaving in the market, plans that have those experience that have been working with those brokers and those small businesses. We heard in the regulatory hearings for the implementation of this loss ratio that businesses in Massachusetts are really concerned about what their prospects look like for their dental plans in the state and we want to make sure that there's not a harm to access there.

Sen. Bob Hackett (OH) stated that I appreciate what my colleagues have been saying but one of the things to remember is, we can't solve a problem the way we try to solve it in medical. The greatest thing about dental plans is that it's a preventative benefit. We've been promised preventive benefit for 40 years in healthcare. All they do is pay claims. But we have preventative benefits and the dentists will tell you the greatest thing about the dental plans is it forces them to go every six months and develop a preventative benefit, the cleaning and the situation like that. On the other side I can see where the dentists want a better reimbursement because of the limited reimbursement. We understand the problem there. I'm okay with the Colorado plan, but I don't want to be forced into a decision at the end of three years. I'm not sure that the MLR will solve any problem and it might drive companies out of business. I think the “may” and “shall” words should be changed where they “may” do it in three years but they're not required to do it in three years. But don't destroy the difference in dental care versus healthcare. You do provide preventative benefits where healthcare doesn’t and it makes people healthier. It makes people have less cavities and less crowns. So that's the only thing I say is I know it's a tough problem to solve and we don't want to run companies out of business but be careful. And I've done dental and medical care for years. They are totally different animals. The cost is so much lower in dental. So I can see why the plans would be upset by forcing loss ratio on them. And I do not want to see less people going to the dentist. That would be the worst thing that can happen and this may cause that.

Mr. Olson stated that regarding the preventive argument, if there is an MLR set that would mean that the plans were incentivized to encourage people to go to the dentist. Currently, even people with coverage only 50% to 60% of them ever access their dental plan. If you have an MLR, suddenly those plans are incentivized to encourage their subscribers to go. You can see this occurring on the Medicaid side. Currently, according to federal regulation on the Medicaid side, a managed care organization (MCO) is required to meet an 85% MLR. We know from experience that dentists have in the states that those MCO's, the companies that usually administer for them, are encouraging subscribers to go get preventive care because of them having to meet the MLR. We also see from the California data that there is no incentive to change the MLR over time. No trend. This is reporting only. So I would say the answer to your question is, yes, the plans are concerned about this. I think they are always concerned about reforms and will always point to this is going to hurt our business. Balancing the consumers' needs and getting a better value is so important. And the last point I'll make is yes, preventive is important, but these plans again are providing sometimes no coverage really beyond two cleanings and one restoration and then it's nothing more. MLR changes the incentive game. It says, we have to now meet an MLR that's really aimed at getting people to good oral health and that should be the goal of everybody. I hear your concerns on the business being destroyed. I just don't buy it. As I said about Massachusetts, there's going to be probably some consideration of we need to look at our business model and how we can exist and then I think just the same thing that happened with the ACA, there'll be people coming back into the market and coverage being better. And the last point I'll make is great dental coverage provided by three carriers versus not great coverage provided by seven. What's better at the end of the day? I think for consumers to have those three options that is better.

Mr. Urech stated that I want to echo the point that the preventive benefit that is included within dental plans is critical to the structure of it. And even speaking outside of the MCO market where you have the different requirements related to being part of the government program that within the commercial market there is a lot of activity that these plans go into making sure that they are incentivizing folks to go get care, to go get their cleanings every six months. Because that saves them money in the long run and that keeps their teeth healthy and that keeps their body healthy. Frankly, a lot of those activities that would be utilized would be considered potentially an administrative cost under some of the loss ratio requirements that have been proposed in some of the states that we raised concerns about. Particularly in Massachusetts, there's been a lot of back and forth about plan activities, trying to make sure that people are utilizing their care. So, I think what we want to do is make sure that the market stays healthy, that there are other areas that are being looked at for the value that a dental plan has coverage. I don't think that it has been borne out that raising the DLR for a plan necessarily intrinsically leads to somebody utilizing care more. It doesn't necessarily mean that the plan is going to provide a richer benefit. There are plenty of other things that they may potentially do. They may cut costs on some of these activities that are beneficial to people and their plans to make sure that they're utilizing care because they would be disincentivized to do so under some of the loss ratio proposals. I think we maybe need to decouple the conversation from saying higher loss ratio equals better value. I don't think that's the case. There have been a couple of presentations to why that have been given to this committee about what dental plans do and what they offer and what coverage range looks like for different types of dental plans that may be

impacted by this. But again, that gets back to having a broader conversation about what structures for the market makes sense.

Del. Westfall asked is the broker's commission included in that MLR? Mr. Urech stated currently broker commissions I believe would be included as an administrative expense in the denominator of a loss ratio. So, it's not something that you could count towards an MLR or DLR. And that's the case in as far as I know all the states that have passed a loss ratio bill to this point. Del. Westfall asked if the broker commission should be included Mr. Urech stated that it hasn't been included up to this point so I don't think that it's something that has necessarily been discussed but it may be part of a later conversation. Mr. Olson stated that I think that there could be some discussion that could be a point where for example, and I'm throwing an idea out and don't hold me to it, if there's a way to maybe instead of it being counted as paying out for care, if an MLR is instituted we want to keep it at the numerator which is the claims paid out remains truly claims paid out but if there was some sort of deduction from the denominator on premium collected then that would allow plans to more easily meet the MLR while keeping the agents remunerated. Mr. Urech stated that we already see deductions from the denominator on state taxes and fees and based on the ACA precedent there's activities to improve care quality that are added on to the numerator in most of those instances because those are the types of things that benefit consumers.

The Hon. Tom Considine, NCOIL CEO, stated that just to follow up on Del. Westfall's point a little bit for clarification because maybe I see a nugget here. On the medical side, it's been 12 years since we wrote these regulations when I was in the National Association of Insurance Commissioners (NAIC). Things like nurses and help lines, they're denominator issues but they count because they reduce the other part of the denominator. Cmsr. Considine asked if he was correct on that. Mr. Urech and Mr. Olson replied yes. Cmsr. Considine stated so the argument would be that since so many people don't have dental, including broker fees in the denominator would be an access to care issue so it would make sense to include it in the denominator to address the access to care issue. Is that something where maybe you both could reach a compromise on? Mr. Urech and Olson replied that they would be open to further discussions on that.

Del. Westfall stated that it is my intention is to have an interim meeting of this Committee in January and vote on either the new version of the Colorado version or whatever we can come up with. I'm going to introduce the Colorado version in West Virginia just to have something to work off of. I think this is an important issue – otherwise I wouldn't be the sponsor of the Model.

ANY OTHER BUINESS

Rep. Ferguson stated somewhat related, since ERISA was brought up, for the new members and maybe members who don't know - we just went to D.C. and educated Members of Congress and staff about the benefits of a waiver process in ERISA. As most of you know, we have waivers for Medicare and Medicaid and the ACA and other federal programs. And ERISA really continues to undermine state based insurance so I think it's very reasonable that all of you when you talk to your Members of Congress that you advocate for a waiver for ERISA to make sure that all plans abide by all of these laws that we fight so hard to pass to protect consumers.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Klein and seconded by Rep. Oliverson, the Committee adjourned at 11:30 a.m.

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

NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

AN ACT CONCERNING PRESCRIPTION DRUG COSTS

Sponsored by Rep. Tom. Oliverson, M.D. (TX)
Co-Sponsored by Sen. Dan "Blade" Morrish (LA)

Adopted by the Health Insurance & Long Term Care Issues Committee on December 11, 2019 and by the Executive Committee on December 13, 2019.

To be discussed and considered for re-adoption during the meeting of the Health Insurance & Long Term Care Issues Committee on April 14, 2024.

Table of Contents

Section 1. Title

This Act shall be known as the [State] Health Care Cost Transparency Act.

Section 2. Purpose

The purpose of this Act is to promote prescription drug price transparency and cost control.

Section 3. Definitions

"Board of Pharmacy" or "board" means the [State] Board of Pharmacy.

"Commissioner" means the Insurance Commissioner.

"Department" means the Insurance Department.

“Director” means the Medicaid Director.

"Drug" means (A) articles recognized in the official United States Pharmacopoeia, official Homeopathic Pharmacopoeia of the United States or official National Formulary, or any supplement to any of them; (B) articles intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease in humans or other animals; (C) articles, other than food, intended to affect the structure or any function of the body of humans or any other animal; and (D) articles intended for use as a component of any articles specified in this subdivision; but shall not include devices or their components, parts or accessories;

"Health care plan" means any individual, blanket, or group plan, policy, or contract for healthcare services issued or delivered by a healthcare insurer in this state.

"Health carrier" or “Health insurer” means an insurance company, a health maintenance organization, or a hospital and medical service corporation.

“Net spending” means the cost of prescription drugs minus any discounts that lowers the price of the drugs, including, but not limited to, rebates, fees, retained price protections, retail pharmacy network spread, and dispensing fees.

"Pharmacist services" means products, goods, and services, or any combination of products, goods, and services, provided as a part of the practice of pharmacy.

"Pharmacy benefits manager" means any person that administers the prescription drug, prescription device, pharmacist services or prescription drug and device and pharmacist services portion of a health care plan offered in the state on behalf of a [HEALTH CARRIER/INSURER].

"Rebate" means any discount or concession which affects the price of a prescription drug to a pharmacy benefits manager or health [CARRIER/INSURER] for a prescription drug manufactured by the pharmaceutical manufacturer.

“Specialty drug” means a prescription drug outpatient specialty drug covered under Medicare Part D program established pursuant to Public Law 108-73, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, as amended from time to time, that exceeds the specialty tier cost threshold established by the Centers for Medicare and Medicaid Services.

“Utilization management” means a set of formal techniques designed to monitor the use of, or evaluate the medical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings.

“Wholesale acquisition cost” means, with respect to a pharmaceutical drug or biological product, the manufacturer's list price for the pharmaceutical drug or biological product to wholesalers or direct purchasers in the United States for the most recent month for which the information is available, as reported in wholesale price guides or other publications of pharmaceutical drug or biological product pricing data, not including any rebates, prompt pay or other discounts, or other reductions in price.

Section 4. Disclosure of prescription drug pricing information.

(a)(1) Not later than January 1, 2020, and annually thereafter, each drug manufacturer shall submit a report to the [INSURANCE COMMISSIONER] no later than the fifteenth day of January, April, July, and October with the current wholesale acquisition cost information for the United States Food and Drug Administration approved drugs sold in or into the state by that manufacturer.

(2) The commissioner shall develop a website to contain prescription drug price information submitted pursuant to subsection (a)(1) of this section. The website shall be made available on the [INSURANCE DEPAREMENT’S] website with a dedicated link that is prominently displayed on the home page, or by a separate easily identifiable internet address.

(b)(1) Not more than thirty days after an increase in wholesale acquisition cost of sixty percent or greater over the preceding five calendar years or fifteen percent or greater in the preceding twelve months for a drug with a wholesale acquisition cost of seventy dollars or more for a thirty-day supply, a pharmaceutical drug manufacturer shall submit a report to the [COMMISSIONER OF INSURANCE]. The report shall contain the following information:

(A) Name of the product;

(B) Whether the drug is a brand name or a generic;

(C) The effective date of the change in wholesale acquisition cost;

(D) Aggregate, company-level research and development costs for the prior calendar year;

(E) The name of each of the manufacturer’s prescription drugs that was approved by the federal Food and Drug Administration in the previous five calendar years;

(F) The name of each of the manufacturer’s prescription drugs that lost patent exclusivity in the United States in the previous five calendar years; and

(G) A statement of rationale regarding the factor or factors that caused the increase in the wholesale acquisition cost.

(2) The quality and types of information and data that a pharmaceutical manufacturer submits to the commissioner pursuant to this subsection shall be consistent with the quality and types of information and data that the manufacturer includes in their annual consolidated report on Securities and Exchange Commission Form 10-K or any other public disclosure.

(3) Within sixty days of receipt, the commissioner shall publish the report on the [INSURANCE DEPARTMENT'S] prescription drug price information website developed pursuant to subsection (a)(2) this section.

(c) A manufacturer shall notify the commissioner in writing if it is introducing a new prescription drug to market at a wholesale acquisition cost that exceeds the threshold set for a specialty drug under the Medicare Part D program. The manufacturer shall provide the written notice within three calendar days following the release of the drug in the commercial market. A manufacturer may make the notification pending approval by the U.S. Food and Drug Administration (FDA) if commercial availability is expected within three calendar days following the approval.

(d) The commissioner may adopt regulations to implement the provisions of this section.

Drafting Note: *States may wish to raise or lower the percentages and dollar amount set forth in Section 4(b)(1) depending upon each state's economic environment as it relates to prescription drug prices.*

Section 5. Disclosure of pharmacy benefit management information.

(a)(1) Not later than February 1, 2020, and annually thereafter, each pharmacy benefits manager shall file a report with the commissioner. The report shall contain the following information for the immediately preceding calendar year:

(A) The aggregated rebates, fees, price protection payments, and any other payments collected from pharmaceutical manufacturers;

(B) The aggregated dollar amount of rebates, price protection payments, fees and any other payments collected from pharmaceutical manufacturers that were passed to health [CARRIERS/INSURERS];

(C) The aggregated dollar amount of rebates, price protection payments, fees and any other payments collected from pharmaceutical manufacturers that were passed to enrollees at the point of sale; and

(D) The aggregated dollar amount of rebates, price protection payments, fees and any other payments collected from pharmaceutical manufacturers that were retained as revenue by the pharmacy benefit manager.

(2) Reports submitted by pharmacy benefit managers shall not disclose the identity of a specific health benefit plan or enrollee, the prices charged for specific drugs or classes of drugs, or the amount of any rebates or fees provided for specific drugs or classes of drugs.

(3) Within sixty days of receipt, the commissioner shall publish the report on the [INSURANE DEPARTMENT'S] prescription drug price information website developed pursuant to subsection (a)(2) of section (4) of this Act. For any pharmacy benefit manager with fewer than five (5) clients, the commissioner shall aggregate all the collected data and publish the aggregated data from all reports for that year required by this section in an appropriate location on the department's internet website. The data from all of the reports must be published in a manner that does not disclose or tend to disclose proprietary or confidential information of any pharmacy benefit manager.

(b) The commissioner may adopt regulations to implement the provisions of this section.

Section 6. Disclosure of health [CARRIER/INSURER] spending information.

(a)(1) Not later than February 1, 2020, and annually thereafter, each health [CARRIER/INSURER] shall submit a report to the commissioner. The report shall contain the following information for the immediately preceding calendar year:

(A) The names of the twenty-five most frequently prescribed prescription drugs across all plans;

(B) Percent increase in annual net spending for prescription drugs across all plans;

(C) Percent increase in premiums that were attributable to prescription drugs across all plans;

(D) Percentage of specialty prescription drugs with utilization management requirements across all plans;

(E) Premium reductions that were attributable to specialty drug utilization management.

(2) Within sixty days of receipt, the commissioner shall publish the report on the [INSURANE DEPARTMENT'S] prescription drug price information website developed pursuant to subsection (a)(2) of section (4) of this Act. The commissioner shall aggregate all the collected data and publish the aggregated data from all reports for that year required by this section in an appropriate location on the department's internet website. The data from all of the reports must be published in a manner that does not disclose or tend to disclose proprietary or confidential information of any health [CARRIER/INSURER].

(b) Reports submitted by [CARRIERS/INSURERS] shall not disclose the identity of a specific health benefit plan or the prices charged for specific drugs or classes of drugs.

(c) The commissioner may adopt regulations to implement the provisions of this section.

Section 7. Severability

If any provisions of this Act or the application of this Act to any person or circumstances is held invalid, the invalidity shall not affect other provisions or applications of this Act which can be given effect without the invalid provision or application, and to this end, the provisions of this Act are declared severable.

Section 8. Effective Date

This Act is effective immediately.

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

National Council of Insurance Legislators (NCOIL)

Value Based Purchasing Model Act

Sponsored by Sen. Mary Felzkowski (WI)

Draft as of March 13, 2024. To be introduced during the meeting of the NCOIL Health Insurance & Long Term Care Issues Committee on April 14, 2024.

Section 1. Title

This Act shall be known and cited as the "[State] Value Based Purchasing Act."

Section 2. Purpose

The purpose of this Act is to allow the State Medicaid Agency to enter into a value-based purchasing arrangement with a drug manufacturer for purposes of the Medical Assistance program. Through these arrangements, the State will both expand access to effective treatments and lower costs by tracking and paying for value.

Section 3. Definitions

(A) "Manufacturer" means a person licensed or approved by the federal food and drug administration to engage in the manufacture of drugs or devices, consistent with the definition of "manufacturer" under the federal food and drug administration's regulations and interpreted guidances implementing the federal prescription drug marketing act.

(B) "Value-based purchasing arrangement" means an arrangement for the Medical Assistance program by written agreement with a manufacturer based on agreed upon metrics to which the department and the manufacturer agree in writing and may include any of the following:

1. Rebates
2. Discounts
3. Price reductions
4. Risk sharing
5. Reimbursements
6. Payment deferrals or installment payments

7. Guarantees
8. Shared savings payments
9. Withholds
10. Bonuses
11. Any other thing of value

Section 4. Implementation

(A) The State Medicaid Agency may enter into a value-based purchasing arrangement for the Medical Assistance program by written agreement with a manufacturer.

(B) Nothing in this subsection may be interpreted to require a manufacturer or the State Medicaid Agency to enter into an arrangement described under Section 4(A).

(C) Nothing in this subsection may be construed to alter or modify coverage requirements under the Medical Assistance program.

(D) If the State Medicaid Agency determines it is unable to implement this subsection without a waiver of federal law, state plan amendment, or other federal approval, the department shall request from the secretary of the federal department of health and human services any waiver of federal law, state plan amendment, or other federal approval necessary to implement this subsection.

(E) If the federal department of health and human services does not approve a waiver of federal law, state plan amendment, or other federal approval under this paragraph, the department is not required to implement this subsection.

Section 5. Effective Date

This Act shall take effect xxxxxxx.

EXECUTIVE COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
EXECUTIVE COMMITTEE
2023 NCOIL ANNUAL MEETING – COLUMBUS, OH
November 18, 2023
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Executive Committee met at the Renaissance Columbus Downtown Hotel in Columbus, OH on Saturday November 18, 2023 at 11:00 AM.

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

Other members of the committee present:

Rep. Matt Lehman (IN)
Rep. Michael Meredith (KY)
Rep. Michael "Sarge" Pollock (KY)
Rep. Rachel Roberts (KY)
Rep. Edmond Jordan (LA)
Rep. Brenda Carter (MI)
Sen. Paul Utke (MN)
Sen. Walter Michel (MS)
Sen. Jerry Klein (ND)
Sen. Bob Hackett (OH)
Rep. Forrest Bennett (OK)
Rep. Tom Oliverson, M.D. (TX) – by phone
Rep. Jim Dunnigan (UT)

Other legislators present were:

Rep. Cherlynn Stevenson (KY)
Rep. Bob Titus (MO)
Asm. Jarett Gandolfo (NY)
Rep. Brian Lampton (OH)

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 Rep. Rachel Roberts (KY), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a motion made by Rep. Forrest Bennett (OK) 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 July 22, 2023 meeting in Minneapolis.

FUTURE MEETING LOCATIONS

Rep. Ferguson stated that the 2024 Spring Meeting will be in Nashville, TN from April 11th – 14th, the 2024 Summer Meeting will be in Costa Mesa, CA from July 17th – 20th, and the 2024 Annual Meeting will be in San Antonio, TX from November 21st – 24th.

ADMINISTRATION

Will Melofchik, NCOIL General Counsel, stated that there were 347 registrants for the meeting including 52 legislators from 25 states and of that number there were seven first time attendee legislators from six states. Additionally, seven insurance commissioners participated with 16 total insurance departments represented.

Mr. Melofchik then gave the unaudited financials through June 30th of this year showing revenue of $1,593,980.92 and expenses of $1,165,877.17 leading to a surplus of $428,102.83.

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. Brian Lampton (OH), Chair of the OH House 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.

Sen. Walter Michel (MS) stated that he would like to nominate Asm. Jarett Gandolfo (NY)

Upon a motion made by Rep. Lehman and seconded by Rep. Jim Dunnigan (UT), the Committee voted without objection by way of a voice vote to add Rep. Lampton and Asm. Gandolfo to the Executive Committee.

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

- The Financial Services & Multi-Lines Issues Committee adopted amendments to NCOIL Insurance E-Commerce Model Act and a Resolution in Support of Establishing National Standards and Procedures for the Reporting and Payment of Premium Taxes Due as a Result of Direct Procurement.

- The Articles of Organization & Bylaws Revision Committee adopted amendments to the NCOIL Articles of Organization & Bylaws.

- The Property & Casualty Insurance Committee re-adopted the NCOIL Model State Uniform Building Code with amendments, and adopted amendments to the NCOIL Delivery Network Company (DNC) Insurance Model Act.

- The 2024 NCOIL Budget as adopted by the Budget Committee on 11/17/23.

- Ratification of decisions made and actions taken by the NCOIL Officers and staff in the
- time between Executive Committee Meetings.

Rep. Ferguson asked if any Committee member wanted anything removed from the consent calendar. Hearing no such requests, upon a motion made by Sen. Paul Utke (MN), NCOIL Secretary, and seconded by Rep. Roberts, the Committee voted to adopt the consent calendar without objection by way of a voice vote.

OTHER SESSIONS

Rep. Ferguson stated that as part of The Institutes Griffith Foundation Legislator Luncheon, Martin Grace, Ph.D., J.D., Professor Risk, Insurance & Healthcare Management at the Fox School of Business at Temple University, gave an interesting presentation titled “Challenges and Opportunities in the California Property Insurance Market: An Academic Overview.”

There were also three interesting and timely general sessions including:

- Artificial Intelligence: A Major Benefit or Likely Menace for Insurance and Society?;
- Part three of our year-long series of general sessions focused on Environmental, Social, and Governance (ESG) Policy; and
- Whose Claim is This Anyway? Examining a Legislative Framework for Litigation Funding.

Ohio Governor Mike DeWine and Ohio Lieutenant Governor Jon Husted each delivered great Keynote Addresses. It was an NCOIL first to have the Governor and Lt. Governor from the host state both speak at an NCOIL National Meeting.

CONSIDERATION OF RE-ADOPTION OF MODEL ACT TO SUPPORT STATE REGULATION OF INSURANCE THROUGH MORE INFORMED POLICYMAKING (Model)

Rep. Ferguson stated that per NCOIL bylaws, all Model laws must be considered every 5 years for re-adoption. If the Model is not re-adopted, it sunsets. This Model has not been adopted in any states so I would recommend that we not re-adopt it and let it sunset. Does anyone object to this approach?

Hearing no objection, the Committee let the model sunset.

NOMINATING COMMITTEE REPORT

Rep. Ferguson stated that the Nominating Committee met on Thursday and voted to recommend a new slate of officers for next year. The Committee's recommendation is Louisiana Representative Edmond Jordan as Secretary, Minnesota Senator Paul Utke as Treasurer, New York Assemblywoman Pamela Hunter as Vice President, and Texas Representative Tom Oliverson, M.D., as President.

Upon a motion made by Rep. Lehman and seconded by Sen. Klein, the committee voted without objection by way of a voice vote to adopt the new slate of officers. Rep. Ferguson then asked if any of the officers would like to be recognized.

Rep. Jordan stated that he wanted to thank everyone for their support and is ready to work hard and keep NCOIL on a strong path.

Rep. Oliverson, who was connected into the meeting via phone, stated that he is very grateful for the opportunity to serve as President and looks forward to working with everyone in the year to come. He said that Columbus was a great meeting and we started working on many interesting issues and he looks forward to continuing those discussions at our meetings in 2024. He encouraged everyone to share any suggestions or ideas that NCOIL should be looking at going forward. He concluded by adding that he hopes to boost NCOIL's profile and increase the organization's exposure around the country so people know of NCOIL and the work the organization does to protect consumers and the state-based system of insurance regulation.

ANY OTHER BUSINESS

Commissioner Tom Considine, NCOIL CEO, stated that while a nonprofit, particularly one of NCOIL's size, is not covered by auditor rotation requirements, we are in the process of receiving bids from other audit firms as it is viewed as a best practice to rotate auditors. However, we've discovered that there are a limited number of auditing firms that do auditing work for organizations like NCOIL, and bringing in another firm may cost a multiple of what we currently pay. Accordingly, staff recommends waiting until our Spring Meeting in Nashville to offer a final recommendation in order to allow us to receive and review other bids to conduct our 2024 audit.

Upon a motion made by Rep. Lehman and seconded by Rep. Bennett, the Committee voted without objection by way of a voice vote to delay retaining an auditor until the Spring Meeting.

Rep. Ferguson then asked if anyone from the Industry Education Council (IEC) would like to make any recommendations for future NCOIL agenda topics. John Ashenfelter, Associate General Counsel for State Farm, stated he appreciated the collaboration the IEC has with NCOIL and suggested NCOIL looking specifically at the portfolio funding aspect of third party litigation funding as that has been tied to virtually all cases of litigation fraud in recent years. He also suggested another topic on independent procurement of insurance and how states protect consumers who obtain insurance in that manner.

Rep. Ferugson stated that it has been a great honor to serve as NCOIL President this past year. She said she decides what organizations she wants to be a part of based on the value it brings to her and from the very beginning she has found NCOIL to be very valuable and is very grateful to be a part of it. She thanked Cmsr. Considine and the NCOIL staff for how the organization has been run the past several years and is very happy with the position the organization is in now.

Cmsr. Considine then presented Rep. Ferguson with a plaque honoring her service as President. He stated that while he's losing a President, he is very glad to be maintaining a friendship with Rep. Ferguson. He said she did an incredible job this year and brought a new perspective to many things and that NCOIL is a far better organization now than it was a year ago.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Dunnigan and seconded by Rep. Roberts the Committee adjourned at 11:30 a.m.

616 Fifth Avenue, Unit 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)**

***Adopted by the NCOIL Health Insurance & Long Term Care Issues Committee on January 26, 2024. To be placed on the Executive Committee's agenda for final ratification at the 2024 NCOIL Spring Meeting on April 14, 2024.**

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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 falls below 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, the amount incurred on activities that improve dental care quality, and other incurred claims as defined at 45 CFR 158.140(a); and

(B) The denominator is the total amount of premium revenue, excluding federal and state taxes, licensing and regulatory fees paid, nonprofit community expenditures as defined at 45 CFR 158.162(c), 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 and Rebate

(a) The Commissioner shall aggregate dental loss ratios for each carrier by year pursuant to Section 4 for each market segment in which the carrier operates. The commissioner shall calculate an average dental loss ratio for each market segment using aggregate data for a 3-year period including data for the most recent dental loss ratio reporting year and the data for the two prior dental loss ratio reporting years.

(1) Newer experience shall be subject to reporting standards at 45 CFR 158.121

(b) The Commissioner shall calculate an average dental loss ratio for each market segment using the data pursuant to subsection 5(a), identify as outliers dental plans that fall outside 1 standard deviations of the average dental loss ratio, and report those plans to the legislature consistent with the manner set forth in subsections 4(e) and 4(d) above.

(1) A carrier shall not be considered an outlier if its DLR in a market segment is within 3 percentage points of the average dental loss ratio. A higher threshold may be set in unique circumstances as determined reasonable by the commissioner.

(c) The Commissioner shall investigate those carriers that report a DLR lower than 1 standard deviations from the mathematical average, and may take remediation or enforcement actions against them, including ordering such carriers to rebate, in a manner consistent with 45 C.F.R. Part 158(B) 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.

(d) The report in subsection (b) shall be organized to show year-over-year changes in a carrier's outlier status relative to meeting the 1 standard deviation outlier standard at subsection (b). If the DLR for a carrier in a market segment does not increase and remains an outlier as defined in subsection (b) after 2 consecutive years, barring unique circumstances as determined reasonable by the commissioner, the carrier shall be subject to a minimum DLR percentage by market segment. The commissioner shall promulgate rules establishing the DLR percentage based on, at minimum, the average of existing carrier loss ratios by market segment in the state to be effective no sooner than 42 months after a carrier is determined to be an outlier as defined in this section.

(e) A carrier subject to remediation in subsections (c) and (d) shall provide any rebate owing to a policyholder 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.

(f) 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.

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.

616 Fifth Avenue, Unit 106
Belmar, NJ 07719
732-201-4133
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) and Del. Steve Westfall (WV)**

***Adopted by the NCOIL Property & Casualty Insurance Committee on February 2, 2024. To be placed on the Executive Committee's agenda for final ratification at the 2024 NCOIL Spring Meeting on April 14, 2024.**

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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 the adjusting 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. 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 a public adjuster unless then licensed by the department as a public adjuster.

(2) (a) An individual applying for a resident 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 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 a 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 a public adjuster license.

(7) 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.

(8) 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.

(9) For purposes of this section, except as otherwise provided in subsection (10) of this section, "home state" means any state or territory of the United States or the District of Columbia in which a public adjuster:

(a) Maintains his, her, or its principal place of residence or business; and

(b) Is licensed to act as a resident public adjuster.

(10) (a) As used in this subsection, "home state" has the same meaning as in subsection (9) 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 public adjuster if the state or territory of the applicant's principal place of residence does not issue a public adjuster license.

(b) Unless refused licensure in accordance with xxxxx, a nonresident person shall receive a nonresident public adjuster license if:

1. The person is currently licensed in good standing as a 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 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 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. Public Adjuster and Insured Contract Requirements

(1) (a) 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) 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) 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.

(d) 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) 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) 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. 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) 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) 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) (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) 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) 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) 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) 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) 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. 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. 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. 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 business;

(e) Intentionally misrepresenting the terms of an actual or proposed insurance 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 or insurance fraud;

(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, 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 or to any other document related to an insurance transaction;

(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, 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 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. 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. Effective Date

This Act shall take effect xxxxxx.