30 DAY MATERIALS AND GENERAL SCHEDULE
NCOIL SUMMER MEETING
JULY 17 - 20, 2024

As of July 8, 2024, and Subject to Change

The Westin South Coast Plaza Hotel
Costa Mesa, California

NCOIL SUMMER MEETING
Costa Mesa, California
July 17 - 20, 2024
SCHEDULE

Note: There will be a room (Capistrano on the 1st floor) available throughout the duration of the conference for informal meetings. Attendees should feel free to meet with legislators there throughout the meeting.

WEDNESDAY, JULY 17TH

NCOIL & The Institutes Griffith Foundation Legislator Workshop ***Open to Legislators Only*** ***Please reach out to Pat Gilbert at pgilbert@ncoil.org if interested in attending. Space is limited.***	1:00 p.m. (Lunch served at 12:45 p.m.)	-	4:00 p.m.
Budget Committee	4:00 p.m.	-	4:30 p.m.
Audit Committee (Members Only)	4:30 p.m.	-	5:00 p.m.
Welcome Reception	5:30 p.m.	-	7:30 p.m.

THURSDAY, JULY 18TH

Registration *Exhibits Open: 8:00 a.m. – 5:00 p.m.*	8:00 a.m.	-	5:00 p.m.
Welcome Breakfast	8:15 a.m.	-	9:45 a.m.
First Time Attendee Legislator & Staff Meeting	9:45 a.m.	-	10:00 a.m.

First Time Attendee Interested Party Meeting	9:45 a.m.	-	10:00 a.m.
Networking Break	9:45 a.m.	-	10:00 a.m.
Joint State-Federal Relations & International Insurance Issues Committee	10:00 a.m.	-	11:30 a.m.
General Session Eye in the Sky: How Insurers' Use of Aerial Images is Impacting Coverage	11:30 a.m.	-	1:00 p.m.
The Institutes Griffith Foundation Legislator Luncheon Guaranty with a "y": A Primer for Public Policymakers ***Open to Public Policymakers and Staff Only***	1:00 p.m.	-	2:00 p.m.
Health Insurance & Long Term Care Issues Committee	2:00 p.m.	-	3:45 p.m.
Networking Break	3:45 p.m.	-	4:00 p.m.
Financial Services & Multi-Lines Issues Committee	4:00 p.m.	-	5:30 p.m.
Adjournment	5:30 p.m.		
CIP Member & Sponsor Reception ***Open to Public Policymakers & Staff, CIP Members, and Spring Meeting Sponsors***	6:00 p.m.	-	7:00 p.m.

FRIDAY, JULY 19th

Registration *Exhibits Open: 8:00 a.m. – 5:00 p.m.*	8:00 a.m.	-	5:00 p.m.
Workers' Compensation Insurance Committee	9:00 a.m.	-	10:30 a.m.
Networking Break **Sponsored by Aflac**	10:30 a.m.	-	10:45 a.m.
NCOIL – NAIC Dialogue	10:45 a.m.	-	12:00 p.m.

Luncheon with Keynote Address	12:00 p.m.	-	1:30 p.m.
General Session NCOIL Special Series on Preventive Medicine Part 1: Early Expenses Prevent Significant Later Costs	1:30 p.m.	-	3:00 p.m.
Life Insurance & Financial Planning Committee	3:00 p.m.	-	4:30 p.m.
Articles of Organization & Bylaws Revision Committee	4:30 p.m.	-	5:00 p.m.
Adjournment	5:00 p.m.		

SATURDAY, JULY 20TH

Registration *Exhibits Open: 8:00 a.m. – 11:00 a.m.*	8:00 a.m.	-	11:00 a.m.
The Institutes Griffith Foundation Legislator Breakfast An Examination of the Role of Catastrophe Modeling in Risk Management: Is it More than Throwing Darts? ***Open to Public Policymakers and Staff Only***	8:00 a.m.	-	9:00 a.m.
General Session Financial Literacy: Providing Students With More Life Skills But At What Cost?	9:00 a.m.	-	10:30 a.m.
Networking Break	10:30 a.m.	-	10:45 a.m.
Property & Casualty Insurance Committee	10:45 a.m.	-	12:30 p.m.
Executive Committee	12:30 p.m.	-	1:00 p.m.

Please note all speakers listed are scheduled to speak as of July 8, 2024. There will be modifications between now and the start of the Meeting.

Note: There will be a room (Capistrano 1st floor) available throughout the duration of the conference for informal meetings. Attendees should feel free to meet with legislators there throughout the meeting.

Wednesday, July 17, 2024

NCOIL & The Institutes Griffith Foundation Legislator Workshop
Wednesday, July 17, 2024
1:00 p.m. – 4:00 p.m. (Lunch served at 12:45 p.m.)
*****Open to Legislators Only*****
*****Please reach out to Pat Gilbert at pgilbert@ncoil.org if interested in attending. Space is limited.*****

Budget Committee
Wednesday, July 17, 2024
4:00 p.m. – 4:30 p.m.

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

1.) Call to Order/Roll Call/Approval of Nov. 17, 2023 Committee Meeting Minutes
2.) 2025 Budget Planning Discussion
3.) Any Other Business
4.) Adjournment

Audit Committee (Members Only)
Wednesday, July 17, 2024
4:30 p.m. – 5:00 p.m.

President's Welcome Reception
Orange County Museum of Art (5 Minute Walk from Hotel)
Wednesday, July 17, 2024
5:30 p.m. – 7:30 p.m.

Thursday, July 18, 2024

Welcome Breakfast
Thursday, July 18, 2024
8:15 a.m. – 9:45 a.m.

1.) **The Hon. Ricardo Lara – California Insurance Commissioner**
    -Welcome to Costa Mesa
2.) **Hon. Tom Considine**
    -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
Thursday, July 18, 2024
9:45 a.m. – 10:00 a.m.

First Time Attendee Interested Party Meeting
Thursday, July 18, 2024
9:45 a.m. – 10:00 a.m.

Networking Break
Thursday, July 18, 2024
9:45 a.m. – 10:00 a.m.

Joint State-Federal Relations & International Insurance Issues Committee
Thursday, July 18, 2024
10:00 a.m. – 11:30 a.m.

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

1.) Call to Order/Roll Call/Approval of April 12, 2024 Committee Meeting minutes
2.) Update on NCOIL Mental Health Parity Model Act
Rep. Rachel Roberts (KY) – Sponsor
3.) Discussion on Resolution in Support of Establishing Catastrophe Savings Accounts
Rep. Matt Lehman (IN); Sen. Walter Michel (MS); Rep. Ellyn Hefner (OK); Rep. Carl Anderson (SC) - Sponsors
Kevin McKechnie, Executive Director, Health Savings Account Council – American Bankers Association (ABA)
Kirsten Trusko, Co-founder - Payments as a Lifeline
Jason Lane, Senior VP, Director of Gov't Relations – California Bankers Association
4.) Discussion on Recent Federal Rules Encroaching on the State-Based System of Insurance
a.) Tri-agency Rule on Short-Term, Limited Duration Insurance; Independent, Non-coordinated Excepted Benefits Coverage; Level-Funded Plan Arrangements; and Tax Treatment of Certain Accident and Health Insurance
Lucy Culp, VP, State Gov't Affairs – Leukemia & Lymphoma Society
JP Wieske, VP of State Affairs – Health Benefits Institute
b.) Federal Trade Commission Noncompete Rule
Jonathan Harris, Associate Professor of Law – Loyola Law School
Wes Bissett, Senior Counsel, Government Affairs - Independent Insurance Agents & Brokers of America (IIABA)
5.) Any Other Business
6.) Adjournment

General Session
Thursday, July 18, 2024
Eye in the Sky: How Insurers' Use of Aerial Images is Impacting Coverage
11:30 a.m. – 1:00 p.m.

Moderator: Rep. Matt Lehman (IN)

Amy Bach	*Dave Tobias*	*David Bairstow*
Executive Director	*Co-founder & COO*	*SVP & GM - Insurance*
United Policyholders	*Betterview/Nearmap*	*EagleView*

Matt Overturf	*Karl Susman*
Regional VP, Ohio Valley/Mid-Atlantic	*President*
Nat'l Ass'n of Mutual Insurance Companies	*Susman Insurance Agency*

The Institutes Griffith Foundation Legislator Luncheon
Guaranty with a "y": A Primer for Public Policymakers
Thursday, July 18, 2024
1:00 p.m. – 2:00 p.m.

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

Weili Lu, Ph.D.
Professor, Director of Center for Insurance Studies
Cal State Fullerton

Health Insurance & Long Term Care Issues Committee
Thursday, July 18, 2024
2:00 p.m. – 3:45 p.m.

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

1.) Call to Order/Roll Call/Approval of April 14, 2024 Committee Meeting Minutes
2.) Continued Discussion on Site-Neutral Payment Reforms
    Randi Chapman, Managing Director, State Affairs - Blue Cross Blue Shield Association (BCBSA)
    Francis Gibson, CEO – Utah Hospital Association
3.) Continued Discussion on NCOIL Value Based Purchasing Model Act
    Sen. Mary Felzkowski (WI) – Sponsor
    JP Wieske, VP of State Affairs – Campaign for Transformative Therapies
    Michael Heifetz, Principal – Infinite Policy Solutions; former Wisconsin Medicaid Director
4.) Presentation on Policies to Support Maternal Health
    Amy Chen, Senior Attorney - National Health Law Program
    Randi Chapman - BCBSA
5.) Presentation on Billing Practices in the Ground Ambulance Service Industry

Nadia Stovicek, M.P.P., Research Fellow, Center on Health Insurance Reforms, McCourt School of Public Policy – Georgetown University

6.) Any Other Business
7.) Adjournment

Networking Break
Thursday, July 18, 2024
3:45 p.m. – 4:00 p.m.

Financial Services & Multi-Lines Issues Committee
Thursday, July 18, 2024
4:00 p.m. – 5:30 p.m.

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

1.) Call to Order/Roll Call/Approval of April 13, 2024 and May 31, 2024 Committee Meeting Minutes
2.) Continued Discussion on NCOIL Transparency in Third Party Litigation Financing Model Act
Rep. Matt Lehman (IN) – Sponsor; Del. Steve Westfall (WV) – Co-sponsor
Ken Klein, Louis and Hermione Brown Professor of Law – California Western School of Law
Brad Nail - Converge Public Strategies
Will Weisman, Director, Commercial Litigation – Parabellum Capital
Jon Schnautz, VP of State Affairs - National Ass'n of Mutual Insurance Companies (NAMIC)
Mahima Raghav, AVP & Senior Consultant, Claims, Judicial & Legislative Affairs – Zurich
Jack Kelly, Managing Director - American Legal Finance Ass'n
Eric Schuller, President – Alliance for Responsible Consumer Legal Funding
3.) Presentation on Regulation of the Bail Bonds Industry
Jeff Clayton, Executive Director – American Bail Coalition
John Looney, Executive Vice President – National Association of Bail Agents
4.) Continued Discussion on NCOIL Earned Wage Access Model Act
Asw. Pam Hunter (NY), NCOIL Vice President – Sponsor
Ben LaRocco, Senior Director, Gov't Relations – EarnIn

Andrew Kushner, Senior Policy Counsel – Center for Responsible Lending

5.) Any Other Business
6.) Adjournment

CIP Member & Sponsor Reception
Thursday, July 18, 2024
6:00 p.m. – 7:00 p.m.
Open to Public Policymakers & Staff, CIP Members, and Summer Meeting Sponsors

Friday, July 19, 2024

Workers' Compensation Insurance Committee
Friday, July 19, 2024
9:00 a.m. – 10:30 a.m.

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

1.) Call to Order/Roll Call/Approval of April 12, 2024 Committee Meeting Minutes
2.) "State of the Line" Presentation – An Update on the Status of and Trends in the Workers' Compensation Insurance Marketplace
Jeff Eddinger, Senior Division Executive – National Council on Compensation Insurance (NCCI)
3.) Presentation on Workers' Compensation Premium Fraud in the Construction Industry
Matt Capece, Representative of the General President – United Brotherhood of Carpenters & Joiners of America
4.) Presentation on Developments in the California Workers' Compensation Insurance Marketplace
Rena David, Senior Vice-President, Research & Operations, CFO And Treasurer – California Workers' Compensation Institute (CWCI)
5.) Consideration of Re-adoption of NCOIL Workers' Compensation Drug Formulary Model Law – Adopted 12/13/19
Brian Allen, VP of Gov't Affairs – Enlyte Pharmacy Solutions
6.) Any Other Business
7.) Adjournment

Networking Break
Sponsored by Aflac
Friday, July 19, 2024
10:30 a.m. – 10:45 a.m.

NCOIL – NAIC Dialogue
Friday, July 19, 2024
10:45 a.m. – 12:00 p.m.

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

1.) Call to Order/Roll Call/Approval of April 12, 2024 Committee Meeting Minutes
2.) Recap of NCOIL and NAIC D.C. Fly-ins
3.) Update on Development of NAIC's Data Privacy Protection Model Law
4.) Discussion on NAIC's "Framework for Regulation of Insurer Investments", Including Proposal Relating to SVO's Ratings Discretion Process
5.) Update on Work of NAIC's Long Term Care Actuarial (B) Working Group
6.) Update on Work of NAIC's Third-Party Data and Models (H) Task Force
7.) Update on Implementation/Adoption of NAIC's Model Bulletin on The Use of Artificial Intelligence Systems by Insurers
8.) Any Other Business
9.) Adjournment

Luncheon with Keynote Address
Friday, July 19, 2024
12:00 p.m. – 1:30 p.m.

Nicholas Whyte
Senior Director – Global Solutions
APCO Worldwide

General Session
Friday, July 19, 2024
NCOIL Special Series on Preventive Medicine
Part 1: Early Expenses Prevent Significant Later Costs
1:30 p.m. – 3:00 p.m.

Moderator: Sen. Justin Boyd (AR)

Carter Harrison
Director of State Regulatory & Legislative Affairs
Alzheimer's Association

Charise Richard
Senior Director, State Policy
PhRMA

Bryan Tysinger, Ph.D.
Director, Health Policy Simulation
USC Schaeffer Center

Keith Lake
Regional Director, State Affairs
America's Health Insurance Plans (AHIP)

Kate Ross
Director of State Programs
California Ass'n of Health Plans

Life Insurance & Financial Planning Committee
Friday, July 19, 2024
3:00 p.m. – 4:30 p.m.

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

1.) Call to Order/Roll Call/Approval of April 12, 2024 Committee Meeting Minutes
2.) Presentation on Retirement Security Bill of Rights
Brendan McCarthy, Senior Managing Director – TIAA
3.) Presentation on Transamerica's Center for Retirement Studies Annual Retirement Survey
Catherine Collinson, CEO and President – Transamerica Institute and Transamerica Center for Retirement Studies (TCRS)
4.) Discussion on Proposed Amendments to NCOIL Life Settlements Model Act
Rep. Forrest Bennett (OK) – Sponsor
Alan Buerger, Chairman & Co-founder – Coventry
Jill Rickard, Regional VP, State Relations – American Council of Life Insurers (ACLI)
5.) Update on Litigation Surrounding the U.S. Department of Labor's Fiduciary Rule
6.) Any Other Business
7.) Adjournment

Articles of Organization & Bylaws Revision Committee
Friday, July 19, 2024
4:30 p.m. – 5:00 p.m.

Chair: Sen. Walter Michel (MS)
Vice Chair: Rep. Brian Lampton (OH)

1.) Call to Order/Roll Call/Approval of November 16, 2023 Committee Meeting Minutes
2.) Discussion and Consideration of Proposed Amendment to NCOIL Articles of Organization & Bylaws
3.) Any Other Business
4.) Adjournment

Saturday, July 20, 2024

The Institutes Griffith Foundation Legislator Breakfast
An Examination of the Role of Catastrophe Modeling in Risk Management: Is it More than Throwing Darts?
Saturday, July 20, 2024
8:00 a.m. – 9:00 a.m.

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

Christopher McDaniel
President
The Institutes Catastrophe Resiliency Council

General Session
Financial Literacy: Providing Students With More Life Skills But At What Cost?
Saturday, July 20, 2024
9:00 a.m. – 10:30 a.m.

Moderator: Rep. Ellyn Hefner (OK)

The Hon. Mike Humphreys
Commissioner
Pennsylvania Dep't of Insurance

Brenda Cude
Professor
University of Georgia

Tim Ranzetta
Co-Founder
Next Gen Personal Finance

Morgan Polikoff
Professor of Education
USC Rossier School of Education

Networking Break
Saturday, July 20, 2024
10:30 a.m. – 10:45 a.m.

Property & Casualty Insurance Committee
Saturday, July 20, 2024
10:45 a.m. – 12:30 p.m.

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

1.) Call to Order/Roll Call/Approval of April 13, 2024 and June 14, 2024 Committee Meeting Minutes
2.) Continued Discussion on NCOIL Strengthen Homes Program Model Act
Rep. Jim Dunnigan (UT) – Sponsor; Rep. Matthew Gambill (GA) – Co-sponsor
The Hon. Glen Mulready - Oklahoma Insurance Commissioner
Karl Susman, President – Susman Insurance Agency
Matt Overturf, Regional VP, Ohio Valley/Mid-Atlantic – National Association of Mutual Insurance Companies (NAMIC)
3.) Update on NAIC's Property & Casualty Market Intelligence Data Call
The Hon. Glen Mulready - Oklahoma Insurance Commissioner
4.) Continued Discussion on NCOIL Online Marketplace Guarantees Model Act
Rep. Brian Lampton (OH) - Sponsor
Byron Wobeter, Associate General Counsel, Insurance - Airbnb
Padma Purushothaman, Head of Product Development - Airbnb
Brad Nail – Converge Public Strategies
Jon Schnautz, VP, State Affairs – NAMIC
5.) Introduction and Discussion on NCOIL Motor Vehicle Glass Model Act
Rep. Michael Sarge Pollock (KY) – Sponsor
Eric DeCampos, Senior Director, Gov't Affairs - National Insurance Crime Bureau (NICB)
6.) Update on Federal Initiatives Impacting the Title Insurance Marketplace
a.) Proposed "Title Acceptance Pilot" from Federal Housing Finance Agency (FHFA)
Elizabeth Blosser, VP of Gov't Affairs - American Land Title Association (ALTA)
b.) Request for Information from Consumer Financial Protection Bureau (CFPB) on Closing Costs
Elizabeth Blosser - ALTA
7.) Consideration of re-adoption of model laws

a.) Model Act Regarding Use of Claims History Information – adopted 7/8/05; re-adopted 11/20/11; 12/13/19
b.) Model Act Concerning State Interpretation of State Insurance Laws – Adopted 7/13/19
c.) State Flood Disaster Mitigation and Relief Model Act – Originally Adopted 11/21/03; Amended 7/13/08; Re-adopted 7/13/19

8.) Any Other Business
9.) Adjournment

Executive Committee
Saturday, July 20, 2024
12:30 p.m. – 1:00 p.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 April 14, 2024 Committee Meeting Minutes
2.) Future Meeting Locations
3.) Administration
a.) Meeting Report
b.) Receipt of Financials and Audit
c.) Consideration of Audit
4.) Consent Calendar
5.) Other Sessions
a.) The Institutes Griffith Foundation Sessions
b.) General Sessions
c.) Featured Speakers
6.) Any Other Business
7.) Adjournment

BUDGET COMMITTEE MATERIALS

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

The National Council of Insurance Legislators (NCOIL) Budget Committee met at The Renaissance Columbus Downtown Hotel in Columbus, Ohio on Friday, November 17, 2023 at 5:00 p.m.

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

Other members of the Committee present were:

Rep. Deborah Ferguson, DDS (AR)
Rep. Rachel Roberts (KY)
Sen. Paul Utke (MN)
Sen. Jerry Klein (ND)
Rep. Forrest Bennett (OK)

Other legislators present were:

Rep. Matt Lehman (IN)
Sen. Walter Michel (MS)

Also in attendance were:

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

MINUTES

Upon a Motion made by Rep. Deborah Ferguson, DDS (AR), NCOIL President, and seconded by Sen. Jerry Klein (ND), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 19, 2023 meeting.

CONSIDERATION OF 2024 BUDGET

Asw. Hunter stated that we're here today to consider the adoption of NCOIL's 2024 budget. For those of you who were at our last meeting in July, you'll recall that we discussed the proposed budget in detail and all questions and comments were resolved. A copy of the proposed budget is before you. Also, there is a separate handout before you which shows the "2023 Actual" financial numbers as of October 31. Those numbers are updated from the June 30 numbers which were the last numbers shown to the Committee at its July meeting.

As you can see, NCOIL is having a very strong year. Some minor changes have been made to the proposed budget since we last met in July. I'll turn things over to The Hon. Tom Considine, NCOIL CEO, who can explain.

Cmsr. Considine stated that the changes consist of just getting expenses in line with inflation and what some more recent numbers that we had access to showed following the committee's July meeting. Spring meeting expenses are proposed to increase from $95,000 to $110,000 to coincide with what we saw from actual 2023 Spring meeting expenses. Summer meeting expenses are proposed to increase from $105,000 to $120,000 consistent with actual Summer meeting expenses of this year. Annual meeting expenses remain the same. Lastly, we propose to increase the travel budget from $22,000 to $40,000 which seems like a big jump but the reason is that NCOIL will have to incur more expenses next year than usual to have NCOIL Officers attend Interstate Insurance Product Regulation Commission (IIPRC) and National Association of Insurance Commissioners (NAIC) meetings.

Hearing no questions or comments, upon a Motion made by Rep. Forrest Bennett (OK) and seconded by Rep. Rachel Roberts (KY), the Committee voted without objection to adopt the budget.

Asw. Hunter thanked everyone and stated that the budget will be placed on the Executive Committee agenda for ratification on Saturday.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Klein and seconded by Rep. Anderson, the Committee adjourned at 5:20 p.m.

JOINT STATE-FEDERAL RELATIONS & INTERNATIONAL INSURANCE ISSUES COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
JOINT STATE-FEDERAL RELATIONS & INTERNATIONAL INSURANCE ISSUES COMMITTEE
2024 NCOIL SPRING MEETING – NASHVILLE, TENNESSEE
APRIL 12, 2024
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Joint State-Federal Relations & International Insurance Issues Committee met at The Sheraton Grand Nashville Downtown Hotel in Nashville, Tennessee on Friday, April 12, 2024 at 11:15 a.m.

Senator Jerry Klein of North Dakota, NCOIL Chair at Large, presided.

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Rep. Deborah Ferguson, DDS (AR)
Rep. Brenda Carter (MI)
Sen. Lana Theis (MI)
Sen. Paul Utke (MN)
Rep. Bob Titus (MO)
Rep. Nelly Nicol (MT)
Rep. Tim Barhorst (OH)
Sen. Bob Hackett (OH)
Rep. Ellyn Hefner (OK)
Rep. Lacey Hull (TX)
Rep. Tom Oliverson, M.D. (TX)
Rep. Dennis Paul (TX)
Rep. Jim Dunnigan (UT)

Other legislators present were:

Sen. Reginald Murdock (AR)
Asm. Tim Grayson (CA)
Sen. Aaron Freeman (IN)
Sen. Mike Gaskill (IN)
Rep. Peggy Mayfield (IN)
Sen. Beverly Gossage (KS)
Rep. Patrick Penn (KS)
Rep. Sean Tarwater (KS)
Rep. Bull Sutton (KS)
Del. Nicholas Kipke (MD)
Rep. Mike Harris (MI)
Rep. Mike McFall (MI)
Rep. Jerry Neyer (MI)
Rep. Julie Rogers (MI)
Sen. Natasha Marcus (NC)
Sen. Vickie Sawyer (NC)
Sen. Bill Gannon (NH)
Asm. Roy Freiman (NJ)
Asw. Ellen Park (NJ)
Asm. Jake Blumencranz (NY)
Rep. Brian Lampton (OH)
Sen. George Lang (OH)
Rep. Forrest Bennett (OK)
Rep. Mark Tedford (OK)
Rep. Carl Anderson (SC)
Rep. Barbara Dittrich (WI)
Sen. Mary Felzkowski (WI)

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. Nelly Nicol (MT), and seconded by Rep. Jim Dunnigan (UT), 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. Paul Utke (MN), NCOIL Treasurer, the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's November 18, 2023 meeting.

BASEL III ENDGAME – DISRUPTIVE TO THE U.S.?

Kevin McKechnie, Executive Director of the Health Savings Accounts Council at the American Bankers Association (ABA), thanked the Committee for the opportunity to speak and stated that the topic today has been named, rather ironically, appropriately. Too much capital regulation means credit is at endgame and I don't know if they meant to name it that way. But that's been the net effect. The federal banking regulators, Federal Reserve Board, Federal Deposit Insurance Corporation, Office of the Comptroller Currency proposed last summer a broad capital rule that has so far drawn three Congressional hearings. Two in the Senate last November and December. One in the House Financial Services Committee just about a month ago. And in those hearings, the question under study and you can see perhaps some of the bias in the name of the hearing especially in the House which is why are we importing international rules when we should be defending the sovereignty of the United States federal system? That has drawn some interesting criticism. What are they talking about? If you could in your mind think about the desk in front of you and on that desk you had ten dimes. If you took one of those dimes and moved it up. That would, roughly speaking, be the capital reserve strategy we currently employ. What's being proposed instead of that one dime is putting another dime forward and taking that capital out in circulation and holding it against risks that other commenters have said remain undefined. Meaning the principal criticism of the Basel III proposal is there has been no robust study of the economy and the harms the proposal seeks to remedy. And until such time as there is, there likely will not be a lot of support for it. There's not a lot of political support for it now in the wake of the Senate Banking Committee hearing in December. All Republican United States Senators signed a letter to the Federal Reserve Board and the other banking agencies asking the question I just asked. Exactly what kind of harms is this proposal trying to solve?

Well, it will affect every bank over $100 billion. And that sounds big. It's not. The largest banks in the country, JP Morgan Chase, has 34 times more assets than that. The next largest bank, Bank of America, has 25 times more assets than that. Which is to say that these new capital rules are going to affect the overwhelming majority of capital being held in financial institutions in this country. And what they mean by that is they're going to idle money and money idle is money you can't use. What can't you use it for? It will affect mortgages. It will affect credit cards. It will affect car loans. It will affect consumer loans. It will mean that if you wanted to have bonds for new schools and new sewer systems for new capital projects in your states and localities the cost of that credit is going to go up. How much up we don't know. But if you take two dimes out

of that ten dime line the worth of those other eight dimes goes up. That's how economics works. It's been criticized rather extensively. And if you need to find a short form way to explain it to others, I recommend the comments of Jamie Dimon in December. To paraphrase, in 2008 there was a financial crisis, and since then the financial institutions in this in this country are holding triple the common equity tier one capital that they used to, 300% more. Well, how much is that? It's seven times more capital than federal financial institutions need to accommodate the anticipated losses from the stress tests the Federal Reserve imposed. That's a lot of capital. And remember that's capital that's not moving. And that's the definition of the problem. I promised I would keep this brief. This is not a simple subject. But that's the summary. And we're waiting to see if there's going to be a modification to the proposed regulation. And of course, this is an election year. And so one side of the political system has said they disagree profoundly with the regulation. The other side has not. Elections matter. We shall see.

Sen. Klein stated that we certainly are constantly bombarded by outside the country influence and my constituents would suggest where we going with this? And is it being suggested that we have to go to this new ratio by some country out of dominance? Mr. McKechnie stated that that's what's being suggested. This is an effort to harmonize capital standards across the globe. And we've seen this in other places. And you have meetings for the rest of this conference on things like data. Data standards are trying to be harmonized across the globe and climate as well but I am not sure that word means anything anymore. No one seems to define it, but that's trying to be harmonized around the globe.

OVERVIEW OF NEW PRIOR AUTHORIZATION RULES FROM THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

Randy Pate, Former Deputy Administrator & Director at the Center for Consumer Information and Insurance Oversight (CCIIO) at CMS, and founder of Randolph Pate Advisors, LLC, thanked the Committee for the opportunity to speak and stated that I'm currently in private consulting practice and I'm also the President of States Work which is an educational nonprofit that provides free technical assistance to states pursuing market based health reforms. But more apropos for this meeting, I'm the former director of CCIIO at CMS. I served in that capacity in the previous administration. I just want to be clear, I did not draft the rules that we're going to be talking about today and I'm not necessarily an advocate of them. I just want to provide background and answer any questions to the best of my ability. So, the U.S. Department of Health and Human Services (HHS) issued this final rule back in January. The rule applies across a wide range of payers and providers. It defines impacted providers as plans, issuers and state programs who are subject to the earlier CMS interoperability of patient access rule. This includes Medicare Advantage organizations, state Medicaid, and Children's Health Insurance Program (CHIP) be for service programs. Medicaid managed care programs, CHIP managed care programs and qualified health plan issuers on the federally facilitated exchange. It does not include self-funded Employee Retirement Income Security Act of 1974 (ERISA) plans, large group, fully insured plans, off exchange individual market health plans, whether they're in federally facilitated exchange states or state based exchanges states, qualified health plans in states with their own exchanges, or alternative plans like short term limited duration. A major feature of the final rule

there's a requirement for impacted payers to implement and maintain a series of application program interfaces or APIs aimed at improving and streamlining the exchange of certain health information as well as prior authorization processes. The final rule also includes provider incentives under the merit-based incentive payment system (MIPS) to encourage adoption of the APIs. It contains certain other requirements related to prior authorization that I'll talk about, they are applicable January 1st of 2026. However, the payer compliance with the API requirements I'm going to talk about was delayed until January 1, 2027. HHS delayed this compliance date in response to feedback from the stakeholders and payers where they expressed the need to have sufficient time to plan, develop, test and implement the required API changes. They also cited feedback relating to the need to further standardize and mature the implementation guidelines for these APIs.

So, the final rule includes requirements for four APIs. The Patient Access API, Provider Access API, Payer to Payer API, and the Prior Authorization API. I'm going to briefly walk through these so you have an idea of what they include. For the Patient Access API, the rule requires impacted payers to include information on prior authorization. All of these APIs exclude any prior authorization data for prescription drugs. I Just want to make that clear. But the data under this API has to be available to patients and it includes individual claims and encounter data, data classes and elements in the U.S. core data for interoperability data set, and specified prior authorization data. The prior authorization data includes the date the prior authorization request was approved or denied, circumstances under which prior authorization would end, items and services approved, the denial reason if any, and provider clinical documentation if it was submitted. The information has to be made available to patients no later than one business day after receipt of the request. It must be updated no later than one business day after any status change. And it has to be available for at least one year after the latest status change.

The second API is called the Provider Access API. It’s intended to facilitate core care coordination and support, the shift to value based payment arrangements. It's not really focused on prior authorization so I'll just gloss over that one. And the same with the Payer to Payer API which is the third one. It’s intended to support continuity of care and has to include claims encounter data but it’s not relevant to prior authorization. And then finally the fourth one is called the Prior Authorization API and it will also go into effect on January 1, 2027. It applies to all impacted payers. Under this API payers must populate a list of covered items and services as well as provide documentation of prior authorization requirements for those services. Payers have to include support for prior authorization requests and responses within that API and they must also communicate whether the prior authorization request was approved or denied and the approval circumstances, denial reason or duration. For all of these APIs, HHS says it will exercise enforcement discretion on payer use of a certain prior authorization transaction standard as long as the payer does use this API. And then finally the rule also includes some improvements to overall prior authorization processes. It requires payers to send prior authorization decisions within 72 hours for urgent or expedited requests and within seven calendar days for non-urgent or standard requests. It also requires a provider notice. All impacted payers must provide specific reason for denial, regardless of method used to send the prior authorization request so that includes facts, e-mail and so on. And it also finally includes some rules around collection and publication of prior

authorization metrics so the payers must start publicly reporting on their websites these metrics beginning of 2026.

Sen. Beverly Gossage (KS) asked where is all of the information on the rules available, and did you say that goes into effect in 2026? Mr. Pate replied the data interchange part is not really in effect until January of 2027 but these earlier changes will start early 2026. So, say March of 2026, you'll see the insurance companies having to start posting metrics on approvals and denials, for example, of prior authorization request beginning at that time.

Rep. Bill Sutton (KS) stated that when they give those breakdowns of approval and disapproval of prior authorizations, is that going to be broken out by subject matter or is that just a gross number that really you couldn't do anything with? Mr. Pate stated that I think there's going to be future guidance issued that really provides the details on that. I don't recall at this time if that information has been provided yet.

CONTINUED DISCUSSION ON NCOIL MENTAL HEALTH PARITY MODEL ACT

Sen. Klein stated that next on our agenda is a continued discussion on NCOIL Mental Health Parity Model Act (Model) and it's in your binders on page 63 and on the website and the app. The sponsor of the Model and Chair of this Committee is Rep. Rachel Roberts (KY) but unfortunately, she's not here today. But this is a model that I know she's very passionate about and looks forward to developing throughout the year. We're not going to be voting on it today as we're still in the information gathering and comment phase and hope we have something ready for consideration by November.

Jess Kirchner, Senior Policy Analyst for the Children and Families team at The National Governors Association (NGA), thanked the Committee for the opportunity to speak and stated that first, on behalf of the NGA and on behalf of Governor Phil Murphy I want to thank you for inviting us here. I think the world is always better when we're all in contact. And the second thing I want to do before I jump into my slides is share that I am absolutely not an insurance expert. I tried this joke earlier, but you're going to get better results if you asked me for medical advice before you ask me for insurance advice. So, I do want to give that caveat here. But I'm very excited to be here. Today, I'm going to talk a little bit about our 2022-2023 Chair's initiative on Youth Mental Health and the development of the Governor's Playbook which was under the stewardship of New Jersey Governor Phil Murphy. Quickly, for those of you that don't know the NGA, we exist to serve the initiatives and priorities of all 55 Governors in the States and territories. It is bipartisan and always has and always will be. I think we beat NCOIL by 60 years or so. We were created in 1908. And we have two primary arms. We have the Center for Best Practices, which is where I sit which is a research and consulting organization that supports the priorities of Governors through technical assistance, long term projects, ad hoc support, peer sharing, and in person convenings. We have 14 different policy areas. So, for those of you that specialize in transportation, I can connect you with my infrastructure team. I sit on the Children Family team, so we touch everything human services. Think childcare, youth mental health, hunger abatement programs, economic mobility, etc. Which is why I'm not an insurance expert. I have a million other things to think about and we also have our government affairs arm which consolidates and collects the feedback from all 55 Governors and works with the federal government to

design solutions that meet state's needs from the top down. So, we are governed in a chaired structure. We have a Republican and a Democrat chair that swaps every year. So, this year our chair is Governor Spencer Cox from Utah and our vice chair is Governor Jared Polis from Colorado. Next year, Governor Polis will be the chair of the NGA.

But the reason that I am here to talk today is because each year the chair of the NGA gets the full power of the NGA to focus on an initiative that's close to their heart. So, they choose an initiative. This year, Governor Cox focused on "Disagree Better" - reducing the political tension divide without reducing disagreement across parties. But last year, Governor Phil Murphy from New Jersey focused on strengthening youth mental health. So, Governor Murphy, who's been a leader on this issue since the beginning of his administration wanted to take it to a national level and involve Governors from both sides of the aisle. Oftentimes we find that youth mental health policy recommendations are viewed or presented in a silo so this initiative was to identify solutions that worked across juvenile justice and child welfare and health human services and schools and then community organizations as well. One of the goals of the initiative was that we didn't want to be too prescriptive with it. We didn't want to be too limited in the scope. We wanted to collect as many recommendations as we possibly could across a number of spaces. And the goal of the initiative was to develop a resource that was immediately useful to new administrations. Something that could be dropped on the desk of a new Governor and set the stage for an agenda for youth mental health in their state. And so, what we did is we developed the NGA Playbook for Governors on youth mental health. I have plenty of copies that I will leave at a desk and I believe it's online as well. And we focused within this playbook across four pillars. We have prevention resilience which is focusing on upstream supports and services. Reducing stigma and increasing awareness of services. Ensuring access and affordability of quality treatment and care. All of those words were very deliberately chosen when we designed our pillars. And then training and supporting caregivers and educators. And so, across those four pillars we worked to identify common pressure points, tension points and state solutions. Because we wanted to collect like I said, things that were actually working and actually happening in the states to help drive change in this space.

So this playbook has 13 policy priorities across the four pillars and across those 13 policy priorities, there are 34 opportunities and under that there's 100a stat examples. What we did create was basically a 50-state scan of what's working in youth mental health across states. Rural, Republican, Democrat, urban, we really tried to come up with a slate of solutions that worked for everybody. So, to do this we hosted a series of four round tables across the country with Governors from both sides of the aisle and hundreds of attendees. And we also hosted conversations with all 55 Governors at our summer and winter meetings and leveraged the expertise of almost 100 thought leader organizations and state leaders themselves some of which will speak after me on this panel providing a lot more context on the insurance piece. But we've been grateful for their partnership and the partnership of several organizations in this room as well. And way that Governor Murphy wanted to approach it was bringing folks to the table as a Governor and I don't have to tell you this as elected officials, you are accountable to every constituent, business and community organization that exists in your state and designing solutions that work in youth mental health requires deliberate and delicate

balance. That includes the voices and interests of everybody relevant to the conversation. And so, what we did is we hosted these roundtables and it was a very similar setup to what is happening here today. But we had Governors and state advisors, we had nonprofit and philanthropic thought leaders, we had private sector stakeholders, service providers, insurers and consultants. And we had federal agencies and youth. And all of their feedback went into development of this playbook.

And so, I'm here mostly to share a little bit about that resource and offer our assistance to you. But before I close for questions, I'll share a little bit about what we learned. Governor Murphy has been a champion of parity since the beginning of his administration but he also recognizes the role that private insurers play in supporting and maintaining this ecosystem of care and the role that they play as major employers in states as well. And I think that's a consideration that's reflected across Governors. In terms of what we're seeing movement on, we're seeing a lot of focus on Medicaid reform. I'm sure the folks after me will talk a little bit more there. Personally, I've seen a big push in drawing down Medicaid and to schools and providing those services. And one thing that's been interesting from our position is that we recognize that states where Medicaid expansion is not a topic on the table or an option or a viable or desirable solution, some of the states that are not or have not expanded Medicaid in that way are some of the most ambitious in drawing down Medicaid into schools. And so, we're seeing a big shift in the messaging on initiatives that are happening in that space and are excited about it. We're also seeing a shift to move upstream as is everything these days, considering how to fund that through public and private insurance. We're seeing Governors in Pennsylvania, Massachusetts and Connecticut also thinking about how to cut through red tape that they have deemed unnecessary to the delivery of service. We're also seeing Governors lean with the power of the regulator. I know Governor Hochul in New York is really leaning into school-based services and leveraging the power of the Insurance Commissioner there as well.

David Lloyd, Chief Policy Officer at Inseparable thanked the Committee for the opportunity to speak and stated that Inseparable is a national mental health policy organization that works on a nonpartisan basis across states and federally to improve access to mental healthcare. And as our name suggests we believe that mental health is inseparable from physical health and well-being. So, today I will be discussing an important aspect of the draft model that Rep. Roberts has put forward and I'll be discussing essentially how we can improve mental health and addiction care by aligning providers and payers around generally accepted standards of care. And I'll discuss more about this concept as we go along. So currently, unfortunately, Inseparable believes that too often for Americans, mental health and addiction coverage and really the system more broadly, not just insurance coverage, is failing to meet Americans needs. We've seen a dramatic increase in needs, particularly among the youth in recent years and this must be addressed by a wide range of stakeholders. But certainly, insurance is a critical piece of the broader puzzle given the important role that health insurance plays in financing healthcare services. So, I wanted to provide just a few examples. So, one in five American adults had a mental health condition in the past year, yet about more than two thirds did not receive any treatment. And additionally, nearly three in four insured adults who received mental health treatment in the past year said they had some problems with their insurance which frankly is too high. So, we want to help address this and make sure that the people can get access to the services they

need. We often find in our experience and hearing from patients and families it's that oftentimes our coverage decisions are made in a manner that frankly aren't consistent with what are generally accepted standards of mental health and addiction care. And that frequently conditions are chronic in nature and require treatment of the underlying condition. And mental health has for a long time been marginalized in our system and we've tended to treat just kind of short-term symptoms and not actually address the underlying condition.

So, recent polling actually demonstrates that these issues are a widespread concern among the American public and that they support increasing access to care. In surveys more than 90% of adults believe that there is a growing mental health crisis in the country. They also believe that expanding access to mental health care should be an important priority through elected officials with more than 60% saying it should be a very important priority. And more than 90% of adults also say that insurance companies should be covering ongoing treatment for what are often chronic conditions rather than imposing arbitrary limits on care. And while Federal parity law has addressed some of these issues, we still think that there are ways that we can improve coverage and ultimately improve health but also reduce costs overall to the health insurance system. So, I wanted to talk just briefly about the alignment of standards that really protects patients, providers and it actually protects payers by aligning around standards of care. We often hear that care is not medically necessary and sometimes, indeed, it's not medically necessary and services shouldn't be covered that are being recommended by the provider. But here I list what are generally accepted standards of mental health and addiction care and I won't read through all these, but I wanted to include them so people got a flavor of what we're talking about that effective treatment requires treatment of the underlying condition, treatment of co-occurring mental health and substance use disorders as well as with co-morbid medical conditions and doing that in a coordinated manner. People should be in the least restrictive and the least intensive setting that is safe for them but also, effective. And that part is often lost in the conversation. We don't want to put people in inpatient care who don't need to be there but sometimes that is necessary. There are also some other really common sense standards of care that we need to consider like the unique needs of children and adolescents and that when we're making decisions on what is the most appropriate level of care and for what duration, it shouldn't be based on arbitrary, predetermined notions of how long it should be for. We shouldn't do 28 days of treatment. It should be based on the individual's needs which again, we think is really common sense.

Mental health and addiction treatment is underutilized and it does lead to higher physical healthcare costs and social costs. McKinsey and Company has done some good research on this and roughly 15% of the total disease burden overall is associated with mental health and substance use disorder, so mental health and addition. Milliman has done some good research and found that mental health and substance use disorder reimbursement is only, at least based on their data, about 5% of the total. So, there does seem to be a little bit of mismatch between the disease burden and the amount we're spending on mental health. Milliman also found that people with behavioral health conditions had between 2.8 and 6.2 higher physical healthcare costs. Yet these people, roughly half of them based on claims data received, had less than $95 worth of mental health and substance abuse treatment a year. So, what's driving the costs are the physical healthcare costs when we don't treat these diseases effectively. Moody's

Investors Service has found that healthcare costs for patients with these conditions are over $12,000 annually on average but only about 8% of the spending for those individuals are for these conditions. And they recommend that in order for insurers to reduce total healthcare costs and improve their competitiveness that they need to invest and honestly spend a little bit more on treating mental health in order to reduce the physical healthcare costs. So, one way of doing this is if states have increasingly aligned providers and payers around high-quality standards from nonprofit clinical specialty associations and the example on the screen is the criteria from the American Society of Addiction Medicine. The ASAM criteria. More than half of states have some requirements now that either commercial insurance or Medicaid use the ASAM criteria for substance use disorder determinations. If followed, it ensures patients get the appropriate treatment at the appropriate level of care for the correct duration of time and it improves quality and really puts providers and payers on the same page to make sure that people are getting appropriate treatment and they're importantly not getting inappropriate treatment. And for mental health conditions there's something called The Level of Care Utilization System (LOCUS) family of criteria from the American Academy of Child and Adolescent Psychiatry, and the American Association of Community Psychiatry. And I should note, United Healthcare, the nation's largest insurer has voluntarily switched to all of these criteria across all of their business across the country in recognition that it creates a common single standard that can align and improve the quality of care. So, essentially, these are elements that are contained in the draft model legislation. I put resources here that link to some of the underlying studies that I referenced.

Tim Clement, Vice President of Federal Government Affairs for Mental Health America (MHA) thanked the Committee for the opportunity to speak and stated that MHA is the country's oldest mental health advocacy organization. We've been around since 1909. We have affiliates in over 40 states and most of your states have at least one of our affiliates in them. I'm going to be brief and I think Mr. Lloyd covered a lot of the points about the model law and what's in it and why that's important. I think one thing that's the most important thing to remember that we all should keep in mind is that every day in this country over 440 people die from an overdose or a suicide. When I first started using those daily figures back in 2017 the number was 245. So, it's gotten almost 200 deaths worse in the last seven years. So, we definitely have a huge mental health crisis and the opioid epidemic which you're all aware of. So, what's important when you have a crisis of that scale is that generally speaking when you're gravely ill and at risk of dying in our country, your insurance covers the treatment you need to survive and then recover. So, it's very important that's also the case for mental health and substance use disorder care that you have insurance coverage and when you have a mental health condition, you're ill, you need treatment and you get that treatment and you survive. But also as Mr. Lloyd mentioned, you need to get the ongoing treatment you need to recover and thrive. So, that's a very important component of why insurance coverage for mental health and addiction treatment is very important and critical. We're not going to solve the opioid epidemic or the mental health crisis if people can't get adequate coverage of their mental health treatment and substance use disorder treatment. And of course, that's only one piece of the puzzle. There's lots of different ways that we need to address both crises and not to imply that it's just about insurance coverage but insurance coverage is important. When you think about it that's how we generally pay for things if you have insurance. That's the bargain we make with you, pay your premiums and you get the

treatment you need when you're ill and you're at risk of dying and being disabled. Another thing that's important to note is that when people don't get coverage for the treatment they need through their insurance it's incredibly expensive for states and municipalities. So, for instance, it's no secret that a substantial portion of jail and prison populations have a mental health condition or substance abuse disorder or often both. Now, of course, that's not to say that's the only reason that contributes to incarceration but when people can't get treatment, oftentimes through their insurance coverage, they'll get treatment through taxpayer funded programs. Or, sadly, they'll end up in jail or prison, which is incredibly expensive. So, making sure that people have the coverage they need is important in saving lives but it's also very important to avoiding I mean, we have the two largest mental health facilities in America – it goes back and forth depending on what kind of survey you look at, it's either the Cook County Jail or the Los Angeles County Jail.

So, that's not how we should be providing mental health treatment, through jails. So, instead of having people with mental health conditions ending up incarcerated, making sure that they can get the coverage they need for the treatment that they need is incredibly important for both keeping them well and also keeping them potentially out of jail and incurring very high costs. And just one other thing I just want to note is that I know one thing that's very important for Rep. Roberts is making sure that people can get annual mental health wellness checks, sort of a checkup from the neck up. And so, that's something that I think is an important feature of the model and something that a number of states have been doing on a bipartisan basis. Making sure that people have a pre-deductible, no cost sharing form of seeking an annual wellness check from a mental health provider, something that generally you can't get right now and it's very important. It's very important to be able to, even if you don't have a diagnosed condition, to make sure you can get that check up to make sure that you don't have a condition and if you do you get routed with the appropriate treatment. So that's a very important component. It's ahead of the curve, it's upstream. As was mentioned before, making sure that you catch the potential illness before it turns into a crisis and spirals out of control. So that's a very important component of any consideration of insurance for mental health conditions is making sure that you can get that annual wellness check which I know is so important to Rep. Roberts.

James Gelfand, President and CEO of the ERISA Industry Committee (ERIC), thanked the Committee for the opportunity to speak and stated that ERIC is a trade association representing large employers on employee benefits issues. Thank you for the opportunity to participate in today's conversation. ERIC has had the opportunity to review the draft NCOIL model. While we support efforts to expand behavioral health access and enhancement parity compliance and in fact agree with many of the points that have been made today, we do have significant concerns about the draft. ERIC's member companies are dedicated to ensuring access to quality affordable mental health and substance use disorder treatment. Since passage of the federal mental health parity legislation employers have worked tirelessly to implement parity for behavioral health services including innovating new approaches and benefits, working to address systemic access issues and driving quality to improve patient outcomes. This has been especially challenging because the federal agencies have defied and ignored Congress. The administration has refused to issue sufficient guidance, illustrative examples, lists of non-quantitative treatment limitations, parity analysis templates and the like. Now, this

may soon change. The federal government is expected, perhaps in the coming weeks, to finalize a new regulation that significantly changes federal parity requirements. To avoid creating disparate requirements between state and federal law, NCOIL should defer any approval of a model act until that rule is finalized and any subsequent litigation is concluded. At that time we hope that NCOIL will ensure any model act approved is consistent with the application of relevant federal law, guidance and sub regulatory guidance. The Model should not go beyond the scope of the Mental Health Parity and Addiction Equity Act (MHPAEA) including by establishing mandates to cover behavioral health services because remember, parity is not a mandate. It is voluntary although every ERIC member company voluntarily does implement parity.

We hope that NCOIL will also acknowledge that systemic issues remain challenging in the behavioral health space due to factors entirely out of the control of employers or insurance plans such as: the national shortage of physicians, including psychiatrists and other behavioral health providers, and a shortage of available, culturally appropriate care; refusal of many behavioral health providers to participate in insurance networks, or to accept insurance at all; concentration of providers in specific urban areas; significant gaps in quality, safety and effectiveness data with respect to behavioral health providers, facilities and treatments; and a national mental health crisis that continues to get worse even as unprecedented funds are invested in behavioral health. All of that being said, we have some specific recommendations on the language of the Model Act. For instance, the Model Act gives too much authority to the lobbying groups that represent providers. I'm sure some NCOIL members object to many of the recommendations that provider societies routinely make. For example, when the American Academy of Pediatrics recommended asking children if their parents had any guns at home, or when the American College of Obstetricians and Gynecologists recommended that COVID vaccines be pushed on pregnant women. Or perhaps some of you may take issue with the guidelines from behavioral health provider groups related to gender dysphoria or puberty blockers. Or the intersection of mental health and abortion. I bet all of you on both sides of the aisle can identify examples where the guidelines put out by some of these groups are objectionable to many of your constituents. These groups should not have so much say in the definition of generally accepted standards of care, utilization review criteria or the like. But there are other authorities with expertise that can be relied upon so the draft should be less prescriptive in terms of defining that and the act should tighten the definition of providers as well. While we do applaud the drafters for not including equine therapy, wilderness therapy or retail therapy professionals we don't think that art therapy should be included here either.

The utilization management requirements are unduly burdensome. The draft requires review of denial and appeals by a professional with the same education and experience as the provider requesting the authorization. We believe that this language would either create a provider credentialing arms race or would simply make it unfeasible for a plan to conduct responsible utilization management. As plan fiduciaries we object to that. The draft's language on medications mirrors failed federal legislation drafted by big-phrma. The draft bans medical management, such as prior auth, step therapy, mandates all products being the lowest tier of a drug formulary and disallows requirements to engage in counseling or other services. We believe this section will create a financial windfall for branded phrma companies, crushing generic and biosimilar competition in these therapeutic areas and will jack up health insurance premiums for working families. We

also oppose inclusion of civil monetary penalties for parity violations. This is a highly partisan, failed policy that was proposed as part of President Biden's Build Back Better legislation but ultimately deemed too radical, even for a bill intended to pass with only the votes of one party in Congress. Simple monetary penalties will not solve any of the problems listed above but they will create perverse incentives for regulators and the plaintiffs' bar and rather than encouraging cooperation and compliance assistance we have numerous other recommendations related to certain minutiae but these are our big picture recommendations in order to create a successful state level parity regime that properly aligns with federal law. Remember that the more complicated, prescriptive and onerous the requirements the more it will raise costs for plans and ultimately price some small businesses and families out of coverage. So, it is in the best interest of legislators, regulators, employers, plans and patients and providers to pursue a parity framework that is reasonable, that promotes compliance over punishment, that strikes a balance between access and affordability, and drives quality not just quantity of care.

Sen. Lana Theis (MI) stated that I actually have a few statements and then a question. Nowhere else in medicine has the increased focus and increased application of the medicinal treatment created such an expansion of the problem as opposed to an expansion of the solution and I have major concerns with the lack of transparency with respect to the androgenic harm and the lack of psychotherapist expressing that in advance. It should be required as with all medical treatments, that should be a mandate. The idea that it should go on ad infinitum is not evidence based. You should definitively have a plan for what good looks like upon the first meeting and then be able to reach that and it sounds like that's not something that you're aiming at. You want an indefinite amount of care. There's no place else in psychotherapy where, up until ten minutes ago, where you would expect there to be a relationship between the psychotherapist and the patient. And now we're putting it into the schools, where it's not only between the therapist and the patient, it's also with respect to their educator. If you want to know how to add stress to a child, to an interaction what you do during the test is you add observation. And that stresses and creates anxiety to the person who's being observed. And now we're going to do that in our educational system where our children already can't read. So, I have major issues with this particular approach. I understand and agree that there is a mental health crisis. I will agree with that. I am fundamentally disagreeing with the solutions that are being proposed at this point in time and I would ask that you come back with some answers. And so this is where I'm asking you, do you require of your providers that they define the iatrogenic harm upon the first meeting? Whether it's to the child or to the parent of the child or to the patient if an adult. Do you require that they provide that and that they provide what good looks like upon the first meeting? Is that part of your plan of care?

Mr. Clement asked do you mean the provider should list any potential harms with medications? Sen. Theis replied yes. Mr. Clement replied absolutely, that's part of the medical standard. That's part of the Hippocratic oath. Sen. Theis stated I have yet to find one that does so if that's a standard I'd certainly love to see it. Mr. Clement stated that I think that if you're a psychiatrist prescribing medications they can have side effects or increase suicidal ideation potentially, you have to disclose that to the patient. Sen. Theis replied not medications, treatment. The psychological treatment itself. Not the medications, the treatment itself provides iatrogenic harm to a certain number of people and they're not informed in advance of what that looks like in order to be prepared for it

and to respond to it and to tell their provider this is causing more harm than good, can we go a different direction? Mr. Clement stated I'm not a provider but I would agree. I think that any harms that could potentially result should be disclosed right away up front to the parent and the child in question and I think that without disclosing potential harms, I think that's a harm in and of itself. So, I do agree that any harms should absolutely be disclosed. I don't think anyone would suggest the provider should be hiding what could be a potential harm to the child, to the parent, to the family unit. So, I do think it is important that any harms are disclosed, potential harms. And yes, the idea that there should be a plan, that's a big component of a lot of insurance utilization review. You have to have a treatment plan. You have to have a road map for what's going to work and if it's not working, you have to change it and that's something called measurement based care as well. So that's something we highly support. We don't want people just to give treatment and say well I hope it works. We want them to give treatment with specific goals and then also if those goals aren't being met, adjust and adapt the treatment.

Sen. Theis stated can you speak to the problem of there not being a wall of separation where now the child has a relationship with their therapist, a relationship with their teacher who's talking to their therapist and that's never actually happened before and how that actually adds to the anxiety potentially of a child. What do you plan on doing to overcome that? Mr. Clement stated that I don't work for a provider organization but I don't think that you should have inappropriate relationships between the parent and the therapist and withholding information from the child. But I do think parents have a right to know about the treatment their child is receiving, though. I think that is important. I think it's always important that parents be kept in the loop about the treatment of their child. Sen. Theis stated that I wasn't speaking to the parent and the therapist. I'm speaking to the child and the therapist. The child at school being observed by their therapist and their teacher and then interacting at school with the therapist, we're talking about paying schools to help provide therapy. Mr. Clement stated this model act doesn't address anything that's school based. It's just about insurance coverage. Sen. Theis stated that Ms. Kirchner spoke to providing funding to schools in order to provide this care so that's where I was going with this. Mr. Clement stated that I think that might be Governor Murphy's initiative. That's not related to this model act.

Sen. Gossage stated that I just want to follow up from what Sen. Theis said. Since we passed in most states mental parity laws years ago, has any data been produced on how much premiums have gone up because of that? Mr. Lloyd stated that under the federal parity law, plan sponsors do have the ability to get an exemption from complying with the law if they can show that premiums increased as a result of compliance. To my knowledge, no plan sponsor has ever received such an exemption or applied for such an exemption. And there's no evidence to my knowledge that mental health parity has increased costs and I think this is in part because as the data that I presented suggests that when you're actually investing in mental health and addiction treatment, you're often decreasing other physical healthcare costs.

Sen. Gossage stated that I happen to be one of the Senators that doesn't like the word invest. It's because that usually means pay a lot of state dollars and a lot of taxpayer dollars. Let's invest in this or that. However, here's why I'm concerned. I've been a health insurance and life insurance agent for 20 years in nearly half the states. And I

can remember when mental health parity started being added in the states and in our state one could have chosen that as a rider. You would pay between 15% and 20% more on your policy if you wanted to add mental health to your plan. But we now know that the expense of the premium has gone up so much due to that. And it's partially because of what was just said here and that is so oftentimes the care never ends. When it comes to physical therapy or any other physical health insurance plan, you must continue to show improvement, otherwise they will stop whatever the services are. I'm sorry we can no longer do physical therapy because we cannot continue to show that you are improving. So, I share the same concerns. Of course, we want folks to have mental health that need mental health. Absolutely. But the medications have become so expensive. The therapies have become so expensive. But what we usually see from the providers is well then the state should pay for it or somebody should pay for it because these people need that. But every time you raise premiums, then you cause people to become uninsured or not being able to insure their families, especially on private insurance. And I agree we have seen more folks now that are needing mental health and all of this has been helping. Why are we seeing the problem grow? And that's a bit of a rhetorical question. I know that was already answered here. But we find that as legislators in our states that it's we need to invest more. But if we don't see a return on that investment, that's when there is an issue.

Mr. Clement stated that we definitely don't want you to invest any state dollars on this. This involves no state spending. We want insurance coverage. And to address your point about the ongoing treatment, you're right - there shouldn't just be indefinite treatment that goes on forever where you see a psychologist once a week for the rest of your life. That's definitely not something we support. We don't support people getting treatment for the rest of their lives because they have just regular life issues that are coming up. We do think, as was said, that there should be clear goals for treatment. These are the outcomes you have to receive to continue getting that treatment. We don't want some blank check to providers. That's not what we want. We want accountability.

Rep. Forrest Bennett (OK) stated that I appreciate all the presenters and this is a complicated issue. To respond to Mr. Clement, I see a therapist because I'm in the legislature and I think we should all do that and I will until I'm not in the legislature anymore. And I don't necessarily think that it's a terrible idea for some folks to see somebody once a week and just talk through their problems. I'm dealing with an Alzheimer's diagnosis in my family and I always ask my therapist for silver bullets to fix my problems. And he says, unfortunately, sometimes all you can do is talk about it and he connects me with a support group. And that has been helpful. In some cases mental health solutions are just being able to talk to somebody who can be helpful to you. In other cases, the mental health treatment needs to be tailored to the individual based on what they've gone through and what their body chemistry is. To Mr. Gelfand's comments I would say politicians love to point at things we've invested in and say we haven't received that ROI that some expect. The problem being that politics is so fraught with folks who think they know about how to address issues like this but they have no subject matter expertise. They just have talking points based on kind of what their echo chamber is. You went through a diatribe of different treatments that based on your comments, seem like you don't necessarily believe in them. I remember you saying, for example, wilderness therapy, and I think that that was a bit tongue in cheek.

But the reality is for some folks, that does help. And when we talk about investment and this sort of black and white, we put X number of dollars in and why aren't we getting these results? I think sometimes the problem is and I know I'm saying this at a national place where we put model legislation together, but there needs to be some flexibility. There needs to be an ability for the provider to create a plan that works specifically for that individual. We do this in education with individualized educational plans (IEP's). Why don't look at mental health treatment the same way? I don't understand. Equestrian therapy may work for some folks. We have a former President of the United States who famously seems to be doing well because of art therapy. So, my question to you and to all the panelists is how do we strike a balance between finding something that can be relatively easily adopted from state to state, but also provides the flexibility for providers and their patients to work together without guardrails that politicians who like myself, frankly do not have the subject matter knowledge outside of talking to the very intelligent people in this room about how these things work. And I say that with all respect to myself and my colleagues. I think that sometimes we need to let our egos take a back seat to experts. We have politicized the hell out of mental health especially as a result of COVID and all that. How do we strike that balance? Ms. Kirchner, you work with Governors, Republican and Democrat, and they have to strike a balance between what Democrats think. And I'm a Democrat in Oklahoma. So, I know very much how it is to try to craft a message that works for my colleagues. Do you Mr. Gelfand believe that there is room for innovation in mental health treatment? And to all of the panelists, how do we strike that balance between bringing stuff back to our state that's relatively easy to implement and, providing that balance and that flexibility for the patient and the provider to craft a plan that works for them?

Mr. Gelfand stated that I think we're largely in agreement here. The point of my comments were that there may someday be data that shows that glamping in the woods is an effective treatment. Or that equine therapy is an effective treatment and is valuable. That data is not there today and it's not there today for art therapy either even though we may have specific examples of individuals who are helped. And as such, our view is that the draft is overly prescriptive in saying this kind of provider must be covered. So, what we were saying is that there should be flexibility rather than having the government say this is who the plans must pay to do this.

Ms. Kirchner stated that I will just quickly clarify the NGA when we talk about these policies we endorse state flexibility and the power of the Governor to determine the best pathway for their state. We can highlight best practices based on state testimony but we don't want to come up here and say that one policy is the silver bullet or anything like that. We endorse the power of the Governors to identify a pathway that works for their unique environment. I'm actually working with the Oklahoma team on a policy academy youth mental health project as well so I understand the dynamics here. I would say just speaking to the balance piece, at least at the gubernatorial level the one thing that we did learn is that there is a lot of alignment between Republicans and Democrats. It's about identifying a shared problem and similar approaches to solutions. I think the thing about this issue is that there's always going to be some burden somewhere and so it's about bringing voices to the table to determine what is a reasonable amount of burden, financial, administrative, etc. And so we've seen Governors do that through like what Governor Murphy did through task forces, commissions, etc. Which I know can be a little bit of a well trodden thing, the idea of another commission, another task force,

another working group. But I will say, at the gubernatorial level we're seeing a lot of alignment on agreements of issues and differences and problems in messaging. So, I would say that messaging been particularly resonant across our level and so as it pertains to your work identifying at least a shared problem to start is important.

Mr. Lloyd stated that I think we have to be guided by the evidence and research and ensure that that it is peer reviewed. And I would agree with Mr. Gelfand about being guided by data. I think that's critical. There is a lot of data that shows mental health and addiction treatment does work. It is often effective. Is it always effective? No, but for few healthcare conditions is treatment always effective. So, I think we have to be insisting on good data and guided by evidence and peer reviewed research that really illustrates what's effective. Because that will change over time. And I think the provisions in the model are really designed to capture that evolution of what is evidence-based care over time? Because that will change as we learn more. Mr. Clement stated that my heart goes out to you as my mother died from Alzheimer's three years ago. It's very tough. But yes, I think flexibility is the name of the game and following what the research says. And in some instances, seeing a therapist every week is appropriate. I have a friend in the Philadelphia area in his 70s. Schizophrenia was first diagnosed in his 70s. He sees a therapist every week because if he doesn't he ends up in the hospital. And so that's of course in addition to the medication he takes. But for some people, yes that is going to be necessary and the proof of that is that if he doesn't do it, it's a worse outcome. I think echoing Mr. Lloyd, we ought to follow what the research says. Things are going to change. Maybe one day, as Mr. Gelfand said there will be very strong therapy evidence for wilderness therapy and equine therapy. But I think that something that we want to make sure is in place is there is that flexibility and you want to follow things to make sure what we're doing works.

Rep. Bennett stated that I've tried different medications for different things but therapy ends up working better for me. For some folks, you're diagnosed with depression and anxiety but it ends up being attention-deficit/hyperactivity disorder (ADHD) and so these proven methods that we know are proven and have therefore been deemed eligible to be paid for by government money for folks who can't afford it themselves it turns out that individual may have been misguided in going down that path. And so I guess the point of this is we have these tried and true treatments, so to speak but now we're learning that for some folks it's actually the wrong way. And they may have gone years down the wrong path. My father-in-law took the wrong kind of medication for a long time and is now dealing with those consequences. And it was a treatment that for someone else who had been properly diagnosed was the right treatment. On the other end of this we have these treatments that some people consider to be ridiculous but other people would swear by. And so I guess my question is how do we get to acknowledging that all of the above approaches are right? And getting policymakers to be willing to and I hate to use the word invest again, but put money towards these treatments so that they can be established as tried and true methods for some and not others. And to answer my own question a little bit I know that we need to educate ourselves. But anyone who wants to respond to that I'd love to hear it.

Mr. Clement stated that I think you're right, some treatments that will work for one person don't work for another. And then the treatment that doesn't work for somebody like your father-in-law, that is the right treatment for others. And I think one thing we need to be

careful of here is we don't want to get too prescriptive as we're not prescribing treatment methods, we're talking about insurance coverage. Which is about treatment, of course. But, I think that's something that we need to leave room for the treatment community to make sure that there are those best practices here and even they learn from their mistakes. And I think that's the biggest thing to do when you have behavioral health treatment is make sure we learn from what didn't work and why it didn't work and see if we can get better in the future.

Rep. Ellyn Hefner (OK) stated that this is a discussion that I I'd like to look at in a different way of sort of turning it about not the treatment here it is and this is for you, but what supports do you need? And that's where we get into that individualized piece which is definitely hard to make a model law about when some of these things don't work for everybody. My comment and something that I'd like to talk about and hopefully maybe get a response to is something that I see in my world, I've been an advocate for adults and kids with disability for 20 years. And dual diagnosis in our world is intellectual developmental disability and mental health and I didn't hear the playbook including the voices and interests of them. I'd like to start talking about disability if we could include those people that know about disability and those needs so we cannot leave it as an afterthought. Because the afterthought now is if a parent has a child with a disability and mental health because you have behavior, they end up in an emergency room which puts on stress and also goes against the Americans with Disabilities Act (ADA). What are your thoughts about maybe some of what you do in your work to include people that have that dual diagnosis so that we don't always have to be in the outside in the emergency room putting the burden on parents? Or maybe out of state because we don't treat it in state? Mr. Clement stated that I think you're speaking to a very important and overlooked fact is that individuals, particular individual's with intellectual disabilities, have a higher prevalence of mental health conditions. And yet, that's almost swept away, as if those individuals don't get mental health conditions, it's just a symptom of their intellectual disability. And that's not true. And also, substance use disorder too, there is a much higher prevalence and that's something that is often overlooked in the mental health advocacy world. And I think you're right to bring attention to that because individuals with intellectual disabilities and other disability developmental delays, they have mental health conditions. They can have anxiety. They can have depression. It's something that you can't ignore and forget about so I thank you for bringing that up.

Sen. George Lang (OH) stated that as you heard from some of my colleagues some concerns, I also share some very serious concerns with this legislation. Like Sen. Gossage, I also have my life and health license for over three decades. I believe between the four legislators here from Ohio, we probably have over 100 years of experience in the industry. I also have a very unique experience that I actually own a captive insurance company that we recently relocated from the Bahamas to Tennessee. And the reason we picked Tennessee is we looked at every state that was friendly to captives and they were far and away the most friendly and we were able to come here and maximize what we can do for our insureds at a greater rate than we could at any other state. My concern with this legislation is we're putting the cart in front of the horse. I think we would be mistaken if we had standards more onerous or more extreme than the federal government. Because keep in mind the standards we put in only affect the little guys. The large self funded companies, they can discriminate any way they want as long as they don't discriminate in favor of the highly compensated. So, my concern is

we're going to be putting an undue burden on the little guys. And I saw in one of the presentations some of the folks that said this is actually going to lower the cost. I would love to see an actuary from one of the plan providers come in and provide us with that information. I believe that if it would lower the cost, plans would already be doing that. And we've all been around for a long time and we have all been told put this in and we're going to see costs go down in health insurance, in Medicare, and Medicaid. And it's never once happened. Now there may be reasons why that's happened that aren't germane to the plans we put in but costs just continue to rise. So my question is, if we have a cost that the little guy has to bear that the self funded guys don't have to bear we are putting those big companies at an extreme competitive advantage when it comes to recruiting and at least in the state of Ohio right now the number one issue with every company, every category, every sector, is workforce development and now we're going to force the small guy to pay more potentially than the big guys are paying. How do we tell the guys, hey, our regulations are more difficult than the federal government and it's going to cost you more money?

Mr. Gelfand stated that I was going to share in a later presentation today that in a recent poll by the Small Business Majority that represents those small guys, they found that 25% of their members are considering dropping coverage today because they already can't afford to provide the coverage based on the prices and that's before a new parity act would be imposed upon them. I also agree with you that as employers, we're always told by every kind of vendor, legislator, activist, whatever it is that what we want to do in the long run it saves money. So, we should definitely do it. And it never actually does save money. In this case, we don't offer mental health coverage with the intention of it saving money. We know that it's costlier. It's an investment that we're making. We do so because it's the right thing to do. I don't have stats on quantifying what that cost is but I'd be happy to follow up with NCOIL staff and share some actuarial stats with you.

Mr. Clement stated that I'll follow-up with actuarial data because Milliman has done a number of studies that show that if behavioral health coverage was increased you would see costs savings. But I do think part of the issue here though is we've never seen mental health treatment covered to the way it should be so we've never had the opportunity.

Sen. Lang stated that I appreciate that and please do follow up with that information. And as part of that follow up, I'd like to know how many of the insurance providers that Milliman represents as well. That would be very helpful. Mr. Clement stated that they do parity compliance work for a lot of the insurers.

Rep. Deborah Ferguson, DDS (AR), NCOIL Immediate Past President, stated that I really just have more of a comment maybe to bring a little balance from the healthcare side to this conversation. I'm certainly for evidence-based medicine but I do think there's still a lot of discrimination in the mental health and substance abuse space that we don't look at it like we look at physical health which it is a part of total health. We look at people who have high blood pressure, they're diabetic, they have high cholesterol, they have chronic conditions. And we don't expect that they're not eventually probably going to have a heart attack or a stroke but we treat them chronically hoping to delay that. Or to delay a crisis episode. I think we have to look at mental health the same way. I'm not sure that it will save money. I'm not sure that treating people for diabetes saves money

in the long run. But I think we make a real mistake when we try to separate it from physical health because it is part of mental health. And when you treat these people chronically you're going to have to treat people with mental health and substance abuse as chronic patients. You are going to save money by keeping them out of the emergency room and from having a crisis. But I think that's a real mistake that I see a lot of people try to look at it as a separate issue than total health.

DISCUSSION AND CONSIDERATION OF RESOLUTION REAFFIRMING SUPPORT FOR THE U.S. STATE-BASED SYSTEM OF INSURANCE REGULATION IN RESPONSE TO GROWING FEDERAL ENCROACHMENT (Resolution)

Sen. Klein stated that we are going to then move right along to a discussion and consideration of a resolution reaffirming support for the U.S. state based system of insurance regulation in response to growing federal encroachment. And you can review that in your binders on page 71. And I'll turn things over to NCOIL President, Rep. Tom Oliverson, M.D. (TX) who is sponsoring the Resolution alongside NCOIL Vice President, Asw. Pam Hunter (NY).

Rep. Oliverson stated that this is a pretty straightforward resolution, but very important to us and the work that we do. If you're new to NCOIL, you probably don't know that one of the organization's primary missions is to preserve the state based system of insurance regulation as established by the McCarran Ferguson Act of over 70 years ago, and confirmed by the Dodd Frank Act of the early 2000s. From time to time, however, federal and international authorities attempt to encroach on the system despite the fact that it has produced the largest and most successful insurance market in the world. And that is why NCOIL always needs to be on the lookout for actions that intrude upon the state-based system of insurance. And unfortunately, we've seen a rash of those pop up in the last few years and they are set forth in the resolution as listed on page 71 to 72 of your book. And there are frankly more that could have been listed. So, this bipartisan resolution will be delivered to all the relevant members of our federal system just to remind them of what federal law actually says with regards to the state-based system of insurance regulation and that we and our friends at the National Association of Insurance Commissioners (NAIC) are charged with maintaining and preserving and protecting that system and that they should let us do our job.

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

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Gossage and seconded by Sen. Lang, the Committee adjourned at 12:45 p.m.

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CHIEF EXECUTIVE OFFICER: Thomas B. Considine

PRESIDENT: Rep. Tom Oliverson, TX
VICE PRESIDENT: Asw. Pam Hunter, NY
TREASURER: Sen. Paul Utke, MN
SECRETARY: Rep. Edmond Jordan, LA

IMMEDIATE PAST PRESIDENT: Rep. Deborah Ferguson, AR

National Council of Insurance Legislators (NCOIL)

Mental Health Parity Model Act

Sponsored by Rep. Rachel Roberts (KY)

Draft as of June 18, 2024. 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.

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National Council of Insurance Legislators (NCOIL)

Resolution in Support of Establishing Catastrophe Savings Accounts

Draft as of June 18, 2024.

To be introduced and discussed by the NCOIL Joint State-Federal Relations & International Insurance Issues Committee on July 18, 2024.

****Sponsored by Rep. Matt Lehman (IN); Sen. Walter Michel (MS); Rep. Ellyn Hefner (OK); Rep. Carl Anderson (SC)***

WHEREAS, the National Council of Insurance Legislators (NCOIL) fully supports the state-based system of regulation for property/casualty insurance coverage, and NCOIL supports states continuing serving their role as sources of innovation with respect to property risk mitigation and management; and

WHEREAS, recent events have demonstrated that no state is immune from natural disasters, whether floods, wildfire, wind (hurricanes, tornadoes, convective storms), earthquakes, winter storms or other events; and

WHEREAS, a natural disaster in one state can have far-reaching consequences there, and in other states and regions, making the need to address natural disasters a national concern; and

WHEREAS, NCOIL believes that a multi-pronged approach to address natural disaster risk is essential and that such an approach should leverage private-market options and personal responsibility against the need for public-sector exclusive involvement and believes further that the promotion of financial resiliency with respect to natural catastrophes benefits states, counties, local communities, consumers, policyholders and the federal government; and

WHEREAS, NCOIL has long asserted the importance of mitigation in helping to reduce insured and uninsured losses stemming from a natural disaster and has adopted several resolutions and model acts in support thereof including a Model State Uniform Building Code; and

WHEREAS, NCOIL recognizes that several states have enacted to date legislation that support the establishment of tax-advantaged "catastrophe savings accounts", e.g. Alabama, Mississippi and Sount Carolina, and that those accounts are intended to assist consumers/policyholders in paying for expenses incurred or related to a major natural disaster, like deductibles for homeowners, flood or earthquake policies and covering various natural disasters and events; and

WHEREAS, catastrophe savings accounts function similarly to Health Savings Accounts (HSAs) which are tax- advantaged accounts that help defray the high cost of health insurance and HSAs have proven effective in that regard, with over thirty-five (35) million account owners in the United States; and

WHEREAS, NCOIL has previously gone on record specifically in support of the then-proposed federal bill, the Disaster Savings Account Act of 2013, by action of the Executive and Property-Casualty Insurance Committees on July 13, 2014, via a Resolution sponsored by Representative Matt Lehman of Indiana; and

WHEREAS, the use of homeowner catastrophe savings accounts would reduce what governments, federal or state must pay following a natural disaster, to the potential benefit of both taxpayers and policyholders; and

WHEREAS, NOW, THEREFORE, BE IT RESOLVED, that NCOIL urges states to take action and pass legislation that would permit consumers to utilize tax-advantaged catastrophe savings accounts that fosters pre-event mitigation and post-event recovery by accumulating funds that can be used to supplement their insurance coverage and offset the costs of remediation and repair, and to otherwise protect their personal, family or household dwelling; and

WHEREAS, NOW, THEREFORE, BE IT FURTHER RESOLVED, that NCOIL urges adoption of federal legislation amending the Internal Revenue Code to support the establishment and use of such catastrophe savings accounts by authorizing a consumer to set aside funds on a tax-advantaged basis into such an account to make their homes more disaster-proof via a specified dollar amount or range per contribution per annum; and

WHEREAS, BE IT FINALLY RESOLVED THAT, a copy of this Resolution shall be sent to the Chairs of the Committees of insurance and tax/revenue jurisdiction in each Legislative Chamber in each state; and each State's Insurance Commissioner and Taxation/Revenue Commissioner or similar officer; other state legislators, regulators, and governors; to Congressional leadership; the Internal Revenue Service (IRS); and to the Federal Emergency Management Agency (FEMA).

HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
2024 NCOIL SPRING MEETING – NASHVILLE, TENNESSEE
APRIL 14, 2024
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee met at The Sheraton Grand Nashville Downtown Hotel in Nashville, Tennessee on Sunday, April 14, 2024 at 9:00 a.m.

Representative Jim Dunnigan of Utah, Chair of the Committee, presided.

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Rep. Deborah Ferguson, DDS (AR)
Rep. Matt Lehman (IN)
Sen. Beverly Gossage (KS)
Rep. Edmond Jordan (LA)
Rep. David LeBeouf (MA)
Rep. Brenda Carter (MI)
Sen. Lana Theis (MI)
Sen. Michael Webber (MI)
Sen. Paul Utke (MN)
Rep. Nelly Nicol (MT)
Sen. Bob Hackett (OH)
Rep. Brian Lampton (OH)
Sen. George Lang (OH)
Rep. Ellyn Hefner (OK)
Rep. Tom Oliverson, M.D. (TX)
Sen. Mary Felzkowski (WI)
Del. Steve Westfall (WV)

Other legislators present were:

Rep. Peggy Mayfield (IN)
Rep. Patrick Penn (KS)
Rep. Bill Sutton (KS)
Rep. Michael Sarge Pollock (KY)
Rep. Jerry Neyer (MI)
Rep. Bob Titus (MO)
Sen. Natasha Marcus (NC)
Del. John Paul Hott (WV)

Also in attendance were:

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

QUORUM

Upon a Motion made by Sen. Mary Felzkowski (WI), 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 November 16, 2023 meeting, and the minutes of the Committee's January 26, 2024 interim meeting.

THE STATE OF HEALTHCARE COST TRANSPARENCY REQUIREMENTS (INCLUDING CONSIDERATION OF RE-ADOPTION OF NCOIL HEALTHCARE COST TRANSPARENCY MODEL ACT)

Rep. Dunnigan stated that today we're going to start our discussion on the topic of the state of healthcare cost transparency requirements. To provide a little bit of background, in 2019 NCOIL adopted a healthcare cost transparency Model Law which you can view in your binders on page 269 and on the website and the app as well. The model requires drug manufacturers, pharmacy benefit managers (PBM's) and health insurers to report certain cost related information to the Insurance Commissioner. And then that information is made public on the Department's website. Per NCOIL bylaws all model laws must be readopted every five years, or else they sunset. Given the importance of this topic and the constant state of change in the overall healthcare marketplace we're going to use the model being up for readoption as an opportunity to discuss the innovations and trends in the drug pricing and healthcare cost transparency arena since 2019 in an effort to see if any changes to the model should be considered or if it should remain as is. Before we go any further, I'm going to turn things over to the NCOIL President and sponsor of the model, Rep. Tom Oliverson, M.D. (TX).

Rep. Oliverson stated that I'm very pleased to see the progress that we've made on price transparency and pharmaceuticals since this model was first adopted. It's clearly struck a chord and I know for a fact that in Texas it has more than served its purpose in terms of informing legislators about what the ultimate disposition of rebates are and providing some clue as to why prices suddenly go up and things like that. And so, I feel like it's been a very good and informative model and we certainly have more information to make better decisions than we did five years ago. With that being said, I would like to offer one technical amendment which I believe you have in front of you. And all it does is clarify that what we're talking about here are health carriers, health insurers and we were not intending to loop in workers compensation or automobiles, or personal injury policy coverage. So, that's just a technical cleanup that was brought to me ahead of time before the meeting that I have agreed to take, assuming the Committee is good with that and so I look forward to hearing from everybody today and I'll turn it back to you, Mr. Chairman. Rep. Dunnigan stated that he wanted to mention that the Model or something substantially similar to it has been adopted in 16 states.

Lisa Joldersma, Strategic Advisor at Avalere Health thanked the Committee for the opportunity to speak and stated that Avalere is a health policy consulting and analysis firm that has been advising clients across the healthcare market for more than 25 years. We do not lobby. And we aspire to be a neutral voice among stakeholders by publishing fact based timely insights into state and federal health public policy deliberation. In recent years, of course, many of these deliberations have centered on ways to lower prescription drug costs for payers and patients. State policymakers like yourselves have, of course, prioritized legislation to increase drug price transparency through

mandatory manufactured reporting of pricing information or advanced notification when prices increase above the specified amount year over year. Some states have pursued a more holistic approach, like the NCOIL model that includes reporting requirements for health insurers and PBMs. While difficult to name a single cause for what impacts a market, we have seen moderation in price increases in recent years and we do think that this is in part because of the reporting that would be triggered in the case of a price increase. For example, the Medicaid program explained in a 2020 report that compared to 2016 there was a 79% decline in the number of drugs reaching the states per year price increase reporting threshold. The program report concluded that fewer manufacturers are excessively increasing the price of drugs.

Similarly, Oregon's transparency program reported that compared to its first year of implementation in 2019, the program received 70% fewer reports for price increases in 2020. However, during that same time, Oregon saw a 15% increase in the number of drugs with high launch prices. And that's another matter to keep in mind here. Vermont and Oregon's findings align with what drug pricing researchers have found generally which is from 2016 to 2020, the amount of wholesale acquisition cost (WAC) price increases among brand medicines have declined. Federal penalties that have been enacted more recently, including inflation penalties in Medicare and removal of the cap on rebates and Medicaid could also further bolster the trend. Earlier this year, a pharmaceutical pricing analysis by 46brooklyn Research reported fewer brand drug pricing increases taken in January of 2024 versus prior years and even noted some drugs had taken price decreases. The analysts characterized 2024 as quote “a noteworthy departure from the norm”, marking a significant shift in the statistical trends since 2012 when they first began tracking prices. Focusing on these trends, of course, does not address prevalent concerns with the launch prices of newly approved medicines or with generic drug pricing increases and shortages. Transparency legislation historically has impacted brand manufacturers, more so than generics and existing products rather than newly approved products. The same can be said about the federal approach to negotiating prices and Medicare. It remains to be seen what options the market and/or policymakers may advance to address these additional issues. One thing is clear, however, and that is that patient groups become extremely concerned with policies targeting the new products that may represent their hope against untreated diseases. And we saw that play out, for example, in Colorado last year when they declined to declare a breakthrough product for cystic fibrosis unaffordable and that was in large part due to extreme patient concern. In sum, the evidence suggests that transparency measures have had an impact on brand drug price increases year over year. Sunlight on PBM and payer practices is more recent but also gaining momentum. It may have a more direct impact on patient cost for medicines going forward.

Scott Woods, Vice President of Policy and Research at the Pharmaceutical Research and Manufacutrers of America (PhRMA) thanked the Committee for the opportunity to speak about prescription drug pricing, transparency and improving patient access to medicines. PhRMA has been a longtime supporter of meaningful transparency, that is transparency that helps patients, employers and other stakeholders make better decisions in the marketplace without infringing on the ability of the private marketplace to operate efficiently. And second, we've supported efforts to improve transparency throughout the supply chain. I want to thank NCOIL and Rep. Oliverson for their leadership in adopting this model back in 2019. It has set the bar high for accountability

and transparency throughout the supply chain. And as Ms. Joldersma mentioned, many states since that adoption have passed various transparency measures, some focused on just manufacturers, some focused on other parts of the supply chain. But really, we've seen many states that have taken on more comprehensive measures and in fact Congress which oftentimes follows the lead of the states passed The Lower Costs, More Transparency Act in December 2023 which actually looks fairly similar to the NCOIL model in that it looks at entities across the supply chain. Now as we look at what has happened in the marketplace and as you're considering action in this space, I just want to point out a couple of facts and figures for you to keep in mind. At the macro level, spending on prescription drugs accounts for just 14% of total healthcare spending in the U.S. And this comes from the National Health Expenditures survey that's conducted looking at not just prescription drugs but costs for providers for durable medical equipment, all sorts of things. Everything that goes into the pot in terms of healthcare spending in the U.S. And I think what really illustrates that the prescription drug market is working the way as intended is that throughout the course of this decade we expect, and this is not just PhRMA's analysis this is IQVIA's, that spending on both retail medicines that you get at your corner pharmacy and non-retail medicines, some medicines that you get at the physician's office or in a hospital or other type of facility, t's projected to remain relatively stable throughout the decade. And an analysis that was conducted looking at the Medicare Part D program, which is the part of Medicare that provides prescription drug benefits to seniors and those with disabilities, found that the vast majority of Part D spending is for medicines that have competition, whether that's brand-on-brand competition or brands with generics. So, the market is working.

So, now I want to shift slightly to talk a little bit about where we at PhRMA have been focused and where we've seen a lot of state action and federal activity in recent years, and that's on patient cost sharing and access to medicines and what transparency really helps us to see where there are some issues in the healthcare system. So many of these types of panel discussions can turn into a food fight between industries and we can lose focus on what really matters most and that is patients, your constituents. And I'm sure across the country in hearing rooms and around tables you have probably been confused and somewhat frustrated at times wanting to just get the answers to why patients are struggling at the pharmacy counter and I would say that a principal reason for that is that there are many entities in the supply chain that have an impact on the cost of prescription drugs at the end of the day for the patients and one major entity are PBMs. Our friends at the Pharmaceutical Care Management Association (PCMA) will say that it's PhRMA that sets the price of drugs and that's the end of the story but really PBMs and insurers play a really key role in determining whether a medicine is covered by an insurance plan and how much the patient is going to pay out of pocket for that. Is it going to be on a lower tier or is it going to be on a higher tier? Are there going to be various access barriers? Are there going to be prior authorization or other types of utilization management - fail first or step therapy that a patient is going to have to encounter as they are trying to get access to their medicine? And the top three PBMs, I'm sure you all know this statistic very well, CVS Caremark, Express Scripts and Optum RX are the top three PBM's in the marketplace. And they control about 80% of the prescriptions in the U.S. and that is significant market power, one which that many of your states are taking a look at as well as the Federal Trade Commission (FTC) because this impacts the prices that patients pay at the end of the day.

Now we've reached a critical inflection point where brand manufacturers, the companies that do the bench research, do all the research and development and bring drugs to market are now making less on those products than all other stakeholders. So, hospitals, the government, state and federal governments, providers, pharmacies, insurers and PBMs combined are now making more at the end of the day after all the dust has settled, after all the accounting is done, than the brand manufacturers who actually make those products. And you can see on the right-hand side of the slide that total brand medicine spending again, after everything is accounted for, payers are now making 180% more than they did roughly a decade ago. But the key question is, are patients benefiting from the discounts, rebates, everything that is going to payers? And despite increasing levels of rebates, discounts and fees that are paid by manufacturers to payers, patients are often exposed to more costs, especially those in the commercial marketplace where nearly half of commercially insured patients are paying for brand medicines based off the undiscounted list price of the medicine. Now that's very different than the medical benefits. So, I'm sure when you've gone to the hospital or you've gone to your physician's office even if you're in the deductible phase of your benefit you're paying off the negotiated rate that the insurer has come to the agreement with for that provider. That is not the case oftentimes for the drug benefit. So, even if a patient is paying in the deductible phase or they're paying a coinsurance, which is a percentage-based cost sharing arrangement, they're paying oftentimes based on the list price of the medicine even though in many cases the insurer or PBM may be getting a rebate on that medicine.

So, this is a very serious concern for a patient's ability to afford their medicines and of course this has an impact not only on pricing. And I think we have in these types of discussions a lot of conversations about pricing and facts and figures but again, it's important to bring it to the patient experience. You know, patients that when they get that high sticker price at the pharmacy counter because they're in their deductible phase, because they're paying a coinsurance based off the list price of a medicine, they are nearly four times as likely for patients who are in the deductible phase to abandon their treatment than patients who are paying based on a fixed copay. The traditional sort of $5, $10, $25 predictable type of cost sharing that we might be accustomed to. And when a patient abandons the prescription at the pharmacy counter that not only has an impact on future healthcare spending, a patient that might be returning to the physician's office or to the hospital because they haven't been taking their medicine, but it also has an impact on health equity and patient outcomes. And I wanted to share this slide because I think it just kind of crystallizes the importance of these conversations that it's not just about the facts and figures but it's about the real patient impact. And if you look across the various disease states – diabetes, asthma, chronic obstructive pulmonary disease (COPD), behavioral health, hypertension, and HIV - the rates of abandonment. So this is for the first fill of a medicine with an out-of-pocket cost of a $125 or more which is not something that's completely unheard of especially if the patient is in the deductible phase or paying coinsurance. The rates of abandonment are quite high for African American patients but really for white patients as well and this just illustrates why benefit design really matters.

So, I never like to leave these types of conversations without talking about solutions. So, what do we do about it? I want to quickly just wrap up with some of our patient-oriented solutions that we have been advocating for across the country and really this

comes down to five kind of key policy ideas. First, sharing the savings, the significant rebates and discounts that manufacturers negotiate with PBMs and insurers. Patients who are taking those rebated medicines should benefit from those savings directly at the pharmacy counter. Second, making coupons count. So, many patients rely on some type of cost sharing assistance whether that's a copay coupon or some other type of patient assistance and there are many barriers that insurers and PBMs put in place whether that's accumulators which are now banned in something like 19 states, maximizers and alternative funding programs, which really target assistance in patient assistance programs. And we want to make sure that patients have the ability to use those types of cost sharing assistance without any barriers in the way of that. Third, offering lower cost sharing options. So, rather than benefit designs that rely on deductibles and coinsurance, providing more options for predictable cost sharing in the form of defined co-pays. Fourth, covering medicines from day one. So, rather than a patient that is paying their premium every month but not getting the benefit of the insurance from day one, making sure that more of that coverage is offered from the first date that a patient has their insurance benefit. And then lastly, hard dollar cost sharing caps. Some of your states have put in place these types of programs for patients who are taking insulin. That's a really wonderful idea and these types of cost sharing caps will really help patients be able to afford their medicines from day one.

Jonathan Buxton, Senior Director of State Affairs at PCMA, thanked the Committee for the opportunity to speak and stated that PCMA is the national association representing PBMs. The role of the PBM is to apply pressure on prices. We apply pressure on pharmaceutical manufacturers to provide the best net rate available for those drugs. We apply pressure on pharmacists to fill those drugs at an affordable rate. And the benefit is to the patient and payer. There is no other aspect of the supply chain that actually is putting the downward pressure on the price of drugs and so that's the role we fill. And a lot of people like to call this the middleman. We are in the middle. We are standing in the gap trying to make things more affordable. And I know that everybody loves to hate us. But insurers, employers, Medicaid plans, the government plans, everybody uses a PBM because there's a benefit there. And so, this transparency model has done a great job of bringing in both PhRMA and PBM's. I think there are over 28 states with some form of transparency reporting requirements. Not all of them include all sides, but over 28 states have some level of PBM pricing transparency. And that's good.

But transparency has got to be to the right people for the right reasons. The right information needs to go to regulators that they know that the costs are being shared in a fair way and done right. Transparency to employers and payers so that they know how to purchase better plans, find ways to get those plans with lower cost sharing that make it easier for patients. Driving around last night after dinner, we were talking about how much a crane operator would make with all the construction here. Their average is $33 an hour working in those high-rise cranes. The average crane operator does not care where the rebate goes or how much we're making as different members of this supply chain for the pharmaceuticals. They care how many hours they're going to have to work to afford their insurance. How many hours they're going to have to work to pay for the copay or they don't care which pharmacy they go to. They just want to know which one is the easiest to get to and which one is the cheapest to get to. So, providing transparency to the right part of the purchasing chain is more important than providing lots and lots of information. There was a state recently that had to roll back some of the

PBM transparency reporting requirements because it was too much data. They didn't even have the internal systems to be able to process it and collect the data. And so, the pricing model transparency here at NCOIL does a good job of saying we're going to get high level aggregated data so we can make informed choices as legislators. Which is important. And also, so our regulators can make sure that things are being done right. And so, in short, we support the model. We think the amendment makes a lot of sense as not all plans are the same and so carving out those is ideal. We do thank Rep. Oliverson and this Committee for the work on the Model. Like I said, 28 states are doing it. A lot of them followed your recommendations and so we would encourage you to readopt the model.

Bailey Reavis, Manager of Gov't Relations at Families USA and head of our state and federal drug pricing work, thanked the Committee for the opportunity to speak and stated that Families USA is a nonpartisan, nonprofit organization that for 40 years has served as one of the leading voices for healthcare consumers. The high and rising costs of prescription drugs in the U.S. is both a profound health problem and a significant economic burden for our nation's families. Millions live in fear of not being able to afford their life-saving medications and one third of people are not taking their prescriptions as prescribed because they are too expensive. The financial burden of high drug costs is clearly felt by those taking prescription drugs but it's even being felt by those that don't. When a drug company increases its prices, the amount the insurance company pays increases and the monthly premiums are going to increase right along with it for everyone regardless of if they are taking prescription medications. That also means if you're taking a prescription drug your price is going to increase at the pharmacy counter potentially but you are also paying that higher premium cost. You're getting hit twice, potentially with the same price increase. For 176 million people in America who get their health coverage from the private market, drug prices account for almost a quarter, 25%, of monthly premiums. Additionally, as health care costs continue to increase, companies and employers cannot provide the same increase in wages in order to offset those costs. Meaning, as drug prices increase, we see wages rising more slowly as a result. The incentives in our prescription drug market are clearly broken. Drug companies are incentivized to getting market exclusivity and ensure that they don't face serious competition allowing them to raise costs year over year. Meanwhile, PBMs who exist to provide plans with relief from high costs are too often incentivized to consolidate and obfuscate the real prices being paid.

In the end, the people stuck in the middle are the millions of families who end up paying the cost of these broken systems. Greater transparency requirements are a key first step to unveil those realities and bring down drug costs. Families USA believes that efforts such as the 2019 NCOIL transparency model that take a comprehensive look at the prescription drug market are a key tool for states to understand and track a variety of data points on how drug prices are increasing and how that is driving costs at the pharmacy counter and beyond. Specifically, we believe that data points such as post WAC requiring justifications for price increases and requiring plans to report on how drug costs are specifically impacting premiums and other healthcare costs are key metrics. We believe that there are also some opportunities to expand the model to make it even more effective including improving the WAC reporting threshold to require a drug maker to report rationale for any price increases above the rate of inflation, ensuring public reporting of data provides as much detail as possible to help lawmakers, researchers

and the public hold the entire drug market accountable and ensure competition across the drug market. And finally expanding the model to require plans to report net price pay in order to determine if out of pocket costs are based on net price rather than list price. In addition to building out transparency in the drug market, we believe that there are additional reforms that states can implement to help address the broken incentives that drive these costs. Reforms can include creating prescription drug affordability boards with unfair payment limits, enacting inflation rebates, when possible, that create penalties when prices are raised above the rate of inflation, and when possible ensure that 100% pass through of rebates and cost sharing that PBMs negotiate are passed on to consumers so that they are paying based on the actual price paid rather than the list price.

It is important to note that there are key reforms happening at the federal level that impact changes and opportunities at the state level. In 2021, as part of the Inflation Reduction Act, there were key changes made to reduce the cost for the millions that rely on Medicare for their healthcare. These major reforms, several of which are going into place the next few years, include this year the final negotiated rates for the first 10 drugs will be announced at the end of the summer. The Centers for Medicare and Medicaid Services (CMS) will also be releasing some information about how that price was decided and negotiated. We are hopeful that this information can be helpful to private payers and state payers to better negotiate their own prices. Those final negotiated rates for the first 10 drugs go into place in 2026. Additionally, next year, Medicare will put into effect a $2,000 out of pocket cap and smoothing which allows Medicare payers to pay that $2,000 over the course of the year. Additionally, on top of these existing reforms, Congress has been considering a variety of additional bipartisan policies that could be enacted sometime before the end of the year many of which, as was noted, hinge on some of these transparency pieces as well. That includes reforms to PBM incentives such as including improved transparency around negotiated prices, gross PBM profits, cost effectiveness of the PBM drug prices and spending patterns. All this would help reduce drug benefit costs by increasing competition between PBM's and empower the clients of PBM's to negotiate better contract terms.

Additionally, Congress is also considering some bipartisan patent reforms that would crack down on things like patent thickets, product topping and pay for delay. These federal reforms could dramatically change the broken incentive systems that lead to year over year increases from companies. However, in closing, I think it's really important to underline the importance of state action to address these costs even while federal action is ongoing. As administrations and congressional majorities change the priorities and opportunities can potentially change as well. However, all of the legislators in this room have the ability to ensure that the people in your state can get relief from these high and rising drug costs. Addressing these costs is overwhelmingly popular across the country, which I'm sure you're all aware of as you hear about it constantly from constituents. But in August of 2023 a Kaiser Poll found that 73% agreed governments aren't doing enough to regulate the price of prescription drugs and when broken down, that will be true for over 65% regardless of political party. That is the level of consensus that again, as we are all aware is extremely difficult to come by on any given issue. We've seen dozens of states from all over the country regardless of makeup or location from California to North Dakota to Texas to New Hampshire pass some form of legislation to get transparency and insight into high drug costs. There should be no reason that every state cannot

advance further reforms to address high drug costs including the transparency model under discussion here today if there is the will to move it.

James McSpadden, Senior Policy Advisor at AARP's Public Policy Institute, thanked the Committee for the opportunity to speak and stated that AARP is a nonpartisan, nonprofit that fights for what matters most for the more than 100 million older adults and their families. And at the AARP Policy Institute we do research and analysis to support those efforts. At the Public Policy Institute, my work focuses on a range of health issues including prescription drug pricing, utilization and access. I'm grateful for the invitation to speak here today since prescription drug prices definitely impact older Americans. As a population, older adults take more drugs than adults of other ages. We know that among adults 65 plus, 42% take five or more drugs a month and 18% take 10 or more. And among the 50 to 64 more than two thirds of this age group take one or more drugs. Midlife Medicaid enrollees take on average 3.3 drugs a month and prescription drug utilization among this age group enrolled in employer sponsored insurance has increased 10% in the past five years. Additionally, older adults may not have the resources to absorb high and increasing prescription drug prices and many are facing the real possibility of being unable to afford the medications they need. We know that the median income of adults 50 plus is just over $30,000. The median income of Medicare beneficiaries is lower than that, around $26,000. Many don't have financial assets to absorb these high costs. So, because of this vulnerability many older adults are concerned about being able to afford their prescription drugs. Our research has shown that more than half of all older adults are concerned with adults 50 to 64 more likely to be very concerned than adults 64 and older. With little recourse to address the high prices, individuals have been forced to make tough choices. Some 20% of older adults have not filled a prescription in the last two years due to cost and others have skipped doses, cut pills in half or otherwise adjusted their prescription medications. Another reason that AARP has supported drug price transparency is because older adults themselves want change. Two thirds of adults 50 plus say the drug prices are unreasonable and an overwhelming majority support price transparency legislation that requires manufacturers and others to disclose how prices are set. The NCOIL model gets to the root of concern, drug prices. While the model importantly addresses both launch prices and annual price increases, I wanted at hone in a little bit on the ladder in my time. AARP has been paying particularly close attention to annual pricing trends. For more than 10 years we've produced a series of price watch reports to track the price of drugs most commonly used by older adults. In our most recent report released earlier this year, AARP examined over 900 drugs, including brand, generic and specialty that are widely used by older Americans. The report examined both retail drug prices and price increases for these drugs. The report found that the average annual cost of therapy reached a little over $26,000 per drug and that drug prices have consistently grown faster than the rate of inflation.

Cumulatively, the average retail price of drugs has increased nearly 280% over 15 years. We also produced a report looking specifically at high price specialty drugs used to treat chronic conditions and widely used by older Americans. This report found specialty drugs are the largest driver of price increases. In 2020, the average annual cost of therapy for these drugs was more than $84,000. More than 40% of specialty drugs increased greater than 8% in 2020 and the prices for 11 chronic use specialty drugs that have been on the market for 15 years increased cumulatively by an average

of 230%. These reports also show the average annual increase of drugs widely used by older Americans alongside the rate of inflation and you can see here that in 2020 the average annual retail price of drugs was 3.1% whereas inflation was 1.3%. If prices had been limited through a rate of inflation the annual cost of therapy would have been considerably less. In 2020 it would have been less than half, around $12,000 compared to $26,000. Because price transparency is an important form of prescription drug reform we have supported passage of the model across the country. AARP state offices have worked closely with legislators and other stakeholders to pass it in at least 10 states. In one of those states, Texas, which certainly based its law on the NCOIL model, AARP was very active in support, and our Texas state office made enactment of the legislation a centerpiece of its advocacy in 2019.

In North Dakota, another state that utilized the NCOIL model, AARP has been involved in implementation. We've analyzed the data for the first year and provided a report to the state noting that manufacturer participation was inconsistent, the data reported was incomplete and we made recommendations about how to improve reporting processes and accountability. AARP has supported price transparency not as a final solution, but rather as a final step toward additional prescription reforms. The implementation of enacting legislation and collecting of drug pricing data transparency can provide critical information for further analysis. Information can show pricing trends and have shown pricing trends, planned spending trends and insights into pricing behavior. Additionally, this data ultimately can be used by states to consider reforms that can bring down the price of drugs for state programs and for consumers. A few of those additional reforms we've supported at the state level are prescription drug affordability boards, anti-price gouging legislation, interstate and intrastate bulk purchasing and international reference pricing. So in conclusion on this five-year anniversary it’s worth noting that the presence and proliferation of the NCOIL model demonstrates that current prescription drug pricing trends remain unsustainable. Thoughtful efforts by states can help provide evidence and direction to prescription drug reform and importantly, can help ensure that all patients have affordable access to the drugs they need to get and stay healthy.

Sen. Justin Boyd (AR) stated that one of the practices I hear a lot of complaints about as far as PBMs and price transparency is that, basically, national average drug acquisition cost (NADAC) is a public number. Anybody can just go look up what NADAC is on any given day and so with that one of the tactics that seems to happen is PBMs still pay below the cost of drugs. I'm not going to name PBMs or anything like that. They've all done it at some point in time but one in particular really targets on brand name drugs and pays below that NADAC. And so, I guess my question is, is this really a tool to keep prices down or is this something that is couched to the legislators and other people who signed PBMs up such as commercial insurers to really just move the marketplace to their mail order owned pharmacies?

Mr. Buxton stated that the way PBMs reimburse pharmacies is determined by the contract they have with the payer. And so, the PBM enters into a contract for a pharmacy and they agree to certain reimbursement rates. Anytime we end up paying a pharmacy more to fill a script then it costs the payer and the plan and the patient more in premiums or in co-pays. So, they use lots of tools to find the most affordable way to get a script filled and in some states I know NADAC reimbursement is the floor and so that's the least PBMs can pay as long as they're a state regulated plan. Sen. Boyd stated that

I guess the follow up though is, there are three major PBMs who control 80% of the market. How does the family-owned pharmacy really compete with that? Or is that really the drive is we don't need them let's just drive them out of business and then we'll fill up more prescriptions on our own mail order pharmacies.

Sen. Beverly Gossage (KS) stated that I'm just curious of the states that have implemented this, what percentage of citizens actually access this data? My next question is, what kind of a cost is it to the PBM's, to the pharmaceutical companies, to the state to implement something like this, especially if it doesn't seem to be being used? Finally, I write Medicare for clients all the time and the Part D premiums last year due to some of the laws that were passed on the federal level went up by 50%. Some of them went up by 75%. So, we can say we're going to bring down the cost of the true out of pocket costs for the prescription drugs which is typically now $8,000 total but very few people ever get to that donut hole. Those that do oftentimes will hit it in February and then they're in the donut hole and they try to get out of the doughnut hole. They're out of the donut hole in November and then they go right back and start this all over. So, the slamming down and saying, you know, we're not going to have people paying more than $2,000 or insulin is going to cost $35 all sounds really good, but then you're charging everyone more to pay for their prescription drug plan. Could someone address that?

Ms. Reavis stated that I think that what we're seeing is actually Medicare will be able to bring down those premium costs which have been rising year over year, partially due to the high cost of prescription drugs that Medicare is paying. The billions and billions of dollars that they are paying every year. And by the ability to negotiate drugs, it'll be 10 this year, but it will go up year over year up to somewhere around 75 I think by the end. By negotiating the prices of those drugs and paying a less amount they are able to clamp down on those premium prices that we're talking about. And we actually at Families USA do have some concerns with capping the price at the pharmacy counter if you're not addressing that underlying price, but we think that's why the Inflation Reduction Act handled that really well by providing an opportunity to reduce the cost that the payer is paying. And also then pass that along to the person at the pharmacy counter. We think that having both of those is a critical tool to address the cost because otherwise, as you say, we'll just have increasing premiums if we're not reducing the actual price paid. Sen. Gossage replied, yes, and I would also say a small percentage of those are using those very expensive medications. Tier one and Tier two drugs are zero cost for most folks and then they may pay 20% for a very expensive drug at the Medicare cost. So, it would be those outlier medications that very few people take. I'm glad to see where it's going to try to do something about that but also, that's a lot less expensive than what it would cost to have a heart transplant or something else if they weren't taking the pharmaceutical medications.

Rep. Bill Sutton (KS) stated that I think this question would probably go to Mr. Buxton. We saw earlier on one of the slides that 50% of the savings that's generated isn't going to the end payers. And could you elaborate a little bit about first, is that accurate? And secondly, where the system is broken that would allow that to happen? Mr. Buxton stated that slide was from PhRMA and its research that they've conducted looking at the spending for medications. If you have $100, who gets what? And they are right in this latest report. PhRMA and the manufacturers who make the drugs on average are getting $49 out of that $100. The rest is spent on us, on health insurers, on pharmacy

reimbursement, on hospital reimbursement. Incidentally, the reimbursement rates for independent pharmacists in that same study have gone up year over year. PBM reimbursement has stayed flat around 3%, I think. And so that's basically everybody that takes a bite of the medication dollar and how it breaks down. PhRMA still gets just under half and our spending has been flat on that at around 3%.

Rep. Michael “Sarge” Pollock (KY) stated that this is a great conversation and that he would like to hear the answer to the earlier question regarding pharmacists from Sen. Boyd. Someone mentioned the term drug price gouging and I'm going to speak on behalf of the independent pharmacists because I'm in Kentucky and the majority of our area is the rural area. These independent pharmacists, we're at close to 60 closing the doors because they cannot keep the doors open. And as crazy as it sounds their production of providing the service to their communities in rural areas is doubling so it’s not like they're not providing a service. Their service is doubling and they're losing money. That is a huge, huge problem. And the rural areas that I'm speaking on, they just want to go to have a conversation with their local pharmacist who they trust. And it’s not all about making the dollar. It's about taking care of your people. It's about putting your pharmacy name on the back of a Little League jersey and those type of things. And so, it's kind of personal because I talked to these people all the time and we passed a bill this past session and we’re trying to keep the playing field level right now. They told me they're shooting on a 12 foot goal and PBMs are shooting on an eight foot goal and so I hope you hear my passion about that but I'm speaking on behalf of them. It is a huge, huge issue. Thank you for bringing this as a model. We need to make this right. We need to fix it and make it right all the way for everybody.

Rep. Dunnigan staetd that I have a question for Mr. Buxton and anybody else who wants to weigh in, go ahead - what are your thoughts on point of sale rebates where the consumer goes and gets it at the pharmacy? Mr. Buxton stated that the vast majority of rebates are passed back to the plan sponsor based upon the contract they have with the PBM. Those rebates are typically used to either offset premiums so that the patient is paying less in premiums or to offset cost sharing and things like that. When you get to point of sale rebates, you're taking those rebates out of the pool that's reducing premiums and you're putting it to just a pool for reducing cost sharing for select patients. And so the problem with point of sale rebates is they overall will drive up the cost of the premium. It will not reduce the cost sharing for all patients. It will only reduce the cost sharing for those patients that are taking those drugs and it will increase the premiums and the cost sharing for all other patients on that plan. Rep. Dunnigan stated that I understand that concept.

Mr. Woods stated that we have heard this refrain from payers a number of times. So, looking at the commercial marketplace, which is where state regulators would be able to implement this type of policy, there are a few states that have already taken this step. Arkansas, Indiana and West Virginia. West Virginia was the first state. Looking at the rate filings for when West Virginia passed this bill, I think it was in 2021, they have not seen anything out of the ordinary in terms of premium increases in the commercial marketplace in that state. And what we've seen in the preliminary research from Arkansas and Indiana is the same is the case for those two states in the commercial market. Milliman did a study that looked at if you did pass along rebates at the point of sale the premium increase would be less than 1%. Now there are figures that are

different for the Medicare benefit because it's just a drug benefit rather than being a medical and a drug benefit. So, saying that we can't do point of sale rebates because it's going to increase premiums, that's the answer that insurers are going to give about any type of reform to insurance. It's going to increase premiums. But really the way that insurance should work is that healthy people are subsidizing people who have illness. That's just the general principle of insurance. But when you're looking at these types of rebates, it's really sick people that are subsidizing the premiums of healthy people and that's just an inverted way of insurance. So, a patient that's taking a very heavily rebated drug and could benefit significantly at the pharmacy counter, saying to that patient well we're going to take your rebate and we're going to spread it across the whole pool, that doesn't help that patient that's trying to afford their medicine. Especially as I illustrated through the data that we've shown that those patients are increasingly subject to skyrocketing deductibles, skyrocketing cost sharing in terms of coinsurance. So, it's the payers are saying well we can't do this because it's going to increase premiums but then they're also increasing cost sharing exposure for patients. The question remains why aren't you doing it? Especially when, Express Scripts, Optum Rx, CVS Health are making these types of programs widely available in some instances in the commercial marketplace. It's just an answer that we can't do this because it's going to raise premiums. Their own members are providing this type of benefit and they wouldn't be providing that benefit in the commercial marketplace if it in fact were increasing premiums and their employer clients wouldn't want to take that option.

Rep. Oliverson stated that I really appreciate all the comments that we received and I will say that I do believe this model has been very successful as is and I heard a lot of good things. I would not at this time be inclined to open the model back up and do a whole lot with it. I think Mr. Buxton and Mr. Woods both being in favor of this, for those of you that weren't here when we were working on this, it underscores the degree to which this took a lot of work to get them on the same page on something that has clearly as we heard had a positive effect on lowering the cost of prescription drugs and educating lawmakers as far as where those costs are going and particularly where the rebate dollars are going which had previously had been entirely a black box. I know now in Texas at least that 98% of manufacturer rebates tend to stay either with the PBM or with the health plan. I don't know what they do with it, but I know that's where they go because I know that's what they report to the Insurance Department so, I have that information. It's useful to me. With respect to Sen. Gossage's comments, we never really intended for this model to provide useful information direct to the patient because the information is being provided in an aggregate format but it was more an opportunity on one hand, that the manufacturer would think twice about just artificially raising the price of the drug for no other reason than just because they could because it would trigger reporting requirements. But also on the other hand that the other players in the market the health plan, the PBM, that they would be able to have to have some reporting requirements for the things that they were doing which may be affecting cost. So, the fact that it's not consumer friendly was not really the intent of it per se but it was more to inform us. It was more to provide useful information to interested parties like AARP and others that would be concerned about the cost of prescription drugs. So, I would move that we adopt this model for a five-year cycle with the one technical amendment that I'm proposing. I would also like to say, though that I don't believe that our work in this sphere is finished.

And Mr. Chairman, I would support any efforts that you might undertake in future meetings to have a more robust discussion on pharmaceutical pricing. I heard several topics that I think would be worthy of discussion including the cost of generics, launch prices, the effect of copay assistance cards particularly as it relates to the value of rebates and where they go. I think also we haven't actually heard in this discussion from our pharmacy friends. The pharmacists are obviously part of this discussion as well and I know that there's some concerns that have been raised to me with respect to third-party discount cards that are being used which are on top of essentially what the in network price would be. And Mr. Woods and Mr. Buxton you may want to cover your ears but I would tell you that my personal bias is having worked on this issue for years that if I could eliminate all manufacturer rebates tomorrow and force these guys to negotiate directly with one another based on a number of covered lives discount per plan, I would do it. But that would require a change to federal law because I do think that the main cost driver that is accelerating the unaffordability of prescription drugs is the rebate itself and the fact that that rebate never seems to find its way back into the hands of the consumer. So, I thought, Mr. Chairman, that your question about the point-of-sale rebate was a very interesting question because the reality is that these rebates very often don't benefit the consumer when you look at what Medicare does with the rebates that they get on insulin rather than give those rebates to the people who are taking the insulin. They tend to use those rebates to keep everyone's Part D premiums down which kind of supports Mr. Woods supposition that you have the sick essentially subsidizing the healthy which is not really the point. So, I think rebates are terrible. I wish we could abolish them. That's my personal bias. You may not want me to have any other models on this but that is my personal preference. And then the patent thicket issues and the pay for delay things are also worthy of discussion by this group although that would be probably more appropriate at a setting of our Joint State-Federal Relations & International Insurance Issues Committee since we can't control what the FTC does but there is a tremendous need for reform there.

Upon a Motion made by Rep. Oliverson and seconded by Sen. Lana Theis (MI), the Committee voted without objection via a voice vote to adopt the technical amendment to the Model. Then, upon a Motion made by Rep. Oliverson and seconded by Rep. Pollock, the Committee voted without objection to re-adopt the Model with the technical amendment for a full five year cycle.

PRESENTATION ON SITE-NEUTRAL PAYMENT REFORMS

Rep. Dunnigan stated that next on our agenda is a presentation on site-neutral payment reforms. For some brief background on the topic, last year, NCOIL adopted a hospital price transparency model law which requires hospitals to disclose certain pricing information in a clear and understandable manner. People want and deserve to know how much a hospital procedure is going to cost – it shouldn't be a complex and vague thing to deal with. And patients deserve to know how much care is going to cost before they show up. So, building off that topic, we're now going to discuss another hospital pricing related issue: site-neutral payment forms. Generally, these types of reforms focus on requiring one price for a procedure wherever it is performed, whether the procedure is done in the doctor's office, a hospital or clinic or clinic owned by a hospital or different entity.

Randi Chapman, Managing Director, State Affairs, Policy & Advocacy at Blue Cross Blue Shield Association (BCBSA), thanked the Committee for the opportunity to speak and stated that I'm going to start today with a quick story. This is a story of Kyoung Yu Lee. Ms. Lee suffered from arthritis in her finger joints and received periodic steroid injections as treatments for that. She received those treatments from the same physician in the same place for years at her out of pocket cost at about $30. One day she went in for her injection appointment as usual but one thing was different. Her doctor's office was now on a different floor – the same building, same doctor, different floor. But once she received her medical bill, there was one more difference and instead of $30 that she usually paid out of pocket, her portion was now over $350 - ten times more than what she had paid in the past. That sounds outrageous to me. And it is. And from the perspective of BCBSA, which my colleague here today and I represent, we think that type of scenario occurs all too often. So, before we unpack how Ms. Lee ended up owing over ten times more for the same service from the same doctor and the same building, I'll very quickly provide some background on BCBSA. BCBSA is a national federation of independent community based and locally operated Blue Cross Blue Shield Companies and collectively we serve and support and cover one in three Americans in every ZIP code in all 50 states and Puerto Rico. BCBSA and BCBS companies are committed to advancing common sense solutions that can improve care and lower costs and we're committed to tackling the key drivers of the rising costs and ensuring access to high quality affordable health coverage for the 150 million Americans that we serve.

So let's get back to how Ms. Lee got here. Well, we think and research shows that key drivers of increased costs are provider consolidation and hospital billing practices. And for years we have seen a growing trend of corporate hospital systems taking over independent doctor's offices and often after the hospital takes control what was the doctor's office is now considered a hospital outpatient department. And with that change, the hospital is able to charge higher rates. So, care designated as being delivered in a hospital setting costs up to 300 times more than care delivered in an office space setting which leads to situations like that of Ms. Lee's where patients can receive the same care in the same room from the same doctor that have a much higher price. Our colleagues at Blue Health Intelligence recently performed a national analysis of over 123 million member claims for 34 commonly administered procedures that occurred between 2017 and 2022. And through that research, they discovered that hospital outpatient department prices grew rapidly at a 27% average increase compared to an 11% average increase for care that's provided in an ambulatory service center (ASC) and a 2% increase over care provided in physicians' offices. The prices for common procedures performed in hospital outpatient departments (HOPDs) are substantially higher, sometimes five times more expensive than might be performed at an ASC. And while there's some variability in prices and costs by site of care across census divisions the HOPD prices and costs were always higher. And the research also found that policies aimed at creating site neutral payments could result in substantial savings for patients, businesses and employers. And now I'll turn to my colleague.

Stuart Hagen, Managing Director, Health Policy Analytics, Policy & Advocacy at BCBSA thanked the Committee for the opportunity to speak and stated that over the next few slides, I'm going to go over some examples of what we see as a broader trend in general. And this comes from the Health Care Cost Institute and they do research on

the commercial claims of insurers like BCBS as well as a handful of other of the large national insurers. And in this example for an endoscopy from 2009 to 2017, the price in the office setting went from $463 to $527, an increase of 14%. That's over nine years. That's a good amount of time. At the same time, there are two things going on with that price in a HOPD. First of all, the prices start at a much higher level and then they grow more rapidly. So, in this case, went from about $1,500 in 2009 to nearly $2,700 in 2017. That's an increase of 73% compared to 14% for the same procedure delivered in the office setting. Now this is an example, this is from research that is just on BCBS claims and as Ms. Chapman mentioned, this is some work that we did with our colleagues at Blue Health Intelligence and it's the results of a couple of studies that we did this past Fall. One study was published in September and the other in December. And this is what we have seen broadly with many different procedures and we're just going to give you some examples here. So, in this case, let's look at the office again and similar to what Health Care Cost Institute found from a somewhat earlier period, the price of a corticosteroid injection for back pain was much lower if it was delivered in the physician office. In 2017 it was $394. Five years later, it was $426.

So, this is considered by far the lowest of the three different sites. And then what we see is a similar kind of not very fast growth in the price if this procedure was delivered in an ASC but if it was delivered in an HOPD, then we see this big increase in price over time as well as the prices themselves being quite high. So, in 2017, $1,350 if it was delivered in an HOPD compared with that $394 if the same procedure was in a physician's office. By 2022, the price was nearly $1,800 so it went from $1,350 in five years to $1,800. So, what we're seeing in general is that HOPD prices have been considerably higher to start with and then over this period they're getting even higher compared with other sites of care. Let me just show one last example. This is the price for a chest X-ray, a very common procedure. In a physician office in 2017 the price was $44. Now we're not showing it in ASC because that happens very rarely so we just are excluding it from this one. In this case, the price did jump quite a bit in 2020 for the office. It went from $44 to $95 and then settled down and it's at $101 in 2022. In the HOPD by comparison it starts out at $126 in 2017 then quickly jumps up to $335 and then to $341 in 2022. So, these are all common procedures, but they're also common examples of what we have seen when we looked at many different procedures over the course of these two studies that we did last Fall.

Ms. Chapman stated that when hospitals acquire physician offices, they often change the way that the practice bills insurance and when they do this, they do this by using the hospital national provider identifier or NPI number and the hospital claim forms. And then the insurer, payer will reimburse at the hospital rates. And so, the insurer has no way of differentiating between the more expensive care provided in a hospital versus care provided in a physician office setting which is less expensive. And more importantly, it's difficult to apply the correct cost sharing for patients which often results in higher prices which means higher costs for consumers and that's how Ms. Lee ends up with a bill ten times greater than what she was paying before the hospital bought her physician practice. And as always we want to offer solutions and not just come to you all with a problem and as we think about our shared role as insurers, as payers and you as legislators, that role is to protect consumers and patients from unreasonably high healthcare costs and to expand coverage. So, for example, we applaud the work that is being done on affordability and proposals to prohibit facility fees for services delivered in

non-hospital emergency department settings. But we think there's an opportunity to build on that and even go one step further towards site-neutral type policies in the commercial space. And so, we support state actions that would require hospitals to use appropriate billing forms and NPI numbers based on the site of care, not based on who owns that site of care. And that would allow payers to correctly identify the site of service and the claim and then provide the appropriate reimbursement rate. And we welcome the opportunity to partner with NCOIL and continue talking with you all about these issues and talk about our shared mission to lower costs and increase affordability for patients.

Joanna Hiatt Kim, Vice President of Payment Policy at the American Hospital Association (AHA), thanked the Committee for the opportunity to speak and stated that the AHA represents almost 5,000 hospital and health systems across the country. To start with some level setting, I want to state that access to quality care is the top priority of hospitals. To achieve this, we need appropriate healthcare system financing that covers costs and provides some room for capitalization. Part of this is healthcare coverage that is adequate and affordable for the individual's circumstances. Site-neutral payment is part of this equation vis-a-vis the adequate financing part of the equation. The term refers to policies that purport to pay the same amount for the same service no matter the setting. However, in reality the services provided in different settings is not the same. The standard and level of care provided in different settings is not the same. And the patient served in these different settings is also not the same. Hospitals have unique characteristics and capabilities that we all have an interest in maintaining. First, regarding the services provided not being the same in each setting. Chief among these is hospital's provision of emergency services, 24/7 to all who need it regardless of their ability to pay. It's among the most, if not the most important function that we provide. But emergency services are provided via standby capacity. What that means is that physicians, nurses and other clinicians are standing by waiting for patients to come through the door for care. They're waiting for responses to natural disasters like tornadoes, hurricanes, wildfires. They're waiting for infectious disease outbreaks, of course, such as COVID-19. And standing by at every moment of every day necessarily means that there will be times that there are not very many patients needing care. What that means is that standby capacity is not something that is explicitly reimbursed. It is funded through the reimbursement for other services. And as such, it is in danger by cuts to reimbursement including site-neutral cuts. Hospitals, of course, provide a lot of other specialized unique capabilities that are also endangered by cuts. This includes the burn units, the neonatal units, infection control and disaster preparedness. Some of these are very costly services because they're so specialized and they are not completely reimbursed by the payment rates. Some of them are in the vein of standby capacity where there is no explicit reimbursement for them and so they are funded through the reimbursement for other services.

Regarding the care provided in different settings. As I said, site-neutral is based on the idea that the care is the same. But this is false. Let's take the example of a 40 year old woman who needs an MRI. She is having trouble swallowing. It's getting worse, and her internist sends her to a freestanding imaging center. She gets her MRI. Easy-peasy. She's in and out. Compare that to an 80 year old man at a care facility who has dementia. He throws up. But he cannot tell anybody why he might have done that. And the care facility is concerned that perhaps he swallowed something. They send him to

the ER which is a very typical response at these facilities. He's disoriented. He's agitated. The technicians help him get into his gown and everyone decides that a light sedation could help get the MRI accomplished. What this means is that must take place in an open MRI machine. Which is a more expensive machine because the technicians will need to hold his hand, reassure him, remind him to keep still. Even so, it may take two, three tries to get a clear, still image. The technicians help them get dressed and help him get back to the care facility. This has taken four times as long and many more resources. But in the claims and the coding, it looks exactly the same. Regarding another example, obstetric ultrasounds. These are very rarely done in, let's call it an a la carte manner in hospitals because they're very commonly done in other settings which means that when they are done in a hospital it's because somebody is generally coming through the ER. They have pain. They don't feel right. And it's not that they come in and say I need an ultrasound and then it's given to them. What it initiates is an entire diagnostic procedure that involves clinicians trying to determine what's wrong. And maybe they do eventually conclude that an ultrasound is needed. But again, this has taken more resources and more time and it's not an equivalent service.

And then finally, I'll give the example of infusion therapy. This is a different, higher standard of care when it's provided in a hospital. Hospitals provide sterile conditions with a licensed pharmacist. They use barcoding to ensure that medication errors are not made and they are overseen by, to name a few, the U.S. Food and Drug Administration (FDA), the U.S. Pharmacopeia and The Joint Commission. Finally, the patients served in different settings are also not the same. Hospitals provide services that are not always otherwise available for historically marginalized and low income patients who are more likely to be duly eligible for Medicare and Medicaid, more likely to be for example non-white. Medicare beneficiaries with cancer are four times more likely to seek care in an HOPD versus a physician office. And again, they are more likely to be duly eligible and non-white. Diving into the specifics on why cuts would endanger patient access to care. Medicare, of course, is one of the largest payers of hospital care and it is not even remotely covering the cost to provide care to Medicare beneficiaries. Hospital Medicare margins have hit a record low. The Medicare Payment Advisory Commission estimated that in 2022 Medicare hospital margins were almost negative 13%. And in 2024 they will fully reach negative 13%. We estimate that mega Medicare payment shortfall totals almost $800 billion annually. And of course other payers do not fully reimburse the cost of providing care to their patients either. Medicaid across the country pays $0.87 on the dollar which nets us another $31 billion annually in underpayments. Hospitals provide quite a bit of uncompensated care either to uninsured or underinsured patients and commercial payers are becoming a huge challenge for hospitals. They routinely deny appropriate care and delay payments.

In fact, 50% of our hospitals report that they have $100 million in accounts receivable that are older than six months and that is the environment we are currently operating in without additional site-neutral cuts. Any additional cuts would be hugely detrimental to patient access to care. For example, some proposals would siphon $180 billion out of hospitals and health systems over the next 10 years. To give you a little bit more magnitude and context, these are some state level cuts of what actually is one of the smaller scale proposals in Congress right now. And you can see that for many states this would yield an excess of $100 million over 10 years in lost funds coming to your state. Of course, payments are one side of the equation and on the other side is costs.

The pandemic and subsequent inflationary environment has been a huge challenge for hospitals. Our input costs have risen substantially. Leading the way is acquisition cost of pharmaceuticals, which has gone up almost 37% over three years. Patients are also staying longer in the hospital because of workforce challenges at downstream discharge destinations that cannot accept as many patients as they used to. And then patient acuity has also gone up as delayed and deferred care is working its way through the system after the pandemic. Hospitals are also economic engines in their communities, so hospital cuts could not only result in loss of access for patients but also job and economic losses for the broader community. To circle back to the beginning, providing high quality care is a hospital's top priority but they need adequate financing to ensure that they can do this. They're already facing gaps in reimbursement and site-neutral cuts will make that significantly worse. Hospitals cannot continue to provide the full scope of their critical unique care if payment is less than cost. Access will be reduced and this is particularly true for rural and underserved communities that tend to rely disproportionately on hospital care.

Rep. Deborah Ferguson, DDS (AR), NCOIL Immediate Past President, stated that I'm completely sympathetic to the hospital situation, I just think that it was unfortunate that whenever this policy of site disparity was created that it was done on the backs of patients and private care. I think Ms. Chapman said how much the employed physician has increased and what has driven this for those who have not been involved, I saw it first in cardiology. A patient would go to the cardiologist and get an echocardiogram and it would cost $160. And if you don't follow insurance, there's a professional fee and there's a facility fee and the facility fee is where the real differential comes in. So, that exact same cardiology office, the exact same quality of care, the exact same ultrasound machine, she went back to have the same echocardiogram. After the hospital bought the practice it was $6,000. We're not talking about inpatient care. I realize they see more acute patients. We're talking about hospital outpatient care. And what that has done is it really forced private practice to sell to hospitals. And so now even the American Medical Association (AMA) is reluctant to take a position because more of their members are employed physicians than they are in private practice. So, the hospital employed physicians who were forced to sell their practice because they couldn't get reimbursed at the hospital rate are now scared to not take the hospital position on site-neutrality because they're concerned their salary will be reduced. So, that's where we are. If a patient has a $2,500 deductible, they're paying all of that fee differential. So, I used to say Marcus Welby's dead and we killed him. And the other thing that bothers me about all this and this was the concern when private practice started advocating for site-neutrality is the $80 billion that was to be saved and payment neutrality, we were hoping we would have some leveling of payments. But instead of leveling of payments, they're just reducing everybody. And if any of you have had parents, it's very difficult to find a specialist much less family practice people to see a Medicare patient these days. You may have your family practice person but when you get ready to be referred to a specialist it's almost impossible to find somebody. So, I know you're not Medicare, but I guess my concern with CMS is take this $80 billion and start doing some levelized of payments particularly in the outpatient setting. I think your inpatient hospital argument is valid. But I think hospitals have to find another way to be compensated. And the other thing I think the uncompensated care is not based on actual uncompensated data but maybe if you can have a comment on that.

Del. Steve Westfall (WV) stated that I have a concern with this because it might be site-neutral but it is not equal. In West Virginia we have about 75% of our people on Medicaid and Medicare. And then we have the Public Employees Insurance Agency (PEIA) which only pays 10% more than what Medicare does. Our private option pays about 19%. Our hospitals struggle now. If you did this, we would put some hospitals under. I just don't see this. It's apples and oranges to me. It's not the same because the hospital is there 24/7, 365 where a physician's office is 9 to 5. The cost is totally different and this would really hurt hospitals in West Virginia.

Sen. Bob Hackett (OH) stated that I was on a hospital board for a long time and we went in the periods where you never had hospital employees and then the same consultants would come back and say now we want hospital employees. But the movement today by far in Ohio is the doctors are hospital employees. The biggest problem and I don't know why the AHA doesn't say this is you have to buy their building to get them in as employees. And why you won't say that? I mean, when you come in to see me about hospital facility fees, I just say to them, why do you pay so much for the building? And they laugh. They say you're right, that is a big problem in that scenario. So, I wish you would say that. I agree with everything else you said but I wish you would say the second point is hospitals have greater negotiated factors than doctors do. So that's a big thing. It's much easier for hospitals to get their fees approved and network fees approved with the insurance companies than it is for the doctors because the hospitals can collectively come together. The doctors can't unionize and I'm not saying they should, but they can't unionize. But the only thing I wish you would say is you have to buy the doctor's building. The doctor won't come in and be an employee and you don't want their building. But you have to buy their building to bring them in. So, I just want people to realize when employees come in, the hospital buys the doctor's building and their ability to charge a facility fee. They don't even want the building. I mean the building, I don't even know if it qualifies. There's ways to say it doesn't qualify but you're going to say it's an ROI. We get a bigger fee by charging that. But that's the problem is we have to buy the building of the doctor to bring them in as an employee.

MEDICAID REDETERMINATIONS – HOW HAVE STATES DONE?

Next, we're going to go hear a quick update on how states have done with regard to Medicaid redeterminations post pandemic. We have Miranda Motter, Senior VP of State Affairs & Policy at America's Health Insurance Plans (AHIP) with us here today. We've had updates on this topic throughout the past few years and now that we're fully removed from the pandemic, we thought we'd get another update to hear the latest data.

Ms. Motter thanked the Committee for the opportunity to speak and stated that I am privileged to talk about three quick things this morning. One, I wanted to just provide a quick update relative to the data that we are seeing from March to December of 2023 relative to what is happening with redeterminations and I will quickly say that this is data that is being reported in a uniform way from states into CMS. So, I know that there is a lot of different kinds of reporting out there but this is what we're focused on today and this link that is included here provides specific information for states if you're interested and I'm more than happy to pull that moving forward. Essentially, where we are with having to redetermine 94 million individuals, we're about two-thirds of the way through. Coverage is renewed for about 53% of Americans that have had their coverage renewed

through Medicaid. The coverage levels in terms of terminations is at 24%. So, 13.7 million Americans have lost their coverage. Some of that has been because of procedural terminations. That is hovering currently at around 70%. That is varied in certain States. And I will tell you some states have actually paused those terminations to make sure that they can do additional outreach for individuals.

The second bucket of data that I wanted to share is where are individuals going that no longer have Medicaid. So, as of October 2023, you can see here in federally facilitated marketplaces nearly four million Americans who lost their Medicaid went through some level of process in the marketplace. And I guess I would point your attention to the four million that went to the marketplace and then to the bottom number of the one million consumers that actually selected a qualified health plan. So, that means they actually selected a health plan in the federally facilitated marketplaces in states where there is a state-based marketplace. Again, that data is as of December 2023. Again, I would call your attention to the four million individuals that went to that marketplace in those States and then half a million individuals actually selected a qualified health plan. Obviously there are levels in the marketplace given the application process and who may be eligible for subsidies that all differs. And so again, I would call your attention to those two numbers. The last thing just quickly I wanted to provide a quick update on. Since this group last had an update about redeterminations there has been a number of guidance that have been issued by CMS. Just very quickly, a special enrollment period. So, individuals who lost coverage as a result of this have a special enrollment period in the marketplace through November of 2024. There has been general guidance issued by CMS to states really outlining ten different areas reminding states what the federal rules are as it relates to eligibility and enrollment. There has been guidance issued to states to really continue to encourage them to work with managed care plans relative to contact information, relative to transitions. Really helping individuals complete those application forms. There are new resources for families that may be, and individuals that may lose that Medicaid coverage through the fair hearing process. And then last, in December of 2023, CMS did issue additional guidance given that there is a high level of kids that are losing coverage. About four in ten that are losing coverage are children of those states that are reporting ages and so CMS did issue some specific information to states to make sure that kids could continue to remain covered, reminding them of the requirements and then also providing some strategies and flexibilities through waivers that states could apply for.

INTRODUCTION OF NCOIL VALUE BASED PURCHASING MODEL ACT

Sen. Mary Felzkowski (WI), stated that I will be very brief as this just is meant to be an introduction of the Value Based Purchasing Model Act that I am sponsoring and then we can fully discuss it at our next meeting. You can view the model in your binders on page 275 and on the website or app. I'm very supportive of this model and I sponsored an identical piece of legislation in my home state of Wisconsin. The model is very straightforward. It simply creates authority for states to enter into a value based purchasing agreement with a drug manufacturer. Importantly, there is no requirement to enter into these agreements, the model just creates the authority if the state wants to do this. And what we're mainly driving at here is the fact that our medical treatments continue to advance. It's opened the door to a wide variety of medical solutions, especially when dealing with very rare diseases. But the cost of these treatments are

extremely high. Sometimes these treatments can actually exceed upwards of $1 million. So, a value-based purchasing agreement aims to ensure that the cost of the treatment is based on the value that it provides to the patient and this is done through an agreed upon metric between the state agency and the manufacturer stating what benchmarks need to be met in order to receive the full payment. I'll stop there and just say I look forward to working on this model throughout the year and hopefully it will be ready for consideration by November.

JP Wieske, VP of State Affairs for the Campaign for Transformative Therapies, thanked the Committee for the opportunity to speak and stated that four gene therapies were approved at the end of last year. Each one of those will likely cost in excess of $2 million for the treatment. Now, they're covering extremely rare, debilitating diseases like sickle cell and hemophilia. These arrangements will allow your Medicaid agency to look at this as an issue and to pay for value when they're effective and make these decisions and align the incentives between the drug companies and Medicaid in the right direction. We're strongly in support of this.

Rep. Dunnigan thanked everyone and stated that we look forward to further work on this in our coming meetings. If you have any questions, I'd invite you to reach out to Sen. Felzkowski.

ANY OTHER BUSINESS

Rep. David LeBOeuf (MA) stated that I would like to propose at a future meeting that we have a conversation about innovations in maternal health. There's definitely been some new practices that have been evolving including birth centers, in home visits, and some of the insurance related matters that our practitioners are facing.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Paul Utke (MN), NCOIL Treasurer, and seconded by Rep. Oliverson, the Committee adjourned at 10:45 a.m.

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VICE PRESIDENT: Asw. Pamela Hunter, NY
TREASURER: Sen. Paul Utke, MN
SECRETARY: Rep. Edmond Jordan, LA

IMMEDIATE PAST PRESIDENT: Rep. Deborah Ferguson, AR

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 discussed during the meeting of the NCOIL Health Insurance & Long Term Care Issues Committee on July 18, 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.

FINANCIAL SERVICES & MULTI-LINES ISSUES COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
FINANCIAL SERVICES & MULTI-LINES ISSUES COMMITTEE
2024 NCOIL SPRING MEETING – NASHVILLE, TENNESSEE
APRIL 13, 2024
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Financial Services & Multi-Lines Issues Committee met at The Sheraton Grand Nashville Downtown Hotel in Nashville, Tennessee on Saturday, April 13, 2024 at 1:45 p.m.

Senator Mary Felzkowski of Wisconsin, Chair of the Committee, presided.

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Asm. Tim Grayson (CA)
Rep. Matt Lehman (IN)
Rep. Edmond Jordan (LA)
Rep. Brenda Carter (MI)
Sen. Paul Utke (MN)
Rep. Bob Titus (MO)
Rep. Nelly Nicol (MT)
Sen. Jerry Klein (ND)
Rep. Emily O'Brien (ND)
Rep. Tim Barhorst (OH)
Sen. Bob Hackett (OH)
Rep. Brian Lampton (OH)
Sen. George Lang (OH)
Rep. Forrest Bennett (OK)
Rep. Ellyn Hefner (OK)
Rep. Tom Oliverson, M.D. (TX)
Rep. Jim Dunnigan (UT)
Del. Steve Westfall (WV)

Other legislators present were:

Rep. Deborah Ferguson, DDS (AR)
Rep. Jeff Keicher (IL)
Sen. Mike Gaskill (IN)
Rep. Peggy Mayfield (IN)
Sen. Beverly Gossage (KS)
Sen. Mark Huizenga (MI)
Rep. Jerry Neyer (MI)
Sen. Natasha Marcus (NC)
Sen. Bill Gannon (NH)
Rep. Mark Tedford (OK)
Del. David Green (WV)
Del. Walter Hall (WV)

Also in attendance were:

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

QUORUM

Upon a Motion made by Sen. Bob Hackett (OH), 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. Hackett, the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's November 17, 2023 meeting.

DISCUSSION ON NAIC'S "FRAMEWORK FOR REGULATION OF INSURER INVESTMENTS", INCLUDING PROPOSAL RELATING TO SVO'S RATINGS DISCRETION PROCESS

Sen. Felzkowski stated that we're going to start out discussing on National Association of Insurance Commissioners (NAIC's) "Framework for Regulation of Insurer Investments", including the proposal relating to the Securities Valuation Office (SVO's) ratings discretion process. We had a good update on this topic yesterday during the NCOIL-NAIC Dialogue and now we'll have a chance to discuss it in a little more detail. For those who weren't at the dialogue yesterday this topic has generated a significant amount of discussion throughout the past several months. And it deals with the NAIC's proposed "framework for regulation of insurance investments" which you can view in your binders on page 104. Within this framework, there's a specific 15 step process set forth that enables the SVO to review all filing exempt securities and to determine whether the rating is unreasonable for regulatory purposes. That 15 step process is on page 111 in your binders. All materials are on the website and app as well. Concerns have been raised by many regarding the framework, mainly focusing on the SVO's authority to overrule the decisions made by rating agencies. We do applaud the NAIC for making progress on the proposal and its willingness to engage in discussions and hear concerns. With us here today is the Insurance Commissioner from the great state of Wisconsin and Chair of the NAIC's Financial Condition "E" Committee, Nathan Houdek.

Cmsr. Houdek thanked everyone for the opportunity to speak and stated that I'm going to provide a little bit of background information before I dive into a little more of the substance of the framework. Some of this might be familiar for those of you who were here for Rhode Island Superintendent Beth Dwyers' presentation last fall when she talked about the investment framework. As state insurance regulators one of the key things we're charged with is ensuring the financial solvency of insurers and as part of that being able to properly analyze investments is really a key function of financial solvency oversight. And what we've really seen and I mentioned this yesterday during the dialogue is we've seen a material and observable shift in insurer investment strategies over the last decade or so, really since the great financial crisis. And we've seen a move towards more private assets, more structured assets, more complex assets. And from our standpoint as regulators just less transparency overall in terms of being able to analyze the risk associated with these newer investments. And so the framework is really we're trying to determine the most effective use of our regulatory resources in this new modern environment of these more complex and more challenging investments so that we feel comfortable that we understand the risks associated with them. And that's really what this project is focused on is how do we enhance the ability of us as regulators to do that financial solvency work and ultimately to protect policyholders and consumers?

The framework document was initially exposed at the NAIC Summer National Meeting last year. During that exposure period, we received comment letters from 17 different organizations, as well as oral comments that were presented by many of those same groups at the fall National Meeting in December. We then put together a small drafting group, which was comprised of regulators who really have subject matter expertise in this area. And they spent the winter months I would say kind of December, January, early February drafting three documents based on the comments we had received and just other information that has come to light since we initially exposed the framework. Those three documents were first a proposed work plan laying out I believe seven action items in terms of kind of next steps of how we move the framework project forward. Second was an update to the framework document itself, fairly minor revisions at this point, but a few changes that we thought were helpful. And then a third more substantive memo kind of generally to interested parties with responses to the comments that we had received during that initial comment period. We then exposed those three documents in February for a comment period that ended just this past week on April 8th. And we also had our spring national meeting last month that provided an opportunity for interested parties to provide verbal comments. I think we had five or six different groups that did that. And so, where we are now is essentially the drafting group members and the E Committee members are now going to go through those most recent comment letters that we had received and spend the rest of this month and next month with the idea then we will revise these documents that had been exposed earlier this year and determine if any additional documents or whatever additional information might be needed based on the comments and expose those for an additional comment period, likely in June. So, there will continue to be a lot of opportunity for all stakeholders and interested parties to have transparency into how we're doing this process and know the changes we're making and providing feedback and providing comments. That's something we've committed to and something that as the process continues we'll definitely adhere to.

So included in the work plan document that was exposed earlier this year were six core principles of the investment framework. The first being that the framework we're putting out there to settle long term strategic direction for really where investment regulation is going to go in the future given these changes that I talked about structured asset, private assets, more complex assets. And also to help ensure that both the current and future initiatives that are happening under the E Committee are coordinated and really supportive of this longer term direction. Second, we really want to ensure that insurance regulators have the appropriate tools, and that's something that you'll hear as I kind of talk through some components of the framework is it's' really about enhancing our resources, our tools and the policies that we have in place to ensure that we can have the appropriate oversight of these new investments. The third principle really restating and just reiterating the fact that the work that has been going on related to the framework will continue and there will not be a delay. We want to ensure that work and those work streams are directionally consistent with where we're going with the framework and we will continue to look at that work and make sure that is the case. But there is no intention to pause or to stop that work. And fourth and this is something that we've heard some concerns and criticisms about, we really want to reiterate that this work is being driven by regulators at the Commissioner level. Yes, we might be hiring consultants for some of the work which we will be transparent about. Yes, we rely on

the SVO staff and NAIC staff. But it is really the regulators and Commissioners, E Committee in particular, that is really driving this work and who are benefiting at the end of the day from all of these enhancements and resources that we're developing. It's really about the fact when you have 56 different jurisdictions that oversee the regulation of insurance it's not practical for each of those jurisdictions to build out the full capabilities on their own from a cost standpoint to be able to do in depth analysis of investments. So, what we're trying to do is do this in a coordinated way where we have a centralized location, the SVO, or whatever the SVO will look like in the future, that benefits all of us as regulators in those 56 jurisdictions. The fifth principle is we're committed to being fully transparent and continuing to have multiple checkpoint exposure periods, comment periods throughout this process. And last, we really want to reiterate that while we're doing this work to bolster our resources, to improve oversight of the ratings from the credit rating providers (CRPs), at the end of the day it's the ultimate responsibility of the insurers to have prudent oversight of their investment. And the work that we're doing doesn't mean that that oversight should be outsourced to regulators. It just means we have to do this work from a regulatory standpoint so that we feel comfortable with the tools, resources and knowledge that we have.

So I'm going to dive in to kind of peel back the framework a little bit and talk about some of the specific proposals that are included in the framework and I'm trying to move through this quickly to provide time for questions at the end. So, the first proposal relates to the issue that we talked about this idea that right now as consumers of ratings from CRPs, the NAIC and insurance regulators really have to blindly rely on those ratings. And a big part of what we're trying to achieve here is to move from blind reliance to informed reliance. We really want to create both quantitative and qualitative parameters that the CRP's have to meet so that we feel comfortable with the ratings that are being provided to us again as consumers of those ratings that there is uniformity and consistency in the level of quality in the ratings that are being performed. And that's really a big part of what we're working through here when we talk about this idea of having more oversight of the ratings and how those track to our NAIC designations. Second, kind of related to that, we want to retain the ability of the SVO to perform assessments of individual securities and to utilize the discretion which we've talked about that is being developed so that when there is identified some concern or anomaly that the SVO has the proper tools to do that credit assessment and utilize the discretion process that has been laid out through those 15 steps. The third proposal - currently, the SVO is really set up to do credit assessments of individual securities and as we're looking to enhance the tools that we as regulators need to understand this more complex investment environment, we really need to look at enhancing the risk analysis capabilities of the SVO itself to move beyond individual credit assessment to look at company specific, company-wide portfolio assessment as well as looking at kind of risk assessments across the industry. This is really in line with the risk focused surveillance move that the regulatory community has been making over the last few years and ties in with broader macroprudential regulatory oversight efforts and responsibilities. So think about it as rather than waiting for some event to occur that leads to a problem, we're trying to develop the tools and build out the resources so that we can identify problems on the horizon and try to take steps to address those before they become a bigger problem. Fourth, we want to continue to build out the modeling capabilities. Again, these are all pieces of a broader whole so if there's a challenge to a particular rating based on the discretionary process we want to have the modeling capabilities to be able

to do the proper assessment and analysis within the SVO. So, building out those additional resources and the governance associated with that is going to be a critical piece of that.

Fifth, we also want to add some policy advisory functions at the SVO. So, instead of just doing credit assessments of individual securities we want to add the ability to have some advisory services that could benefit all of us as regulators to really understand what are some of the emerging issues and potential problems that we need to be aware of as we continue to see the investment landscape shift in the coming years. This is something that's similar to how the American Academy of Actuaries supports the NAIC and state regulators right now in terms of our risk based capital (RBC) and reserving initiatives. This would be similar, but more focused on the investment side. Sixth, currently we have two regulator-only working groups that are really designed to provide a forum for discussion about confidential troubled company specific information. And those are referred to as the Financial Analysis Working Group (FAWG) and the Valuation Analysis Working Group (VAWG). Proposal six would have us develop a similar regulator-only working group that would provide a confidential forum where we could just discuss investment related risks and concerns in a way where we could bring in a broader regulatory group to really understand across states, across different subject matter experts what are issues that we as the broader regulatory community need to be aware of as it relates to the shifting investment landscape and the challenges that might be associated with that. And lastly, the seventh proposal relates to kind of some restructuring of the SVO and renaming the SVO and the Valuation of Securities Task Force (VOSTF) to better reflect the responsibilities that these groups should have based on all the changes that I just talked about as well as making sure the SVO is empowered to utilize these new tools and resources that we intend to develop to support not just regulators across the country but the various working groups and other committees under the NAIC structural overall. And then also look at potentially reducing the size of the VOSTF membership to encourage more active participation and membership who have more of a subject matter expertise and really are willing and able to dive into these issues in a more substantive way.

So, in conclusion, there are four points I want to touch on. Again, these are really tools and resources that we're looking to develop to make sure that we as regulators can properly analyze the risks associated with these new investments to ensure that companies remain solvent. The ultimate goal is equal capital for equal risk. So, capital requirements, capital charges should be the same for similar types of investments and that's not always the case right now, and we're hoping with better tools, with better resources that we can do a better job of accomplishing this goal of equal capital for equal risk. Related to that, as the financial regulators, the more we can capture the accurate risk and assess the appropriate capital charge the more we can reduce the need and desire of companies to pursue regulatory arbitrage. So if we can get all these other parts right we should create an environment where we don't see companies trying to take advantage of loopholes and opportunities for regulatory arbitrage. And then the last point to make is the SVO and regulators overall are completely committed to continuing to rely on CRPs and the ratings that they provide for NAIC designations. There is no goal to have the SVO compete with the CRPs. There's no goal to put any of the CRPs out of business. The goal is again to ensure that right now we have to blindly rely on the ratings that come from CRPs that feed into our designation process which

have an impact on capital requirements and accounting standards and a number of other functions for us as regulators. We want to shift that to being a system where we have informed reliance on those ratings. And ultimately that's the change that we're looking to do with regard to CRPs. There's no way that the SVO could take over or in any way compete with the work that the private CRPs do and we don't want that to happen from the E-committee standpoint. We're not pushing that. There are no task forces or working groups that are pushing that. So, that's something we always like to reinforce because I know there's some misinformation out there about that but there is no attempt to compete with or displace any of the CRPs.

Rep. Matt Lehman (IN) stated that we've been talking about the SVO for the last several meetings and even at some of our meetings with the NAIC. There are a couple of things that still may be a bit of a concern that I'm hearing. In the 15 step proposal, there's some language in here about, well we'll review, but if we're off three points we'll discard that rating and use our rating or we'll discard the rating, and then one of your bullet points there was to use the term "empower" the SVO. And whenever I see the word "empower" I just wonder where that's going to go. Because it does concern me that when you said we don't want to compete and it's just a resource. And so my only concern is I don't want to see that creep over into that becomes our rating service and we don't really need them anymore. So that'd be my only concern and as we keep moving forward on this, I think it needs to be something that we continue to have a dialogue about. Cmsr. Houdek stated that I appreciate that feedback and I know the discretion and oversight process is still in the process of being developed. I talked with the VOSTF Chair on Thursday and the plan is to take the most recent round of comment letters and take the rest of this month and into May and continue to refine and update the 15 step process. And the overall kind of process that's being laid out with regard to discretion, I don't know the details enough to speak to those issues but just know that there is additional analysis being done in initial kind of refining being done in terms of the feedback that we've been getting on some of these issues.

Sen. Bob Hackett (OH) stated that we went through 2008 and 2009 and we had a major crisis, not as much a crisis in our area, but a crisis in the financial markets. And the major mistake that was made was made by rating services with mortgage-backed bonds. The only thing that I worry about is, did we learn from the past? People made mistakes. That's the way those bonds were rated. They were rated tremendously different than they should have been under that scenario. And so I understand what you're trying to do and I commend you for what you're trying to do but in the same token, it still worries me that we might hit a crisis because we only look at the rating services and not other areas like the consultants and other things. Cmsr. Houdek stated that I know what you're saying and I think the tools and resources that we're talking about will hopefully identify those risks and potential problems. But I think to your point, it's then incumbent on us regulators to take action when we see problems. And I wasn't in a role at that time to have done anything but I think we need to continue to proactively identify where there are risks in the system, where there are potential problems and try to identify those and when necessary, take action to mitigate and prevent those risks from becoming bigger problems. So, I don't have an answer because all I can say is hopefully, we're doing the right thing and hopefully when that time comes these tools and resources that we've developed will serve us well and the right action will be taken to prevent those kinds of things from happening.

INTRODUCTION AND DISCUSSION OF NCOIL TRANSPARENCY IN THIRD PARTY LITIGATION FINANCING MODEL ACT (Model)

Rep. Lehman stated that I'm really privileged to be able to bring this Model before the Committee today and you can look at it on page 235 in your binder. For those of you that may have been around here awhile, this issue first hit NCOIL's radar screen in 2011 at our Annual Meeting in Santa Fe, NM and then over the next three years myself, Sen. Neil Breslin (NY), and Rep. Charles Curtiss (TN) worked on some language and came to a final vote at the Annual Meeting in 2014 and it failed 15 to 14. But there's been a lot of discussion as to what's changed since then. Well, it's been a decade and I'll tell you what's changed. I think we've seen a growth in the consumer space, we've seen some growing changes that I know in Indiana we've addressed and some other states have as well. The other thing is we've seen the influx now in the commercial space and I think that's what's really caught our attention as public policymakers because we're beginning to see more and more of these lawsuits turning into nuclear verdicts. And eventually we the policyholders bear the brunt of that. And what was troubling in a way I would say is we began to see or did not see who was behind the funding. Who's putting the money into this process? There was no transparency in that. We began to see cases where they were directing the case. They were directing the suit. The funder was. We began to see that some of these cases might be around not so much an investment to get a return on that money but simply I'm data mining. I'm going to sue Google because I want their mapping technology and as long as I can be a seat at that table maybe I'll get that data. These were coming from foreign investors. They were coming from foreign countries. And you saw articles after articles began to hit. And the one quote I really liked just said "our courtrooms have become a trading floor." And I'm a student of history. I've read The Federalist Papers multiple times. And never did I find anywhere there where our founders wrote the judicial branch to be set up as an investment tool. And so I think we have to be very careful when we get into this world of the judicial branch and litigation. Now that being the case, there's been some that have said "why don't we just get rid of this?" I think there's still a need for the product in certain cases because it would level the playing field and make sure people do have access to the courts. And in some cases we can't just say because I have more money than you, I win.

So, what I've tried to bring here now is a Model that addresses both of the issues that I think are before us as policymakers and that is the issue of consumer lending as well as commercial lending. From a consumer's perspective, I think these become very complicated and very troublesome in that we've seen some cases on the consumer side where the litigation went forward and they took the loan and walked away with less money than anybody else involved. And so again, I think that needs to be addressed. So, I'll briefly walk through a little bit of the Model and then turn it back over to the Chair. In the consumer space we do put in language around registration and making sure that we're regulating the industry that is doing this within your states. We put language around the limit on charges. I think this one has it at 36%. And then on the commercial side we prohibit the funding from the foreign entities of concern. I'll delve into that a little bit. But then what would apply to everybody is that issue around driving the litigation. You'll have no say in what the attorney and the clients decide they want to do on a case. If they want to settle or they want to continue, that's up to them and not up to you the

funder. The other thing is you will not have access to proprietary data. If I sued somebody over something, a trademark, a lot of that information is disclosed. It's held in confidence by the court. But if I'm the funder sitting at that table, I've now got access to it. That needs to stop. And so that's in both sides of this. On the commercial side, what I attempted to do in Indiana, and I still lean that way but I understand where we ended up and where this is at, is we really want to focus on prohibiting those who are investing in our legal system who are not our friends. What passed out of the Indiana House was any foreign entity or country of concern which the federal government has a list of those. Those are China and Venezuela and Cuba, and countries like that. So, this Model does address the countries of concern and I'm going to now go to my philosophy at NCOIL has always been and always will be, we will never craft the perfect Model. There's no perfect Model and I think NCOIL's role, and I think we have 31 different states represented here, is you're always going to go back to your state and find it fits different in your state than it does in my state.

NCOIL's role really should be and my philosophy has always been that we build the foundation, we put the walls around it. Maybe we put a roof on it. We seal it up so it's nice and secure and a neat thing to look at and we get it as a good template. Go back to your state and fill in the blanks. We put it in the Model that the agreements are open to discovery. Now that's going to be a problem in some states because in some states, insurance policies and their limits are discoverable so then the contents of this should be discoverable. Other states don't allow that. So, maybe we have in here that the disclosure of the existence of it is mandated but not the contents of it. So, I think when you get back to your state there's always going to be a different path you may take. I'll wrap up with this and that is I think we're on the forefront of this issue in a big way. I know as we were going through our session, Florida had a bill and Georgia had a bill and at the end of the day the last two standing were us and West Virginia. So, I have talked to Del. Steve Westfall (WV) and asked him if he would be willing to be my co-sponsor on this. There is some language I know that came out of West Virginia that we would like to look at. And my path here would be to listen today and I want to hear you tell me what we need to change in this bill. And we'll take copious notes and I'd like to have an interim meeting of the Committee between now and Costa Mesa in July. If we can get it to the right place, then we'll move the Model. If not, we'll have another vigorous debate. We'll have another interim meeting and then hopefully in November we pass this out as states begin to draft their language for upcoming sessions. They can have a good Model to work with. And if I may, Chair Felzkowski, I'll defer to Del. Westfall and see if there's anything he would like to add to that before we open this up to the panel.

Del. Westfall thanked Rep. Lehman and Chair Felzkowski and stated that SB 850 was passed in West Virginia and it went a little bit farther than Indiana's bill and this Model we have here. So with no objection, I would like to be co-sponsor on this Model. The WV bill is not perfect but we had a lot of support for it and while there was some objection, we got it passed and the Governor signed it so it is law in West Virginia. Rep. Lehman and Chair Felzkowski had no objections to Del. Westfall being added as a co-sponsor.

Harrison Hosker, on behalf of the American Legal Finance Association (ALFA), thanked the Committee for the opportunity to speak and stated that ALFA is the oldest consumer

litigation finance trade association consisting of the nation's largest and leading companies in this market. Our organization has long been an active attendee and participant at NCOIL. Most recently, we testified last November at the Columbus meeting discussing litigation finance. ALFA is not new to NCOIL's discussion of the subject. Ten years ago, ALFA proactively sought NCOIL's adoption of past NCOIL President NY Sen. Neil Breslin's model legislation to address oversight and regulation of this practice. Regrettably the model was not adopted at that time. However, I note that NCOIL members returned home to their States and adopted legislation modeled on the proposed language. We commend NCOIL and Rep. Lehman for taking up this issue again with his introduction of this model. I want to take a moment to discuss the unique distinctions between consumer and commercial litigation funding as both are captured under the proposed Model. These two transactions are distinctly different fundings that are often conflated creating significant confusion in the development of public policy.

Commercial litigation funding is a product that is used to fund the prosecution of litigation by funding the actual cost including attorney fees, the cost of discovery, research, deposition, witness fees, marketing and other expenses associated with the initiation and pursuit of a legal claim. Commercial litigation funders often include private equity large institutional investors and investment funds that become involved in the litigation before the legal action is actually filed and initial. Commercial fundings in many cases involve millions upon millions of dollars in effect investing into the pursuit of the litigation and its results. These sophisticated institutional investors and underwriters have numerous analysts and legal professionals to determine and underwrite the risk and value of the investment in large multi-million-dollar complex disputes involving amongst other things, intellectual property, product liability, bankruptcy and antitrust. This type of litigation often involves multiple jurisdictions resulting in hundreds of millions of dollars in settlements or judgments. Commercial litigation funding is distinctly different from the transactions that the members of ALFA provide. ALFA members provide consumer litigation funding transactions where a small amount of money, typically several thousand dollars is provided to personal injury plaintiffs to assist them with their personal life needs. Consumer litigation funding is only provided after the plaintiff has filed their case. Therefore, such funding has no role in the litigation being initiated. While pursuing a personal injury claim these funds were provided for life needs such as rent, car payments, mortgages, groceries and other personal financial needs. Consumer litigation funders do not provide funds to prosecute litigation. It is critical for the committee to know that the funds provided by ALFA members are contractually prohibited from being used for any cost, fees or expenses related to the prosecution of litigation. All ALFA members must adhere to this contractual standard and all other standards established in our best practices. ALFA's best practices include prohibiting any funds from being used for the cost of litigation, prohibiting the funding company from being involved in any decisions relating to the litigation, prohibiting funding companies from paying any referrals or kickbacks, and prohibiting funding companies from using false or misleading advertising. The model before you today contains many of the policies such as registration and reporting requirements, banning referrals and kickbacks, and mandating clear and easy to read contracts that ALFA has worked tirelessly to adopt in law across the country. We have several technical amendments that we'd like to see included before the Model is approved but it is our intent to be fully supportive of this model.

Eric Schuller, President of the Alliance for Responsible Consumer Legal Funding (Alliance) thanked the Committee for the opportunity to speak and that the Alliance is the trade association that does represent the companies that do offer this product. Currently, we have 46 members in our association. I won't repeat a lot of the stuff that Mr. Hosker stated because I agree with a lot of his statements. But there are a couple things I just wanted to maybe reiterate on. One is, we respectfully request that this piece of legislation be divided into two pieces of legislation. One dealing with the consumer side and one dealing with the commercial side. I can tell you I've been dealing with this issue for about 17 years now across the country and I can tell you the two issues get conflated all the time. When you have someone talking about funding of litigation, they think it's a consumer getting $400,000 to bring a class action lawsuit. Our average funding to a consumer is about $3,000 to $5,000 and that's used for specifically household needs. As Mr. Hosker stated, the roof over their head and food on table. As was stated by one of the largest funds that offer this, Burford Capital, in the 60 Minutes piece I'm sure a lot of you have seen, their minimums serve about $3 million dollars, so just a couple of zeros difference between the two. One of the things we want to make sure about too in this is that by having two pieces of legislation you're not going to conflate it. The Alliance, like ALFA, welcomes regulation on the industry. Unfortunately, it has been stated a lot of times that the commercial folks don't want regulation on the industry. That's their issue. That's not ours. And my concern is by putting this all into one piece of legislation is you're going to have people within the space that are going to be divided on it. The equating of this is that we're both fruit but we're an apple and they're an orange.

One of the other things we'd like to address is the issue on the rates that are currently in the piece of legislation. Our recommendation and suggestion would be to take a specific rate out of the bill and let each individual state determine that. We have some states like Missouri last year that didn't have rate restrictions, but we have other states like we worked with Rep. Lehman in putting in a rate restriction in Indiana. And just let each individual state address that issue. One of the other issues that we'd like to address respectfully with this is on the disclosure of the product. What was initiated years ago and in last few years was automatic disclosure of the product. We don't agree with that. What we've come to kind of agree to is kind of what we worked with Rep. Lehman on in Indiana last year where there's an acknowledgement that the consumer has one of these transactions but if you want any more information on it, it goes to the discovery process, but the normal discovery process of that state. It should not be more discoverable or less discoverable than any other financial product that the consumer has. So, if you need access to their bank accounts or whatever it is, this should not be treated any differently. And then finally, it should be inadmissible against the consumer, it cannot be used against them in any way. And then finally, what we'd like to do is work with the members of this committee and anybody else that has interest in this in making sure that there is a piece of legislation out there. As I stated before we like to have this industry regulated, but also we want to make sure that it's good for the consumer and good for the legal system and also good for our companies.

Daniel Hinkle, Senior Counsel for Policy and State Affairs at the American Association for Justice (AAJ), thanked the Committee for the opportunity to speak and stated that AAJ is the largest plaintiff's trial bar in the country. I'm here today to be helpful to the committee. Each individual state has their own state trial lawyer association that speaks

for their state association. So, I can't speak for them. I am in communication with them. I will talk to them. I can explain things to them. But they make their own decisions. Similarly, AAJ works on federal policy, not on state policy. That's our state associations. So, I am a man who speaks from nowhere right now. But hopefully I can be helpful to the committee and to you all and sort of understanding where the trial bar comes down and sort of thinks about this issue and understands it. So from a big picture perspective I agree with both Mr. Hosker and Mr. Schuller. Commercial litigation financing and consumer litigation financing are two separate issues. I think of it as commercial real estate versus title loans. They're just different products that are thought of differently and addressing them both in the five minutes that I have is going to be complicated but I'm going to try to keep them separate, as I talked about. When you talk about this though, there is one similarity between them. And the access to these products can be either useful or smart. It is useful for the family that cannot put food on their table to have access to some financial product that lets them get to the point that the insurance company finally decides to pay on a valid legal claim. They need help during that interim period so they can put food on their table because they can't work. Having access is helpful. Similarly, the small business that's been exploited by a giant corporation whose only shot at maintaining their business is access to commercial litigation financing so that they can maintain their profitable business. It's important for them to have access to it. On the smart side of it, this is kind of like reinsurance. It's probably not a perfect analogy. But it can be a risk mitigation tool, particularly on the commercial side of this for sophisticated players working on some sophisticated issues. With that said, the biggest issue that we have with the model and what you're going to find from trial lawyers across the country is the automatic disclosure provision that's in the bill. I appreciate that it's narrow. We have seen automatic disclosure requirements that go so far as trying to get at partnership agreements within law firms and trying to really dig into the finances of every single person who might be involved on the plaintiff's side of the issue here.

This is a much narrower provision and I appreciate that. And I specifically appreciate that it already carves out the issue of entities of concern. That is a serious problem and I completely agree with you. Those sort of entities should have no place in the legal finances in this country. The one thing I would add though is that they should not have any place in it on either side. Currently, this bill is drafted so that it's only entities of concern who are providing litigation finance on the plaintiff side are carved out. Which is great. But it should be expanded to cover when that litigation financing is provided to defense firms for after the event insurance and other things like that. There are lots of financial products that are in this area that don't just cover the plaintiff side but also cover people on the defense side and I think that the committee should take a look at that when they're thinking about this policy. The other thing about the automatic disclosure that a lot of our members have is that most people do not use these products. Especially on the commercial litigation funding side as Mr. Schuller mentioned. It is a very narrow group of some cases and some firms that will potentially use these products. The vast majority of the time, this is not an issue at all in the litigation. But by forcing automatic disclosure, you make it a part of every single case. Because whether someone does or does not have litigation financing provides a tactical advantage to the defendant in a particular litigation, on the consumer side as well. So, whether a consumer needs to take a loan out so that they have the ability to put food on their table is wholly irrelevant to the case. But if we have to disclose that to the insurance

defendant on the other side they have a duty to represent their client as thoroughly as possible. They can drag out that litigation process knowing that the client will eventually need to take a lowball settlement just to make sure their family has food on the table.

On the commercial side, similarly, the issue isn't necessarily that you disclosed there is litigation financing but did you disclose that you don't have litigation financing. Because if the defendant in a high stakes bet the company case does not have litigation financing, the defendant, who already has more resources than they do, knows that if they drag this out, they have a much better shot at either forcing this company to fold before the end of litigation or they're going to have to take a lowball settlement just to get some money in the door so that they can repay their other investors so that they can dissolve the company later. They just won't have the money to pull this out. So, that automatic disclosure provision is a problem. I do want to point out two more things - it gives negotiation leverage to the other side as well to know what position the plaintiff is in. And then the last thing is the public relations pressure. That's obviously part of this conversation across the board. We're already seeing this issue of litigation finance being used to delegitimize the civil justice system in general which I think is wildly hypocritical in certain circumstances that we're talking about a litigation finance measure around litigation when that's what the insurance industry is in the business of to a large extent. And I think that there needs to be sort of a general ratcheting down of the sort of rhetoric and understanding around this tool so that we can have a much more common sense, straightforward discussion about what exactly this industry is and what the pain points and what the issues are in terms of some of these proposals and I'm happy to do that. There are some good parts of this bill and I'm more than happy to work with the Committee on figuring out the best way to draft this policy.

Robert Gordon, Senior VP, Policy, Research & International at the American Property Casualty Insurance Association (APCIA), thanked the Committee for the opportunity to speak and stated that APCIA represents the majority of the property casualty industry. We greatly appreciate the Chair and the committee's consideration of the model legislation to protect our civil justice system from the hidden funders seeking to tip the scales of justice for their profit. And I particularly commend Rep. Lehman for advancing solutions to provide more consumer protection and more transparency into these hidden practices. And I want to strongly endorse and agree with Rep. Lehman's comments about how much has changed since he earlier identified the need for more sunlight in this area and the potential harm of shadow financing by third-party litigation funders. And one of the things that changed is the Government Accountability Office (GAO), which is a federal agency and not a public relations operation, did an investigation of third-party litigation financing published just last year. And they found it is expensive and they deter plaintiffs from accepting the settlement offer because they want to make up the amount they will have to repay the funder. The GAO also cited the warnings that sovereign wealth funds may be involved in third-party litigation funding to further foreign policy or military goals. There's been a lot of discussion about sovereign wealth funds pouring billions of dollars into encouraging lawsuits in the United States and five of the largest ten sovereign wealth funds are in China or Singapore and another four from the Middle East.

Secret third-party interests are now funding tens of billions of dollars into increasing litigation in United States. An estimated 30% of intellectual property claims now have

hidden third-party dark money involved and not only are large funders being increasingly shown to control litigation, but again, we're uncovering that foreign actors and a number of our adversaries are essentially weaponizing the third-party litigation funding in our U.S. litigation. Fortunately, the policymaker reforms to create more transparency in third-party litigation funding are already starting to help. So, just last month, the Wall Street Journal uncovered that Abu Dhabi conglomerate owned the company, Forest Investment, a litigation financier that owned VLSI Technologies. That's a former chip manufacturer, been defunct for decades it but filed a multibillion-dollar litigation against Intel in Delaware. But when the Delaware judge told VLSI they would actually have to disclose its litigation funding origins it actually dismissed its suit rather than reveal its true master. And then only a week later, on March 28th of this year Bloomberg Law exposed that Putin's billionaires dodged sanctions by financing lawsuits and Bloomberg revealed that billionaire founders of a Russian conglomerate evaded both U.S. and European sanctions after Russia's invasion of Ukraine through third-party litigation funding around the world including in New York in London. So we now see state and federal policymakers and courts very much waking up to the dangers of this hidden money, they're actively investigating the third-party manipulation of the justice system. Just this last week in Congress, the Deputy United States Treasury Secretary discussed with the Senate Banking Committee the national security implications of illicit third-party financing and the challenges of foreign adversaries investing in U.S. legal system abuse. And the Deputy Secretary agreed before Congress that there needed to be more transparency of the shadow funding system and supported working together to address the problem including potentially through litigation. Although this legislation and oversight is being done so far primarily through the states which is why NCOIL's efforts are so critical. We saw just recently four states adopting statutory requirements for disclosure of both consumer and commercial litigation funding. I'm a little surprised others on this panel think legislators can't draft legislation dealing with two colors of essentially the same fruit. They suffer the same damages and defects, especially when the focus is more sunlight to help detect and limit that abuse. And Indiana and Montana, West Virginia, and Wisconsin have already done the right thing and what we're now seeing in these cases is with the third-party litigation funding a majority of expenditures are going to the funders and the lawyers. And the funders have no fiduciary duty like the lawyers do to act in the victim's best interest. So, a lot has changed since Rep. Lehman had the foresight to identify this issue as a problem. It's something very important to deal with. States and the federal government are waking up for the need for more oversight. It's beginning to gain traction and it's very good timing for the Chair to consider model legislation and for the Committee to consider its adoption. We strongly support proceeding with the model. We look forward very much to working with you on it to make sure it achieves the intent and very much the need for additional transparency.

Jon Schnautz, VP of State Affairs at the National Association of Mutual Insurance Companies (NAMIC), thanked the Committee for the opportunity to speak and stated that the model that's before you, there are several fairly small pieces of a much bigger issue. And the bigger issue is like it or not, litigation is becoming an investment market in a lot of different ways. And we don't know all the repercussions of that. It is still a fairly early thing. But I think probably one of the things that everybody up here would probably agree to is it's not going away and it has grown over the years. So, I would start with that and then just point out this is looking at some fairly narrow pieces of that much broader issue. So, a couple of aspects of the model that I think are very positive

and I'll speak to one and this seemed to be a point of agreement is that the model clearly prohibits control of litigation by a funder. I think that's a really important thing and a good piece of the Indiana bill. We think the model needs to reflect that throughout and we'll have some suggestions on how to make that more clear. I will speak to you since it was raised about how the model does include a limitation on the consumer side on the amount that can be charged. Because it's not obvious in the model, I'll just tell you the rate that is being referred to there is a 36% interest rate. So, in terms of what the committee might want to do there I would just advise that's what's on the table so you may want to consider whether you think that's a reasonable limit or not but I think that is an important issue to at least have be part of this conversation. There may be better ways to structure it but I wanted to bring your attention to what specifically is included there. On the disclosure point, I think that the model needs to be viewed carefully in light of what the Indiana situation was on the ground there. Rep. Lehman and I have had several conversations about this. Many states have different provisions on disclosure and discovery. In our view the way that the bill ended up treating these agreements is very similar to how insurance policies are treated in the discovery process and we think that is well justified. The analogy is not perfect but in terms of what ought to be disclosed we think it is a very strong one across both sides of the v as to what the disclosure ought to be and we look forward to thinking about other ways that that might be made more clear. Maybe it's the West Virginia approach, maybe it's something a little more modular but we want to be part of that conversation.

I have a couple of other responses to other points that have been made and then I'll stop. First, on the issue that there ought to be two models. I guess I would just point out this is already a fairly bifurcated model. It's got one set of rules for consumer. It's got one set of rules for commercial. They don't overlap a great deal. The one thing that's in for both and that we think is the most important part of the model is disclosure. That's the commonality. Otherwise, I guess they could be on two different sets of paper but other than that the model already recognizes some very key distinctions so that's already done to some extent. Finally, one of the previous speakers talked about kind of this leverage argument on disclosure and if I understood him right, he was arguing that in certain circumstances the opposite things are true. The argument that I've heard most often on disclosure is well, if the plaintiff' has to disclose it they're going to disclose that they're in financial dire straits. That's kind of a strange argument to me because it's sort of like saying "well I would have been in financial dire straits but guess what I got this funding and now I'm not." So, I don't really understand how that disadvantages the plaintiff from a leverage standpoint, it would seem if anything the opposite. On the other hand, the fact that the plaintiff doesn't have funding I think tells you almost nothing about why they don't have funding. Maybe they don't have funding because they don't need funding. There's no real inference you can draw there that the plaintiff is in financially some sort of destitute state just because they don't have funding as part of the case. So, those are the points I'll make for now. We look forward to continue to be part of this process.

Rep. Brenda Carter (MI) stated that I'm glad you brought this situation to light because I think it's very similar to payday lending. Regarding the 36% interest, who can afford that? I'd like to know what's the difference between what you're proposing and payday lending? Mr. Schuller stated that there's a big difference. Payday lending creates a cycle of debt for the consumer and consumer legal funding does not create debt. The

Internal Revenue Service (IRS) has even weighed in on this and says if a transaction is consumer legal funding is done as a loan and the company gets back less than contracted amount, meaning the case settled short and there's not enough money to pay, then that funding company has to 1099 that individual because it is a forgiveness of debt. But if it's done as a funding like we have in the states where we pass it like Indiana and Missouri and several others, that is not debt. So, we do not put consumers in the situation of debt. It's also the only financial product out there that you only have to meet your obligation if a third-party gives you money, meaning you win a settlement. If that that third-party does not give you money, then you're not contractually obligated to make it. Whereas in payday lending, car title loans, home mortgage, credit cards, the person that provides you those funds, they don't care where you got your money from. They just want your money. We want to make sure you get it from your settlement and then secondarily if there's enough money to pay us back that's the process. The way we have a draft in the states is attorneys, medical liens, statutorily they all get paid first. Then we get paid. So, it may sound the same as payday lending, but it's a whole lot of difference between the two. Finally, this is the only transaction that I'm aware of anywhere that's offered and your attorney has to sign off on it. If the consumer's attorney looks over that contract and says this is not in the good interest of my client, it doesn't happen. In fact, we've put that in statute that if the attorney doesn't sign off on that, it doesn't happen. In most states you can go and get a $500,000 mortgage and you don't have to have an attorney at closing but just getting $500 from any one of our companies, the consumer's attorney has to look over the transaction and say this is okay for them to do.

Del. Westfall asked Mr. Hosker when and why do people seek your type of funding you were talking about? Mr. Hosker stated that to reiterate some of what Mr. Hinkle said, it's just a way of while they are pursuing justice after they've already filed their claim. So, this is not initiating any litigation in any form. But let's say for example someone gets in a car accident through no fault of their own and while they're awaiting the settlement from their claim they have no way to fix their car. They have no way to get to work. And so this allows someone to come in and fill that gap for them or put food on their table or any other life need that they would want to spend it on.

Rep. Jeff Keicher (IL) stated that I wanted to go back to the story that we started out with that just caught my ear. Does the financing company have access to the discovery documents through the course of the trial or the discovery process? Mr. Schuller replied no, we don't. And in fact, we're very clear that we do not request privileged information. Rep. Keicher asked what about the other side where we're financing on the business end of the Intel example if you will? Mr. Hinkle stated that I'm not aware of that being a condition or a part of any of this. I'm not opposed to that provision being included in this bill or being a model policy. I would think that's protected already. Rep. Keicher stated that he hopes so. I just think about the nature of some of the more expensive ones that are going out there and the more detail that needs to be there and I think that should be a consideration. And out of curiosity what's the most common setup for interest or a range of interest that is assessed on these fees that are lent? Mr. Schuller stated that a lot of it is risk assessment in states like Indiana where we have rate restrictions in place. Some states don't. I can tell you that two examples I point to are Oklahoma and Utah. There are no rate restrictions in either state. I can tell you for a fact those two states have probably the lowest rates in the country because the market is dictating the rate

and in both those states companies have started up that were not there before the statute went into place and they're all local companies and they are giving the national players a run for their money because they are right there in Oklahoma City and in Tulsa and in Salt Lake and they're going to the attorneys who they deal with on a regular basis and saying, "hey, if you got a problem, I'm right down the street here from you. You don't need to deal with that guy in New York or the guy in Los Angeles or the guy in Chicago."

Rep. Keicher stated let me ask it this way - what is the lowest to highest range during your career that you've heard assessed on these dollars on an annual basis? Mr. Schuller stated that I'd say probably in the mid-30% to the mid-40% range. And I think a lot of times it is they're also risk assessed meaning that the case is more riskier. Just like in insurance, if a driver has a very poor driving record, they are going to pay more for it. Rep. Keicher stated that and I'm not trying to mitigate the risk, but I want to understand that the average typical rate is between 30% to 40% per annum on the monies lent? Mr. Schuller replied yes, typically.

Sen. Beverly Gossage (KS) stated that this issue came up in our legislature last year and what's interesting to me is I had to have them come into my office several times, and I was asking "what am I missing?" I don't quite get this. So, I was trying to understand it because what we heard was "we just to level the playing field." And I'm like, but if somebody is suing someone you typically assume the person doing the suing is the one that was harmed and they're trying to say maybe they don't have the money to come against this person. And so they've got somebody who's invested in them and what was shared with me is that we're not trying to stop that. We're just trying to say disclosure - they should just be able to disclose that they have that. Could someone address the difference? Mr. Hinkle stated that I can try to address what you're talking about. So, I assume you talking about the consumer side and not on the commercial side? Or are you talking about the commercial side? Sen. Gossage stated that typically what they tell me is commercial.

Mr. Hinkle stated that with the commercial side, I guess I'm not quite sure where they're coming from in terms of the issue too in one regard and so maybe we'll talk about that but I do want to talk about the remedy that they've proposed here which is disclosure. And so even if you assume that there's something problematic maybe I guess with where the money is coming from, which despite the fact that it is completely covered in this bill seems to still be the basis of their testimony here today, that somehow the disclosure needs to come from the lawyer to the opposing side and this side. I can tell you from my conversation with our members, they are working with a firm, a reputable U.S. based, commercially regulated firm that's providing sort of litigation funding in a handful of cases where this sort of thing is available. They don't know where that firm got their money. And so, the idea that the lawyer is going to be the one who's going to know to disclose it to the other side is I don't know how we get to that. They're not the ones there. But even if you assume that there's something problematic with this and that the lawyer might know about it, what does disclosure do other than provide the sort of tactical advantage that are already laid out here? I think if there's a problem with the funding then you can ban the funding and that's what this bill does for the sort of funding that we've identified from foreign entities of concern. If you have a problem with litigation funding in the commercial space, regulate the problem you have with funding in the

commercial litigation space. The disclosure doesn't really do anything from that perspective. But even if you assumed the disclosure somehow did do something in these cases and that disclosure was an appropriate remedy in some way, why is the disclosure not to the Attorney General or the Secretary of State or some sort of entity within the State that could somehow do something with that information to regulate whatever the problem is with that? Maybe the Bar Association -- somebody who could do something with that would be a much more appropriate sort of target for that disclosure. But even if you assume that somehow there is a problem with third-party litigation disclosure in the commercial space and that the lawyer is the one who should know about it and should be the one that's disclosing and that the litigation funding should be disclosed in the context of a particular piece of litigation, why is the insurance defense counsel the appropriate party to be disclosing that to? Why not to the judge who could do something about it in camera if there's a problem, which I have yet to see. And so, I think that that's kind of the chain that you're probably maybe sort of correctly intuiting that it doesn't really make any sense as to why it is that the insurance defense is the particular party that needs to know about this.

Sen. Gossage stated that I've been told that on one side the one being sued has to disclose how much insurance they have. And so they're saying that this kind of equalizes that by you have to disclose how much money somebody has invested in your case. Mr. Hinkle stated that I apologize for misunderstanding. The reason why is because it's relevant and proportionate to the issues that are before the court. It goes to the standard rules of discovery generally. And the reason why you'd want to know if they have insurance or not is you want to know if you have the ability to satisfy a judgment against them. There is no corresponding need to know if the plaintiff has the capacity to bring the litigation. That's just sort of implied by the fact that they sued.

Rep. Tom Oliverson, M.D. (TX), NCOIL President, stated that this is all new to me and I'm learning a lot here. My question is more simple and that is, I've heard this number 36% finance charge thrown out. I'm sure that's not the case in all cases but that does sound like a large number to me. Assuming they're also lawyers that are representing these clients that don't have the money, are they getting their legal fees paid on top of that? And if so, if there is a judgment in their favor, what are they left with in these circumstances where an attorney may claim 20% to 40%, right? And then there's a 36% finance charge. So, in that case, what's left for the plaintiff?
Mr. Schuller stated that we typically fund no more than about 10% of what we think the value of the client is to make sure there is money leftover for the consumer on it. You have to remember, at the end of the day, the consumer is not going to settle the case unless they're comfortable with the money that they're going to get in the end of it. The number that has been offered is 36% and everybody thinks "oh my God that's high." Just because the company charges a rate doesn't mean they make that rate. You have to remember too, there's a lot of costs associated with this. Right now, the cost of capital for some of the companies, especially the smaller companies, is 15% to 20%.

Rep. Oliverson stated that, related to what you just said, obviously most of the attorney's fees in these situations are probably contingency based. Mr. Schuller replied, yes. Rep. Oliverson asked what about the financing company - if their judgment doesn't go their way do they lose all their principle? Mr. Schuller replied then we get absolutely nothing even in the case, and it does happen on occasion, where the consumer drops the claim.

So let's say they're living in northern Minnesota and say I'm done with cold weather and I'm moving to Maimi and they drop the case, we can't do anything about it. The only time we can go after a consumer is if there's fraud involved and in order for fraud to be involved, because we have the attorney sign off on it, their attorney would have to be involved with it. I don't know many attorneys that would lose a law license for $3,000 that somebody else got. Rep. Oliverson stated that it is fair to say then there's parity in that for both the attorneys as well as the financiers, it's high risk, high reward essentially. Mr. Schuller replied correct. And just to give you some quick numbers, when we polled our members last year, 30% to 40% of the time they get less than the contracted amount and about 10% of the time they get absolutely zero. That could be caused by a lot of things, they lost the case or they dropped the claim or there wasn't enough money left over even if there's a verdict. Let's say we projected the case would settle at $50,000 but it settled for $10,000. After everybody's paid, there's nothing there. I've seen transactions where the consumer, because they got legal funding, in the end got more money than anybody else. That does happen.

Rep. Lehman thanked everyone for their comments and stated that I think I've narrowed this down to two issues that probably need to be tweaked or at least looked at and those are separating the two issues, and disclosure. And so, with that, I look forward to working with everybody moving forward to get this to a place where hopefully we can have something to vote on. Sen. Felzkowski thanked Rep. Lehman and stated that I look forward to discussing this throughout the year and if anyone has any comments or questions please reach out to me, Rep. Lehman or the NCOIL staff.

DISCUSSION ON DEVELOPMENT OF NCOIL EARNED WAGE ACCESS MODEL ACT

Sen. Felzkowski stated that next on our agenda is a discussion on the development of an NCOIL Earn Wage Access Model Act (Model). As a reminder we had a discussion on this topic at our last meeting in November and you may have heard of this in your state where these types of providers grant workers access to wages that have already been earned before their scheduled payday. A few states have taken action and enacted laws with licensing and other provisions. After the discussion in November, NCOIL Vice President, New York Asw. Pam Hunter expressed an intent to develop a model law on this issue. Unfortunately, Asw. Hunter couldn't be here today as there was some last-minute schedule changes relating to New York's budget adoption. But she did convey that before introducing a first draft of a model she wanted to get some feedback on whether it should follow the direction of Nevada which was the first state to enact a law on this issue, or follow other states such as a bill that has been introduced in her home state of New York. You can view the Nevada law and New York bill on the website and app and some material comparing and contrasting the laws has also been distributed before you.

Matt Smith, Director of Gov't Relations and Consumer Affairs at the Connecticut Department of Banking thanked the Committee for the opportunity to speak and stated that I'd like to start off a little bit talking about Connecticut's small loan and related activities law. Under this law, it allows lenders to lend up to $50,000 beyond the 12% usury rate in Connecticut. The interest rate cap for this is 36%. Under this Act a license is required for companies that are leading beyond the 12% for a variety of activities. But particularly for our discussion it does define as licensable activity advances of money on

a borrower's future income or advance of pay. And I think that that's important here today. So, again under this law your annual percentage rate (APR) cannot exceed 36%. So last year, the Connecticut Legislature at the request of the Department made some modifications that included that tips, subscription fees, and expedited transfer fees are now treated as "finance charges" when calculating the APR on a loan or advance. This was a proposal the Department had placed publicly back in January of last year. There were public hearings on it by the legislature as well as the opportunity for public testimony on this bill. The legislature passed the bill and then on September 11th of 2023, the Department issued industry guidance that captured not only earned wage advances but litigation settlement and some peer to peer lending companies as well both of whom had reached out to the Department during the last legislative session to talk about the department's proposal. It's important to note that one of the reasons that earned wage advances should be subject to oversight and licensure is we've already seen some bad actors in this space, particularly a class action lawsuit that resulted in a $3 million return of monies to consumers that were harmed and $9.5 million in forgiveness. That was EarnIn. And then Brigit, another earned wage access direct to consumer model, was fined $18 million by the Federal Trade Commission because of unfair and deceptive practices.

So, with that, earned wage advances are indeed loans captured under the Connecticut small loan and related activities act. And I know that there are a lot of insurance people here, but if you were to ask any banker, what is it when you give somebody money and you expect payment in return for a fee? They would call it a loan. And that's exactly what these are, small loans. It's another iteration of a payday loan that we've seen consistently over the years designed to prey upon vulnerable consumers, to circumvent lending laws. We've seen this with storefront payday lending in Connecticut and tribal lending. This is just a high-tech innovative way because you can use your smartphone to make it easier for you to have access to cash at an APR that exceeds 300%. When considering the Model Law I think it's important that it requires: unfettered access to company records for the regulator; thorough examinations; the vetting of ownership and control people in the organization; the need to have a surety bond; as well as a disclosure to the consumer on the actual cost of the money in the form of an APR calculation. It is something consumers are familiar with. It's how you buy your car. It's how you find a rate for your mortgage. While they may not understand exactly what an APR is, they generally know that the lower the APR is the better it is for them. And then finally, there should be no exemption for any money transmission exemptions in any model law. Money transmission is a very different space through the small loan lending. One can imagine that as this business model evolves, you're going to see, and this is only me conjecturing, the possible movement of money between the consumer and another friend of theirs. Or paying a bill or something like that. And I think that it's important that as non-bank services begin to move into the spaces of traditional banks which do not have the proper supervision that we can expect or essentially a deregulating of the financial services space. And when you're deregulating non-banks when banks have such strong regulation on safety and soundness then more services move over to the deregulated space. Small ripples in that space can have larger consequences for the entire financial system as a whole. So, I think that's important as we look at this to think about what kind of regulation we want. We want regulations that protect consumers and also balance that with a healthy financial services system.

Ben LaRocco, Senior Director of Gov't Relations at EarnIn thanked the Committee for the opportunity to speak and stated that I'm going to start with a little bit of a recap from what we talked about a couple of months ago. When you earn your money, you have a legal right to that money. If you are working and living paycheck to paycheck, you might only have $50 in your bank account but have hundreds or even thousands of dollars that's legally yours. And you should have access to it. So, we provide that service with no mandatory fees and no recourse if somebody doesn't get paid back. So EarnIn, we have about two million customers and we estimate there's about five million customers across the country that use this service so every elected official has earned wage access customers in their district. Who uses this service? Amazon and Walmart employees are generally always our top two employers but some other surprising top employers are postal workers are always in the top ten. Hospitals and school districts are also often in the top ten. So, folks where it's very human capital intense. And a lot of people are making an hourly wage. We don't sell any data. The only way that we make money is by voluntary fees or tips. We say, "hey, if you like the service, give us some money." If you need this money immediately you can pay a fee for that but nobody ever has to pay anything and many of our customers never pay anything. There's no late fees. There's no interest. So, as we're talking about the model policy here, the first eight bills came about four or five years ago. They were not really very well thought out. We've done a lot of work in the interim. Last year, the Council of State Governments (CSG) adopted the Nevada bill as their model bill, which was the first EWA bill that passed. Three other states have passed that bill. Missouri and Wisconsin have both been signed into law. In Kansas, the bill is sitting on the Governor's desk. So, that'll be the fourth state. California did a law by rule. It's sort of interesting. They consider it a loan but exempted it from the lending statue and said you don't need to become a lender, you can get registered under this other statute. So, I think there's maybe 15 or so other states that have considered this kind of legislation in one way or another.

So, I'm gonn do a little pre-buttal to the Center for Responsible Lending (CRL) presentation and then I'm going to respond to Mr. Smith a little bit as well. For CRL, why do they care about this so much? They generally don't disclose this but CRL is a subsidiary of a multibillion-dollar credit union that essentially has almost no capacity to compete with digital first financial services. You can see if anybody is on their phones. You can look at their app in the App Store and you can see some of their ratings. You know 3.3 stars compared to 4.7 stars. So, they have a model where they claim to be an impartial actor but then they essentially just attack anything that is new and innovative. And it is frustrating. So, my apologies that it's a little bit negative but I want to talk a little bit about some of the data that they have put out recently which I'm sure they will talk about. So they put out this report that basically claims that if you use earned wage access you get more overdrafts. But correlation is not causation. You know, it'd be like saying we followed nursing home patients for six months and we found that anybody that went to a hospital had more stitches afterwards, therefore hospitals are very dangerous. There's just a ton of reasons why the data that they disclose about this industry is misleading at best. One question that's going to come up a bit in all presentations and you already heard from Mr. Smith is a question of APR and fees. Basically, the Connecticut Department of Banking changed the way that APRs are calculated. It is not the way that APRs are calculated under federal law that everybody has been abiding by for 70 years. There's also a number of other fees that most financial services

companies can use. You can see here our fees compared to some of the fees that Self Help Credit Unions use. So $45 if you lose your PIN for your ATM and you need it soon, that's a lot.

Comparing EWA to credit cards. The average earning customer spends about $60 a year using EarnIn. The credit card user spends $1,000 on late fees and interest. That's from the Consumer Financial Protection Bureau (CFPB). And just to give you an example of what happens if you don't pay EarnIn back. If you get $100 from EarnIn and you don't pay us back, you never owe us more than that $100. If you take $100 on a credit card, specifically the Self Help Credit Union credit card, a year from now you're going to owe $182 even though the APR for that is only 16% but once you compound that monthly and you add in the late fees that really adds up quickly. So the fees are quite high and the APR is pretty misleading. So, that's the next thing I want to about, APR. The Truth in Lending Act (TILA) is about a seven year old federal law that governs how APR is calculated. So, there's a number of transactions that technically have 0% APRs the way the law is calculated. But essentially, what the CT Dep't of Banking did and what CRL has done to attack this industry is said well, we want to redefine APR differently to essentially scare people about this product. And so using their claim we have about a 200% APR with our $3.99 fee but the late fee for their credit card is higher than that at 300%. An ATM fee would be 700% and an overdraft is 1,800% So, all of those things are 0% APR but if you recalculate it differently there are high numbers that you could scare people with. But even at that, ours is still lowest.

So, what happened in Connecticut? The first quote up here is from Mr. Smith's testimony on this CT bill. The change in the bill from his testimony was about income share agreements. Earned wage access never came up in any of the testimony, in any of the discussions. It doesn't appear in the bill. It doesn't appear in any of the materials. We've asked dozens of legislators, "how'd this happen? Have you ever heard of earned wage access?" Zero people had ever heard of earned wage access before they voted on it that we've talked to. We had a conversation with the Department asking "how'd this happen?" When we first talked to them they said "Oh this was a misunderstanding, this wasn't our intention." And then as time went on they said "Oh yeah this has always been this way." So we put in a Freedom of Information Act (FOIA) request for their emails and we asked, "tell us about all of the earned wage access conversations you had with legislators." There were none. They never talked to legislators about them. So, as legislators I think you should be very wary of regulators that come to you and say a bill does one thing and then it does something very different. And in this particular instance it was very harmful to our customers. And I heard stories from our customers about this. We had to pull out of the state on basically two weeks notice because of the Department's guidance and people were just devastated. We followed folks in Connecticut and compared them to folks in New York and we found the folks in Connecticut had 10% more overdrafts compared to similar people in New York. Thousands of dollars in overdrafts that they shouldn't have had to get. They're very stressed out. So there was a lot of financial stress that happened to these people because a financial service that they had been relying on for years was taken away from them because of the change of this law.

Elyse Hicks, Gov't Relations Manager at DailyPay thanked the Committee for the opportunity to speak and stated that I am just going to highlight some things that I think

you went over at the last meeting and tell you a little bit more about DailyPay. At DailyPay, our model is employer integrated which means we actually contract with the Targets of the world or the employer to integrate into their time and attendance and payroll systems. And that data updates four times a day. So, we get fairly close to the net amount that people are able to access and transfer to their accounts. Companies run payroll about once or twice a month. My husband was a teacher and he got paid once a month. So, you can just kind of think about how much he had to budget. He was also in the military and he got paid semi-monthly so twice a month and at that point we were living in California on his income. So 11% of companies run payroll monthly and 36% of companies run payroll bi-weekly and 32% of companies run payroll weekly and 0% of companies run it daily. I want to take a look at some strategies that our customers used before DailyPay: 57% paid a bill late and 49% borrowed money from family and friends and 39% overdrew their bank accounts and 21% took out payday loans and 21% made a loan payment late. DailyPay likes to say that we are overdraft fee eliminators. So, 38% of people that were surveyed overdrew their accounts before DailyPay and 97% rarely or never overdrew their accounts after DailyPay. And 75% of those people attributed that savings to DailyPay's use. We also like to say we're payday loan pillars. So, 28% of people that were surveyed took out a payday loan at least once a month. After DailyPay's access, 95% stopped using payday loans and then 88% of those people attributed that to the use of DailyPay.

Here we can see that 39% missed a loan payment or they paid the bill late. After DailyPay, 88% had less trouble paying their bills late. DailyPay has partnered with 970 employers. We have 1.6 million enrolled users and a 36% adoption rate which means the employees that are employed by the employers that we contract with have access but they don't adopt it. So, 36% of people that have access adopt or start using DailyPay. The average transfer amount is $108 and 49% of platform users make no transfer, but they kind of use it to see what their net earnings are. This is also important, 66% of all platform users each month then take a three month to one year break after using our platform for the first time. There is probably trepidation about overuse or high frequency. This is what we're seeing when we are surveying our customers. Regarding our fee structure, there's no employer fee. If someone wants to use DailyPay and their employer has given them access to use DailyPay we have two free options. One is a standard Automated Clearing House (ACH) delivery so they can wait about a day to three days. It's usually a day to get that if they want to transfer to their bank. We have an instant transfer fee to our Friday card which is our prepaid debit card if they would like to use that. If they would like to get that money instantly to their bank account there is a $2.99 to $3.49 instant transfer fee. We all know that we do not live in a real time payment system so it does take money to move money. And that is a flat fee. So, depending on when the employer signed up with us their fee is either $2.99 or $3.49. We also have a financial wellness platform and people do use this as a financial wellness tool. One thing that I'd like to point out is 93% of DailyPay users check the app for their earnings to make spending decisions and 83% of DailyPay users say DailyPay helps them make better choices because they know their earning from day to day. We're also good for businesses. We lessen the turnover rate by 45%. My neighbor noted that I worked for DailyPay and she told me that she actually took her job because DailyPay was offered. People like having access to their earned wages when they need them most. So, that goes to my next point of the product being 52% in faster recruiting for businesses and three times more engagement for businesses and it lowers

absenteeism for workers. I want to focus on the three states that have already signed and passed laws on this: Neveda, Missouri and Wisconsin. And there were over 10 state bills that were introduced in this legislative session. In six states the bill passed at least one chamber and in two states it passed both chambers. And within the laws that are already on the books and those that were presented we do as an industry advocate for strong consumer protections and these are the lists of consumer protections and hopefully my slides are available for you to look at those consumer protections and I don't have to go through all of them and I'll stop there.

Monica Burks, Policy Council at CRL thanked the Committee for the opportunity to speak and stated that CRL is a non-partisan, non-profit, policy advocacy organization. It was started in North Carolina in Durham and its initial mission was to shut down payday lending in the state of North Carolina because we came to recognize a pattern of the debt cycle, patterns of harm and patterns of usage that prevented people who access payday loans to build true wealth and stability for themselves. And I found it interesting that one of our speakers today mentioned how folks have been relying on their products for years and when it was taken there was this fallout. And that is the exact type of harm that we recognize in payday lending and similarly in earned wage advanced products that our research is affirming. And so, I just want to talk about that a little bit. And so the report that was mentioned was an analysis of over 14 million transactions from consumers. From that report, nearly 2,000 customers completed over 37,000 earned wage advanced products and we took a snapshot of an 18 month period of them using this product. And 75% of the users took out an additional advance the next day or the same day that they repaid the other one. So, that cycle of reborrowing that is signature to payday loans continues with the use of this product and I find it interesting because we heard that when folks switch over to DailyPay they stopped using payday loans because it was replacing the same exact purpose they were using the payday loans for. We also saw from this study that 48% of users use multiple earned wage access apps in one pay period and that's probably because as you see on the next slide, most of the earned wage advance aps limit the amount that you take out to $100. I'm a single mother with two children. When I go to the grocery store I'm praying that it comes in at $100 these days. It's such a small amount of money that folks are stacking the apps against their same paycheck that they're hoping to try to make ends meet between those periods.

Those small frequent transactions result in high fees for users. Just like payday loans you can see on the screen here the APRs are astronomical. What that means is if I didn't have $80 to get groceries and gas before my payday, when I have to repay that loan on payday I need to take it back because I still don't have the money. I took it away from money that I was anticipating and as soon as I get that money I have to pay it back. So, what's happening with the companies is they're giving you that same $80 and repeating the fees that you pay on that same amount of money and that is why it's so profitable. That is why some of these industries are looking toward going public. Because they're bringing such a healthy amount of return on the funds that they're lending. And to note this term "access" is misleading because they're not facilitating access to wages from their employer to the employee. They're third-party companies giving their own money from their own capital to facilitate these transactions and that's an important distinction because you can't do that for free. And they don't want to hear us talk about APR because APR illuminates the finance charge to access this money. It's telling the consumer how much it costs compared to other options to handle the

financial issue that they're facing. But when you conceal that, when you defuse it for tips and fees and subscription it makes it harder to compare. It makes it almost impossible to know exactly how your money is being drained. And so, as you can see from the research, and I encourage you all to take a deeper look at the full report, these markers of payday lending are the exact reason why we think there's some essential protections that need to be included in any model law. And clearly from the research it's clear that these products are more harmful than helpful to consumers. But even if you as a policymaker sincerely want to make sure this product is available to consumers in your state, guardrails are essential. I mean, even if you have a vehicle, cars are useful but we still mandate seatbelts. So, regardless of how amazing and life changing some folks believe these products are, as regulators and as policymakers there's a powerful opportunity to make sure consumers who do see a need in these products have appropriate protections. Those minimum protections include and I think one thing that's really wonderful about the New York bill is the tips that these lenders can solicit are a part of the total cost and it does contemplate a cap on those sort of costs. That's great. However, it doesn't state what that cap is and it leaves it to the regulator to decide. And then paired up with that provision it says that if you are offering earned wage access under this bill then you're not subject to the state usury cap. And what that does is it kind of allows the regulator to allow fees that would exceed the state cap. And in a state like New York, like Connecticut, like Vermont where they have already put in comfortable, reasonable limits on APR, we don't want to allow these payday-like products to get a carve out from those strong protections.

Rep. Ellyn Hefner (OK) thanked everyone for their presentations and stated that I recall hearing this at the last NCOIL meeting and my first initial thought was that the thing that we do is we forget about the education on financial literacy first. I did have that in high school but I know that I had to teach it to my kids because they don't teach it. And even if I think it's a good idea that we could get the money that we earned earlier, you know that but they don't even know really what that is all about and what the next steps are. I remember when I was young my Mom said you need to have good credit so you can buy a house. Well, I bought a house when I was 20, I have great credit, but it's not possible for young kids to buy houses these days. So that's not even one of those scare tactics to have good credit. So, I'm just wondering in each of your presentations I didn't hear a lot about that where we should start that earlier. I know education in my state is something that we're really talking about and related requirements. And you all can talk about the use of this and I said this and he said that but the only thing that I know is that we're talking to a big culture of people who have no understanding about what those missteps are with saving. I did like in a previous presentation talking about putting money in a place for later. Maybe we start out and look at a different model when you go check and you take $5 away and put it into an account and it grows and if there's an emergency we use it. I don't know. But right now we're not really teaching all the things that you are referencing like lending and comparing it to your credit card or bank drafts – there is still a huge population that has no idea. So, I'd just like to hear where financial literacy comes into all this and if that's being something that you push also instead of just talking about these products.

Ms. Burks stated that I appreciate you raising that issue and I spent most of my time in law school trying to understand how to increase literacy in the exact frame that you mention. And during my time I was honored to hear a distinguished Professor who

spent his career and his research focusing on this exact issue. And one of the things that his research actually revealed is that financial literacy, while it is important and powerful, actually has a much smaller impact on the wealth gap that we're witnessing in our country. And the main thing is an ongoing gap between living expenses and reasonable wages. And so you can understand everything about how to manage your money but if you're constantly trying to take care of yourself or your family on a salary that just does not cut it, that's an issue. And a lot of times you'll hear folks or certain industry people say there's no other solution and that's why we have this product but there are solutions. But in the meantime, it's important to recognize we don't want to overburden people with fees they can't afford in the absence of real viable solutions for that gap.

Mr. Smith stated that the Connecticut Department of Banking does have a fairly robust financial literacy program and we were very supportive of the bill that finally got passed last year that made financial literacy, wellness and education part of a requirement to graduate high school. So, to answer your question we are making some strides in that regard.

Sen. Felzkowski thanked everyone and stated that Asw. Hunter is going to be introducing a first draft of a Model for discussion at our summer meeting. And in the meantime if you have any questions or comments please reach out to myself, Asw. Hunter, or the NCOIL staff.

ANY OTHER BUSINESS

Sen. Felzkowski stated that I have one last piece of business to raise. Our Workers Compensation Insurance Committee has jurisdiction over a model law dealing with structured settlements. It was brought to our attention that some folks who have an interest in structured settlements weren't aware that the model was in the Committee as it does also have an annuity aspect to it as well. So, starting now and going forward this Committee will provide notice to everyone when that model is being discussed by the Work Comp Committee. For those who may have missed the Workers Comp Committee, yesterday morning there was a presentation on structured settlements for those that may not be familiar with this product and the laws surrounding them. It hasn't been decided yet as to whether the model or structured settlements in general will be put back on the Work Comp Committee's agenda for the next meeting. If you have questions or comments, reach out to the Chair, Sen. Lana Theis (MI), or the NCOIL staff.

ADJOURNMENT

Hearing no further business, upon a motion made by Del. Westfall and seconded by Rep. Lehman, the Committee adjourned at 3:30 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
FINANCIAL SERVICES & MULTI-LINES ISSUES COMMITTEE
INTERIM COMMITTEE MEETING – MAY 31, 2024
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Financial Services & Multi-Lines Issues Committee held an interim meeting via Zoom on Friday, May 31, 2024 at 12:00 P.M. (EST)

Senator Mary Felzkowski of Wisconsin, Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Rod Furniss (ID)
Rep. Matt Lehman (IN)
Rep. Brenda Carter (MI)
Sen. Paul Utke (MN)
Asm. Ken Blankenbush (NY)
Asm. Jarett Gandolfo (NY)
Asw. Pam Hunter (NY)
Del. Steve Westfall (WV)

Other legislators present were:

Sen. Lana Theis (MI)
Sen. Natasha Marcus (NC)
Asw. Shea Backus (NV)
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 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 FELZKOWSKI

Sen. Felzkowski thanked everyone for joining the meeting and stated we have two model laws on today's agenda to discuss, both of which we would like to try and get across the finish line by our annual meeting in November. That may seem like a tall order given the complexity of the issues today, but I think that's why we're meeting today as these interim meetings are a good tool to continue conversations on models in between our national meetings.

CONTINUED DISCUSSION ON NCOIL TRANSPARENCY IN THIRD PARTY LITIGATION FINANCING MODEL ACT

Sen. Felzkowski stated that we'll start with a continued discussion on the NCOIL Transparency in Third Party Litigation Financing Model Act (Model). We had a very

productive discussion on this Model at our spring meeting in Nashville. We heard several different perspectives on what the best approach is for the Model going forward. And I'll first turn things over to the sponsor of this Model, Rep. Matt Lehman (IN) for remarks.

Rep. Lehman thanked everyone who has reached out to discuss the Model. We've had good participation and I've got a lot of feedback since this first came out for discussion. As Sen. Felzkowski noted, we had a productive meeting in April and many of you have reached out since then so thank you. As you can see on the website, included in the materials today is a copy of the West Virginia litigation financing law that passed earlier this year. I've included that in the materials at the request of my colleague and co-sponsor Del. Steve Westfall (WV). Please look at that and if you have suggestions when you look at that as to what might need to be brought over into this Model I'd like to hear from you. So let me take a step back for a second. It seems like from what came out of the Nashville meeting there's three core issues that have really been the theme of a lot of your comments to me. One has been the splitting of the Model between the commercial and consumer. And we can have that discussion but what we try to do at NCOIL, and you've heard me say this before and I'll say it again, is to have a good foundational piece of legislation that you can take back to your States. If you take this back to your state and split it in two, so be it. But right now, I would like to see us continue this discussion as one Model. We've had a lot of discussion on the amount consumer lenders can charge. Currently the Model is set at 36%. Or should we just be silent on that and let the states decide? Some states have different usury laws than others and so maybe we take that approach of let your state meet whatever standard they have. And then the last thing has been under what circumstances should the litigation funding agreement be disclosed? I think that's a discussion we need to continue to have. I think that's a valid discussion because I do think there are things within those agreements that may play a part in all of this.

Those aren't the only comments that have been out there. Those are the three main buckets, so to speak. A few other factors that have come out that I think are worth discussing - one was around the definition of who the bad actors are. We have certain foreign governments and countries included but should that be expanded to include bad actors individually? We have Russian oligarchs that the federal government says you can't do business with these people, not the entities, not the governments, the individual people. And there's data out there and resources out there to reference so maybe we look at expanding this to the bad individuals, not just the bad countries. Montana had some language on capping the amount of fees funders can collect. So maybe that's a different incentive as you're going to put money in is to know your return on your investment may not be what you think it's going to be. And then just some miscellaneous changes to definitions for some clarity and consistency.

So, what I want to hear today from comments really are anything we need to change in the Model before we meet again in July. They don't necessarily have to relate to these specific issues I just listed but I want to hear suggestions on how we can make this Model more effective. I feel we all agree that we must address at some level the potential disruption of this in our balance of scales of justice. I think you're seeing more and more evidence that this is distorting our judicial system and return on investment should not drive litigation. So, I can't stress enough my willingness to hear your

comments and if you worked with me in the past you know I'll listen to everybody. We may not agree but give me your ideas and we'll try to find a place we can all land successfully. So, I want to continue the conversations. The Model development needs to be fluid and collaborative. And again, thank you to everybody who's already provided comments. I look forward to the discussion today. I think this is a great opportunity for NCOIL, on an issue that's getting a lot of national attention, to take the leadership position and get the states to a place where they have the ability to act on this. And so while it may take another meeting even after July, I do want to get this to a place where we can go back to our respective chambers and get this out next session. So, with that I hope we're ready to vote on this come November.

Del. Westfall stated that we did pass this year Senate Bill 850 with bipartisan support. It passed the Senate unanimously, and overwhelmingly in the House. I think the West Virgnia bill is a pretty good one to go with and it has some similar provisions to Indiana's bill. And the U.S. Chamber of Commerce and the West Virginia Chamber of Commerce helped a lot with the West Virginia bill and I think it's a pretty good piece of legislation.

Jack Kelly of the American Legal Finance Association (ALFA) thanked the Committee for the opportunity to speak and stated that ALFA is the association of companies that do consumer funding, not commercial funding. And the provisions that I'm talking about are on the commercial side of the disclosure of foreign money. If we want to address bad actors, you can just go to the sanction list. The sanction list issued by the U.S. Department of Treasury delineates individuals besides delineating countries and enterprises. I think that would in a major way address what Rep. Lehman is talking about and get to a much broader parameter to get to the individuals. On the consumer side I have suggested a couple of changes which are truly technical. And I don't want to belabor the members of the committee with those type of issues that I think we could work with staff on. A very similar bill passed the New York State Senate sponsored by Sen. Jeremy Cooney, a member of NCOIL, two days ago 62-0 which addresses the consumer side. It does not address disclosure because to be very honest if anybody knows anything about New York, the New York trial bar is very challenging to deal with.

Dai Wai Chin Feman of Parabellum Capital which is a commercial legal finance provider, thanked the Committee for the opportunity to speak and stated that I'm here on behalf of the International Legal Finance Association (ILFA) which is the trade association for the commercial litigation funding sector. I was invited recently to participate in this. I'm very grateful to have the opportunity. I just wanted to speak very briefly about where I come from and kind of the commercial sector's perspective on this. And I look forward to working with everybody. I will have a colleague who's coming to Costa Mesa in July to participate. But generally, just some background about what we do. We do mainly business to business litigation investment. It is not personal injury in nature. So, I think that's a pretty easy place to draw the line between consumer and commercial - personal injury, non-personal injury. Either is fine with us. We don't really have a dog in the fight on the consumer side. That's really issues of consumer protection as far as we're concerned. We do pre-settlement business to business litigation predominantly. These are cases where there is rarely and almost never insurance on the other side because these are things like breach of contract, antitrust, international arbitration and patent infringement. So, there isn't really a lot of intersection with insurance. On the other hand there's a lot of insurance companies that invest on our side doing judgment

preservation insurance or collateral protection insurance for plaintiffs. So, there's actually a lot of overlap positively and synergies with insurance and funding.

So, I wanted to make that clear. And also, that I don't think we're really on the other side here of insurance interests given that there really isn't insurance on the other side of the types of things that we do. We also don't object to anything about foreign adversaries dismantling our legal system. Really the issue that's important to us is disclosure. This is a model law I'm actually kind of confused about because this looks not to be an insurance law it looks like a litigation funding bill. Just so everyone knows the litigation funding regulatory push is Chamber of Commerce driven. If you go to their website it's a big priority. I'm surprised this is being considered as a model bill given that only a few outlier states in the country that are not major hubs of commercial litigation funding have passed these bills. I think it's no surprise to know that there's almost no documented proof of any litigation funding on the commercial side happening in Indiana, Montana or West Virginia. And that's no coincidence these are states that our industry doesn't particularly have a big interest in given that there isn't a lot of commercial litigation there, big ticket stuff that's worth tens and hundreds of millions of dollars. And so the Chamber has sponsored dozens of bills over the past couple years and they've succeeded in four or five states and none of these tend to be the ones where there's really any proof that this industry even exists. So, I'm confused why this would be model legislation.

But in any event I think I'm excited to kind of correct misconceptions and hopefully take a data driven approach to some rational regulation here. We totally support limited disclosure to identify conflicts of interest and things like that. But any disclosure of an actual funding agreement is going to be highly prejudicial to the parties. It's a road map for the defense to know the litigation budget and the return. It's the equivalent not of getting an insurance policy done before the case arose but instead of getting the defense budget and the defense strategy and insurance and information on the reserves. It's not in parity with insurance disclosure requirements. It's very different for a lot of reasons. I can explain. We don't have control over these cases. We're not indemnitors. And generally it's just very different. So, I think rational regulation recognizes that we don't want to prejudice the parties that need the funding to begin with. We don't want a David suing a Goliath and having to take outside money because they can't otherwise afford lawyers but then their defendant now has a road map to bleed them dry. Because when a case is funded, it's not funded with unlimited dollars. Investment funds have limits just like everybody else. We have duties to our own investors and can't overcommit the money. And so there's just a lot of differences with insurance. And we need to protect against prejudice. So, if there's discovery about a litigation funding agreement it should be clear that there's nothing prejudicial that gets disclosed. All sensitive terms must be able to be redacted but important things like who the funder is so there's no conflicts of interest, statements that the funder is not unduly controlling the litigation, that's all fine.

Again, as long as there's protections against prejudice and I look forward to working with everybody towards kind of a reasonable solution here because I do think there's an opportunity to do something new, not like Indiana or West Virginia which are outlier states but things kind of in the middle that recognize this prejudice. It's something that actually the federal rules civil advisory committee has been grappling with since 2014. This very issue sponsored by the Chamber of Commerce, they've done nothing that

whole time. And if you read their agenda books they're not really interested in it because it's pretty clear that this is a Chamber driven initiative that is only intended to help big business. And in light of that it's a very partisan issue. But I do think if there's a rational approach that recognizes both sides and the legitimate interests here then it is a real opportunity. I look forward to working with everybody and answering any questions here or offline. As representatives on the consumer side know, we're both out here in the game of education largely and just making sure people know there's a lot that can be said about our opaque industries. We're really just trying to protect the interest of those that we fund because they need us from an access to justice perspective.

Eric Schuller of the Alliance for Responsible Consumer Legal Funding (ARC) thanked the Committee for the opportunity to speak and stated that to address some of the things that Rep. Lehman said, first of all we hope to see the Model divided into two separate pieces of legislation. I've had some conversations with some of the members of the committee and there still is a lot of confusion as to what it is that the consumer side does and what it is that the commercial side does and I think that confusion would just be exasperated if it went into one piece of legislation. So, that's one of our recommendations. The second recommendation that we've had is again what Rep. Lehman brought up - maybe toning down on the disclosure aspect of it in that it would just be acknowledged that yes the consumer has one of these transactions. Secondly, that then follows a normal course of rules of discovery for that particular state, not giving more weight or less weight to either side. But then finally in the end then it's inadmissible against the consumer because we don't want to have someone being able to go into court and have that piece of information if they had to get some financial assistance to pay their rent or mortgage or keep a roof over their head to be used against them in the courtroom. And then finally I've looked at several model bills from NCOIL and have not seen any in which they limit the profit restrictions of a particular company in it. And I don't know if necessarily that NCOIL wants to kind of go down that route a little bit of limiting the profits of companies, what they can and cannot do. As Rep. Lehman has said, and you can look at our website, there have been a variety of different types of legislation passed on this. Some with restrictions, some without restrictions. And I think that should be something that should be left up to the individual states to make that determination. We believe in a free market solution that the market should dictate what that is.

And then finally, a couple of issues to kind of reiterate my initial point of being put into two separate pieces of legislation. The bills that were highlighted talking about Montana and also the bill that passed this year on West Virginia. Those specifically were on the commercial litigation financing end of things. And by putting it into one piece of legislation it really muddies the waters as to what can and cannot happen and I think it just puts a lot of confusion as to what things are being talked about. I've heard things of people talking about well you give someone on the consumer side $3,000 so they could pay their mortgage and keep a roof over their head and now it's leading into $20 million verdicts. That's just not the case. So, I think we just need some clarity on that and again, as a model bill it should be as generic as possible and then let each individual state take it as they need.

The Hon. Tom Considine, NCOIL CEO, stated just factually in terms of NCOIL models, the prior statement wasn't correct so I just would like to get that into the record.

Danielle Waltz, and attorney at Dinsmore & Shohl LLP in Charleston, West Virginia thanked the Committee for the opportunity to speak and stated that I'm here in my personal capacity but I did work with several clients in West Virginia including the U.S. Chamber and the American Property Casualty Insurance Association (APCIA) on the bill and I want to echo what Del. Westfall said that in West Virginia the bill that included the disclosure requirement was supported by a number of parties included the American Association for Justice (AAJ) who actually testified in favor of the bill. I worked on the bill in 2019 in West Virginia with Mr. Schuller and then again on these revisions. And primarily, I believe the legislators thought it was important to extend the disclosure requirements to commercial funding. This litigation financing is something that sunshine's just beginning to shine on and by allowing the disclosure and making the disclosure mandatory as the West Virginia legislators chose to do it just puts sunshine on the information and gives all parties a level playing field in litigation.

Mr. Feman stated that Mr. Schuller's comments reminded me that in 2020 the Uniform Law Commission (ULC) conducted a study as to whether to issue model legislation similar to this. It was also a Chamber sponsored initiative. And the Uniform Law Commission, we had a process run by Professor Cassandra Burke Robertson at at Case Western Reserve School of Law and there's a memorandum associated with the ULC's conclusion that due to the so many differences in state laws on these issues ranging from champerty to usury, they said it wouldn't be appropriate for uniform law. I'm going to dig that up and circulate it to NCOIL just so it's added to the library for everyone to consider.

Del. Westfall stated that I hope we can pass something. I really like what we did in West Virginia and Indiana's version as well. I think disclosure needs to be a part of it. We were really concerned of any type of suit who was funding it and we saw some cases or heard of some cases that there were some countries and people that we shouldn't be doing business with and they shouldn't try to wreck havoc with some businesses in West Virginia. That's why we passed it and it passed pretty overwhelmingly. I hope we can get some amendments to the Model and then vote on this in November.

Rep. Lehman stated that I appreciate all the comments and we'll continue this discussion. A couple of comments kind of bothered me when I hear the terms being used about well we're not interested in the non big-ticket states. You know, Indiana, Montana, West Virginia that's okay there because we're not doing litigation funding there. We talk about elimination of profits, return on our investment, free market. Can you please help me understand where our founders said we need to create a judicial system that's fair and balanced where you can get a good return on your investment. That's the one area that I don't think capitalism and free markets really should reign is in our judicial system. That's me personally. I hear from people saying we need to make more money. I don't think the judicial branch is where that should be. I do think there's true evidence too of where you need to make sure that everybody has access and there's going to be times I need to be able to have that access. That's why we're not doing a total prohibition. There needs to be some parameters around this. So, I look forward to more discussion. I look forward to Costa Mesa and I think that we're going to have a good result in the end.

Sen. Felzkowski thanked everyone for their comments and stated that for anybody that's interested if you have some other comments or questions you can always reach out to the legislators on the committee to further discuss in between now and Costa Mesa. And please be sure to reach out to Rep. Lehman, myself or NCOIL staff with any other comments on this.

CONTINUED DISCUSSION ON NCOIL EARNED WAGE ACCESS MODEL ACT

Sen. Felzkowski stated that next on our agenda is a continued discussion on the NCOIL Earned Wage Access Model Act (Model). We had a very good discussion on this issue at our spring meeting in Nashville and since that time the first draft of the model has been distributed which you can view on the website with our meeting materials. I'll turn things over to the sponsor of the model and NCOIL Vice President, Asw. Pam Hunter (NY).

Asw. Hunter thanked everyone who has participated in the discussions on this issue since we first introduced it in November. A lot of what Rep. Lehman said regarding his litigation financing model applies here in the sense that it's a great opportunity for NCOIL to provide guidance to states looking at this issue. You can't watch anything on television without hearing about earned wage access (EWA). You don't hear those specific terms but it's basically getting paid early for work that you've already done. And our conversations here come at a good time because when you look at the states that have taken action on this issue and passed legislation, they've taken different approaches. So, we can use this model as an opportunity to review and discuss what states have done and what should be included in the model and what shouldn't. Earlier this month South Carolina became the latest state to pass an earned wage access law and last month Kansas did. That brings us to five states that have earned wage access laws. So, our conversation here is very timely. Turning to the model itself, it essentially mirrors a bill that has been introduced in my home state of New York. But I want to stress that I'm open to suggestions on anything that should be changed and I know that some redline changes were already distributed from some interested parties. We can use this New York bill as a starting point and I hope that we can get something discussed again at our July meeting and then get something to vote on in November.

The Hon. Mick Campbell, Commissioner of the Missouri Division of Finance, thanked the Committee for the opportunity to speak and stated that first, just a little background on the Missouri Division of Finance. We're responsible for the oversight of 194 State Charter Banks with about $190 billion in assets as well as almost 2,500 non-depository licensees. EWA was first introduced last year during our 2023 session and was passed into law as part of a larger Omnibus Bill. And in Missouri we have a five month session each year from January to May. And for a new concept like this to be introduced and then passed in its first year is pretty rare. And admittedly we really didn't have as a regulator a ton of information about EWA at the start of that session last year and didn't have the benefit of several sessions to kind of get acclimated to this new concept. But certainly we had discussions both before and during session and then after passage with both association groups and individual companies as well as sponsors and that really helped us kind of gain a comfort level with this EWA space. It was enacted and went into effect August 28th of last year so we had a short period of time from passage in May to enactment but we did have a licensed application that went live to industry a couple

weeks before August 28th and I think a lot of the questions we had from industry kind of going in to enactment and once it was enacted was were we going to do rule making or not. Would rule making delay implementation and hamper reliability to move forward with the enacted language? And we really felt like the language that was passed in Missouri which was an industry initiative was pretty straightforward and the way we like to do rule making is to kind of give a new concept like this a couple years to kind of season so we know better where clarity may need be needed by regulation.

But we did start accepting those applications as I said right before enactment date and within about the first two weeks or so we had 10 licenses and right now we have 29. I think about this time we anticipated maybe having 15 or 20 licenses. But this isn't some huge kind of crush of hundreds or thousands of applications. There's just not that many players in this space. There's really not any pain points that I could point to for Missouri. And in our experience so far industry has communicated very well and their representation in Missouri we have a very good relationship with them and communicate with them and very transparent with them so I think that really helped the process both for industry and the legislature and for us as the regulator that was going to be taking this on. But I did want to maybe point out a few things for you all to kind of maybe be on your radar for peers of mine in your state, questions they may ask or things that may come up as part of the process as this model act starts to be introduced in more places. I think going back to what I mentioned earlier, just kind of lack of awareness and understanding. We didn't really know much about it but we have a pretty open mind here. Not all of my peers may be as open-minded about this new type of product or service that they don't know a ton about.

So I think education is very key. And I think the legislation and oversight is beneficial to both citizens and industry. So I think trying to tie that in could help make you successful. I know a lot of my peers will get hung up on whether these are loans or not and most will be adamant that they are. I'm really indifferent on the topic. Now that we've had a chance to kind of learn more about the industry I'm more inclined to believe that they really technically aren't loans especially for the employer direct product but that'll probably be a question and maybe a sticking point for a lot of state regulators. Also, assessment of fees and charges and whether those are limited or not especially for states that have usury rate caps for lending already. I've had a chance to go over the model act. I do think that a lot of the concerns I just mentioned have been addressed in the model act compared to maybe what was passed in our state back in 2023 which should make it more palatable to a wider range of state regulators in my opinion. As I mentioned we only have 30 licensees so far so budget and full time employee concerns or burden to me is very minimal and we've easily been able to include this in our regular capacity for non-depository oversight. We've had no complaints on EWA both before licensing was required and after licensing was required so we've not had to conduct any investigations or haven't got to the point of having to conduct regular exams either.

So, a couple of other technical situations that might come up is when is a license actually required? I think we would like to have some kind of de minimus situation and this would apply to the employer direct model where they have 1,000 employees in one state but they have two or three remote employees in a couple other states. If they're doing an employer directed product, does that EWA provider have to be licensed in those two states where they just have one employee? I think the way that the model act

reads as well as what was enacted in Missouri the answer to that is yes but I think it would do both regulators and industry a lot of help if there was some, and I don't know what the number is five transactions, ten transactions a year, or clients, or 100. I don't know what the number should be. But maybe some type of de minimus situation would be very helpful. And then you may see some state regulators that want to push for bonding requirements in this space. To us we didn't feel like that is necessary or even down the road as EWA is much different than say money transmission licensing or mortgage licensing where surety bonds do play an important role kind of to the nature of those products and the monetary risk to citizens.

Asw. Hunter thanked Cmsr. Campbell for being here today. It's rare when we have these interim committee meetings that we get Commissioners from different states to join us so we really appreciate you being here today.

Ben Larocco with EarnIn thanked the Committee for the opportunity to speak and stated that we submitted some suggested red lines to the model that we believe make it a little bit more applicable across states and a little bit more applicable for our businesses to be able to continue to operate. So, I just want to say thanks for the process. We want to participate as it goes forward and I look forward to working with the legislators.

Andy Morrison of the New Economy Project thanked the Committee for the opportunity to speak and stated that I just wanted to weigh in about our position on earned wage access. We represent groups across the state. We've been doing fair lending work in New York for many years and just want to point out that from our perspective EWA, particularly with the direct business to consumer model that's exemplified by companies like EarnIn and others, is not a new concept. It's a very old concept known as usurious lending. And we think that most problematically with any model legislation and bills that have been advanced in New York are provisions that exempt these products from our usury law. In New York we're one of I think 17 states that have really strong usury laws that have effectively barred payday lending which extracts massive wealth from black and brown neighborhoods in particular. And we don't want to see EWA products circumvent that really strong protection so that they can charge usurious rates that extract money from those communities. So, just wanted to share that that's most fundamentally our issue that these products, if they want to operate, they must do it under the usury law.

Penny Lee, President and CEO of the Financial Technology Association (FTA), a Fintech Trade Association representing the Fintech Industry which includes the earned wage access products and companies, thanked the Committee for the opportunity to speak and thanked Asw. Hunter for all your effort and your leadership and your work on this bill. And what we've seen is that for the American worker, the two week or one month pay cycle no longer applies oftentimes to their own economic needs and their own liquidity needs. And so these type of products are really helpful to those to try to meet those short-term gaps and those short-term needs because the two-week pay period oftentimes doesn't fit their own needs. So, we appreciate the work of this Committee and of Asw. Hunter and others in a very collaborative and very deliberative process to be able to come to this model law that we have to give clarity to other regulators in other states. As you've seen, there has been a lot of questions with this new product in the marketplace. Different states have reacted in different ways with five

having laws passed. Others are reacting as well. So, I think it's incredibly helpful to have an organization such as NCOIL take the lead on this model law to be able to provide that clarity. So, we appreciate everyone's leadership on this.

Lauren Saunders, Associate Director of the National Consumer Law Center (NCLC), thanked the Committee for the opportunity to speak and stated that we've done a lot of work on earned wage access. We work for economic justice for low income and vulnerable clients. We have concerns about some aspects of the draft model law and also see some positive aspects of it. I support the fact that you are taking a different approach from Missouri, South Carolina and the other states that have adopted laws so far. Those states all allow payday loans. They do not have rate caps. And the approach of exempting the advances from lending laws and having no cost limit whatsoever is not appropriate in states that protect people against predatory payday loans. I do strongly object to the provision in the draft that exempts these advances from usury caps and also don't think it's appropriate to give unfettered discretion to a regulator to decide what fees should be allowed above the usury cap. I strongly believe that these are a new kind of fintech payday loan. The data is clear that these loans are trapping people in a cycle of debt – 36 to 100 loans a year, 300% annual percentage rate (APR) loans. And as others will discuss, some of the models are triggering overdraft fees. The broad definition of earned wage access in this draft and in others is broad enough to potentially encompass traditional payday lenders. So, we have to be very careful that we're not just allowing another kind of high-cost loan. It is appropriate obviously to cap the costs and cap fees. Any cost cap should also be per month and not just per transaction in order to prevent snowballing costs and manipulations to push people to take out several advances when they really just want one loan.

There are aspects of the proposal that I support. I support requiring the disclosure of an APR that includes all fees, all costs including tips before each transaction. And I support the quarterly disclosure of all costs. The data shows that the rates on these loans are very high and with people taking out dozens a year, several a month, small costs add up. And it's important to disclose that rate so people can compare. Also I strongly support including any tips and other so-called voluntary charges when measuring costs, and prohibiting any default or suggested tip or anything that requires the consumer to take affirmative action to opt out of those costs. We have seen many manipulations that these lenders have used to push people into paying tips. I've seen a video of one user using an app and had to take five different steps in order to undo tips and other costs that the app kept putting in and had to sort of power through eight different messages about why they really should tip and why they should feel guilty about tipping. Some reviews talk about they try to trick you into giving them more money. The first screen is a tip screen. You say zero and next loads the advanced screen which automatically puts in another $10 tip. I won't read the whole review but there's a lot of manipulations there. So, again I strongly oppose exemption from usury caps but support addressing all these manipulations. Make sure you include expedited fees too and focus on all costs that are received by the lender whether or not they are so-called charged to avoid manipulations there.

Ryan Naples of DailyPay thanked the Committee for the opportunity to speak and stated that DailyPay is a business to business EWA company. So we sign contracts with businesses and then we take four to six weeks to integrate with their payroll and their

time and attendance systems and then everyone who works for these companies are able to download our app. We get about 36% of people downloading the app. There's about 50% of people just watching to see how much they make because we pull data four times a day. So, people are able to see how much they make throughout the day and throughout the payroll period. The people that do transfer the wages they've already earned, I do want to be clear that these are not usurious rates. These are either zero dollars if you can wait until the next day or it's $3. I do want to also object and we have also objected to the California data that was released publicly and gets mentioned a lot about this 300%-plus APR rate. There are 20 business to business companies like mine. There are far fewer direct to consumer companies and California used three companies that asked for tips. There's only two companies now left in the industry that do ask for tips and they only used two companies that don't as opposed to the 20. So the data was extremely skewed which is how they got this 300%. Because they were not comparing the correct number of companies when they were making this calculation. I do also want to say the data and the research shows the opposite of what was just mentioned by the previous panels about how this does help people. And the Financial Health Network which has done panel discussions and surveys with people who they did not find from any company, hey just got them from anyone who actually used it. They all showed positive results. Because you can't think about this in a vacuum. The people that use us are using us because otherwise they're going to pay bills late. And so I think the model bill is a good thing because it actually sets up criteria for disclosures around tips. Right now there are none.

So it actually has strong, helpful disclosures. There's also an important strong mechanism to control the cost because there are no loans in the country where they're either free or $3. There are no loans in the country where you cannot pay it back and there are no negative consequences. Keeping that as the standard for the industry going forward is also really important we think. So, that's why I think it's a good idea for this model bill to be considered and we appreciate it. And I do also want to mention in South Carolina every single Democrat voted for this bill in both houses. I think there were two people who voted against the bill in the Senate who were Republican. And these are laws and regulations that get codified into law after a great deal of discussion and education. No one is rushing to codify industry best practices. We want to make sure everyone understands what this is and why it exists and why it helps people. So, we're not trying to rush and we appreciate the conversation.

Andrew Kushner at the Center for Responsible Lending (CRL) thanked the Committee for the opportunity to speak and stated that CRL is a nonprofit, nonpartisan advocacy and research organization that works predominantly on predatory lending issues. I second everything that Ms. Saunders said but I'm also going to add just a little bit on an issue specifically about direct to consumer EWA products and debiting of users bank accounts. So, if you look at Section 8(b)(4) of the model law, it gives to the state regulator the authority to promulgate rules around the debiting of users bank accounts. I'm going to address that. So, just to give a little bit of context. I believe my colleague Monica Burks talked about this in depth at the NCOIL meeting in Nashville but we recently at CRL did a study based on actual transaction data that we received through another nonprofit that looked at overdraft incidents by EWA users. And it actually found that with direct to consumer EWA users on average, user incidents of overdraft increased 56% once they started using the product. So that's part of the context here.

Our position is that it doesn't make sense for any law to exclude these products from state usury caps but it especially doesn't make sense as applied to direct to consumer products. I put in the chat the study that I referenced. But if the committee is going to go down that road then we would say it absolutely makes sense to have in the law specific restrictions around the debiting of user bank accounts. And that the companies be allowed to attempt to collect a single time. If it's unsuccessful in collecting they're not able to re-present that transaction. That makes sense to protect users from overdraft fees that can flow from using these advanced products and it also is perfectly consistent with industry's narrative that they're not offering loans, that there's not an obligation to repay these products. If they're not loans, if there's not an obligation to repay them, if they've tried one time to get payment from a user's bank account and that's not successful that should be the end of it.

Molly Jones, Head of Public Policy at Payactiv thanked the Committee for the opportunity to speak and stated that I know this is a new topic for a lot of people and it's really nuanced as I'm sure you're hearing today. We are an employer integrated provider. So, we have a contractual relationship with the employer. We integrate directly into the time and attendance payroll system and we make an accessible balance based on those verified earned wages. So, again it's using earned wages that someone has earned and it's not a lending product. I find this can be a very philosophical issue for people. Some people think that the bi-weekly pay cycle is this sort of sacred forced savings device for consumers and that anything you access before payday must then be a loan. That's not the modern world that we're living in with the technology that we have today and it's certainly not the reality for workers living paycheck to paycheck when you don't need a force savings device every two weeks. You need to access money that you have earned. You want to pick up a shift at work and be paid immediately afterwards so you can pay a bill. Things like that. And this is a really highly valued service for employees. The fees are only voluntary. And such an APR calculation is not appropriate. There's a handful of very serious issues with the data that has been cited. I'm happy to talk offline further with anyone interested in digging into that. I'll spare the rest of you because it is pretty wonky. And there's been some statements made that are simply not accurate with how the EWA industry operates and I think it's certainly fair for all of us to have appropriate scrutiny of this sector and to wonder how to regulate it and I think let's take those concerns and put them into the regulation. I heard some things that were cited and those are actually consumer protections that are added into this bill. So, let's think about the consumer protections here and I think it's a very high standard model that you're considering.

Chuck Bell, Financial Policy Advocate at Consumer Reports, thanked the Committee for the opportunity to speak and stated that we are highly concerned that unless the fees are very low or minimal for the use of earned wage advanced products that consumers will bear a high net cost at the end of the day. There is research that shows many consumers in every state are living paycheck to paycheck, roughly 30% on average if you look at certain data. And people are full in their budget with expenses that they cannot afford to pay. So, if we're saying that it's okay to shift $200 or $300 of the cost of being paid through earned wage advance to consumers, where is the room in that budget going to come from? And the California data that we have does take account of the fact that these are very short term loans and when you include the fees in that they do have very high equivalent APR rates for many of the products. We're a little more

comfortable with the employer integrated model where there's actually access to the wage data but I want to also point out we're letting employers off the hook. There's nothing stopping employers from giving people early pay at no cost to them and that would be a better model than shifted legalizing fintech to payday loans and making it sort of a wild west environment. We're concerned in New York that if you start allowing exceptions to the banking laws other companies are going to come in and lobby for the same holiday from regulation.

And historically it's been very difficult to keep out the high cost usurious payday lenders. So, we do think if there is a model law then it should keep the fees low and the caps should be low and tightly enforced but we don't think it should be solely up to the regulator. We'd like to know where we're going before these products are legalized and what the costs are actually going to be at the end of the day to consumers. There should be stated in the form an APR equivalent so the consumer can compare that to the other credit options that they may have. Or they may also get a quarterly statement with the net costs so they know how much they're paying throughout the year for this product and whether there's an alternative way to get that service for less money. The problem of loan stacking for the business to consumer loans is also a highly significant problem. The study by CRL has found out that 25% of consumers use more than one of these services and that multiplies the risks of becoming insolvent, of getting into a debt trap and of incurring overdraft fees. So, we are concerned about that feature of the model law and we hope that those features could be addressed in further conversations with the advocates and people who are concerned about financial health and stability.

Asw. Hunter stated that it's great to hear from both sides on this but I do feel like there needs to be clarity and if we could maybe find a way to get some of this clarified either in advance of the next meeting or part of the discussion at the next meeting relative to concisely what providers are actually making folks pay. Because we hear it's equivalent to Venmo or PayPal and you're not paying anything and some people are only paying $3 if they want it early compared to the other conversation relative to all of these fees and mission creep into payday lending. And so I think that there needs to be significant clarity between "I work for this, I'm getting my pay early" vs. usury rates, high fees, and what exactly are all of these other products that potentially we're talking about so that we can be very clear. We don't have to have a lengthy conversation about that but I think based on the chat's going on there definitely needs to be significant clarity as to the products and fees and where all of this 300% APR is coming from.

Sen. Paul Utke (MN), NCOIL Treasurer, stated that as we go forward I'd like to discuss the fees because when I heard the fees were voluntary it was something that caught my ear. And going forward that is something that we need to address is we know that those that are advancing the money need to get paid and so it's figuring out, it's uncovering, it's clarity, it's transparency. And hopefully in the months ahead if this is something that gets entertained and that transparency is brought forward, we'll talk more about it as it goes on.

Sen. Lana Theis (MI) stated that as someone who has had to make use of these things back in a prior life, you need to be careful about how much you're protecting somebody from their ability to actually have these products. If you make the products impossible to provide then they're not going to have access to them. And so it's great that you've

protected them but then they really do have the overdraft fees. They really can't purchase their groceries that they need to purchase for their kids. People get themselves in a bind and they're a risky person to lend to. They may not have the credit cards because they have bad credit. They may not have access to bank accounts because they might not be banked at all. These are things they're going to be able to need. And I appreciate that you want to protect them and financial literacy is absolutely essential in this space, full transparency is essential in the space. But I don't suggest legislating from these products being available to people who need them.

Asw. Hunter stated that I think I said this when we had our annual meeting last year when we first introduced this that these products wouldn't be available if people didn't need them. Whether it's wage gap, low wages, high inflation, many different factors are creating a scenario where people are enticed to need these products. And yes financial education is definitely important. And as the saying goes, it's hard to make $1 out of $.15, it makes perfect sense. So, I'm just looking forward to any additional recommendations. I am collaborative, and want to know how we can make this a strong model and then you take it back to your state and make it work for what works for you. New York is a financial capital around the globe and we want to make sure that we have super strong consumer protections but it doesn't escape me that we're having this conversation because people are desperately in need and these products are out there. And we don't want bad actors. We don't want people to prey on people who are obviously poor and need these kind of services. We just want to make sure that they're protected so I definitely look forward to any additional amendments that you have, please send them NCOIL's way and we'll walk through them. And I look forward to getting a little more clarity at our meeting in July.

Sen. Felzkowski thanked Asw. Hunter and everyone for their comments today. Please be sure to reach out to Asw. Hunter, myself or NCOIL staff with any questions or comments on this model or the previous model that we talked about today.

ADJOURNMENT

Hearing no further business, upon a Motion made by Rep. Lehman and seconded by Del. Westfall, the Committee adjourned at 1:30 p.m.

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IMMEDIATE PAST PRESIDENT: Rep. Deborah Ferguson, AR

National Council of Insurance Legislators (NCOIL)

Transparency in Third Party Litigation Financing Model Act

Sponsored by Rep. Matt Lehman (IN)

Draft as of July 1~~March 13~~, 2024. To be discussed by the NCOIL Financial Services & Multi-Lines Issues Committee on July 18~~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 annually not exceed the maximum ~~annual percentage~~ rate as provided for in Title 10, United States Code, section 987(b) and a one-time document preparation fee as established by the [official identified in Section 18]. 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 or person of concern” includes the following:

(a) A foreign government or person 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 an individual, 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~~ provided 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. Except as otherwise stipulated or ordered by the court, a party or his or her counsel shall, without awaiting a discovery request, provide to the other parties, and each insurer that has a duty to defend another party in the civil proceeding, any agreement under which any consumer litigation funding company, other than an attorney permitted to charge a contingent fee representing a party, has a right to receive compensation that is contingent in any respect on the outcome of the legal claim. ~~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.~~

2~~3~~. A plaintiff or the plaintiff's attorney shall provide the agreement~~written notice~~ required by subsection 1~~2~~. within a reasonable time after the date on which the consumer litigation funding contract was executed.

3~~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.

(b)~~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."

(c)~~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.

(d)~~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)."

(e)~~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."

(f)~~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, or a foreign country or person 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. Except as otherwise stipulated or ordered by the court, a party or his or her counsel shall, without awaiting a discovery request, provide to the other parties, and each insurer that has a duty to defend another party in the civil proceeding, any agreement under which any commercial litigation financer, other than an attorney permitted to charge a contingent fee representing a party, has a right to receive compensation that is contingent in any respect on the outcome of the legal claim. ~~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 agreement~~written notice~~ required by subsection 1~~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.

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

PRESIDENT: Rep. Tom Oliverson, TX
VICE PRESIDENT: Asw. Pamela Hunter, NY
TREASURER: Sen. Paul Utke, MN
SECRETARY: Rep. Edmond Jordan, LA

IMMEDIATE PAST PRESIDENT: Rep. Deborah Ferguson, AR

NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

Earned Wage Access Model Act

Sponsored by Asw. Pam Hunter (NY) – NCOIL Vice President

Draft as of May 15, 2024. To be discussed during the interim meeting of the Financial Services & Multi-Lines Issues Committee on July 18, 2024.

Table of Contents

Section 1. Title

This Act shall be known as the [State] Earned Wage Access Act.

Section 2. Definitions

As used in this Act, the following terms shall have the following meanings:

(a) “Consumer" means an individual who is a resident of the state of [State].

(b) “Debt collection activity" means the business of collection of any debts, directly or indirectly, owed or due or asserted to be owed or due another and the business of a buyer of debts who seeks to collect such debts either directly or indirectly, as well as the

business of any creditor collecting its own debts if such creditor uses any name other than its own that would suggest or indicate that someone other than such creditor is collecting or attempting to collect such debts.

(c) “Earned but unpaid income" means wages or compensation that have been earned or have accrued to the benefit of a consumer but have not been paid by an obligor to that consumer for labor or services performed for or on behalf of an obligor.

(d) “Earned income access rate cap" means the limit on the amount that may be charged for an earned income access transaction that is established by the [insert appropriate regulatory department].

(e) "Earned income access transaction" means the payment of earned but unpaid income to a consumer at a time other than the consumer's regular payday or other regularly scheduled time on which the obligor pays to the consumer wages or compensation earned or that have accrued to the benefit of such consumer.

(f) "Earned income access provider" or "provider" means a person or entity that:

(1) provides, or offers to provide, on behalf of an obligor earned income access transactions to consumers earning wages or compensation from the obligor; or

(2) offers earned income access transactions to, or enters into earned income transactions with, consumers.

(g) “Exempt organization" shall mean any banking organization, foreign banking corporation licensed by the [insert appropriate regulatory department] to transact business in this state, national bank, federal savings bank, federal savings and loan association, federal credit union, or any bank, trust company, savings bank, savings and loan association, or credit union organized under the laws of any other state or any instrumentality created by the United States or any state with the power to make mortgage loans. Subject to such regulations as may be promulgated by the [insert appropriate regulatory department], "exempt organization" may also include any subsidiary of such entities.

(h) “Non-recourse" means the unavailability of any legal cause of action or remedy against a consumer relating to an earned income access transaction.

(i) “Notice" means communication from the provider to the consumer in a clear and conspicuous manner.

(j) “Obligor" means a person or entity who is obligated to pay a consumer any sum of money on an hourly, project-based, piecework, or other basis for labor or services performed by the consumer for or on behalf of that person or entity. Obligor does not include the customer of an obligor or another third party that has an obligation to make

any payment to a consumer based solely on the consumer's agency relationship with the obligor.

(k) “Fees" means any amount charged by a provider to a consumer for an earned income access transaction, including amounts to be paid as described in paragraph (i) of subdivision two of section 8 of this Act.

(l) "Proceeds" means funds received by a consumer pursuant to an earned income access transaction.

Section 3. License

(a) No person or entity, except for an exempt organization as defined in this Act, shall engage in the business of providing or offering earned income access transactions to consumers, or enter into an earned income access transaction with a consumer, without first obtaining a license.

(b) An application for a license under this Act shall be in writing, under oath and in the form prescribed by the [insert appropriate regulatory department].

(c) At the time of filing an application for a license, the applicant shall pay to the [insert appropriate regulatory department] an application fee.

(d) A license granted pursuant to this Act shall be valid unless revoked or suspended by the [insert appropriate regulatory department] or surrendered by the licensee.

Section 4. Action by [insert appropriate regulatory department] on Application

(a) After the filing of an application for a license accompanied by payment of the fees for license and investigation, it shall be substantively reviewed. After the application is deemed sufficient and complete, the [insert appropriate regulatory department] shall issue the license, or the [insert appropriate regulatory department] may refuse to issue the license if [insert appropriate regulatory department] shall find that the financial responsibility, experience, character and general fitness of the applicant or any person associated with the applicant are not such as to command the confidence of the community and to warrant the belief that the business will be conducted honestly, fairly and efficiently within the purposes and intent of this Act. For the purpose of this subdivision, the applicant shall be deemed to include all the members of the applicant if it is a partnership or unincorporated association, and all the stockholders, officers and directors of the applicant if it is a corporation. Such license to engage in business in accordance with the provisions of this Act at the location specified in the application shall be executed in triplicate by the [insert appropriate regulatory department] and the [insert appropriate regulatory department] shall transmit one copy thereof to the applicant, file a copy in the office of the insert [appropriate regulatory department], and file a copy in the office of the clerk of the county in which is located the place designated in such license.

(b) If the [insert appropriate regulatory department] refuses to issue a license, the [insert appropriate regulatory department] shall notify the applicant of the denial, return to the applicant the sum paid as a license fee, but retain the investigation fee to cover the costs of investigating the applicant.

(c) Each license issued pursuant to this Act shall remain in full force unless it is surrendered by the licensee, revoked or suspended.

Section 5. License provisions and posting

(a) A license issued under this Act shall state the name and address of the licensee, and if the licensee be a co-partnership or association, the names of the members thereof, and if a corporation the date and place of its incorporation

(b) Such license shall be kept conspicuously posted in the office of the licensee and on the mobile application or website of the licensee and shall not be transferable or assignable.

Section 6. Grounds for suspension or revocation of license; procedure

(a) A license granted pursuant to this Act shall not be renewed, and shall be revoked or suspended by the [insert appropriate regulatory department] upon a finding that:

(1) the licensee has not complied with reporting requirements;

(2) the licensee has violated any provision of this Act, the act of Congress entitled "Truth in Lending Act" and the regulations thereunder, as such act and regulations may from time to time be amended or any rule or regulation lawfully made by the [insert appropriate regulatory department] under and within the authority of this Act;

(3) any fact of condition exists which, if it had existed at the time of the original application for such license, clearly would have warranted the [insert appropriate regulatory department] refusal to issue such license; or

(4) the licensee has failed to pay any sum of money lawfully demanded by the [insert appropriate regulatory department] or to comply with any demand, ruling or requirement of the [insert appropriate regulatory department].

(b) Any licensee may surrender any license by delivering to the [insert appropriate regulatory department] written notice that the licensee thereby surrenders such license, but such surrender shall not affect such licensee's civil or criminal liability for acts committed prior to such surrender.

(c) Every license issued hereunder shall remain in force and effect until the same shall have been surrendered, revoked, suspended, or shall have expired, in accordance with the provisions of this Act, but the [insert appropriate regulatory department] shall have authority to reinstate suspended licenses or to issue new licenses to a licensee whose license or licenses shall have been revoked if no fact or condition then exists which clearly would have warranted the [insert appropriate regulatory department] refusal to issue such license.

(d) Whenever the [insert appropriate regulatory department] shall revoke or suspend a license issued pursuant to this Act, the [insert appropriate regulatory department] shall forthwith execute in triplicate a written order to that effect. The [insert appropriate regulatory department] shall file one copy of such order in the office of the department, file another in the office of the clerk of the county in which is located the place designated in such license and forthwith serve the third copy upon the licensee, which order may be reviewed in the manner provided by article [xxxxx] of the civil practice law and rules. Such special proceeding for review as authorized by this section must be commenced within thirty days from the date of such order of suspension or revocation.

(e) The [insert appropriate regulatory department] may, on good cause shown, or where there is a substantial risk of public harm, without notice and a hearing, suspend any license issued pursuant to this Act for a period not exceeding thirty days, pending investigation. "Good cause", as used in this subdivision, shall exist only when the licensee has engaged in or is likely to engage in a practice prohibited by this Act or engages in dishonest or inequitable practices which may cause substantial harm to the persons afforded the protection of this Act.

Section 7. Investigations and examinations

(a) The [insert appropriate regulatory department] shall have the power to make such investigations as the [insert appropriate regulatory department] shall deem necessary to determine whether any provider or any other person has violated any of the provisions of this Act, or whether any licensee has conducted itself in such manner as would justify the revocation of its license, and to the extent necessary therefor, the [insert appropriate regulatory department] may require the attendance of and examine any person under oath, and shall have the power to compel the production of all relevant books, records, accounts, and documents.

(b) The [insert appropriate regulatory department] shall have the power to make such examinations of the books, records, accounts and documents used in the business of any licensee as the [insert appropriate regulatory department] shall deem necessary to determine whether any such licensee has violated any of the provisions of this Act.

(c) The expenses incurred in making any examination pursuant to this section shall be assessed against and paid by the licensee so examined, except that traveling and subsistence expenses so incurred shall be charged against and paid by licensees in such

proportions as the [insert appropriate regulatory department] shall deem just and reasonable, and such proportionate charges shall be added to the assessment of the other expenses incurred upon each examination. Upon written notice by the [insert appropriate regulatory department] of the total amount of such assessment, the licensee shall become liable for and shall pay such assessment to the [insert appropriate regulatory department].

(d) All reports of examinations and investigations, and all correspondence and memoranda concerning or arising out of such examinations or investigations, including any duly authenticated copy or copies thereof in the possession of any licensee or the department, shall be confidential communications, shall not be subject to subpoena and shall not be made public unless, in the judgment of the [insert appropriate regulatory department], the ends of justice and the public advantage will be subserved by the publication thereof, in which event the [insert appropriate regulatory department] may publish or authorize the publication of a copy of any such report or other material referred to in this subdivision, or any part thereof, in such manner as the [insert appropriate regulatory department] may deem proper.

Section 8. Compliance

(a) An earned income access provider shall not operate in this state unless:

(1) the provider is licensed pursuant to this Act, unless the provider is an exempt organization pursuant to this Act;

(2) in the event a provider takes custody of a consumer's earned but unpaid income before paying proceeds to the consumer, the provider ensures that the proceeds are fully insured by the Federal Deposit Insurance Corporation at the consumer's individual account level;

(3) the provider complies with National Automated Clearing House Association rules, and when a debit is initiated to a consumer's account for a payment, and the debit is returned for insufficient or uncollected funds, the debit can be reinitiated only in accordance with paragraph (4) of subdivision (b) of this section;

(4) the provider does not provide to any third party, including obligors, any non-public personal information about consumers except in compliance with applicable federal and state law, and the provider does not sell, share, or otherwise disclose personal information that the provider solicits or collects from consumers in connection with offering earned income access transactions or related services;

(5) the provider gives notice to the consumer of the costs of earned income transactions in accordance with rules established by [insert appropriate regulatory department]; and

(6) the provider, no less frequently than quarterly, delivers notice in writing to each consumer to whom it has paid proceeds in that quarter containing information to be prescribed by the [insert appropriate regulatory department], including but not limited to an itemization of transactions and costs, the total amount the consumer has paid in fees, information on how to report complaints to the provider and to the [insert appropriate regulatory department], definitions of terms used in the notice, and an explanation of the costs of the services provided;

(b) It is a violation of this Act to conduct an earned income access transaction unless:

(1) the transaction is non-recourse;

(2) the provider has a reasonable basis to believe that the total amount of the proceeds and fees associated with the transaction does not exceed a percentage, to be set by the [insert appropriate regulatory department], of the consumer's earned but unpaid income;

(3) the provider does not engage in debt collection activity or retain the services of another to engage in debt collection activity in connection with the earned income access transaction and does not convey the debt itself;

(4) if repayment is to be made through a debit of a consumer's account, the debit is made in accordance with rules established by the [insert appropriate regulatory department];

(5) the provider charges a fee for the earned income access transaction that does not exceed the earned income access rate cap or charges no fee for such a transaction;

(6) no portion of the earned but unpaid income to be paid as part of the earned income access transaction is used before receipt by the consumer to settle or pay down an obligation arising from a prior earned income access transaction, and no proceeds roll over or are structured in any way to create any continuing obligation to the provider on the part of a consumer;

(7) the consumer receives the proceeds no less than one business day prior to the next regularly scheduled date on which the obligor is scheduled to pay earned wages or income to such consumer;

(8) before a consumer enters into the earned income access transaction, the provider gives the consumer notice, in writing, of all fees associated with the earned income access transaction and the cost of the transaction, including the cost expressed as an annual percentage rate;

(9) if the provider offers consumers the opportunity to pay an additional amount for an earned income access transaction voluntarily, such as a tip

(i) the provider gives notice to the consumer in writing that paying such additional amount is not required for the consumer to receive the proceeds,

(ii) the provider does not suggest an amount to the consumer by, for example, offering amount options from which the consumer may select or pre-filling an amount in any form used in the transaction process, or otherwise using a transaction process designed to require the consumer to take affirmative action to avoid or opt out of paying such additional amount, and

(iii) such voluntary payment amounts do not, when added to the total cost of the transaction, cause the total fees for the earned income access transaction to exceed the earned income access rate cap;

(10) the provider does not charge a late fee or prepayment penalty on the earned income access transaction;

(11) the provider does not pull a credit report or otherwise assess credit risk of the consumer prior to, during, or after the earned income access transaction except that the provider may verify the consumer's source of income as part of determining the amount of the proceeds;

(12) the provider does not report on the earned income access transaction to a consumer reporting agency prior to, during, or after the transaction;

(13) the provider does not require a consumer to waive the right to class action to engage in an earned income access transaction;

(14) the provider gives a consumer written notice of any amendment to the contract or terms of service for earned income access transactions, and the consumer agrees to such amendments before proceeding with an earned income access transaction to which such amendments would apply; and

(15) the consumer is eighteen years of age or older.

(c) Transactions made in accordance with this section shall not be subject to usury laws.

(d) If a provider charges indirect transaction fees, such fees shall not exceed the maximum allowable amount as set by the [insert appropriate regulatory department].

Section 9. Advertising

(a) No advertisement for an earned income access transaction service shall be misleading or otherwise deceptive.

(b) An advertisement for earned income access transaction service shall clearly and accurately disclose the costs of the service to consumers.

(c) The [insert appropriate regulatory department] shall adopt rules governing advertising of earned income transaction services consistent with the purposes of this section.

Section 10. Regulations and rulings

The [insert appropriate regulatory department] is hereby authorized and empowered to make such rules and regulations, conduct hearings and make such specific rulings, orders, demands and findings as may be necessary for the proper conduct of the business authorized and licensed under and for the enforcement of this Act.

Section 11. Changes in control

(a) It shall be unlawful except with the prior approval of the [insert appropriate regulatory department] for any action to be taken which results in a change of control of the business of a licensee. Prior to any change of control, the person desirous of acquiring control of the business of a licensee shall make written application to the [insert appropriate regulatory department] and pay an investigation fee. The application shall contain such information as the [insert appropriate regulatory department], by rule or regulation, may prescribe as necessary or appropriate for the purpose of making the determination required by subdivision (b) of this section.

(b) The [insert appropriate regulatory department] shall approve or disapprove the proposed change of control of a licensee in accordance with the provisions of subdivision (a) of this section.

(c) For a period of six months from the date of qualification thereof and for such additional period of time as the [insert appropriate regulatory department] may prescribe, in writing, the provisions of subdivisions (a) and (b) of this section shall not apply to a transfer of control by operation of law to the legal representative, as hereinafter defined, of one who has control of a licensee. Thereafter, such legal representative shall comply with the provisions of subdivisions (a) and (b) of this section. The provisions of subdivisions (a) and (b) of this section shall be applicable to an application made under such section by a legal representative.

(d) The term "legal representative", for the purposes of this section, shall mean one duly appointed by a court of competent jurisdiction to act as executor, administrator, trustee, committee, conservator or receiver, including one who succeeds a legal representative

and one acting in an ancillary capacity thereto in accordance with the provisions of such court appointment.

(e) As used in this section:

(1) the term "person" includes an individual, partnership, corporation, association or any other organization, and

(2) the term "control" means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a licensee, whether through the ownership of voting stock of such licensee, the ownership of voting stock of any person which possesses such power or otherwise. Control shall be presumed to exist if any person, directly or indirectly, owns, controls or holds with power to vote ten per centum or more of the voting stock of any licensee or of any person which owns, controls or holds with power to vote ten per centum or more of the voting stock of any licensee, but no person shall be deemed to control a licensee solely by reason of being an officer or director of such licensee or person. The [insert appropriate regulatory department] may in the [insert appropriate regulatory department] discretion, upon the application of a licensee or any person who, directly or indirectly, owns, controls or holds with power to vote or seeks to own, control or hold with power to vote any voting stock of such licensee, determine whether or not the ownership, control or holding of such voting stock constitutes or would constitute control of such licensee for purposes of this section.

Section 12. Violations and Penalties

(a) Any person, including any member, officer, director or employee of a provider, who violates or participates in the violation of any provision of this Act, or who knowingly makes any incorrect statement of a material fact in any application, report or statement filed pursuant to this Act, or who knowingly omits to state any material fact necessary to give the [insert appropriate regulatory department] any information lawfully required by the [insert appropriate regulatory department] or refuses to permit any lawful investigation or examination, shall be guilty of a misdemeanor and, upon conviction, shall be fined not more than [xxxxx] or imprisoned for not more than six months or both, in the discretion of the court.

(b) No provider shall make, directly or indirectly, orally or in writing, or by any method, practice or device, a representation that such provider is licensed under the banking law except that a licensee under this chapter may make a representation that the licensee is licensed as an earned income access provider under this chapter.

Section 13. Books and records; reports

(a) The provider shall keep and use in its business such books, accounts and records as will enable the [insert appropriate regulatory department] to determine whether such provider is complying with the provisions of this Act and with the rules and regulations lawfully made by the [insert appropriate regulatory department] hereunder. Every provider shall preserve such books, accounts and records for at least six years after making the final entry in respect to any earned wage access transaction recorded therein; provided, however, the preservation of photographic reproductions thereof or records in photographic form shall constitute compliance with this requirement.

(b) By a date to be set by the [insert appropriate regulatory department], each provider shall annually file a report with the [insert appropriate regulatory department] giving such information as the [insert appropriate regulatory department] may require concerning the business and operations during the preceding calendar year of the provider within the state under the authority of this Act. Such report shall be subscribed and affirmed as true by the provider under the penalties of perjury and be in the form prescribed by the [insert appropriate regulatory department]. In addition to such annual reports, the [insert appropriate regulatory department] may require of providers such additional regular or special reports as the [insert appropriate regulatory department] may deem necessary to the proper supervision of providers under this Act. Such additional reports shall be in the form prescribed by the [insert appropriate regulatory department] and shall be subscribed and affirmed as true under the penalties of perjury.

Section 14. Severability

If any provision of this Act or the application thereof to any person or circumstances is held invalid, the invalidity thereof shall not affect other provisions or applications of the Act which can be given effect without the invalid provision or application, and to this end the provisions of this Act are severable.

Section 15. Effective Date

This Act is effective [xxxxxxxx].

WORKERS' COMPENSATION INSURANCE COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
WORKERS' COMPENSATION INSURANCE COMMITTEE
2024 NCOIL SPRING MEETING – NASHVILLE, TENNESSEE
APRIL 12, 2024
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Workers' Compensation Insurance Committee met at The Sheraton Grand Nashville Downtown Hotel in Nashville, Tennessee on Friday, April 12, 2024 at 8:15 a.m.

Senator Lana Theis of Michigan, Chair of the Committee, presided.

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Rep. Deborah Ferguson, DDS (AR)
Rep. Matt Lehman (IN)
Rep. David LeBoeuf (MA)
Rep. Brenda Carter (MI)
Rep. Mike McFall (MI)
Sen. Paul Utke (MN)
Rep. Nelly Nicol (MT)
Sen. Jerry Klein (ND)
Rep. Tim Barhorst (OH)
Sen. Bob Hackett (OH)
Sen. George Lang (OH)
Rep. Mark Tedford (OK)
Rep. Lacey Hull (TX)
Rep. Dennis Paul (TX)
Rep. Tom Oliverson, M.D. (TX)
Del. Steve Westfall (WV)

Other legislators present were:

Asm. Tim Grayson (CA)
Rep. Toby Overdorf (FL)
Rep. Bruce Williamson (GA)
Rep. Peggy Mayfield (IN)
Sen. Mike Gaskill (IN)
Sen. Beverly Gossage (KS)
Rep. Patrick Penn (KS)
Rep. Bill Sutton (KS)
Rep. Sean Tarwater (KS)
Rep. Larry Bagley (LA)
Sen. Mark Huizenga (MI)
Rep. Mike Harris (MI)
Rep. Jerry Neyer (MI)
Sen. Michael Webber (MI)
Rep. Bob Titus (MO)
Sen. Natasha Marcus (NC)
Sen. Vickie Sawyer (NC)
Sen. Bill Gannon (NH)
Asm. Roy Freiman (NJ)
Rep. Barbara Dittrich (WI)
Sen. Mary Felzkowski (WI)
Del. Walter Hall (WV)
Del. John Paul Hott (WV)

Also in attendance were:

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

QUORUM

Upon a Motion made by Sen. Justin Boyd (AR), and seconded by Sen. George Lang (OH), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Sen. Lang and seconded by Rep. Mark Tedford (OK), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's November 16, 2023 meeting.

WORKERS' COMP ALTERNATIVES FOR INDEPENDENT CONTRACTORS

Brad Nail, Partner, Multi-State Gov't Relations at Converge Public Strategies, thanked the Committee for the opportunity to present on the topic of occupational accident insurance and stated that I've worked on occupational accident insurance products for both the insurers that underwrite them and for the policyholders that prospectively buy them in terms of filings and then creation of the products.

Michael Saporito, Sr. VP for Accident & Health at Zurich thanked the Committee for the opportunity to speak and stated that I have underwritten this product since 2007 and have led our team since 2011. What I wanted to accomplish today is to give a little bit of history to this product and help to demystify the product a little bit and then Mr. Nail is going to speak to more of the application of the product today. So, occupational accident insurance is in essence a work injury protection product for individuals that are not covered under statutory workers' compensation. Primarily, that would be independent contractors, you may also see individuals that are companies that have a number of employees less than the statutory requirement. This product actually has a genesis going back to the early 1980s. The Trucking Deregulation Act of 1980 caused a boom of independent owner/operators in the trucking industry growing from about 100,000 individuals to today about 350,000 individual owner/operators across the country. And those individuals generally are not covered under statutory workers' compensation. They are sole proprietors, some incorporate themselves, but generally, they are sole proprietors and they will work with trucking companies. What was identified is these individuals when they are injured at work, they generally were not able to afford workers compensation for themselves and they were not covered under workers compensation by the trucking companies that they worked with. So, the occupational accident product was created to help to address some of those needs.

The program will often be sponsored by, in the trucking world, the trucking company, and in today's world, there will be gig or sharing platforms that will sponsor a product. And these independent contractors can either purchase that product that's sponsored or they can go out into the open market and purchase a product from an association or other methods. Generally, what we'll see is that this product has four main components. You'll have an accidental death and dismemberment component that will provide benefits for their loved ones should somebody unfortunately pass away or be dismembered. There will be be an accident medical expense component that will

provide for the medical bills from that injury. And there will be a short term and long-term disability replacement benefit if they're unable to work. Some of the benefits of this product are that there's flexibility as far as how the rates are developed. We've seen it on a per month, per individual basis, percent of revenue basis, cost per mile. So, there's a lot of flexibility in how individuals can pay for this coverage. The product provides consistent benefits across all 50 states so there's no issues regarding jurisdiction in shopping for better benefits. It's consistent in that individuals that are injured can seek treatment from their own doctors, there's no direction of care, it's completely up to the individual and the doctors that they're comfortable with. And there are no deductibles or co-pays associated with this product. Ultimately, we found in the trucking space that generally claimants are happy with the product and that the cost is generally substantially less than traditional workers' compensation. And ultimately, our goal is to make this Committee aware that this product exists and it really helps to fill a gap for individuals that would otherwise not have that benefit if they're injured.

Mr. Nail stated that it's really been the growth of the gig economy in the last decade or so that has put occupational accident insurance back on I think the regulatory and legislative radar. This is the Workers' Compensation Insurance Committee, so I think we should ask the question, why isn't this just covered by workers' compensation? And well, workers' compensation first of all is statutory coverage, it is tied to employment. A significant component of it is the grand bargain where the employee has agreed not to sue the employer in exchange for the employer providing these benefits for injuries in the workplace. And I think it assumes a level of control over work conditions, over how work is performed to allow the employer to mitigate the risk. And that level of control does not really exist in the independent contractor relationships we're talking about. So, as we look for alternatives to how to insure for workplace injury, we start to look at occupational accident insurance and its success within the independent contractor trucking world from the '80s and forward as a model that can apply to gig economy workers today. Uber, DoorDash, Taskrabbit, and others, all have developed occupational accident programs to date and others I know are working on that as well. Mr. Saporito talked about some of the benefits, the typical program that I see offers $1 million in medical benefits. Since it's not a statutory coverage, the benefits are not prescribed in statute, so it allows the companies to be a little creative. How you calculate lost wages for someone who works in a gig type job is different from traditional employment and what I have witnessed is that they are doing that to the benefit of the worker to try to get an accurate reflection of the wage loss that they're going to experience.

And then I would ask what are the public policy implications? What are the situations where this type of coverage and this type of insurance might be discussed in your legislatures? And I really have two situations for you. The first is that this type of insurance is not approved for sale yet in every state. In the programs that I've worked on, we were successful in getting approval in 41 states. So, there are still 9 states out there where this type of coverage is not available and it's typically because the Department of Insurance, even if they view the insurance positively, feel like their hands are tied by something in the statute that prevents them from approving this type of insurance. And so, it may very well be that someone is coming to you to talk about how the statute can be adjusted to permit this type of insurance to be sold in that limited number of states. And then the second situation where I think this might come to you

folks is that some states are discussing worker classification for gig workers, and there are a number of issues involved in that discussion but work injury coverage tends to be one of them. We think occupational accident insurance will usually be the best option for work injury coverage for these types of workers. And we would like all of you to be well versed in this type of insurance. Our experience is when we introduce that topic in the legislatures, in the initial discussions over those types of bills, there's a lot of education to be done. People just aren't necessarily familiar with occupational accident insurance. So, to that end, we will always be available to you to answer your questions and provide you with more information. If these sorts of debates and discussions are going on in your states, please reach out to us and we can take any questions on this topic here and as I said, we'd love to be a resource to all of you here when you're back in your states.

Rep. Tom Oliverson, M.D., (TX), NCOIL President stated he appreciated the presentation and we were just sitting over here discussing this and learning a lot. So, as I understand it this doesn't provide any property coverage from an accident standpoint. This is solely for the worker. Can you give us just some idea because we're sitting over here wondering what's the cost of a 6 month premium or however you price it? What does a trucker have to pay to get coverage like this? Mr. Saporito stated what we see generally, for example in trucking, is costs between $100-$150 per individual per month. Now, that will obviously vary based upon the characteristics of what's being hauled and past loss history, but that's generally a range that you'll see in the trucking industry. In the gig economy space those rates will be substantially lower because the risk is lower. Rep. Oliverson stated I think one of the interesting features about the gig economy versus the trucking industry is that if you're an independent contractor trucker, that's a full time job. If you're delivering for DoorDash, you're probably maybe doing that once or twice a week or whatever your free time is. So, are these policies essentially designed in a way that you can turn them on or off based on your activity, whether you're engaged in commerce or you're just driving the kids to school? Mr. Nail replied they are and I can give you an example actually on the pricing as well within the gig economy because this is where there's an opportunity to innovate because it's outside the statutory work comp scheme. In one of the products that I was working on, it provides work injury coverage for the entire time that the app is on and that they are engaged in activity on that particular company's app. The premium, and I think this is innovative, is only calculated on trip miles so, while you have a passenger in the vehicle. So, we're going to calculate the premium off of those miles but we're extending the coverage to the entirety because it's more predictable. And it was as low as less than two and a half cents per mile, so it was reasonable. Rep. Oliverson stated that's great, and are there any regulatory barriers that you're aware of in any of our states that prevent this coverage from being available? Mr. Nail said yes, like we said, we got the approval in 41 states and the ones that didn't, it tends to be either there's a little something in the statute that the Department of Insurance thinks precludes them from doing this or there may be something within the Department of Insurance's own practice relative to loss ratios or other elements there that we have to revisit.

Rep. Matt Lehman (IN) thanked Mr. Nail and Mr. Saporito for their presentation and asked with workers' comp being, in many states, the sole remedy, meaning I can only go there to get my benefit, if I'm one of the gig drivers and I purchase this, have I waived my right to go after someone who might hit me in a car accident? Mr. Nail stated you have not. Rep. Lehman said in some states we have an issue with compliance with statutory

work comp regulations which makes it sole remedy. So, if I'm in an auto accident as a truly covered work comp driver, my sole remedy is to go to the work comp policy. So, with this they would get access to both. Kind of the quote unquote, "work comp" but also the right to then sue. So, doesn't it kind of put work comp on its ear? Mr. Nail said well there are subrogation provisions and the ability to prevent double recovery exists within the policy terms itself. Mr. Saporito agreed. Rep. Lehman stated yes, but in work comp, it is my sole remedy, I can't sue my employer. So, I take whatever the benefit is statutorily. I can't go back and say I want $5 million for that. But if I were in an auto accident I could sue for as much I want. So, I give that up if it's a work comp related incident, I don't give it up if it's not? Mr. Nail responded correct, in this scenario, you're receiving the benefits, you might treat it almost like a no-fault scenario where you're receiving these benefits but you have not given up your right to pursue an employer. In this case, it's not an employer, but you haven't given up your right to pursue if there are legal grounds, if there's a basis for it.

Sen. Mary Felzkowski (WI) stated really what you're doing is you're taking short term, long term, a small med policy, all policies that currently exist, but you're packaging them in a different form, am I correct? Mr. Saporito stated yes, I would say that in most cases those short-term, long-term policies are generally 24 hour in nature. Sen. Felzkowski asked so, you're not reinventing the wheel. These independent contractors could already purchase all of these products, but they would be annual products. So, all of this already exists in the marketplace. You're taking and packaging them in a form into what the gig worker needs. Mr. Nail said and doing it at scale that allows for pricing because I think the pricing attractiveness is a key element for where independent contractors might feel priced out in the marketplace. Sen. Felzkowski asked if you're using the same contractual language, the same subrogation language, everything is still going to be in that, but it's more or less redesigned to fit a new class of worker that we haven't seen before. Mr. Nail said it's written in such a way to describe the activity.

Sen. Beverly Gossage (KS) stated I had the same question as Sen. Felzkowski, but I guess what I'm asking is how does it compare in price? So, one can buy a disability policy. One can buy an accident plan. But if you couple it together perhaps that would help with price and as far as buying each one of these individual products, do you know? Mr. Nail stated it certainly does help with the pricing when you bundle those together and when it's written at scale for a large number of workers who are engaged in the same activity versus just one sole person trying to approach an insurer to buy those types of policies.

Rep. Mark Tedford (OK) stated in my experience with these policies they're very flexible, it could be something that's a business expense, something that could be at a contractor's expense. Do you see many businesses try to make it a required expense for their independent contractors? Mr. Saporito said generally, in the trucking world it is required per the independent contractor operating agreement. In the gig economy I think it's still developing. And you'll see it sometimes required, sometimes not required.

Sen. Lang stated typically, is there a requirement from the employer or from the government? Mr. Saporito stated the requirement is generally from, in the trucking world, it would be the trucking company, in the gig world it would be the technology platform that would require it per contract. Sen. Lang stated thank you for bringing a

private sector solution to the market in this regard. My question is, is this limited only to physical injury? Because an accident for a trucker on the highway could create PTSD for that individual. Is it limited just to physical? Or does it cover mental and emotional injuries as well? Mr. Saporito stated the product is flexible and generally, I will see benefits tied to mental anguish or if you need therapy sessions, or if you're unable to work because of mental challenges related to a past incident, it really just has to be validated by the treating physician in order to have that be a qualified disability.

Sen. Theis asked who are the 9 states and why would they be prohibited if these products are just merely being bundled and made more readily accessible? Are they not available in the 9 states where this is prohibited? Mr. Saporito responded with what I have seen of the states that do not allow the coverage, often it is a question of it's a valid group for the purposes of this type of insurance. You know, generally employer groups are allowed, association groups are allowed. But this is I'll say quasi-employee group and some states will not kind of allow that gray area to connect to a true employee group. Mr. Nail stated Mike's experience is the same as mine. It's a group insurance product and the disapproval tends to come from the technical requirements to form a group and buy insurance for the group. And we worked it and there are some states that just kind of threw up their hands and said we can't approve this as a group under our current scheme and I have the list of states I can provide to you.

STRUCTURED SETTLEMENTS 101

Sen. Theis said next on our agenda is a presentation focused on structured settlements. Before we begin, some brief background. NCOIL has an existing Model State Structured Settlement Protection Act, which you can view on your binders on page 25 and on the website and app as well. The model was amended during the summer of 2022 and since that time there were some requests to provide a presentation on the basics of structured settlements for those that may not be familiar with the product and laws surrounding them. Before we go further, I'll turn things over to the sponsor of those 2022 amendments, Sen. Paul Utke (MN), NCOIL Treasurer.

Sen. Utke stated, as mentioned I did sponsor the amendments here in 2022. I also sponsored the legislation that we passed the same year in Minnesota. The amendments that we had before us or that are being talked about is an exact mirror to what was passed in Minnesota. So, as we have those discussions going forward here today that's kind of what we'll be talking about. But, over the last year or so there have been some calls to re-open this model. I've had conversations with both sides and others. And at this time, it's not my plan or our plan to reopen it, but I think it is good to have discussions. We always learn from conversations and we can see what we might want to entertain in the future. And so, I look forward to what everybody's got here today. The one thing that I would just like to remind people is that as we saw when we talked about this two years ago both in Minnesota and even when it was proposed here, conversations can get a little in-depth and a little heated and I would just ask that as we go forward here today that we be respectful to everybody and make this an educational process so that we can all learn more about this from both sides why there might be a request to add further definitions to things and maybe why we don't want to add those definitions. So, I look forward to our conversations here today and let's see what we can learn on this model act.

Sen. Theis said before we get started I'd like to reiterate what Sen. Utke just stated regarding maintaining civility and decorum. I realize we got into our jobs because we're very passionate about what we do and we just need to make sure that we maintain that civility. We don't have to agree on everything, but we can disagree respectfully.

Susan Stauss, Member, Cozen O'Connor (on behalf of the National Structured Settlement Trade Association (NSSTA)) thanked the Committee for the opportunity to speak and stated with me today is Sally Greenberg, CEO of the National Consumer League and we're both here to have a conversation along with others to educate you all on structured settlements and why the NSSTA, the trade association, believes that the model should be amended and perhaps maybe sooner than typically would happen on an NCOIL agenda, meaning typically model acts get reviewed every 5 years and we understand that we're asking for this to be done a little bit earlier than that, but we really believe that in what has been happening and what has been going on throughout the country there's a need to actually revisit the issue. So, I understand from speaking to some of you that structured settlements may not be all that familiar to everybody. Generically speaking, a structured settlement is when there is a personal injury or wrongful death lawsuit and it is settled, and instead of taking a lump sum payment, the injured party takes periodic payments over time. So, they'll get monthly payments for 30 years and then perhaps guaranteed for life, they'll also get some lumpsum payments over life. And the entire point of the structured settlement is to ensure that the injured party has money and income over time to account for their injuries and perhaps their inability to work again or work at a reduced rate. So, the money is really designed, it's tax free, it is designed to protect this injured party for their future. Structured settlements have been around for quite a long time and NSSTA, the trade organization, drafted the Model Structured Settlement Protection Act. That was then adopted by NCOIL and it is now the model act. And it has been amended over many years and recently there have been a lot of negative issues in the press that we're going to talk about. My trade association is comprised of insurance companies, and producers, and insurance professionals. The industry's goal is to promote and maintain the establishment of structured settlements. This is the insurance company and the producers. This is their product. This is a brand name. This is something that we do not want to have negative publicity about.

And sometimes, and I know some of you have heard this, I think what you hear if you hear structured settlements is perhaps the television commercials with the jingle, "it's my money I want it now". That's what we're talking about. The jingle about the structured settlement is actually created by a factoring company. And so, structured settlements are future payments for the injured party and then in the early '90s, factoring companies came into the mix. And factoring companies are the company behind that jingle on television. Factoring companies buy future streams of injured parties periodic payments and in exchange they give them a lump sum payment, often a heavily discounted lump sum payment in exchange. That means that the future payments paid by the insurance company will no longer go to the payee, that money will now go to the company who bought the payments. And the injured party will have received the lump sum at the time, but once that lump sum is dissipated, if they've sold their future payments there is no more income for them. So obviously the public policy behind this is also significant. I've been doing this since 2001 and I've worked with others on the other side all these years and there are many factoring companies that I would say do the right thing. That look at

these issues similarly as I do. But there are enough factoring companies, it's an almost a $9 billion industry, out there that we have to ensure that the laws protect the injured party, and the laws protect the insurance companies that are involved, and the product that we're talking about, the actual structured settlement. Factoring came into play in the early 1990s and in the late 1990s in order to curb factoring abuses the model act was created. The model act is designed to give states guidance as to what should be included in their particular structured settlement protection act. I spent the better part of my career helping states across the country enact their own model act. I'm very proud to say that all 50 states and Washington D.C. all now have their own model structured settlement protection act.

The NCOIL model act has served as a blueprint for all the state structured settlement protection acts. Historically, and unfortunately, I venture to say even now that model act lags behind what we are seeing in states changing their own model acts. And the reason for that is plentiful. There has been massive negative publicity over the years about the factoring industry. There have been exposes written, and they will be talked a little bit about soon, in The Washington Post, the Minnesota Star Tribune, the McClatchy Media articles down in South Carolina, and they've really brought a negative kind of connotation when you hear structured settlements. If you Googled structured settlements right now, the first thing you're going to get is a factoring company. The biggest factoring company out there, that's the first thing you're going to get if you Google what a structured settlement is. Not that it is tax-free payments meant to provide for the injured party. You're going to get a company who buys that injured party's payments. So, while there have been changes to the model act, we believe that the model act should set the gold standard, that states are looking to the model act to see whether or not their own act is up to par. And while states can obviously go ahead and do that, what I've been seeing is what I would call a domino effect, which is unfortunate. What we would hope to not have is we had a horrible expose written in the Washington Post, a state changed their model act. There were blistering articles in the Minnesota Star Tribune, Minnesota changed its model act. There was a horrible expose written in the McClatchy Media, South Carolina changed its act. And what I would say is, I would not want to wait for the next bad expose about structured settlements to get another state and one by one have a domino effect in each state. If the model act takes this head on and we really ensure that the model act encompasses everything that we'd like to see in it, then we have a chance of all the states looking at the model act and saying, "you know what, we're going to change to make that" instead of waiting for these horrible exposes. And I'm going to talk about briefly the four amendments that we're talking about. I would also say that I would like to think that they're not controversial. And the reason why I say that is because what we're promoting benefits the injured victim. It benefits my constituency which is the insurance companies and the producers. And it also benefits the factoring industry because when these deals are completed and the law is changed the way the new laws have been coming out, it would be much more difficult to unwind one of these transactions which behooves everyone. The amendments that we're proposing are not that controversial. But we'll talk about them in a minute. I'm going to turn it over to Ms. Greenberg for a moment to talk a little bit about the consumer aspect of this.

Ms. Greenberg thanked the Committee for the opportunity to speak and stated I am here because I believe representing the consumer advocacy community, that structured

settlements are a pro consumer protection issue and factoring companies are too often predatory actors. So, structured settlements provide injured individuals with financial independence. After hearing from Ms. Stauss a bit now you have some history on the anatomy of a structured settlement and it's easy to understand why and how structured settlements provide financial independence and security to the injured and often disabled individuals. They provide personal injury victims with a planned, dependable cash flow to cover their long-term medical and basic living needs. And structured settlements serve a strong public policy of providing relatively unsophisticated and many times uneducated injury victims with secure streams of future periodic payments. Thereby, they ensure that these people are not left destitute and relying on public funds to support them. Abuse of practices in the structured settlement factoring industry take advantage of structured settlement payees. Many structured settlement payees suffer from cognitive impairments and other mental health issues that render them incapable of understanding the terms or consequences of factoring transactions. The Minneapolis Star Tribune, which is my hometown paper, and so I was very proud to see that my hometown paper had a series of articles reporting that factoring companies go to great lengths to find people who receive settlements. They swamp them with checks, calls, ads, gift cards, sometimes hotel rooms. One company, Catalina Structured Funding sent out thousands of flyers each week. In March 2021 a Minnesota customer received three realistic looking checks totaling $4,500 each and so called, 90-day COVID-19 assistance from Catalina. And on the back of the checks, in the fine print, Catalina noted that funds were actually an advance that would be released only if the recipient signed a contract selling some of his future payments to the firm.

Another company, Access Funding, instructed agents to call potential clients 9 to 10 times a day for at least 3 days after making initial contact. The South Carolina Sun News issued a series of articles that also remarked on the aggressive marketing tactics of factoring companies. One payee, the reporter spoke with, said these people are like roaches with the constant phone calls, checks, and gift cards. And in 2015 the Washington Post detailed how a factoring company in a very long series published in the Post was able to befriend marginalized structured settlement payees treating them to fancy meals, gift cards, promises of vacations, and thereby convinced hundreds of lead poisoned poor African American individuals to enter into factoring transactions. The proposed amendments to the NCOIL model act will strengthen consumer protections. The NCOIL model act and the state structured protection acts are consumer-based legislation. I am here today to advocate for the changes to the NCOIL model act that will strengthen protections for consumers but particularly the class of consumers most vulnerable to the predatory nature of the factoring industry. Since the NCOIL model act serves as a model upon which state legislatures rely when amending state specific laws, amending the model act is vital. And I would like to think that if the good people of Minnesota agreed to amend their law, that would be a good model for the rest of the country.

I should explain one aspect of what happens so that it will put in context the amendments that we're seeking. When an injured party decides that they would like to sell their future payments to a factoring company, the model act requires basically a mini court procedure. So, there is a legal document that is filed by the factoring company with the court. It's called a transfer petition. They file it with the court. The court sets a hearing date. And at the hearing the factoring company and hopefully most states

require that the payee actually, the injured party, show up in the courtroom. In the courtroom the court is supposed to listen to testimony and make a determination as to whether the sale of the future payments by the injured party to the factoring company is actually in the best interest of the payee. So, an injured party decides I don't want to wait, I'm going to sell 10 years of my monthly payments to a factoring company. The factoring company files a transfer petition, the transfer petition sets a hearing date with the court. then there's a court hearing. What we found, and I can tell you from firsthand experience I have been to hundreds of these hearings. I can tell you that judges often are stuck. They don't understand this body of law and what they're supposed to do. They don't have clarity I think they would say about what best interest actually means. I've also held judicial education panels across the country with the Judiciary because judges are begging to know what questions to ask. And what information they should be asking about this injured party and whether or not this sale to the factoring company makes sense. So, that's kind of the court proceeding that governs each one of these transactions. So, the amendments that we're seeking, the first one very simply is a list of factors that the judges can consider when the payee is in front of them. This is not new, other states have this list of factors. California, Minnesota, South Carolina, and other states already have the factors. The judge is clearly not limited to these factors, they're just suggestions. I can tell you that judges don't know that maybe they should ask "have you ever sold your money before?," because eliciting that answer to that one question may allow the judge to learn that the payee has sold 14 previous times. So, the amendments are that we would like the court to have factors to determine what best interest actually is. We'd also like the court to have discretion to appoint an attorney ad litem. Perhaps the judge doesn't have time and these are often set for ten minute hearings so maybe the judge doesn't have time to get the information he or she needs to make a best interest finding. If the court's allowed to appoint an attorney ad litem who can work with the payee and find out why the payee wants to sell their money and if it makes sense, we would like the court to have that ability. We would also like to have enhanced protections about the harassment and the phone calls, and the gift cards, and all of the kind of nefarious things that certain factoring companies employ to get these people to sell their payments. And the last amendment we're hoping to do is have an affidavit from a payee to explain whether they've sold payments before and why they're selling their money and what is the reason for selling their money. I know this is a lot of information. I gave you all the slides. I knew we weren't going to get through them today. But we really just wanted to open the dialogue about the necessity to make these changes sooner than later.

Brian Dear, General Counsel for the National Association of Settlement Purchasers (NASP) stated he appreciated the opportunity to speak. Our organization is the sole trade association for participants in the secondary market for structured settlements. Over the last 25 years our organization has participated in every state legislature and in Congress helping to craft the laws that govern these transactions to ensure adequate consumer protections while also permitting these transactions to be available for individuals for whom they are appropriate and valuable. NASP has long been a supporter of NCOIL, of this Committee's work, and the model act. NASP has advocated in state legislatures across the country to adopt the model act at great financial expense to our membership. Over the past several years we have worked with NCOIL to strengthen consumer protections contained in the model resulting in the amendments of the model act in July of 2022. The model act was originally scheduled for review in July

of 2021 on the normal five-year cycle. That review was extended so committee members could consider the final bill adopted by the Minnesota Legislature in 2022. The 2022 amendments to the model act included strengthened consumer protections previously adopted in Louisiana, Nevada, and Georgia requiring the registration of companies to do business in the state, to create numerous prohibited acts by companies, and creating the ability for courts to revoke the right of bad actors to do business in those states. The model act requires cases involving individuals seeking to transfer a portion of their structured settlement to be filed in the county of their residence and for individuals to personally appear before the court, allowing the judge to review the facts of the cases and the merits of the needs for the transfer. These provisions eliminate forum shopping by bad actors which led to some of the issues we've seen in other states. These amendments also importantly adopted some but not all of the provisions from the recently adopted Minnesota Structured Settlement Protection Act. Minnesota's act was one of the first in the nation, adopted in 1999 before there was a federal law that governed these transactions. And unfortunately, Minnesota never updated its act with the NCOIL model when the Star Tribune articles were published which led to the legislation in 2022.

During the legislative process, we spent time on the ground in St. Paul. We learned what the issues were in Minnesota so that we could properly address them. The resulting legislation addressed many of the issues which were specific to Minnesota. Minnesota specific provisions include as Ms. Stauss mentioned, the inclusion of best interest factors which were taken directly and codified from a Minnesota court of appeals opinion. There was already existing case law that's where those factors came from in Minnesota, we codified them so the judges were crystal clear what Minnesota law was. The need for the provisions specifically permitting the appointment of attorney advisors was unique to Minnesota because unlike other states the state judiciary is limited in their ability to swiftly appoint guardian ad litems. To address this unique situation the attorney advisor provision was included in the Minnesota act. Following the passage of the Minnesota legislation the model act was amended in 2022 to include several provisions from Minnesota. Specifically including the provisions addressing and severely limiting transactions involving minors. The committee in our opinion wisely left out provisions which addressed specific to Minnesota out of the model act. In 2023, our industry unfortunately faced negative media attention in South Carolina which resulted in the state adopting essentially a carbon copy of the Minnesota act. Unfortunately, at that time South Carolina's act contained a fatal variance from the NCOIL model act which permitted bad actors in the state to forum shop transactions to a specific judge who failed to adequately examine transactions. Had South Carolina adopted the model act in its entirety with a requirement that cases be filed in the county of residence of the payee, or the individual involved in the transaction and personally appear before the judge it is likely that the vast majority of the issues that were the subject of the media attention in South Carolina would not have occurred. The common theme in Minnesota, South Carolina, and in the 2010s in Maryland was that none of these states at the time the issues arose had the NCOIL model act in place. We believe if they had there would have been a different story, or no story at all.

NASP has been leading the efforts in the state legislatures across the country to update the state acts with the NCOIL model. We support and advocate for strengthened consumer protections contained in the 2022 amendments to the model act. NASP is

actively seeking to drive out bad actors from the marketplace in which we operate. And the new provisions of the 2022 amendments are helping us do just that. We do not however support the NSSTA's request to reopen debate on the model act mid cycle to wholesale replace the model act with the act recently passed in Minnesota. As discussed previously many of the provisions addressed in the Minnesota act codified Minnesota case law. The Committee adopted portions of the Minnesota act which were appropriate such as the provisions limiting minor transactions. We believe it is premature to essentially copy and paste Minnesota's law into the model act now. Just last Thursday, legislation was introduced in Minnesota, Senate File 5338 which seeks to create a study by the Attorney General in the Minnesota Supreme Court to determine the impact of the changes of the 2022 Minnesota law and to report back to their legislature on how that act is operating and to see if it's being effective, and what modifications can be further made to that bill. So, clearly Minnesota is still reviewing the issue. While we believe it is premature to adopt changes to the model act at this time, we do not believe it is premature for the industry participants to begin a dialogue on potential improvements to the model act when it is scheduled to come back for review in 2026. In the past, our organization and the NSSTA have worked together to improve the marketplace. The original NCOIL model act was mutually agreed to between our organizations. Unfortunately, we have not seen that spirit of cooperation under its current leadership but we hope that will change. The NSSTA were notably absent in the legislative process in Minnesota in which NASP spent hours upon hours meeting with bill sponsors and interested parties in the state to address the problems in Minnesota. And they were also absent during the year long process that NCOIL adopted the amendments in 2022. The secondary marketplace for structured settlements exists in large part because structured settlement themselves while a good product is not a perfect one. Our industry exists as Americans seek and need liquidity when the original structured settlement no longer meets their financial needs. Secondary market transactions are a vital tool for people with structured settlements when they need to utilize it. Our customers come from all walks of life. Additionally, as a practitioner in this marketplace, I have seen who our customers are over the past two decades. Overwhelmingly, the folks who are seeking funds in these transactions are doing so to buy a home, to start or grow a business, to obtain transportation, to get out of debt, or to help with an immediate financial crisis usually caused by recent job loss. The majority of our customers are receiving structured settlements not as a result of an injury to themselves but are receiving structured settlements as a result of a wrongful death of a loved one. And those customers who have been injured have in large part recovered from those injuries before they come to us to seek a transaction. These are the folks we want to do business with. Our members, just as much as everyone else, want to ensure that minors and folks who have cognitive issues have all the protections in the world on these transactions. And realistically to discourage them from entering these transactions at all. We hope to work with all stakeholders over the next few years to see how the current updated statutes are operating, to review the report from the Minnesota legislature in 2025, and to improvements of the model act under the next review cycle in 2026.

Rep. Deborah Ferguson, DDS (AR), NCOIL Immediate Past President asked since the structured settlement is tax free income, what happens when a company like yours buys that out? Does the person then have to pay tax on the lump sum you give them? Mr. Dear stated no, the amount to be paid to the payee is still a tax free asset. So, they're

not paying taxes on any of the proceeds. So, if a person's involved in a transaction to raise funds for a down payment on a home, whatever amount they're agreeing to receive from one of our member companies is the amount they'll be receiving. It still retains its tax free status.

Rep. Ferguson said I don't see a limit on the amount of money you're allowed to make on the transaction in our structured bill. What amount typically does your company or these companies keep? Mr. Dear said this industry at this point is quite hyper competitive. There are a number of players in the marketplace. They fiercely compete. There is a common misconception that our member companies are making massive amounts of money on these transactions which is just simply not the case. Companies compete against each other. They try to outbid each other for business for these customers. And with all of these transactions we are obviously subject to the interest rate environment. So, when interest rates go up unfortunately the interest rate on our transactions go up. During the period of time during the pandemic, it was not uncommon for deals to be done at 4% or actually probably closer to 5%, 6%, 7% on guaranteed transactions as far as what the discount rate would be on these transactions. Currently, that's obviously higher as with all things. So, it's a common misconception that our member companies are making a ton of money on these transactions, it's simply not the case. I haven't seen an interest rate under 15% in the last probably two years, they go up to 25%.

Rep. Ferguson asked what do these companies do with the annuity once they buy it? Do they continue to draw it as a structured settlement? Or do they cash in the annuity? How does that work? Mr. Dear responded saying with all of these products there are end investors who are seeking to basically use these. They're basically investor classes who purchase these assets from our originating companies. Often they're pension funds or other similar type product funds that are looking to buy these as secondary class assets from our member companies.

Sen. Theis stated I am curious are the issues that Ms. Stauss was describing happening in Minnesota? You used that as your kind of defense of the legislation. Mr. Dear stated just to clarify, in the Minnesota articles there were a number of issues that were raised. Some of the judges in Minnesota did voice some of the concerns. Basically, there was some confusion about the Minnesota court of appeals article that included the best interest factors. Some judges for some reason appeared to read that as that they didn't have a guidebook on how to address that. In our opinion, they misread what that opinion said. So, it was codified in Minnesota specifically that court of appeals decision to make sure that the judges knew here are what the courts have decided in that state of the factors you should look at.

Ms. Stauss stated just to clarify one thing that Mr. Dear mentioned earlier, NSSTA was heavily involved in the Minnesota legislation. We worked directly with Legal Aid to actually draft the legislation and had a lot of input with the same amendments that we're seeking here today to put into the Minnesota legislation. That said, I don't think we need to focus solely on Minnesota. Yes, it was recent, yes it has all the things that we would like to have included in the model act. So, does South Carolina. Again, both of them were as a result of these blistering exposes. California also has the best interest factors that we're talking about that allow judges to look at a list of things and give the judges

some sense of what kind of questions they should be asking to get the information. In terms of the other things that we're asking for each amendment is not solely limited to Minnesota or South Carolina. There's a whole host of states that have each of the four bolded items that we're talking about. Other states have also adopted those. And the point here is we're talking about the model act. The model act is all encompassing and has the best of the best. Then states really can't go wrong when they look back to the model act and say how can we be better? The model act should be the gold standard. How can we be like the model act? And that's simply what we're trying to do here.

Sen. Theis thanked the presenters and said I would like to express my personal concern about the contracting with respect to minors. The idea that they would be subject to something that they most definitely cannot understand is very concerning and I believe requires significant oversight.

Sen. Utke thanked everyone and stated as we all see it's a topic that's not just going to go away anytime soon because there are important things yet to discuss. It all started three years ago in Minnesota with the newspaper article that just highlighted how outdated our policy was at the time. And it's been talked about it and that's what made it come to the forefront at that point and it got addressed. But it's also we're dealing with money and we all know when we're dealing with money there's challenges because there's people out there always trying to get one step ahead and scam somebody. So, that's the reason that I think the conversations around the structured settlements will be something that probably won't be forgotten about anytime soon just because there's always a bad actor out there trying to take advantage of somebody and none of us want that to happen. We're all in it for the best interest of the people that are going through this, for whatever reason they might want to sell their settlements. I look forward to further discussions as these years proceed. I'm sure everybody involved will stay in touch with us. So, we will continue to learn more and see if at some point there is something we should look at. But at this point I just thank you for letting us have this conversation. Sen. Theis stated she appreciated the discussion. If anybody has any questions or concerns or ideas related to this topic please reach out to myself, Sen. Utke or NCOIL staff.

OVERVIEW ON EXPERIENCE RATINGS AND THE SUBROGATION PROCESS

Sen. Theis stated that last on our agenda is an overview on experience ratings in the subrogation process. This topic actually relates to a bill that was introduced by Rep. Lehman which you can see in your binders on page 38 and on the website and app.

Rep. Lehman stated that we've talked about this issue here before. I actually filed a bill but we did not move the bill in Indiana but I think it needs some discussion. And that gets around without getting too deep in the weeds when someone has an accident, going back to kind of the sole remedy, you go to workers comp, workers comp pays that claim. Let's say it's an auto accident. So, I didn't cause the accident, I'm not responsible but my employee has a $500,000 loss. That now hits my modification. When they do the experience modification I'm going to pay for that with an increase in my premium over the next three years. There's a trail and you're in there. But it's the next three years I'm going to pay for that. If they're successful in their subrogation, so they go to subrogation, they get the money from the person who actually hit my

employee and they are made whole. My concern was always how does the employer, the insured, end up getting back their money they paid in that additional premium because of the experience modification? It also tosses in the issue of a lot of contracts are based on bidding on your experience mod. You can't bid a contract if you're over 1.0. And so again, if I'm not responsible for that we're allowing a kind of an artificial loss to my mod affecting me on bidding. So, I've talked with the National Council on Compensation Insurance (NCCI) about this in the past. They have some regulations about going back as the carriers and recalculating those mods but subrogation doesn't have a timeframe. So, if subrogation's 5 years from now, and I'm made fully whole and I go back and recalculate two years I'm really going to miss probably two years of the experience mod. So, I really think we need that and NCCI can address this what's the solution. I think some states have said, you just have to go back and recalculate regardless which is kind of what Indiana we're attempting to do. So, I'm just curious how NCCI as kind of the regulator of all things workers comp, will weigh in on this.

Tim Tucker, Washington Affairs Executive, Regulatory Division for NCCI thanked the Committee for the opportunity to provide a brief overview of the impact of subrogation and other recoveries on workers compensation experience modification factors. Of course, Rep. Lehman did a great job of talking about some of the impacts that he has seen in Indiana. NCCI maintains a portion of the infrastructure of the workers compensation system for 38 states. Those are proposed rules they're filed with the states and approved by state insurance regulators. Our rules are just that, they're proposed. Some states have deviated as what is being proposed by Rep. Lehman in Indiana. There're two aspects of this issue that need to be understood as it relates to our infrastructure. The first is our statistical rating plan. And the second is our experience rating plan. Those two plans as I mentioned are filed and approved in each NCCI state. So, essentially for each policy period and for every policy we receive reports that include audited payroll, premium, and claims. And we receive those on an annual basis. The first three years of those reports are used to calculate an experience modification factor. And that is recalculated each year using the current and two preceding years. So, what happens when there's a recovery either through subrogation or through a another fund such as a second injury fund, NCCI rules in both our staff plan and our experience rating manual require that the carrier file a correction report. That report reflects the recovery that was made again through subrogation or another fund or other third-party. With that correct report we go back and correct the mod of the current year and past two years. And we'll do that for the first five years of that policy. Beyond that there is no subrogation. But we found that most subrogation's occur within that five year window. So, the other aspect here is to understand that there is a mechanism to address this within our rules. States have deviated as I've discussed with Rep. Lehman, and he is well aware. So, we propose this framework. But certainly, states are free to adjust that and some have.

ANY OTHER BUSINESS

Rep. David LeBoeuf (MA) stated I would like to propose a future discussion in this Committee related to workers' compensation and fraud particularly in the construction industry. Back in 2009, NCOIL adopted some model legislation around protections and worker compensation qualifications for contractors and workers in that industry. But we are seeing a couple of challenges, at least in my area related to fraud in regard to certain

contractors misrepresenting their payroll to companies and creating premium fraud or labor brokers that are actually not getting insurance. They're presenting that they have workers compensation insurance, getting it for a short term period and then we find out later on that they actually do not have coverage and the worker is lost. And so, it puts a competitive disadvantage for those companies and those contractors that are doing the right thing.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Utke and seconded by Rep. Lehman, the Committee adjourned at 9:30 a.m.

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Sen. Jason Rapert, AR
Sen. Travis Holdman, IN

National Council of Insurance Legislators (NCOIL)

Model Workers' Compensation Drug Formulary Act

Sponsored by Rep. Matt Lehman (IN)

Adopted by the Workers' Compensation Insurance Committee on December 12th, 2019 and the Executive Committee on December 13th, 2019.

To be discussed and considered for re-adoption during the Workers' Compensation Insurance Committee on July 19, 2024.

Table of Contents

Section 1. Short Title

This Act shall be known as the "Model Workers' Compensation Drug Formulary Act"

Section 2. Purpose

The purpose of this Act shall be to require the establishment of a drug formulary for use in a state's workers' compensation system in order to facilitate the safe and appropriate use of prescription drugs in the treatment of work-related injury and occupational disease.

Section 3. Selection or Development of Drug Formulary

(A) It is the intent of the Legislature that the [insert appropriate state agency/department] select a nationally recognized, evidence-based drug formulary, for use in the workers' compensation system, or to develop such a formulary, by rule. Such formulary shall apply to prescription drugs that are prescribed and dispensed for outpatient use in connection with workers' compensation claims with a date of injury on or after [insert date]. The drug formulary shall not apply to care provided in an emergency department or inpatient setting.

(B) In developing by rule or selecting a nationally recognized, evidence-based drug formulary for adoption, the [department] shall consider the following factors:

(1) Whether the formulary focuses on medical treatment specific to workers' compensation.

(2) Whether the basis for the formulary is readily apparent and publicly available.

(3) Whether the formulary includes measures to aid in management of opioid medications.

(4) The cost of implementation and post-implementation associated costs of the formulary.

(5) Evidence-based guidelines for the treatment of workplace injury and disease.

(C) Within [thirty (30)] days of the effective date of this Act, the [department] shall solicit public comments regarding the selection of a nationally recognized, evidence-based prescription drug formulary under this section. The public comment period shall be [ninety (90) days]. During the public comment period, the [department] shall conduct at least one public hearing on the selection of a drug formulary. The [department] shall publish notice of the public comment period and public hearings on its website. The public hearing shall include, but not be limited to, employers, insurers, private sector employee representatives, public sector employee representatives, treating physicians actively practicing medicine, pharmacists, pharmacy benefit managers, attorneys who represent applicants, and injured workers.

(D) Commencing [insert date], and concluding with the implementation of the formulary, the [administrative director] shall publish at least two interim reports on the internet web site of the [division of workers' compensation] describing the status of the selection of the formulary.

(E) The [department] shall [annually] review updates issued by the formulary publisher to the selected formulary.

(F) The [department] shall ensure that the current nationally recognized, evidence-based prescription drug formulary is available through its publicly accessible Internet website for reference by physicians and the general public.

Section 4. Operation of Formulary

(A) Beginning [insert date] reimbursement is not permitted for a claim for payment of a drug that:

(1) is prescribed for use by an employee who files a notice of injury under this Act; and

(2) is listed but not approved in the formulary, or omitted from the formulary, unless the employee begins use of such drug after [insert date], and the use continues after [insert date].

(3) if the employee begins use of the such drug before [insert date], and the use continues after [insert date], reimbursement is permitted for such drug until [insert date].

(B) If a prescribing physician submits to an employer a request to permit use of a drug that is listed but not approved in the formulary, or omitted from the formulary, including the prescribing physician's reason for requesting use of such drug and the employer approves the request, the prescribing physician may prescribe such drug for use by the injured employee.

(C) If the employer does not approve the prescribing physician's request under subsection (B) to permit use of a drug that is listed but not approved in the formulary, or omitted from the formulary, the employer shall:

(1) send the request to a third party that is certified by the [Utilization Review Accreditation Commission (URAC) or another Accreditation Organization] to make a determination concerning the request. The use by the employer of an independent review organization selected by the [department] shall also satisfy this subsection; and

(2) notify the prescribing physician and the injured employee of the third party's determination not more than [three (3)] business days after receiving the request.

(D) If an employer fails to provide the notice required by subsection (C)(2), the prescribing physician's request under subsection (B) is considered approved, and reimbursement of the drug that is listed but not approved in the formulary, or omitted from the formulary, and prescribed for use by the injured employee is authorized.

(E) If the third party's determination under subsection (C) is to deny the prescribing physician's request to permit the use of the drug that is listed but not approved on the formulary, or omitted from the formulary:

(1) the employer shall notify the prescribing physician and the injured employee; and

(2) the injured employee may apply to [workers' compensation board] for a final determination concerning the third party's determination under subsection (C)

(F) Notwithstanding subsections (A) through (E), during a medical emergency, an employee shall receive a drug prescribed for the employee even if the drug is a drug that is listed but not approved on the formulary, or omitted from the formulary.

Section 5. Third Party Conflict of Interest

(A) The URAC certified third party identified in Section 4(C)(1) shall be independent of any workers' compensation insurer or workers' compensation claims administrator doing business in this state.

(B) No URAC certified third party identified in Section 4(C)(1) shall have any material professional, material familial, or material financial affiliation with any of the following:

(1) The employer, insurer or claims administrator.

(2) Any officer, director, employee of the employer, or insurer or claims administrator.

(3) A physician, the physician's medical group, the physician's independent practice association, or other provider involved in the medical treatment in dispute.

(4) The facility or institution at which either the proposed health care service, or the alternative service, if any, recommended by the employer, would be provided.

(5) The development or manufacture of the drug proposed by the employee whose treatment is under review, or the alternative therapy, if any, recommended by the employer.

(6) The injured employee or the employee's immediate family, or the employee's attorney.

Section 6. Rules

The [state department] shall promulgate rules necessary for the implementation of the formulary.

Section 7. Effective Date

This Act shall take effect [xxx days] following enactment.

NCOIL – NAIC DIALOGUE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
NCOIL – NAIC DIALOGUE COMMITTEE
2024 NCOIL SPRING MEETING – NASHVILLE, TENNESSEE
APRIL 12, 2024
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) NCOIL – NAIC Dialogue Committee met at The Sheraton Grand Nashville Downtown Hotel in Nashville, Tennessee on Friday, April 12, 2024 at 1:15 p.m.

Representative Tom Oliverson, M.D. of Texas, NCOIL President and Co-Chair of the Committee, presided.

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Rep. Deborah Ferguson, DDS (AR)
Rep. Linda Chaney (FL)
Rep. Matt Lehman (IN)
Sen. Beverly Gossage (KS)
Sen. Lana Theis (MI)
Sen. Michael Webber (MI)
Sen. Paul Utke (MN)
Rep. Bob Titus (MO)
Rep. Nelly Nicol (MT)
Sen. Vickie Sawyer (NC)
Sen. Jerry Klein (ND)
Rep. Tim Barhorst (OH)
Sen. Bob Hackett (OH)
Rep. Brian Lampton (OH)
Rep. Ellyn Hefner (OK)
Rep. Lacey Hull (TX)
Del. Steve Westfall (WV)

Other legislators present were:

Asm. Tim Grayson (CA)
Rep. Toby Overdorf (FL
Rep. Jeff Keicher (IL)
Sen. Aaron Freeman (IN)
Sen. Mike Gaskill (IN)
Rep. Peggy Mayfield (IN)
Rep. Jerry Neyer (IN)
Rep. Patrick Penn (KS)
Rep. Bull Sutton (KS)
Rep. Sean Tarwater (KS)
Rep. Larry Bagley (LA)
Del. Nicholas Kipke (MD)
Sen. Mark Huizenga (MI)
Sen. Natasha Marcus (NC)
Sen. Bill Gannon (NH)
Asm. Roy Freiman (NJ)
Sen. George Lang (OH)
Rep. Forrest Bennett (OK)
Rep. Mark Tedford (OK)
Rep. Carl Anderson (SC)
Rep. Dennis Paul (TX)
Rep. Barbara Dittrich (WI)
Sen. Mary Felzkowski (WI)
Del. Walter Hall (WV)
Del. John Paul Hott (WV)

Also in attendance were:

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

QUORUM

Upon a Motion made by Sen. Lana Theis (MI), 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. Paul Utke (MN), NCOIL Treasurer, 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 November 17, 2023 meeting.

INTRODUCTORY REMARKS

Before getting started with the agenda, Rep. Tom Oliverson, M.D. (TX), Co-Chair of the Committee and NCOIL President, stated that he would like to acknowledge and thank our representatives from the National Association of Insurance Commissioners (NAIC) who have joined us today: Indiana Commissioner Amy Beard; Kansas Commissioner Vicki Schmidt; Louisiana Commissioner Tim Temple; Oklahoma Commissioner Glenn Mulready; Pennsylvania Commissioner Mike Humphreys; Tennessee Commissioner Carter Lawrence; Utah Commissioner Jon Pike; and Wisconsin Commissioner Nathan Houdek. I really appreciate everyone joining us. One of the really important things to me not just as NCOIL President, but just as a member of NCOIL, is the very close relationship that we have consciously worked very hard over the last many years to develop between our regulators and our legislators. We can't do what we do without you all. And you need us as well. So, we're grateful to partner with you and we're grateful that you're here as we've worked together on these issues.

RECAP OF NAIC SPRING MEETING AND DISCUSSION ON NAIC 2024 PRIORITIES

Rep. Oliverson stated that last month the NAIC concluded its Spring Meeting in Phoenix, AZ and myself, Rep. Matt Lehman (IN), NCOIL Past President, and Rep. Jim Dunnigan (UT) were privileged to be able to join you all at that meeting where we had a very nice discussion about several issues. Normally, the NCOIL Spring Meeting precedes the NAIC's Spring Meeting but since we're doing it in reverse now we thought that it might be a good idea to begin the dialogue by discussing sort of a quick recap of the highlights of your Spring Meeting.

Cmsr. Mulready stated that before we get to that, I'll just echo your comments about the effort that's been put in and the progress that's been made with NAIC and NCOIL. I think you need no more proof than that than to see you've got seven regulators here at this meeting. And I don't know how many but probably about a dozen staff as well from our departments are at this meeting. So, that speaks volumes I think on the progress that has been made. And I speak especially to the new members who are here for the first time. I previously was a legislative member and was very engaged with NCOIL and the great work that they do here. I will kind of kick it off here, but then we've got folks lined up to hit on the different topics. As you mentioned, last month we had our meeting in Phoenix. We had 2,300 attendees for that meeting. We did have a great breakfast with the NCOIL officers. and the NAIC officers. Those are just so helpful to have that

small group and have really helpful conversations that take place there. I'll start out with, as many of you know that on April 30th of 2023 Commissioner Mike Consedine resigned from the NAIC as CEO and at the meeting in Phoenix we announced the designation of the new CEO, Massachusetts Commissioner Gary Anderson. He is a friend of all of us on here and I think very uniquely qualified. He served as staff in the Massachusetts Senate. He's an attorney. He has served as a Commissioner under Republican and Democrat Governors and he also has Chaired the NAIC International Committee. So, he has his head and hands around the international space better than anyone at the NAIC. He will begin on May 1st in that role and that was announced in Pheonix and I know we are very much looking forward to that. One other thing I might add and it wasn't announced in Phoenix but just sort of some late breaking news in the NAIC world, Illinois Director Dana Severinghaus has resigned and the Governor appointed Ann Gillespie who will actually begin on Monday. She has quite a background in healthcare and was elected to the IL Senate six years ago in the northwest suburb of Chicago and Arlington Heights so we're looking forward to meeting her and welcoming her there. So, that is sort of the quick snapshot of the NAIC and I will now toss it over to Cmsr. Humphreys who will talk about some of the regulatory priorities that we're working on.

Cmsr. Humphreys stated that I am glad to be back at NCOIL. As some of you know. I was the NCOIL Director of State Federal Relations 15-plus years ago at a time when Dodd Frank was popular and fights about the optional Federal Charter were popular and of course the Affordable Care Act (ACA) went through. So, I'm glad to be joining you again. As part of the beginning of every year the NAIC will get together and will discuss what our priorities are going to be for that year. You heard NAIC President, Connecticut Commissioner Andy Mais, roll them out largely at the spring meeting. I will talk about them again today. We have five key priorities that we're focusing on this year, the first being our continued work on climate risks, natural catastrophes and resilience. I know later in this agenda we'll talk about one of the issue areas within that bucket and that's data collection and the data call that we are working on independently but we'll collaborate with the Federal Insurance Office (FIO) on. We're also looking towards advocating for mitigation funding and I think that's another issue on your agenda. In addition to climate issues, insurer financial oversight and transparency remains a key priority for us. We have a number of accreditation bills that many of you have already passed. I think the two largest bills, I would say from a financial regulatory standpoint that 31 states have already passed were the Holding Company Act revisions that included what we call a group capital calculation and then also Holding Company Act amendments to a liquidity stress test framework. So, neither are particularly interesting. Combined, they are very long and when they come before you, they are very technical and you'll hear us kind of talk about what they mean for accreditation purposes and what accreditation means for the insurance department. I don't think I need to get into too much detail on what accreditation is other than it's really the argument NCOIL made 16 years ago about why we don't need a federal charter is because the accreditation program is so strong in where uniformity is required across the states on financial regulation of insurance companies, we have provided it through the accreditation program. So, it's important legislation that many of you will still see probably if not this session, then next session. A third priority is marketing of insurance products. We continue to look at and spread the word on how to address bad actors in our markets. Many of us have partnered with you in our respective states on things like fingerprinting reform and providing resources to the departments to help oversee our thousands of

licensees at the state level. One area that I think we can probably collaborate more on is the NAIC continues to push Congress to restore state regulatory authority over Medicare Advantage marketing. We have no authority in that space today. All of our states here and our departments of aging will get complaints on an annual basis about what happens in the Medicare Advantage space. We can try to work with those complainants. We try to work with the federal government. But, ultimately we have very limited authority so I think that's an area where we can work together and with Congress on to try to see if we can increase the authority that state insurance departments have to crack down on those that seek to take advantage of insurance consumers.

The fourth priority is our continued work in the race and insurance financial inclusion and protection gap space. This is a key priority again of Cmsr. Mais who focused a lot of his welcoming remarks on closing protection gaps. As one of our next agenda items I'm going to talk about, I co-chaired the life work stream of our special committee on race and insurance and we are working there on a policy statement that I'll talk about shortly that I think is another area where regulators and legislators can really work together to improve. In particular, the financial literacy of our graduating high school seniors. And finally, the last highlight that I think Cmsr. Beard will talk about shortly is the use of artificial intelligence (AI) by insurers and cyber risk. We have continued to try to balance innovation with consumer protection and privacy of consumer data and you'll see us continue to work in that space throughout this year both from an implementation standpoint of the bulletin that Cmsr. Beard will talk about and also, further development of privacy legislation. Also, you have heard time and again about suitability in annuity transactions. It's one way that we counter the Securities and Exchange Commission (SEC) and the Department of Labor (DOL) when they try to bring fiduciary requirements to our agent producers. We countered that with a best interest standard in the annuity space. Many of you that have been around for 20-plus years remember that suitability started off as NAIC had a model suitability bill for 55 and over. That was amended probably in the early 2000s with the argument from legislators and regulators being if suitability is good for people over 55, shouldn't it also be good for people under 55? The answer is yes. So, we adapted the model. I think NCOIL at the time endorsed it if I remember correctly that was probably during my tenure at NCOIL. And then more recently we have gone beyond just the suitability standard to develop a “best interest standard”. So, not only does it have to be a suitable product for a consumer but it also has to be in their best interest to pursue that policy over another policy or conflicting policy. The other model I would highlight for you, and 23 states have adopted the Data Security Model Act, Pennsylvania being one of them. And that really talks about requirements for insurance companies and the security preparations that they need within the companies. I think we've all seen data breaches become more common in the insurance space. We have a very significant one in Change Healthcare that I'm sure you all have heard about and it continues to be a challenge for many of our hospital systems, many of our providers. The data security model was the NAIC’s answer a couple of years ago to heighten standards for insurance companies and those that they do business with to ensure that they have mechanisms and procedures in place to protect consumer data.

Cmsr. Mulready stated that just to add an exclamation point to something that Cmsr. Humphreys talked about and that was the marketing of insurance products, talking about Medicare Advantage. An issue that we're all dealing with right now is the switching of

individual health plans. You may have heard about or read about it but there's just a lot happening there. My personal opinion is that a lot of that is tied to this continual open enrollment for anyone at 150% of the federal poverty line or below. So, they can make a plan change any point. We've got some I'll just call them rogue agents out there moving folks without their permission and people are ending up in plans that they didn't sign up for. We have folks in Oklahoma I know that are Native American who've been moved to plans and lost those sort of additional Native American benefits with the ACA. So, just to bring that to your attention that that is a big issue happening right now that we are focused on at the NAIC.

UPDATE ON IMPLEMENTATION/ADOPTION OF NAIC'S MODEL BULLETIN ON THE USE OF ARTIFICIAL INTELLIGENCE SYSTEMS BY INSURERS

Rep. Oliverson stated that we're going to transition at this point to an update on the NAIC's model bulletin on the use of AI systems by insurers. So, just for the benefit of my colleagues, after extensive discussions the NAIC wrapped up last year by adopting a model bulletin on the use of AI systems by insurers. You can view the bulletin in your binders starting on page 93 and also on the website and app. NCOIL worked with the NAIC throughout the development of the bulletin. We submitted some comment letters noting some concerns that we had, chief among them being the importance of making sure that a bulletin would apply only existing law rather than creating new law. And our concern dealt with the fact that the NAIC chose to deal with AI, a topic that is perhaps the most important and relevant one facing not just the insurance industry, but our society as a whole through a model bulletin rather than a model law or regulation, which I know you're going to clarify for us why you chose that path. We understand the perspective that AI is evolving rapidly and that legislation may not be able to keep pace and so we understand that this provides some agility, but as legislators we are responsible for oversight and we do need to be mindful of the NAIC using model bulletins on controversial matters as a possibility of being a means around legislation. And we don't believe that's what you're doing here but we would be remiss if we didn't at least talk about it. So, with that being said, can you share with us an update on what states have adopted the bulletin and what the next steps are with regards to the bulletin and any other model bulletins that may be in development that are related?

Cmsr. Beard stated that it has been about a year of work and development and working with stakeholders on developing the AI Model Bulletin. And this concept was first discussed back in 2022 at the Innovation Cyber Security and Technology "H" Committee. They announced that they were going to do some form of guidance that would take the form of a principle-based bulletin. And so, the Commissioners, we discussed what form or what vehicle we would want to use to address AI and we thought the bulletin made the most sense because it is based on existing law. It is not trying to create new law. It's based on existing law in some states, some regulations that deal with claim settlement practices, unfair discrimination laws, underwriting, market conduct rates and corporate governance laws. And so, because of that the bulletin is really a place to address things such as responsible governance, risk management policies and procedures and also lays out the expectation of a risk management program to be developed by the insurers. It is there to remind insurers that decisions impacting consumers, making sure that those are supported by already existing law, the state rate making laws, the regulations, the unfair claim settlement processes. Drafts were

exposed for public comment in July 2023 and then in October of 2023. There was a new comment period to allow input from industry, consumers and legislators. So, once we had that feedback, significant edits were made to the bulletin at that time and some of the edits addressed some of the National Institute of Standards and Technology (NIST) standards and updating the language on third-party contracting and testing and validation processes. So, to answer your question, there are eight states that have currently adopted the Model Bulletin: Alaska, Connecticut, Illinois, Nevada, New Hampshire, Rhode Island, Vermont and Pennsylvania. There's a state adoption map that is on the NAIC website that you can access and it'll be updated as states continue to adopt the bulletin. And then the NAIC is also developing a reference guide that will show how each states bulletin compares to the original version that was adopted.

Rep. Oliverson asked, as these states are adopting this and it is sort of rolling out now from conceptual to implementation phase, have there been any issues, hiccups, pushbacks, or any problems that you've seen as this has sort of played out? Cmsr. Beard stated that speaking personally, I have not seen anything in my state and working with my colleagues but I'm happy to take that back and report back if there are any hiccups. Cmsr. Humphreys stated that Pennsylvania adopted it after vetting it with the industry so we put it out there and we received comments and they largely track the comments that were received through the NAIC process. It was a spectrum from full support to you should look at these couple issues. In the end for the purposes of uniformity and giving kind of a consensus approach to the companies we deferred to largely the NAIC model and obviously we had the Pennsylvania eyes it but no other issues have been seen since we issued it. Granted, that was a week and a half ago

Sen. Mary Felzkowski (WI) stated that I was reading through this and when I look at your definitions, I understand the idea of what you're trying to do and I applaud you because when it comes to AI nothing is easy. Nothing is easy when you're trying to do law or you're trying to do definitions. But “adverse consumer outcome” - if I'm settling a claim and it doesn't go the way the consumer wants that's an adverse consumer outcome. Or if I'm underwriting and the person has a low credit score and I deny that person coverage, that's an adverse consumer outcome. Can you elaborate a little bit on the broadness of that definition and how you arrived at that definition? Cmsr. Beard stated that I think looking at that definition I would want to take that back to the group that worked on the bulletin itself to make sure that any comments about the development of that definition were accurate and we can certainly do that. As for the definition in the bulletin as it stands as states are adopting it I know for example, Indiana, my department has not adopted the bulletin yet. And every department has the ability to change certain things in the bulletin to make it appropriate for their state. So, I think something in my state that works really well when working with the legislature is I tend to make sure that the department tries to stay in its lane. And so, they are the policymakers, I am the regulator. And I would not want to overstep and I would probably look to existing state law, some of the state laws that I described earlier when implying that interpretation of the definitions. I think whatever the interpretation is of the bulletin’s definitions it kind of leans on whatever that state’s laws are as they exist but I'd be happy to call some of my colleagues who have adopted the bulletin to opine on that but I think what we'd like to do is take that back to the working group that handles the bulletin. Sen. Felzkowski stated that because if we're adopting a model and we're going to suggest that we take this back to our states and NCOIL’s going to put a stamp of approval on it, I think we'd like to know

how those definitions were arrived on and what the intent was behind them. So, thank you. I would appreciate that. Cmsr. Mulready stated that I'll just speak to what I believe the intent of was – I think it was unfair or unwarranted adverse outcomes as opposed to adverse outcomes in and of itself.

AUTO AND HOME INSURANCE AFFORDABILITY AND AVAILABLITY CRISES

Rep. Oliverson stated that next on the agenda, we were hoping to visit with you about auto and home insurance affordability and availability. We've obviously been talking about this a lot already this morning and I think the insurance specific media loves to talk about increases and decreases in rates but if it ends up being the New York Times or the Wall Street Journal as it has been recently, that kind of gets my antenna up that maybe this isn't a localized problem. Maybe it's not just California, maybe it's not just hailstorms in Texas. But maybe this is a nationwide thing. And I know we've spent some time talking about this already and I know that you all have been looking at this very carefully and are continuing to do so. So, I was wondering if you could just give us your perspective on what the NAIC is seeing in property and casualty affordability and availability and what you're game plan is moving forward and how you're addressing that just to help us see where you're going so we can figure out where we're going.

Cmsr. Pike stated that I think probably the best place to start with this is the data call that the NAIC just announced on March 8th, a property and casualty market intelligence data call. And most of you probably know the history of this but FIO came to us basically saying we want this data and we want it to be from the property and casualty marketplace. We want it to be very granular. We want it to be zip code based. And though many states gather that kind of information at that level of detail, some don't. And so the NAIC couldn't provide what they were after as quickly as they wanted it. They wanted it now basically. And so it became this discussion as to what they would do about it and I'm speaking for myself but I think that many of us anyway didn't want to see FIO get into this area. I imagine some of you feel similarly. And so we had some pretty heated discussions about that to say what do we do to avoid having them get into this space. I think that started last summer when we met as Commissioners and kind of finished up in the end of November and we basically finally played a little bit of chicken and in the end I think I'd like to think that they blinked. We're able to say, "we'll do the data call rather than there be two" which would have been, I think, a disaster and awful in a number of ways. So we'll do one. We didn't cave on everything that they wanted. It's got to be anonymized data and we are hoping and we've put it in writing that once we finish the data call, which, by the way, that data is due June 6th, we will basically make our summary and response first and then we will give it to them.

We certainly are pleading with them asking them not to try to use it for political purposes. They probably will. But in my view, it's a snapshot at a point in time that should not be used inappropriately or to assume certain things. So that remains to be seen what they do with it but the good news is we will have data about all the things you mentioned and more that we don't currently all have. And of course we looked at it and together they wanted to have 80% of the market basically captured through this data call on a premium basis. And so we found a way to do that and we have a majority of the states, I don't know the exact number, that agreed to do this and either wanted the nationwide data or at least their states. Like in my case I'm interested to get the data for Utah. And

so, that's the long and short of it. It certainly will provide we think deeper insights into market concentrations, competitiveness and could identify geographic coverage gaps and affordability of coverage issues. So, we hope that it will provide some good things and we also are glad that at least for now it keeps FIO out of the data gathering business. Are there any examples from my colleagues that you've received so far of pushback from insurers or just any experiences so far since announcing the data call or any comments otherwise on this topic?

Cmsr. Humphreys stated that I wear another hat as I'm on the Federal Advisory Committee on Insurance (FACI). I'm one of two Commissioners on it and participated in the recent FACI meeting and we talked about the data call and I think there's broad support for a single data call. There's not going to be a redundant data call from FIO right now. I think to Cmsr. Pike's point, it's the messaging is going to be important. It goes back for five years of data so can we make 200 year generalizations over five years of data? Probably not. But it puts many of our states in a good position to have more data on our own markets and look at where we may have pockets across the state that my team will want to focus on in the future. I would say separate from the data call which I'm happy to talk about kind of FIO vs. NAIC, but separate from this and I recognize that you all have a general session on cost, it's not just property homeowners. It's also auto. One of the issue areas that I get a number of questions on and I did at my budget hearing this year is auto insurance rates. And I suspect that as part of your conversation tomorrow there will be some p&c trades that will come and tell you part of the reason auto insurance rates are going up is because of regulatory efficiencies, they say that all the time. But I think what I would implore you to look at as you have that conversation is there needs to be a recognition of the substantial increase that inflation plays as part of this process. When we have seen double digit increases in inflation it is hard to keep an auto rate down. So yes, they're going to complain that sometimes some of our departments take longer than others to review a new proposed rate or a new proposed policy but I think what we're trying to do when we get faced with these rate increases that companies will come in and I approved I think two Geico rate increases two years ago and they were actuarially justified. I don't like approving a rate that's 35% but these companies can actually show us and we make them go back on a quarterly basis over the past five years to show us their claims runouts, to talk about what the projections look like on a going forward basis. And our teams really do try to balance kind of the regulatory need for rates and the standards that we all apply to that rate, that the rate shouldn't be excessive. It shouldn't be inadequate. It shouldn't be unfairly discriminatory as we review those rates. So, it's not just the "regulatory inefficiencies" that I would argue maybe are inflated from time to time. My team turns around a p&c rate increase less than 20 days on average. I think that's eminently reasonable. But there are these other cost factors that anybody that's bought a car, that has had to lease a car, can recognize that these costs are really significant now. They are growing in price, parts are growing in price at significant rates and that ultimately does have a significant cost on automobile insurance. And we'll get this question from time to time that you personally may not have had an auto accident over the last year, but as we all know, insurance is the pooling of risk. And as the cost to insure those overall risks increase at pretty substantial levels you too will face a rate increase as the system works its way through and accounts for the additional and new costs that are coming into the system. I know you're going into that conversation tomorrow and I just

wanted to give you some additional perspective, at least from Pennsylvania on other cost drivers that I think you should consider as part of that conversation.

Rep. Oliverson stated that I'm curious from our other Commissioners from different states, is it your consensus that you're all seeing the same kind of rate increases and availability challenges in your states that I might be seeing in Texas? I guess what I'm asking is, is it a fairly uniform problem? Because that's what I keep hearing. Cmsr. Pike stated that I'll speak from Utah's perspective, yes. Inflation, higher priced vehicles, more gadgets, technology - all those things factor in here but one of the big things is inflation.

Cmsr. Schmidt stated that I think in Kansas, the macroeconomic factors that we can't control are very hard to hard to justify when you have a consumer calling and voicing their concern about their rates going up. But I do think we all want these new gadgets on our cars, right? And a lot of them are for safety. As a physician, I know they save lives and they do wonderful things but they're very expensive to replace. I wanted to return quickly to the data call and I don't know whether you said this or not but over 80% of the premium written will be included in that data call. And I think that's an important number - we're surveying both local companies and companies that do business across state lines and I think that's a good point to make. And I also think that might be why FIO was more agreeing to just have that one data call. And I know from my insurers that are being surveyed they don't want to answer these questions 50 times. It's time consuming for them and it wouldn't be good for everybody to do that individually.

Rep. Matt Lehman (IN), past NCOIL President, stated that I want to go into something that we have talked about in the past and I think what your data call is going to prove is what most of us in this room know and that is inflation is killing us. What we've been replacing roofs for four or five years ago has almost doubled. Cars are more expensive for repairs. The other side of this coin is the availability. And so my question is what's the data call going to show? Because what we see on the broker side is we're seeing a carrier get deeper into the technology whether it's telematics with cars, whether it's drone technology looking at roofs and things like that. And we're starting to see now this movement I think there might have been an article a week or so ago about, “Hey, we looked at your roof and your roof has used up its life. We're going to non-renew your insurance.” So, some of this technology is leading to a potential availability crisis and I think when there's been some pushback to that like well what if I go out and get an independent inspection? Or what if I go out and get a second estimate? The answer is “our decision is our decision.” And again this hard market, I'm very sensitive to the affordability portion of this because everybody's taking rate increases and as an agent, we hear that every day. I'm more concerned honestly with the availability because I think that some of this technology we're getting into is we're going to use that to basically get rid of anything that potentially is going to cause us a serious claim and so we're going to have a crisis coming, I think.

Cmsr. Beard stated that looking at rates we specifically try to focus on Indiana experience and I think that is important to note because we have had some serious storms in the state. And so, I think we are going to continue to see the effects of those storms not only just immediately, but for a prolonged period of time as we look at these rates. And so, as we're considering rates, we also are working with the carriers to make sure that the other factors that are at play are not adversely impacted and availability is

one of those things. So, we can work with the carrier during a rate filing to talk about maybe the carrier wants to stop doing business in a certain area or non-renew. We have been able to work with a couple of carriers to work on some of the rate filing aspects of their request to also talk about availability. And so, I think it's important for the regulators to look at different areas that are impacted by rate filings not just traditionally in the sense of the actual rate filing itself, actuarially, but pulling in other areas of the department's expertise to look at the subject matter expertise of some of the policies that go into place behind some of these filings and what's available. And then I think also relaxing some regulatory requirements that are reasonable I think can be helpful for ensuring that insurers are able to do business and uphold their consumer promises. And I'm all for consumer protection but I also want to make sure that industry is able to remain financially solvent and so with those things in mind we look at what parts of the state are being hit hardest and where are we seeing some of the availability issues and trying to go, I know that we did a town hall in southern Indiana a few weeks ago where there was a storm. And we wanted to make sure that people were able to continue on their coverages. And if they were going to be non-renewed, we put in a moratorium and then we are saying that we will work with the carriers to try to help with placements of products and encouraging them to work with their agents.

Cmsr. Mulready stated that the only thing I would add to that is I think that the best thing that we can do from an availability perspective is that we ensure that we have a competitive free market happening in our states and that we aren't putting up artificial hurdles that would take away the ability for the players in the market to fully underwrite and price accordingly. I am not taking a shot at anyone from California but we've seen what's played out there and some of those artificial hurdles were put in place and then you see that availability disappearing and that competition is disappearing. And so I believe that's the best thing we can do is ensuring that we aren't hindering that. In Oklahoma, we have over 100 companies licensed to write homeowners insurance in the state. So, ensuring that they have the ability to underwrite that and price out accordingly is important. It's math. That's something that we can do to best address the availability issue.

Cmsr. Schmidt stated that in Kansas, thank you to our legislators because working with them we've been able to reduce a lot of fees on the industry and we're trying to do our best to make it a better place to do business in. I think you have to constantly look at things like that.

Cmsr. Humphreys stated that at the risk of being the wet blanket, at the same time and I think it's something that Rep. Lehman brings up, there are more third parties now as part of the process that the NAIC is grappling with now. We created a third-party working group that is these modelers that are coming in with these different scoring systems or different roof reviews. I looked at a couple of pictures with some of my consumer teams. They were so high up you couldn't see a darn thing on the roof and then you're going to try to take negative action against that individual and they have very few rights or limited opportunity to appeal based on that one picture that's 1,000 feet up in the air. It's not a drone in this example of what I saw but there are some with drones and there are others that we've even seen that come in and they've developed tree scores. So, I live in a wooded area, but what they're not doing is giving necessarily each individual an opportunity again to impact the score that they're being provided. So, if I'm in a wooded

area, but this system is not fully developed it doesn't have every house in every neighborhood, so instead of giving me a score it gives me the average of the area that I live in. So, regardless of whether I've cut every tree down on my property so there's not going to be a tree that falls on my roof, because they don't have a rating for my specific neighborhood, I get the average of that group in the wooded area. That's not fair. And what we have been looking at is when there is undetermined data and you see it even more in the models where undetermined will come up is areas that we think are common like we will get proposed scores that will talk about the number of car doors that your vehicle has and it's undetermined and there will be a factor that applies to undetermined. The consumer in these instances has got to have some opportunity for recourse as part of that underwriting decision because the average is not fair necessarily to all individuals. So, I think that's the hard part with the balance and kind of the new innovative and there is much good from a lot of the innovative strategies that companies are employing but there has to be a balance. And I guess to Cmsr. Beard's point, our most important consumer protection is the solvency of our industries. So, that is obviously at the top of our mind and how we approach it but also want to make sure that as these new systems are being developed there is a balance, there is an opportunity for consumers to understand what they're being rated on and the process they can have to potentially have input into how that rate is developed and applied to that specific individual in those cases.

Cmsr. Beard stated that Cmsr. Humphreys raised a point in my mind, which was the better tools that regulators have to be able to do their jobs I think it's helpful. And so, we're trying to innovate some of the resources we have to be able to keep up with industry or address some of these new technologies. So, for example, at the NAIC, we're doing a System for Electronic Rates & Forms Filing (SERFF) Modernization Project. SERFF is the forum where rate filings and form filings get made with the states for review. So, that should be an innovation that will be available to the states to use. We also have our p&c actuaries across the states have developed a working group and they're very active and they have a place where they can upload some of these models that they're seeing or some of these new innovations that companies are using. And so, I think as there's more collaboration across the states with fellow regulators and an increase in the resources that we have I think that will continue to be able to address some of the concerns raised here today.

Rep. Oliverson stated that I'll close this portion of our dialogue by saying that it's obviously encouraging to us that NAIC was able to get to a resolution with FIO. I would point out that FIO's actions along with the Department of Labor's fiduciary rule, along with the new proposed rules on short term limited duration insurance - it seems like the federal government is flexing its muscles again against McCarran Ferguson. And I would just say as NCOIL President, it might be worthwhile for our organizations to consider penning a joint letter to our federal agencies reminding them about the importance of the state based system of insurance regulation. So, if you all would like to work with us on that, we'd love to stand shoulder to shoulder with you on that. Cmsr. Pike stated that we will take that back to the NAIC Officers – it's a great idea. Rep. Oliverson stated that and secondly, we are very interested in your data call. On page 113 of the legislative binders we have a copy of the press release from NAIC and I've asked for this to be a standing item of update at all of our future P&C Committee meetings, an update on the data call. So, we really want to participate with you. We're

excited about the work that you're doing. We're looking forward to the information and the data as that may help us be better informed about what we need to do as lawmakers in making sure these markets are healthy and strong. I think we're in agreement that we want consumers to be protected. But obviously, if there's no market there, there's no concern about protection because there's no availability so it's a balancing act.

DISCUSSION ON NAIC'S EFFORTS TO SUPPORT FINANCIAL LITERACY COURSES IN HIGH SCHOOLS

Rep. Oliverson stated that I wanted to turn our discussion to the NAIC's efforts to support financial literacy in high schools. As many of you know, April is National Financial Literacy month. I think everybody can appreciate the importance of folks actually having financial literacy, especially our younger generation. And so, I wanted to give you a chance to comment on your work and to just also thank you for prioritizing that and making that an important issue for NAIC.
Cmsr. Humphreys stated that I am the Co-chair of the Life workstream of the NAIC's Special Committee on Race and Insurance and one of the issue areas that we are tackling this year is one that I've actually worked on for the last 10 years. When I was a regulator in Tennessee, Tennessee was one of the first states to require a completion of a personal finance Financial Literacy course as part of its high school curriculums. It is an issue that is constantly one that we're challenged by. When we go out, when we meet with constituents, when we go into storm ravaged towns following catastrophes, there's obviously an information and a knowledge gap often. Because insurance can be complicated. And the idea behind this policy statement would be is really to put the NAIC on the map as being supportive of your efforts that I think is really growing across the states. Even over the last couple of years in terms of requiring our graduating seniors who have completed a course of personal finance, we believe that as part of a course in personal finance there should be at least some teachings towards the basics of insurance, premiums, deductibles, maybe a 101 overview of the general lines of insurance that somebody coming out of high school will encounter. And it's one that I looked at from a special committee lens because there are so many different challenges with one parent households, foster children, and others, and even in states where it's made optional you tend not to see schools in lower income districts in more diverse districts that will stand up a financial literacy program. So, what I think is incumbent on all of us to do is to work together. And I tried not to be prescriptive in the policy statement because I think each state is going to be different. I think insurance Commissioners have a role to work with you and then to work with our departments of education who are responsible for developing what the curriculum should look like. It's easy to put out a policy statement. I know you'll hear from teacher groups and others sometimes about whether it's an unfunded mandate or not and I think needing to be able to work together to help develop teacher training is important to help them be able to teach these courses.

But we issued this document for public comment at our last meeting, the comment deadline was April 1st. We received positive comments from the American Council of Life Insurers (ACLI) and some of the NAIC funded consumers. I think we'll probably adopt it from the life work stream maybe at our next meeting later this month, if not probably in May and send it up to the full committees because really it's not necessarily just a life insurance issue but it's a conversation that I thought we had to have and it

needed to start somewhere. So, our workstream took it on ourselves, Arkansas Insurance Commissioner Mark Fowler and I are moving this forward. We heard from a resource called the Center for Financial Literacy at Champlain College and this is where the data comes from to suggest that it's grown so significantly. So, today, for the graduating class of 2023 seven states have requirements that their senior graduating class have taken a personal finance course before graduation. By the time that we roll into 2028, that is already going to be 25. So, we are halfway there in a short period of time and this is all happened over the last five years and I think we can do more to help those remaining states build resources, build opportunity and we should work together with the insurance legislators around the table. It may not even always come through your committees. It may be economic matters committees, education committees, but I think it's such an important issue for young adults today that we need to start earlier and I think the earlier we can start the better. I have actually challenged my professionals, in Pennsylvania we have a Junior Achievement program where you even go in it in lower levels in schools. I'm going to teach second grade personal finance over the course of two weeks later this month. But when I get the roster of individuals participating in personal finance, the insurance industry is woefully underrepresented. It's about 80-86% banking industry, maybe 5-10% at least in Pennsylvania of individuals going into the classroom to talk about insurance. And that's really where we can get this started. I think the game has changed substantially over the past 30 years. I grew up playing that board game Life and at the beginning of Life you start buying auto insurance. You buy homeowners insurance. So when you land on one of those spots and your house catches on fire you get paid. If you don't, then you end up losing and you owe the bank money. So even simple games like that and just starting the students by understanding what the basics of insurance are can go so much further and any study is going to tell you, they get the basic introduction here that leads to better credit in the future, better understanding their personal finances. That all ultimately bears itself out on the insurance side also. So, to me it's a no brainer and it's one that regulators and legislators can really work collectively on in our two groups specifically to encourage other states to follow suit and get this level of basic understanding for our future leaders.

Rep. Oliverson stated that I particularly liked what you said about role-playing in games really is a very valuable teaching tool instead of just lecturing to kids but giving them the chance to actually experience a loss and the difference between a loss when you're insured and when you're not insured. That's a pretty powerful example. So, we appreciate your work on that.

UPDATE ON NAIC'S "FRAMEWORK FOR REGULATION OF INSURER INVESTMENTS", INCLUDING PROPOSAL RELATING TO SVO'S RATINGS DISCRETION PROCESS

Rep. Oliverson stated that we are running a little short on time but I did want to arrive at I think one of the more pivotal discussions that we'll have here and that is an update on the NAIC's "framework for the regulation of insurer investments" including proposals relating to the Securities Valuation Office (SVO) ratings discretion process. So, for the benefit of my colleagues that may be new to this discussion, this is an ongoing conversation that the NAIC has been having and this is a conversation that we've been involved in. If you are new, I would ask you to look at page 104 in your binders. That's where you'll find the NAIC's proposed framework for the regulation of insurer

investments and within that framework there is a specific 15 step process set forth that enables the SVO to review all filing exempt securities and determine whether the rating was reasonable or unreasonable from a regulatory standpoint. You can find that 15 step process on page 111 in your binders. Obviously, I know this is a process we've been talking about for quite a while. This is certainly not the first conversation I've had with the NAIC members on this issue, and I believe my predecessors as well. So, I know we've been talking about it for a while but we had flagged some potential issues to be addressed really into three buckets as the concerns that we raised to you. And one was the due process and appeal rights that someone that's under this review would have under this proposed document. The other was unintended consequences for the macro economy; and then the fact that there may or may not be a poorly aligned or misguided financial incentive for the SVO itself in the event that it actually begins functioning as its own ratings agency and would essentially attempt to enter into the free market and compete against a regular Nationally Recognized Statistical Rating Organization (NRSRO) that's already in the market space. And I know we have talked about this, but for the benefit of many of my colleagues that are hearing this conversation for the first time, I do want to say that I sincerely appreciate our ongoing dialogue and the fact that you have responded to our comments very positively and many of the issues that we've raised have been taken into consideration and addressed. But I was just wondering if we could maybe begin the conversation with sort of a understanding of how this proposal has evolved from when it was first introduced and what the next steps might be as we go through this journey together.

Cmsr. Houdek stated that I know we don't have much time and we do have this item on the agenda tomorrow with more time so I can go into more detail at that point but given the limited time, I'll just touch briefly on the timeline as you mentioned and a couple things to mention. First, we definitely intend to still rely on the credit rating provider ratings (CRPs). There is no intention of having the SVO replace or compete with the CRPs. From kind of a process standpoint, there are a couple of different specific workstreams or initiatives that are underway with regard to kind of the CRP oversight or discretion. One, it's been in the works for a while under the Valuation of Securities Task Force (VOSTF) where they're developing the multi-step process that you refer to for discretion if there is a need to potentially challenge a rating and how that process would work. And I know the appeal issue is a big issue. I actually just spoke with the chair of VOSTF yesterday and she informed me that they are still working with industry, working with other stakeholders to try to come up with a workable solution that's efficient and effective. They recognize that what's been out there now in the latest exposure is not the most efficient and they're still working to find a way to make that better. I know there was specifically to that proposal, a recent comment period exposure period that had ended. There were a number of comments that were received from various stakeholders. The members of VOSTF will be meeting I believe next month to really do a deep dive on where we are in terms of that multi-step discretion process that's been exposed currently and what comments have been received and what changes should be made before doing another exposure and providing another comment period. So, it's very much an involved process as we're working through this. Very much trying to be transparent, listening to stakeholder feedback and I would say it's great that NCOIL has been involved, and I would encourage continued involvement as we work through this process. So, that's the kind of the current ongoing SVO rating discretion issue under VOSTF.

Separately, but relatedly under the investment framework, one of the action items is to hire an outside consultant to help the NAIC and to help regulators develop a due diligence and governance framework for how CRP ratings are used as NAIC designations. And at the spring national meeting last month we received approval from the Executive Committee to move forward with developing an RFP to hire that consultant. And as part of that process we've committed publicly and we will continue to commit and be transparent about it through not just the process of developing the due diligence framework but actually developing the RFP itself. We will be reaching out to and communicating to the CRPs to get their feedback, their input and other stakeholders as well. And then once that RFP is developed we'll go back to get approval from our executive committee to actually issue that RFP with the idea being we'll bring in this independent outside consultant to help develop this due diligence governance framework that will essentially give us more comfort because the current model right now is a model where we have blind reliance on ratings from the CRPs that then track to NAIC designations. And part of the issue here with the concern about the rating accuracy and consistency is just kind of the broader what's driving the broader discussion around updating the regulatory framework that we use for oversight of insured investments, which is the increased complexity of the investment landscape that we've really seen since the great financial crisis. We've really seen it move towards more private assets, private credit, structured assets and just in general more complex assets. And that's been a challenge that we hadn't seen previously with regard to how the CRP ratings tracked the NAIC designations which then we used for our capital requirements in accounting standards. So, the intention is to continue to rely on the private CRP ratings but to create this due diligence framework that will give us comfort that the ratings that are coming out from the CRP's are consistent, are accurate and the credit risk is essentially being analyzed and assessed accurately so that as it tracks to an NAIC designation we as consumers of those ratings can feel comfortable with what that designation is and what that credit rating or what that credit risk assessment is.

Cmsr. Schmidt stated that I want to echo some things that Cmsr. Houdek said and express my appreciation to him because I sit on his committee and transparency is a big word for us and we're trying to be very transparent and I think that Cmsr. Houdek has done that. And I want to invite the interested parties to stay engaged with us because it won't be the last exposure that we have. I bet we go through a couple more. And it's a measured approach. And I appreciate all the interested parties that have responded to the previous exposures and know that they're going to keep coming and Cmsr. Houdek has done a great job navigating a difficult and complex item.

ANY OTHER BUSINESS

Rep. Oliverson stated that I did want to bring one small item to your attention and ask you if you've heard anything about it because it came on our radar screen recently and that is an effort at the federal level by the Federal Housing Finance Agency (FHFA) to work on a program that would essentially waive title insurance requirements for certain mortgage loans. That kind of scares us in a way, because it sounds like a brand new encroachment on the state based system of insurance regulation in a completely different area and may involve these federal entities acting as unauthorized insurers. We were wondering if you had heard of that.

Cmsr. Mulready stated that we have heard of it and I think even there was mention of it in the President Biden's State of the Union Address but it's something that we are very concerned about from a federal preemption standpoint. Eric Dunning is the Nebraska Commissioner who chairs the NAIC's Title Insurance Working Group and I've had conversations with him unrelated to this but at our Phoenix meeting, I chair the NAIC's American Indian and Alaska Native Liaison Committee and we had a session on tittle insurance and potential issues with the Native American communities across the country. But we don't have a lot to say about it now except that we too are concerned about it and will continue to monitor it.

Cmsr. Lawrence then thanked everyone for coming to Tennessee and stated that he hopes everyone is enjoying the conference and the city and state. There certainly is a concern about title insurance. That was maybe one of the more surprising inclusions in the State of the Union Address and it is something that certainly the NAIC is tracking.

Sen. Beverly Gossage (KS) stated that we were talking about some new issues that have come from the federal government and I was wondering if you all gave your public comments regarding short term limited duration plans and what the federal administration is doing there. Cmsr. Beard stated that for Indiana, we made a public comment on the proposed rule and also the final rule and we oppose any encroachment onto our state rights. And we have some innovative short term limited duration plans in our state. We have a state law that was enacted that put some consumer protections in place, but made it so insurers could offer some innovative products. And so, we are looking at how our current bulletin on some of the association health plans are affected and looking to see what we need to update in the state and we will continue to take the stance that the federal gov't is overreaching into the area of the Department of Insurances.

Cmsr. Humphreys stated that we in Pennsylvania joined with a few other states in support of the regulation and I can share that letter if anyone would like. Short term plans have been a significant challenge in Pennsylvania. A lot of my consumer representatives time is resolving consumer complaints where they thought they bought major medical insurance just to find out it was a package group of excepted benefit plans or limited benefit plans and they had very limited coverage. They had pre-existing condition exclusions. They had caps and maxes that negatively impacted the consumer's opportunity to seek healthcare services that he or she needed. So, we have had significant challenges with them. We've drafted our own legislation in Pennsylvania to try to regulate them further but we were supportive of the suggested limitations on the duration of short-term plans.

Rep. Peggy Mayfield (IN) stated that I know we're running late but I wanted to share this because there was a comment made earlier about financial literacy and how it's mostly banking versus insurance. As a legislator, I take every opportunity and I seek opportunities to go into the classrooms. I've volunteered as a substitute teacher at second grade, reciting the preamble of the Constitution, a 400 level class and at a school of environmental and public affairs at Indiana University. This one day I spent with the senior class at a high school on advanced social studies and took Schoolhouse Rock about making the law. We do a lot of top-down, legislators making policy, regulators implementing – so many students came up with the idea of we need to know

more about financial literacy. These are the students. So, don't mistake a lack of interest. These kids are sponges. And they want to know whether it's homeowners' insurance, credit cards, student loans. They are dying for information. So, I just want everyone to know that kids want to know.

ADJOURNMENT

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

LIFE INSURANCE & FINANCIAL PLANNING COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
LIFE INSURANCE & FINANCIAL PLANNING COMMITTEE
2024 NCOIL SPRING MEETING – NASHVILLE, TENNESSEE
APRIL 12, 2024
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Life Insurance & Financial Planning Committee met at The Sheraton Grand Nashville Downtown Hotel in Nashville, Tennessee on Friday, April 12, 2024 at 4:45 p.m.

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

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Rep. Brenda Carter (MI)
Sen. Michael Webber (MI)
Rep. Bob Titus (MO)
Sen. Vickie Sawyer (NC)
Sen. Jerry Klein (ND)
Rep. Tim Barhorst (OH)
Sen. Bob Hackett (OH)
Rep. Brian Lampton (OH)
Sen. George Lang (OH)
Rep. Ellyn Hefner (OK)
Rep. Lacey Hull (TX)
Rep. Tom Oliverson, M.D. (TX)
Rep. Dennis Paul (TX)
Del. Steve Westfall (WV)

Other legislators present were:

Sen. Aaron Freeman (IN)
Sen. Mike Gaskill (IN)
Rep. Peggy Mayfield (IN)
Sen. Beverly Gossage (KS)
Del. Nicholas Kipke (MD)
Sen. Mark Huizenga (MI)
Rep. Mike McFall (MI)
Rep. Julie Rogers (MI)
Sen. Paul Utke (MN)
Sen. Bill Gannon (NH)
Rep. Forrest Bennett (OK)
Del. David Green (WV)
Del. Walter Hall (WV)
Del. John Paul Hott (WV)

Also in attendance were:

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

QUORUM

Upon a Motion made by Sen. Vickie Sawyer (NC), 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. Justin Boyd (AR) and seconded by Rep. Ellyn Hefner (OK), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's November 16, 2023 meeting.

PRESENTATION ON DEVELOPMENTS IN LIFE INSURER'S USE OF WELLNESS PROGRAMS

Matt Gibson, Head of Behavioral Insurance Enhancement at John Hancock/Manulife, thanked the Committee for the opportunity to speak and stated that it may seem kind of funny with the slide visual of helping customers live longer, healthier, better lives. And it's like well I thought John Hancock was a life insurance company. I think that's really the key component is who else besides perhaps your immediate circle of friends and your family would want you to live a really long time? Obviously, there is commercial success if we can help customers live a longer, healthier life. But of course, most people want to live longer, healthier lives themselves. So, it's that kind of unique opportunity to have that shared value component and really trying to use that as a catalyst for change in longer-term healthy behavior. For those of you who are unfamiliar with what we've done at John Hancock, I will briefly go over what we've done with the John Hancock Vitality Solution, which is our Wellness platform that we've integrated into our products. We originally launched it in 2015 and we just crossed our 9 year anniversary of launching just this past Monday. But the real change for us was in 2018, where we made the decision to provide Vitality automatically on every policy that we write out the door. And that's what we did when we introduced Vitality Go. So, Vitality Go is included on all policies at no additional cost to consumers. It gives them access to the Vitality platform, the educational materials, and some base level benefits really to kind of act as incentives for positive health behavior including discounts on fresh fruits and vegetables at over 1,400 grocers nationwide. We have a fantastic relationship with the Tufts Friedman School of Nutrition in the Boston area and provide a lot of that material and information to consumers. And again, that's Vitality Go with no cost. But where it really comes to life at the consumer value level is with Vitality Plus that does have a charge, just a minor $2 a month charge onto the policy, but that's really where we're seeing the strongest engagement within the wellness program itself. It actually gives consumers access to discounting the premium as well as kind of a more substantial suite of incentives to drive that healthy behavior.

Most recently, with the addition of the GRAIL and Galleri Multi-Cancer Early Detection Test which I'll get into a little bit more detail later for those of you who are unfamiliar. But again, the access to the program itself is completely up to the consumer as to which version they may choose to get and their participation is completely voluntary as far as what areas of the program they use. Which begs the question of, well, how does it functionally work? Customers earn vitality points, it's what we call them, for simple health-related activities that they might be doing to stay or become healthy like getting their annual screening, walking the dog, going to the gym, getting their teeth cleaned. Those points translate to a vitality status. And then the higher the status the greater the premium savings that would unlock with Vitality Plus. So, think of it not functionally dissimilar to perhaps a safe driving program that you might see in a car telematic. This is just taking a little bit of a step further with that there. And we do believe that it is functionally working and I am excited to share some of the stats here. I'm not going to

go over each of them individually, but I want to just really kind of highlight the core message which is we, as a life insurer particularly, enjoy the privilege of having very long relationships with our consumers. So, driving this type of health change is really a long-term solution here. I'm not suggesting we've changed mortality in the short period of time of 9 years, but these are often obviously the leading indicators that we may be seeing it come to bear. I want to specifically call out the cholesterol, blood pressure, and blood glucose statistics that you see on the screen here. Because those are highlighting the specific individuals who had measures that were outside of a healthy range, but then were able to bring them into a healthy range. That may be through personal medical intervention or actual behavioral change. Of course, we don't have the individual person's information associated with this. This also is important to understand that we do have a really high as I like to call it retention rate or stickiness rate as far as participation is concerned. The analogy I tend to use is don't tell me who's still doing their New Year's resolution in the gym in February. I want to know who's still there in November. And we're really pleased to see that about 70% percent of our consumers that are using the program either maintain or increase their engagements year over year.

And health and wellness does go beyond just simply being physically active, eating well, mental well-being, and getting your preventative care. But we did put a pretty intentional focus on early cancer detection. I'm sure everyone here has either a direct or an indirect unfortunate relationship with cancer. One in three people in the United States will develop cancer in their lifetime. And what's most challenging is that 70% percent of cancer related deaths are from cancers we don't look for and don't find until after they're symptomatic. We only really screen regularly for 5. That's colorectal, cervical, breast, prostate, and if you're a smoker, CT scanning. So, there's only 5. So, that's part of the reason why we brought the GRAILS and Galleri tests to the platform and are providing access to John Hanock Vitality to customers to access that. It is a simple blood draw. They get two vials of blood taken and they can actually screen for about 50 different cancers. It's not a risk of cancer, it actually has to be we believe you have this cancer currently to get it early. So, their kind of mantra is detecting cancer early when it's treatable. And how consumers actually go through that, we have it through the digital experience both on the web and on the app where they learn a little bit more about the test and they can ultimately request the test, test kit is sent to them directly, and they can then facilitate their blood draw through a phlebotomy partner like a Quest Diagnostics. And the results are then provided to the prescribing physician, John Hancock does not receive any of the information. In fact, we don't even know which consumers have opted to take the test or not, we're just really providing access to it.

And the big question is, well, what do the results look like? Well, it's very clear if cancer is not detected, it's pretty much in big bold letters and if they do believe that there is a cancer signal detected, there are two kinds of predicted locations to help guide customers and their primary care physician for follow up diagnostic and ultimately treatment within that. When we were bringing GRAIL and Galleri on, one of the things that we have is obviously a certain duty of care to our consumers. We didn't want just to say, hey, we think you have cancer, good luck with your cancer. We wanted to make sure that there was actually a lot of support on the back end for consumers to do that. So, both either needing possibly a primary care referral, getting access or guidance as to how to navigate their existing healthcare coverage, and what might be needed there.

But I'm not going to go through all the specifics here, I want to just point out that it really is about providing care to consumers. I will end this with a quick personal anecdote. So, last Thanksgiving, my father-in-law was diagnosed with Stage 4 Melanoma. He was not symptomatic. He had no skin lesions. It manifested in his small intestine and spread to his adrenal gland and liver and other lymph nodes in the surrounding areas. Access to early detection is obviously very critical because he was asymptomatic. There's no reason for him to do that until things started to poke into his skin. We're hoping his outcome will be positive. We're still kind of undergoing a lot of immunotherapies for the last 18 months. But we are looking forward to hopefully a positive outcome. I share that because wellness programs and early cancer detection can feel very cerebral. It's about this future health improvement that may or may not manifest itself. But it's those micro moments that we're really trying to bring forward to facilitate that type of change.

Brenda Cude, Ph.D., Professor Emeritus, Financial Planning, Housing and Consumer Economics – University of Georgia, stated I think we can all agree, and I've certainly heard conversation today, that improving our health matters to all of us. I don't know anything more about Mr. Gibson's program than you heard today. But what I did was take some time to think about some of the questions that I think we should be asking about programs like his. And I will in full disclosure, say I participate in a health insurance wellness benefit that's similar to this. So, my questions all relate to the cost versus the benefits, accessibility of the activities as well as the benefits of the programs, protection of personal information, is there relevant regulation, and finally, how this impacts the portion of our society with life insurance. So, first of all, I did some research. I'm a researcher, so I looked online to see what I can learn about anything we know from previous wellness type programs and there's an excellent report from Rand that looked at workplace wellness programs. And it makes Mr. Gibson's program sound like a superstar because in general this analysis indicates that at best there's only modest benefits from workplace wellness programs. For example, they cite no significant reduction in the cost or use of ER's or hospitals, no significant reduction in cholesterol, the average weight loss is 1 pound a year over 3 years. So, nothing stellar in terms of the results of these programs based on their analysis and I think they're asking the right kinds of questions in this. And one of the points that they make I think is that motivation matters more than the program. So, I think about my friend who has access to the same health insurance wellness benefit that I do. For me, it's a matter of which gym do I go to? She's not going to the gym, it doesn't matter that that's one of the benefits available to her. So, I'd like to see for programs like this, some very careful short term as well as long term analysis of the costs and the benefits. I'd also like to hear more about the accessibility of the types of activities in the programs as well as the benefits to everyone. So, I grew up about 50 miles from here in a farming community where the only McDonald's was the local funeral home. They do actually have a restaurant there now. But are these activities and are these benefits as accessible to the folks in my community as they are to someone who lives in Boston?

And you could ask the very same questions about certain urban areas where they don't have any additional access beyond what individuals in my farming community might have. Also, I think about how those with physical limitations can participate. For example, in activity-based programs. And I think another question is what about mental health? We've heard a lot about mental health today. And I know there are some mental health benefits, but what are those and how are they accessible? And are they

the benefits that people actually need? Thinking about protection of personal information should be something that comes to mind right away, of course. Probably everybody here is affected by the AT&T data breach and I know I've gotten multiple emails already about that. And we're all just getting numb, right? Every week there's something that's happening. But if there's a data breach about my personal health information, changing my username and my password's not going to fix that. I can't change my personal health information. So, I would have questions about how this information that's being accessed is being collected, stored, used. And you know the euphemism shared, which means sold. So, what's happening to personal information that's being collected here? And you talked about not getting in between the cancer detection and the patient, but you have other information that's being accessed as part of this program. And this is not specific to Mr. Gibson and I don't expect you to answer the question. I'm just saying these are important questions that we should be asking about any program because what I don't have up here is that, to the best of my knowledge, these programs aren't regulated. There are regulations that apply to workplace wellness programs but I couldn't find any indication of how an insurance based program is regulated so who holds the insurer responsible if data isn't protected in the way that it should?

Another question I would have is about how these types of programs might change underwriting? Is the underwriting somehow designed to screen out the less motivated individuals? Are there cross subsidies in the pricing of products that mean that those of us who choose not to participate in this type of program are actually paying for the program that offers these types of wellness benefits? And then the final point that I want to make is that I also care about increasing the portion of our population who have access to life insurance and who have life insurance. A theme this year at the National Association of Insurance Commissioners (NAIC) is minding the gap and one of those gaps is folks who don't have life insurance. The Committee that was mentioned earlier today heard a presentation last month about individuals who have served their prison sentences but can't buy life insurance. The Federal Financial Literacy and Education Commission that met just this past week also talked about that topic. This is Financial Literacy Month, but it's also national Second Chance Month. So, giving people who've served that prison sentence and cannot buy life insurance from most insurance companies is a topic that people are talking about. I can't answer any questions about that, I just know that it's an example of ways that we all could be working together to increase the proportion of our population who have life insurance.

Sen. Beverly Gossage (KS) stated that in my 20 years of being a health insurance and life insurance agent so many times even in employer sponsored wellness programs, it's the people who are already trying to be fit and already go to the gym that participate. It's not really the ones you want to do this. It seldom happens. I noticed in your slide that you said 40% of those that participate, 50% of those, 70% of those. Great, but of the total people that have a life insurance plan with John Hancock how many of those people participate in the program? Mr. Gibson stated we're going to isolate just the period of time in which we offered it just for point of order because we don't have the total number of customers that we have in force on that. So, there's two components here that I want to address. First, we're at roughly about 66% opt in for the full version of the program with consumers and as far as getting started and engagement in the program it covers a little over 60%. Sen. Gossage stated that's far better than the

typical. Mr. Gibson stated it is and just to add one point of clarity. I think one of the things, and I may have missed it in my commentary, is employer based programs versus life insurance based programs since there's obviously the component of time that is a big part of that. I think that I saw a statistic somewhat recently saying that the average employee is at an employer for 3 to 5 years before leaving. You're not going to see real health improvements over that short window of time. And in reality, in the 9 years that we've had Vitality up and running at John Hancock we're really just starting to see that come to bear. We are hoping at our 10 year mark to do a pretty comprehensive mortality study release. Sen. Gossage stated I might just mention my colleague here brought up the point that there is a difference of course with people who have employer sponsored health insurance purchased on their behalf than someone who chooses to purchase life insurance, perhaps a different population.

Rep. Brenda Carter (MI) stated first of all, I want to thank you for the program that you're presenting and your presentation. But what I'm looking at is what initiatives do you currently have for outreach to our populations who are underinsured or uninsured? They need to have a long life as well. Mr. Gibson stated that's one of the key things that we really focus on. We recognize particularly the markets that a lot of the life insurers tend to serve are a little bit more on the higher end of the income window. Tax reasons aside, there's still important protection that is needed for Main Street consumers in that space. So, when it came to bringing Vitality, we don't have a face amount requirement as far as gaining access to the program. In fact, we have a more mass-market product that provides a slightly different delivery mechanism of the premium savings. It's actually a cash back component versus a policy credit component. But that is specifically designed for the really more mass market Main Street consumers that aren't getting coverage as you mentioned. But also, they still have access to the same portfolio of incentives and benefits including the food benefit and other piece there. But I do encourage any other insurer that would be looking to do any sort of wellness program rollout to really keep in mind the point that Rep. Carter made about access and not just necessarily discriminating off of face amount or income base bans.

Rep. Carter stated that as an aspiring life insurance producer, I'd like to know if we wanted to download your app is it available now and if so, where? Mr. Gibson stated the Vitality Experience app is available for download, but you wouldn't be able to actually log in without a policy. That actually is in place for a lot of actual privacy component reasons, as Dr. Cude mentioned, because we obviously have an agreement with Vitality to bring that forward and as far as data not being shared with them, we only share information to Vitality as far as Matt Gibson bought a policy, he now has access to the program, make sure his profile is set up so when he attempts to register it is. Conversely, we don't receive information back from Vitality as far as any sort of health information that they're being provided as well. But we do have a lot of information on the public Johnhancock.com website.

Rep. Anderson stated that I'll just note that NCOIL does have a Rebate Reform Model Act which was adopted almost 5 years ago to modernize state anti-rebate statues and regulations so that they recognize new products being offered by the insurance industry and maintain necessary consumer protections. It may be worth taking a look at the Model to see if it needs to be amended at all to recognize the type of programs we've

heard about today. If anyone has any questions or comments on that, please reach out to the NCOIL staff.

PRESENTATION ON EFFORTS TO PROMOTE LIFETIME INCOME

Bret Hester, EVP, General Counsel, Strategy, Policy & Operations; Government Relations & Public Policy at Teachers Insurance and Annuity Association of America (TIAA), thanked Chair Anderson and the Committee for the opportunity to talk about retirement savings and lifetime income today. I'm going to give you just a little bit of a brief background on TIAA. It was founded as a nonprofit in 1918 by Andrew Carnegie to solve the problem of teachers retiring in poverty. We're very much committed to the same mission today of helping those in the education, healthcare, nonprofit, and government sectors retire with financial security and dignity. Over the last 100 years we've paid over half a trillion dollars in retirement income payments to our participants. It's a good segue actually from the last panel in terms of talking about how long people are living and making sure that as many people as possible have access to their retirement system. 2024 is actually the 50th anniversary of the Employee Retirement Income Security Act (ERISA), which celebrates its birthday on September 2nd. So, it's a good opportunity to reflect on ERISA's successes and what remains to be done. In one sense, ERISA has been a terrific success. It was passed in 1974 and it took a long time to get there following the 1963 failure of the Studebaker and Packard Automobile Companies which resulted in the loss of thousands of jobs for employees and also the loss of their pension benefits. It has done a great job of making sure that employees who are covered by retirement plans are managed and protected in accordance with fiduciary standards and safeguarded. On the other hand, as the slide shows, there's still a lot of work to be done. It's astonishing, but there are 55 million American workers who don't have access to a retirement plan through work. And in the 50 years since ERISA passed there's been another phenomenon that has occurred, which is the decline and near disappearance in the private sector of defined benefit pension plans.

In 1975, shortly after ERISA was passed, more than 70% of private sector workers had access to a defined benefit plan and the promise of lifetime income and a paycheck for life that it promised. Today that number is down to 12% percent in the private sector. So, it's been a significant change. So, there's clearly a significant amount of work to be done. We're also in the middle right now of what I've heard called the Silver Tsunami. 11,000 to 12,000 people a day are turning 65, which is more than 4 million people a year. And the result of that when you look at the coverage gap and the income gap is that there is a projected 4 trillion-dollar savings gap in the retirement system and it's projected that as many as 40% of American families will retire without enough savings to last them throughout their retirement. But the good news is that while we've been calling it a retirement crisis, we could reframe it as a relatively easily solvable retirement challenge, because there are steps that we can take to address this problem. They're really four basic principles. First, the important thing is to make sure that as many employees as possible have access to a retirement plan at work. A key here is auto enrollment. There's also a really promising development for people who don't have access to an employer plan which is roughly 19 states have enacted or are in the process of implementing so-called state facilitated retirement plans or auto IRA programs and there are a couple of more states that are in train of doing that this year. Washington, for example, just updated a more robust version of theirs and enacted new

legislation I believe in the last week or the preceding week. So those are very promising. The statistics show that people who have access to a workplace retirement plan are 15 times more likely to save for retirement than people who don't have access to a plan from work. There's also another step that we can take which is to make sure that people are saving enough money. And that needs to be in the 12% to 15% range and obviously even higher can be better. One step that has proven very promising is automatically enrolling and automatically escalating employees' contributions so that it starts at something like 3% and steps up gradually 1% or 2% a year until they're getting to that desired level of savings. So that's another promising step that we can take.

Third, it's really crucial for retirement plan menus to include in plan lifetime income solutions. Making these options, and it's important to emphasize that they can be options, available through plans lowers the cost of these valuable solutions and helps workers gain access to them and information about them. And that's a good segue to the fourth principle that we can follow, which is providing adequate education and advice to workers about the options available to them, about the consequences of their decisions in terms of enrolling and how much they save. At the state level, in terms of state and public plans there also are things that members of this Committee and other policymakers can do. First, you can ask the simple question, do our laws provide language and direction to ensure appropriate contribution levels and lifetime income options? Do hybrid plans and supplemental and core defined contribution plans have enough lifetime income options embedded in them to help people not only ensure that they have enough savings but can also convert that into a guaranteed stream of income that they won't outlive? And this may be particularly important in states that don't participate in Social Security for public workers. So, the culmination of all of this is that last year, and it followed the adoption by Congress of SECURE 2.0 following SECURE 1.0 which was passed in 2019, major comprehensive retirement bills that still leave work to do, is we introduced what we're calling pretty simply a Retirement Bill of Rights. I don't think there's really anything in here that's particularly complicated or controversial. The first premise is that if you work a full career you should have the right to a financially secure retirement. And I want to emphasize it's not an entitlement it's just making the tools available to workers to allow them to do that. The second principle is that every worker should have access to low-cost investment options that help them generate sufficient savings and ample income for a dignified retirement. The third principle is that every worker deserves clear information to allow them to compare savings and income options and make informed choices to achieve a secure retirement. And finally, it's not really a right, but it's a principle is that it's a shared responsibility of workers themselves to enroll in their plans to save enough of the private sector to make plans available to their workers that help them do this and to policymakers to put the right policies in place to allow this to happen.

Sen. Bill Gannon (NH) thanked Mr. Hester for his presentation and stated my only problem is in reality I represent 90,000 people who are barely able to afford pizza on $4.99 pizza night. So, in reality the vast majority of my constituents do not have the ability to save 12% or 15%. In fact, I would have to say that they're spending negative because I know nationwide our credit card use is soaring and the amount of debt that each one of us is accruing is just multiplying every year. So, although I would love that to be a possibility of the 12% to 15%, I don't see it as realistic for anyone who doesn't have a real savings plan through an employer which you guys said you're like 15% more

or 15 times more likely to save if there is a plan. These people who are late in the game, nearing 65 and they're just barely getting by, they're not going to be able to put any of that 12% to 15% away. Mr. Hester stated that's absolutely right. And I do think it's even valuable for that initial amount. And we have found that when there is automatic enrollment that people do actually tend to and it's a hardship but in addition to paying your current self, you have to pay your future self. And it's understandably very hard for certain people to get to 12% to 15%. But it's also vitally important to start and to build that up to provide a cushion. So, any amount helps, but yes, you're absolutely right.

Dr. Cude stated we share a lot of the same ideas and I'm not going to repeat, but I want to add a beginning and an ending thought really to what he said. So, I think a Retirement Bill of Rights starts with making sure we have that solid base of Social Security and Medicare. Regardless of what you think of those two programs, that is the basis that most people are planning their retirement on. And we know that Social Security was only ever intended to provide one third of income, so, we certainly have to do more than that, but we have to start by keeping that strong. Then we need to make sure people have savings. And the kinds of things that Mr. Hester talked about are plans to make sure that happens. It is absolutely critical if people are going to accumulate wealth in their lifetime, that they have access to workplace plans that include automatic enrollment and payroll deduction. That's how people actually build wealth in the U.S. Especially given all the questions about the housing market today. So, we know that from research that's the way those things are happening. And I'm glad that Mr. Hester mentioned states that are making that happen through various forms of automatic IRA plans that incorporate this very important concept of automatic enrollment, which you can opt out, and then automatic payroll deduction. And with the auto escalation again those are key features in helping people accumulate wealth. I'm concerned, though, about two populations. So, one is the low-income population, as you mentioned. We've had something called the savers income tax credit that was supposed to help lower income individuals save. And it basically hasn't worked. It wasn't well known, it wasn't well used. I understand that based on SECURE 2.0 there will be something that's a savers match that's intended for lower income individuals. So, we'll see if that's effective.

And I also think this notion of, and I taught financial education for my entire career, reaching people where they are is so important to start. So, with a college student, I would never say save 15%, or 10%, or 12%. I would say your goal should be to try to save $1,000. If you get $1,000, set a new goal. Then that might be saving 10% of your income. But you have to reach people where they are. Although I always say to my college students, enroll in your retirement savings plan at work the day you're eligible, at the minimum if that's what you have to do. But begin as soon as you can. The other group that I'm really concerned about is those who are in what's called the contingent or the gig economy. I've seen statistics that no more than 3 in 10 of those folks have a traditional full time job. So, they don't have access to this automatic enrollment, except that both Uber and Lyft are working to make that possible for them. I've read that both are offering or working to offer payroll deduction IRA. So it's an automatic withdrawal from their pay to participate in an IRA. There are apps that will automatically sweep an account and put the excess, you define the excess, into an IRA. So, those are the kinds of things that we have to think about for people who are not going to have a 9 to 5 job with regular pay payment. So, and I agree that if we are successful in accumulating

significant savings then a lot of people won't know how to manage that to make that last for their lifetime. And that is where an annuity comes into play. However, I have two caveats. One is that they know they're choosing an annuity. When I began as a college professor, I put money in TIAA. I don't know if I knew it was in annuity. It would have been better had I known that. And today onboarding is a website. It's not a person, it's not a session in a room in which someone explains what your options are to you. And my second caveat is I want to make sure that those annuities that are offered are basic annuities that are relatively easy to understand and that are low cost, which means they're not the ones being marketed to investors or as the way to avoid taxes.

And then finally, I couldn't leave here if I didn't talk about improving financial literacy, because that is the thing I've spent my life doing. And financial literacy also includes attitudes. So, personal responsibility. It also includes perceptions, if nobody else is saving why should I? If everybody else is saving, I should too. So, we have had programs to try to change the way people think about saving to see that it's something that everybody does. Earlier today, we heard that states are doing a better job at encouraging or even mandating financial education in the school system. And if anybody here is from Illinois and was to claim they were the first to do it, I can help you with that, because Illinois required consumer education in the 1970s. And that was what we now call financial education. But teachers are not prepared to teach it. So, if you're in a state where you have the opportunity to influence funding, please do that. They're no more prepared to talk about credit cards and how they work then somebody else might be. So, teaching that is pretty intimidating. And I also want to encourage you, if you don't know, to go home and find out if your state has a council on financial literacy where everyone associated with state government is coordinating what they do or look for something called a council on economic education which is probably located at a university in your state. And if you want to support and encourage financial literacy that's a way that you can do that.

Rep. Anderson thanked Mr. Hester and Dr. Cude and stated that this is great information. Savings has always been a part of my teaching from coming up so certainly I want to thank you for those words of encouragement for us.

Rep. Hefner thanked the presenters and said something that just caught me while I was listening to your presentation is when you said your goal is $1,000. In my state in Oklahoma, we have an Achieving a Better Life Experience (ABLE) account that we encourage families who have kids with disabilities to put money in. And I'm going around the state as a financial advisor helping families who have a child to plan for that third retirement. And I have a friend in the disability world that she's a parent and she's from eastern Oklahoma and she said Ellyn, our family has never learned how to save and you're talking about things that I don't trust. And so we have to take another step back, $1,000 is too much. She taught me a different way to talk to people who have never put in a dime or saved and have a savings account. That she would say it's a gallon of milk and its loaf of bread. And so, I think we have to take another step back when we talk, even the words financial literacy, that's not even explaining to people what that is. And so really it's not dumbing down, it's that a lot of people in our world have never learned to save. I appreciate your presentation, but again, I think that we have to talk with people and teach them a little bit more about the savings piece. My mother-in-law, who lived through the depression, she told me, “You need to save $5 a week and

then one day you'll be a millionaire." And I was like, "be quiet", when I was 20. And of course that's true but at the time, I didn't know anything about annuities and that word too is something that people have to learn to trust. Again, I appreciate your presentation, this is just an added-on insight into a world of families who have high medical costs, high medication costs, and they're counting on Social Security and Medicaid to take care of their kids who have benefits that leave them in poverty. And people that have disabilities that I talked to who want to save money and we talk about maybe we don't have a pizza this week and we can put that money in your ABLE account. So again, all those experiences we have to listen to their stories and find them where they are so we can support them.
Dr. Cude said just let me say quickly, I said you have to meet people where they are. So, for my college students, $1,000 is attainable. But I grew up in a farming family. I remember the day my dad came home and said the bank's offering something called a CD and that sounds really risky to me. I've spent a career teaching so I would never walk into a room and assume $1,000 is attainable for any audience unless I know who that audience is. Rep. Hefner replied yes, it was just more information for everyone because that $1,000 just hit me and I thought we've got to give a little bit more experience because I'm sure there's some students in your class that wouldn't have told you they didn't know how to save and that $1,000 was too much.

CONSIDERATION OF RE-ADOPTION OF MODEL LAWS

Rep. Anderson then turned things over to the Vice Chair of the Committee, Sen. Vickie Sawyer (NC). Sen. Sawyer stated that we're going to move to the consideration of the readoption of model laws. Per NCOIL bylaws, all model laws must be readopted every 5 years, or else they will sunset. The models up for readoption are on the app and website and appear in your binders starting on page 135. The model acts are the Model Unclaimed Life Insurance Benefits Act and the Life Settlement Model Act. We're going to handle these separately as there have been some amendments proposed to the Life Settlements Model Act. So, for the Model Unclaimed Life Insurance Benefits Act, it has proven to be a very successful model and it has been adopted in over 30 states. Accordingly, I'll entertain a motion to readopt the model. Hearing no comments or questions, upon a motion made by Rep. Anderson and seconded by Rep. Tom Oliverson, M.D. (TX), NCOIL President, the Committee voted without objection by way of a voice vote to readopt the Model.

Sen. Sawyer stated that the Life Settlements Model Act has also been proven to be a very successful Model with it being adopted in about 15 states and about another 10 states having adopted a combination of the NCOIL and NAIC model. Amendments to the Model have been proposed for discussion by the Life Insurance Settlements Association (LISA) so we won't be voting on the amendments today, they have been offered up only for discussion purposes and there is no sponsor attached. With us here today to briefly summarize the proposed amendments is Alan Buerger, Chairman and co-founder of Coventry, on behalf of LISA.

Mr. Buerger thanked the Committee for the opportunity to speak and stated that I'm here representing LISA which represents all licenses of both brokers and providers, which is what Coventry, my company is. At the risk of being somewhat presumptuous, I don't recognize very many of you from the time a very controversial Model was created. And

so, I'll just say this in the event a couple of you aren't familiar with life settlements. A life settlement very simply is the purchase of an existing life insurance policy when the policy owner no longer needs or can afford that policy. That makes up approximately 20% of individuals insured, aged 65 and older, and literally hundreds of billions of dollars of insurance lapse are surrendered by that demographic every year. So, a life settlement is simply an option. A consumer choice. It was controversial when it began, it was an outgrowth of the viatical settlement business which had its problems. The life settlement business is meant to give consumers a choice so on behalf of LISA we appreciate NCOIL accepting suggestions. We reached out to NCOIL and said we thought that 17 years was long enough and there was a need for some changes. I agree the Model has been successful. In fact, the insurance departments, and I think legislators rarely see complaints about our industry. But there are some issues in the 17 years I think should be addressed.

They fall into two categories. Basically, one I'll call electronic. We live in a different world. Electronic signatures should be accepted. It's inexcusable. And I don't mean to be pejorative, but some carriers willfully don't accept electronic signatures and make it difficult to get a transaction completed. And that's unfair to the consumer. It can take 30, 60, 90 days. And so some of the amendments we're suggesting are meant to help the consumer with respect to getting a transaction completed. Additionally, we have made suggestions and these suggestions came from all of the members of the LISA. They were asked, what do you see as issues? And these are issues that they're confronted with every day. In terms of signatures and verification of coverage, that's necessary. We should be able to get that electronically, not by snail mail, and sent where it's authorized to be sent. So, they're all housekeeping, efficiency type changes. The other change that many members suggested we come to you with has to do with should agents be prohibited from saying to a client who comes to the agent thinking of dropping their insurance, "Well, you know you have another option. You could see if there's value in excess of what the insurance company will give you in the way of a life settlement." Right now, and it's a minority of companies it's probably no more than a dozen, prohibit their agents from even doing that, from even suggesting that there is this option. That's anti-consumer and I think we can do better. I recognize the American Council of Life Insurers (ACLI) would prefer to leave what has been successful left alone. We worked very hard with the ACLI 17 years ago. It was controversial then, because of stranger owned life insurance (STOLI) which is not an issue today. We embrace the idea of working with you as legislators and members of NCOIL and with the ACLI and any other stakeholders to see if we can find ways to improve what's already a good Model and make it more responsive to consumers.

Jill Rickard, Regional VP, State Relations – American Council of Life Insurers (ACLI) thanked the Committee for the opportunity to speak and stated that ACLI does oppose the reopening and amendments of this model at this time for the reasons stated. We don't see any evidence of consumer harm in that marketplace. And I don't know how many of you were around when this was negotiated but it was a period of two years and many hours and all stakeholders participated in those negotiations, insurers, insurance agents, consumers, as well as the life settlement industry. Some of the changes being proposed such as the electronic information, I don't think that's controversial, nor do I think it's prohibited. The time frames and then the notice of secondary market options were heavily negotiated at that time and decided when the NCOIL as well as the NAIC

Viatical Settlements Model Acts were adopted. And again, without evidence of harm to consumers in the marketplace we do not support renegotiating this Model at this time. I'm happy to answer questions, but really just to respond to the prohibition on mentioning life settlements, that not only would apply to independent agents who do represent a number of insurance companies, but also to captive agents, who are basically employees of one specific insurance company and I don't think anybody would agree that those individuals should be obligated to advertise a product that is in competition to, for example, the options available under a life policy such as accelerated death benefits, etc.

Rep. Anderson thanked Mr. Buerger and Ms. Rickard and stated since there are some proposed amendments to the model that I believe warrant at least some further discussion, I will entertain a motion to readopt the model until our next meeting in July rather than for the full 5 years. Hearing no further questions or comments, upon a motion made by Rep. Oliverson and seconded by Rep. Hefner, the Committee voted without objection by way of a voice vote to readopt the Model until the July meeting.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Jerry Klein (ND) and seconded by Del. Steve Westfall (WV), the Committee adjourned at 6:00 p.m.

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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.

****Re-adopted by NCOIL Life Insurance & Financial Planning Committee on April 12, 2024 and NCOIL Executive Committee on April 14, 2024 until NCOIL Summer Meeting in July while proposed amendments are discussed.***

****Proposed amendments sponsored by Rep. Forrest Bennett (OK)***

****To be discussed during the Life Insurance & Financial Planning Committee's meeting on July 19, 2024.***

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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.

ARTICLES OF ORGANIZATION & BYLAWS REVISION COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
ARTICLES OF ORGANIZATION & BYLAWS REVISION COMMITTEE
2023 NCOIL ANNUAL MEETING – COLUMBUS, OHIO
NOVEMBER 16, 2023
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Articles of Organization & Bylaws Revision Committee met at The Renaissance Columbus Downtown Hotel in Columbus, Ohio on Thursday, November 16, 2023 at 4:45 p.m.

Senator Walter Michel of Mississippi, Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Edmond Jordan (LA)
Rep. Brenda Carter (MI)
Sen. Jerry Klein (ND)
Rep. Carl Anderson (SC)

Other legislators present were:

Rep. Matt Lehman (IN)
Sen. Lana Theis (MI)
Sen. Paul Utke (MN)
Rep. Bob Titus (MO)
Asw. Pam Hunter (NY)
Sen. George Lang (OH)
Rep. Forrest Bennett (OK)
Rep. Ellyn Hefner (OK)
Rep. Tom Oliverson, M.D. (TX)

Also in attendance were:

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

MINUTES

Upon a Motion made by Rep. Edmond Jordan (LA) and seconded by Rep. Carl Anderson (SC), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 21, 2023 meeting.

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

Sen. Michel stated that we're here today to discuss and consider some proposed amendments to the NCOIL Articles of Organization & Bylaws. Those amendments can be found on the conference app and on the website and they also appear in your binders starting on page 129. Sen. Michel stated that as a reminder, this Committee met and adopted amendments to the Articles of Organization and Bylaws but they were held at the Executive Committee so that some of the amendments could be revised. I'll turn

things over to Will Melofchik, NCOIL General Counsel, who can go through the amendments.

Mr. Melofchik stated that as Sen. Michel just noted, staff did revise some of the amendments and, in consultation with Sen. Michel and others, we have proposed a couple of new amendments as well which we will review.
The amendment with the revised language focuses on Section 4(C) of the Articles of Organization on page 129 in your binders. This amendment was the reason for the Executive Committee holding everything as we needed to revise this language. As a reminder, this deals with limiting the number of legislators from any one State that may vote on any matter before a Committee, and then setting forth a process to determine who may vote on a matter if a State has more than four legislators serving and present on a Committee. The new language we drafted we believe clarifies the process to determine who may vote in the situation described above where there are more than four legislators from one State. In such a scenario, the process would be:

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

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

- If both have been exhausted, then members shall have preference in order of seniority in the legislature.

Asw. Pam Hunter (NY), NCOIL Treasurer, asked for further clarification of why the proposed amendment is necessary – is there an issue of states trying to "stack" a Committee to vote a certain way on a model law or resolution? The Hon. Tom Considine, NCOIL CEO, stated that the Executive Committee has long had a rule that is set forth in the Articles of Organization & Bylaws that there can only be four legislators form one state on the Executive Committee and that hasn't bene the case on policy committees. And there was a little bit of "stacking" a couple years ago on a model law. So the thought was to align the Executive Committee rule with policy committees and then come up with guidelines and we discussed what was the most bipartisan way to do it. And we actually spoke to someone who was in the minority party in a legislature to run it by him (Rep. Carl Anderson (SC)) to make sure they didn't feel like they were getting slighted. And by having the Chair, Vice Chair, and Ranking Member be the first guideline, that made it bipartisan and then the second and third guidelines are purely by seniority so that's the luck of the draw which we think is bipartisan as well so really a bipartisan spirt drove the whole nature of the language.

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

Mr. Melofchik stated that the next proposed amendment is one that wasn't discussed in July – it's to Section 5(A) of the Articles of Organization on the same page in your

binders. The amendment deals with changing the Officer membership to include only the most recent Immediate Past President rather than the two Immediate Past Presidents. The reasoning behind this is twofold: first, due to some officers in the past several years leaving the legislature, Indiana Senator Travis Holdman has stayed on as one of the Immediate Past Presidents, despite his term as NCOIL President ending in 2016. Having two Immediate Past Presidents in the Officer ranks significantly increases the chances of a similar scenario happening again in the future due to the unfortunate realities of Officers either losing elections or leaving the legislature for another reason. Second, one of the reasons the change was made several years ago from one Immediate Past President to two, was to increase the bipartisan nature of the Officer ranks. But, with the significant turnover we've had the past few years, it's actually resulted in the opposite with the two Immediate Past Presidents being from the same political party. So going back to one Immediate Past President lessens the chance of that happening.

Hearing no questions or comments, upon a motion made by Sen. Klein and seconded by Rep. Anderson, the Committee voted without objection by way of a voice vote to adopt the amendment. Mr. Melofchik then stated that Rep. Matt Lehman (IN), NCOIL Immediate Past President, just noticed a technical change that needs to be made in light of the amendment that was just adopted. On page 129, Section 5(A) and (B) would need to be amended to have the total officer number be five instead of six. Hearing no questions or comments, upon a motion made by Sen. Klein and seconded by Rep. Anderson, the Committee voted without objection by way of a voice vote to adopt the amendment.

Mr. Melofchik stated that the next proposed amendment is one that was discussed and agreed upon in July. In Section 5(B) of the Articles of Organization on page 130, in the 4th sentence that starts with "A state committee chair from a Contributing State…." we propose to add at the end of that sentence: "….unless, upon good cause shown, such attendance is deemed by the President to be unreasonable."

This deals with the requirement that state Committee Chairs must be physically present at their first Executive Committee meeting in order to be recognized as a new member. We were presented with a scenario where a member who is Chair of their state's insurance committee and attending their first NCOIL conference couldn't attend the Executive Committee on Saturday due to religious reasons. Accordingly, we think this language is reasonable to accommodate those types of situations.

Hearing no questions or comments, upon a motion made by Sen. Klein and seconded by Rep. Anderson, the Committee voted without objection by way of a voice vote to adopt the amendment.

Me. Melofchik stated that the next proposed amendment is to Section 3(B)(10) of the Bylaws which is on page 133 of your binders. This is an amendment that was not discussed in July and is one that we noticed when preparing for this week's Nominating Committee. It struck us as odd that under the current language, one of the current NCOIL Officers, the Secretary, is not a member of the Nominating Committee and therefore doesn't have a role in choosing the next Officer. Accordingly, by adding the language you see before you, that cures that oddity.

Hearing no questions or comments, upon a motion made by Sen. Klein and seconded by Rep. Anderson, the Committee voted without objection by way of a voice vote to adopt the amendment.

Mr. Melofchik stated that the last amendment is another one that was discussed and agreed upon in July – it's straightforward and just delineates another method that legislators can use to sign up for Committees. And it also describes how legislators that serve on their state's insurance committee and are attending their first NCOIL meeting are able to sign up for Committees in advance of the conference, which is currently allowed under our bylaws.

Rep. Anderon stated that when legislators come to NCOIL for the first time and join committees and then they don't show up anymore, is there a certain amount of meetings that they can miss before being removed from that committee? Mr. Melofchik stated that that for policy committees there isn't a strict time limit but we have implemented somewhat of a loose timeframe of if you haven't attended any meeting, whether it's in person or via Zoom, in two years then you'll get letter or e-mail saying you will be removed unless you attend a meeting, whether in person or via Zoom, or request to stay on the committee which will have to be approved by the NCOIL president.

Hearing no further questions or comments, upon a motion made by Sen. Klein and seconded by Rep. Anderson, the Committee voted without objection by way of a voice vote to adopt the amendment.

Sen. Michel thanked everyone and stated the amendments will be presented to the Executive Committee tomorrow for final ratification.

ADJOURNMENT

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

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
ARTICLES OF ORGANIZATION
AND
BYLAWS

ARTICLES OF ORGANIZATION

PREAMBLE

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

I. NAME

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

II. PURPOSE

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

III. MEMBERSHIP

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

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

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

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

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

IV. MEETINGS/VOTING

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

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

C. A majority vote of those Committee members present and voting shall constitute the requisite vote necessary on measures before their Committee. No more than four (4) legislators from any one State may vote on any matter before any one Committee. If a State has more than four (4) legislators serving and present on a Committee, then the four (4) legislators voting shall be determined in the following order:

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

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

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

D. Voting by proxies shall not be permitted.

V. OFFICERS/EXECUTIVE COMMITTEE

A. The officers of NCOIL shall consist of the following five (5) officers: a President, Vice President, Secretary, Treasurer, and the Immediate Past Presidents. No person shall be elected as an officer of NCOIL who is not a member of the Executive Committee.

B. The Executive Committee shall consist of the five (5) officers, (as stated in Article V, Section A) ~~and at least one (1)~~ and not more than four (4) representatives of each Contributing State of NCOIL. New members of NCOIL Contributing States shall be elected by a majority of the Executive Committee Members. Notwithstanding any other provision of the NCOIL Articles of Organization or Bylaws, the chair of the committee responsible for insurance legislation in each legislative house of each Contributing State shall automatically, by the nature of his or her office, be a voting member of the Executive Committee at his or her first meeting. A state committee chair from a Contributing State must attend the Executive Committee meeting at his or her first NCOIL conference to be recognized as a new Executive Committee member unless, upon good cause shown, such attendance is deemed by the President to be unreasonable. Past Presidents who are still state legislators shall be voting, ex-officio members of the Executive Committee and shall not constitute a representative of a member State. The President shall not constitute a representative of his state during his term.

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

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

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

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

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

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

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

VI. DUTIES OF OFFICERS AND THE EXECUTIVE COMMITTEE

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

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

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

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

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

VII. AMENDMENTS

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

VIII. REASONABLE DEPARTURE FROM ARTICLES OF ORGANIZATION

In the event of any emergency resulting from a military or terrorist attack, widespread pandemic, or similar disaster resulting in the declaration of a state of

emergency (or similar declaration) by Federal or State officials, reasonable departure from these Articles of Organization shall be permitted upon the Officers and Executive Committee declaring that such action is warranted.

BYLAWS

I. QUORUM

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

II. VOTING

A. Voting at meetings of the Executive Committee or any other Committee, whether in person, virtual, or telephonic, shall be by voice vote except that a roll call vote shall be taken at the direction of the Chair or upon the request of a member of that committee in instances where there are dissenting votes.

B. Written Consent in Lieu of Meeting:

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

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

III. COMMITTEES

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

B. Standing Committees of NCOIL shall be:

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

relating to Congressional or Federal agency action affecting insurance and the State regulation thereof.

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

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

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

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

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

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

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

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

10. A Nominating Committee, consisting of all NCOIL past presidents, the current NCOIL president, the current NCOIL officers seeking to advance through the chairs, and current standing committee chairs with one year or more of service as a standing committee chair that shall interview potential officers for the upcoming year, report nominations for officers to the annual meeting of NCOIL,

and reconvene when there becomes a vacancy among the officers in order to nominate a replacement. A Nominating Committee member seeking to be a candidate for an officer shall recuse herself or himself from Nominating Committee participation; if said candidate is a current officer seeking to advance through the chairs, then recusal is warranted only if she or he has an opponent for the position.

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

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

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

1. Standing Committees shall be open to all NCOIL Member Legislators during an Open Registration period. At the Annual Meeting each year, Standing Committee Registration Forms for the upcoming year shall be available in the registration area, on which NCOIL Member Legislators shall register for the Standing Committees on which they will serve in the upcoming year, whether or not they currently serve on those committees.

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

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

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

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

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

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

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

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

IV. FINANCES

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

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

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

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

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

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

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

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

V. RULES OF PROCEDURE

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

model act, or allow the model act to “sunset.” Readopted models shall be sent to the Executive Committee for final adoption.

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

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

VI. AMENDMENTS

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

VII. REASONABLE DEPARTURE FROM BYLAWS

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

ARTICLES OF ORGANIZATION/BYLAWS AMENDMENTS

Adopted 4th Annual Meeting, San Francisco, November 28, 1972;
Amended 10th Annual Meeting, Detroit, November 14, 1978;
Amended 11th Annual Meeting, Charleston, November 14, 1979;
Amended 12th Annual Meeting, San Antonio, November 22, 1980;
Amended 16th Annual Meeting, Little Rock, November 17, 1984;
Amended 17th Annual Meeting, Phoenix, November 24, 1985;
Amended 18th Annual Meeting, Nashville, November 16, 1986;
Amended 19th Annual Meeting, Palm Springs, November 18, 1987;
Amended 23rd Annual Meeting, Scottsdale, November 20, 1991;

Amended 24th Annual Meeting, Charleston, November 18, 1992;
Amended 26th Annual Meeting, New York City, November 13, 1994;
Amended 27th Annual Meeting, San Francisco, November 11, 1995;
Amended 28th Annual Meeting, Austin, Texas, November 20, 1996;
Amended 30th Annual Meeting, San Diego, California, November 21, 1998;
Amended 31st Annual Meeting, Orlando, Florida, November 19, 1999;
Amended Spring Meeting, San Francisco, California, February 25, 2000;
Amended 32nd Annual Meeting, New Orleans, Louisiana, November 16, 2000;
Amended Summer Meeting, Williamsburg, Virginia, July 11, 2003;
Amended Summer Meeting, Chicago, Illinois, July 16, 2004;
Amended Annual Meeting, San Diego, California, November 19, 2005;
Amended Summer Meeting, Boston, Massachusetts, July 21, 2006;
Amended Annual Meeting, Napa Valley, California, November 10, 2006;
Amended Summer Meeting, Seattle, Washington, July 21, 2007;
Amended Annual Meeting, Las Vegas, Nevada, November 17, 2007;
Amended Spring Meeting, Washington, DC, March 1, 2008;
Amended Summer Meeting, New York, New York, July 11, 2008;
Amended Annual Meeting, Duck Key, Florida, November 20, 2008;
Amended Spring Meeting, Isle of Palms, South Carolina, March 7, 2010;
Amended Summer Meeting, Newport, Rhode Island, July 17, 2011;
Amended Annual Meeting, Santa Fe, New Mexico, November 20, 2011;
Amended Summer Meeting, Philadelphia, Pennsylvania, July 14, 2013;
Amended Annual Meeting, Nashville, Tennessee, November 24, 2013;
Amended Summer Meeting, Boston, Massachusetts, July 13, 2014;
Amended Annual Meeting, San Francisco, California, November 20, 2014;;
Amended Spring Meeting, Charleston, South Carolina, March 1, 2015;
Amended Summer Meeting, Portland, Oregon, July 14, 2016;
Amended Annual Meeting, Phoenix, Arizona, November 19, 2017;
Amended Annual Meeting, Oklahoma City, Oklahoma, December 8, 2018.
Amended Spring Meeting, Nashville, Tennessee, March 17, 2019
Amended via Conference Call Meeting of Executive Committee, July 1, 2020
Amended Annual Meeting, Scottsdale, Arizona, November 20, 2021
Amended Annual Meeting, New Orleans, Louisiana, November 19, 2022
Amended Annual Meeting, Columbus, Ohio, November 18, 2023

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PROPERTY & CASUALTY INSURANCE COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
PROPERTY & CASUALTY INSURANCE COMMITTEE
2024 NCOIL SPRING MEETING – NASHVILLE, TENNESSEE
APRIL 13, 2024
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Property & Casualty Insurance Committee met at The Sheraton Grand Nashville Downtown Hotel in Nashville, Tennessee on Saturday, April 13, 2024 at 9:00 a.m.

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

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Asm. Tim Grayson (CA)
Rep. Linda Chaney (FL)
Rep. Matt Lehman (IN)
Rep. Michael Sarge Pollock (KY)
Rep. Edmond Jordan (LA)
Rep. David LeBeouf (MA)
Rep. Brenda Carter (MI)
Rep. Mike McFall (MI)
Sen. Lana Theis (MI)
Sen. Michael Webber (MI)
Sen. Pauk Utke (MN)
Rep. Nelly Nicol (MT)
Sen. Vickie Sawyer (NC)
Sen. Jerry Klein (ND)
Rep. Brian Lampton (OH)
Sen. George Lang (OH)
Rep. Mark Tedford (OK)
Rep. Tom Oliverson, M.D. (TX)
Rep. Jim Dunnigan (UT)
Sen. Mary Felzkowski (WI)
Del. Steve Westfall (WV)

Other legislators present were:

Rep. Deborah Ferguson, DDS (AR)
Rep. Jeff Keicher (IL)
Sen. Mike Gaskill (IN)
Sen. Beverly Gossage (KS)
Rep. Mike Harris (MI)
Sen. Mark Huizenga (MI)
Rep. Jerry Neyer (MI)
Rep. Bob Titus (MO)
Sen. Natasha Marcus (NC)
Asm. Roy Freiman (NJ)
Asw. Ellen Park (NJ)
Rep. Ellyn Hefner (OK)
Del. David Green (WV)
Del. Walter Hall (WV)
Del. John Paul Hott (WV)

Also in attendance were:

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

QUORUM

Upon a Motion made by Sen. Vickie Sawyer (NC), 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. Michael Webber (MI) 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 November 17, 2023 meeting, and the minutes of the Committee's February 2, 2024 interim meeting.

INTRODUCTION AND DISCUSSION OF NCOIL STRENGHTEN HOMES PROGRAM MODEL ACT (Model)

Rep. Jim Dunnigan (UT), sponsor of the Model, stated that I'm looking forward to our discussion today as we continue to work on this Model. Let me provide a little bit of background and just kind of summarize what's led us to this point. I started last year by introducing a model that was essentially only Section 4 of the model before you today. It required insurers to provide an actuarially justified premium discount to insureds that retrofit their homes and bring them up to certain standards. As I've looked into the actuarial justified concept, it still needs some more work. It's got some challenges. And also, upon further consideration, I wasn't convinced that such a policy would really move the needle by itself. So, I withdrew that proposal. But I'm still very interested in policy that overall incentivizes people to take steps to strengthen their residences from natural disasters. As you know, natural disasters are a big area from East to West Coast and that's why I'm working on this. So, that brings us to the model before you today. It still contains the language regarding the premium discounts but as I said, that needs more discussion. But on the front end, it establishes a strengthen homes program within the Department of Insurance that provides grants to people to retrofit their roofs to certain standards. I think the grant program is critical to make the policy worth considering. As some of you may know, this concept is actually proving to be very popular as it has recently either been enacted or introduced in several states. And in fact, I know the sponsor of those bills and laws may even be here today. So, now's a good time for NCOIL to be involved in this area of insurance policy. It's a chance for the organization to provide guidance and leadership to other states. I look forward to hearing everybody's feedback on this model and I'm certainly open to suggestions on how it can be improved. This is a first draft and hopefully we can make progress for our November meeting. This is a little aside, a month or so ago, I attended the National Association of Insurance Commissioners (NAIC) meeting in Phoenix and this is on their radar and they're doing some analysis and study on the availability of insurance to cover these natural disasters, where there's hurricane, hail, fire and so, they're going to do some good work on this as well.

Rep. Bennett stated that we'll start with Brian Powell with NAIC's Center for Insurance Policy and Research who actually was the former director of the Alabama Strengthen Homes Program which I understand was the first state in the nation to implement this type of program. Also, Oklahoma is now running some very similar legislation to the model under discussion today.

Mr. Powell thanked the Committee for the opportunity to speak and stated that I recently retired from the Alabama Department of Insurance and started working for the NIAC. While at the department I worked in various roles, more notably the deputy receiver for the State of Alabama for a while and then I moved to the director of the Office of Risk and Resilience and then retiring as a Deputy Insurance Commissioner. Also, during my time there I developed the strengthen Alabama homes program and was the founding director and oversaw the program until my retirement. So, I oversaw the program for about 10 years in operation but during the development from the legislative piece forward was about 13 years. The Strengthen Alabama Homes Program is a grant program that offers grants in the amount of up to $10,000 to Alabama homeowners to retrofit their homes to the Insurance Institute for Business and Home Safety (IBHS) fortified standard for hurricane and high wind and hail. I believe Tom Travis from Louisiana spoke to this committee last year on the Strengthen Louisiana Homes Program. And just to note that Louisiana program is basically a carbon copy of the Alabama program. To date, Alabama's program has issued approximately 7,000 grants to Alabama homeowners but what it's really done is it's really worked to create a culture of resiliency. And working with partners like the Robert Wood Johnson Foundation where we utilize the $250,000 grant that foundation was kind enough to grant the Strengthen Alabama Homes Program. We've been able to perform some pretty outstanding work on outreach and education, especially through the most economically challenged parts of the state. Educating homeowners on the benefits of insurance and basically creating a resilient home. Strengthen Alabama homes also partnered with nonprofit organizations such as Habitat for Humanity to bring additional resources to the table. And also partnering with the insurance industry to meet some of their strategic goals and some of their community programs. Recently we partnered with Protective Life Insurance Company out of Birmingham and mitigated homes in the downtown area and these were the most economically challenged areas of Birmingham. And what we've seen is a very successful initiative that has mitigated homes and now those homes are insurable. And what's more is that the insurance is affordable for those homeowners. To demonstrate the cultural of resilience that's grown in Alabama, of the 62,000 fortified homes in the U.S., 58,000 of those are in Alabama. And those numbers are as of last week. As there was market interruption in the early 1990s and continued deterioration of the state's insurance market into around 2008, 2009, regulators agreed that there was a need to stabilize insurance markets, especially on the southern coastal parts of Alabama. In 2007 we particularly saw the market have about a negative 7% return in the investment. And in 2011 after the Super Tornado outbreak the losses were even higher than that. In order to stabilize the market, it was realized that in order to change the economics after the storm you had to act before the storm to prevent the loss through legislative support and the resilience movement began for Alabama. And that's when Strengthen Alabama Homes was established.

Fast forward a decade, we're starting to see the development of other programs in states like I mentioned before in Louisiana and I've personally worked with those programs. I've also worked with the development of programs in North Carolina, and Minnesota and last week received an e-mail from the Kentucky Insurance Commissioner that their legislation had been passed and they will start standing up a program. It's apparent that states are using the Alabama model to establish these programs and why should we reinvent the wheel? But the program is absolutely critical, in my opinion, for the success of the insurance markets in the states that are most vulnerable to losses due to these

natural disasters. In response to that need the Commissioners are telling the NAIC that they need resources and the NAIC Center for Insurance Research and Policy has established the resiliency hub. The resiliency hub is designed to support those insurance commissioners in establishing the operations of these types of programs. The type of support that the hub can provide is things like data analysis, program operation design and implementation strategy and provide subject matter experts and resources and counsel on the operation of these programs to help ensure the success of the departments and programs. I would like to add that the resiliency hub is also a resource for insurance legislators. We have experience and resources to support any legislation the state may be considering to use, including NCOIL. We would certainly offer our resources to help you in any questions or any concerns you may have because of our experience with that. So, if your state is considering enacting legislation to establish a program like the Strengthen Alabama Homes program please feel free to reach out to me. We can discuss the feasibility to include these options for funding that doesn't necessarily come from your state general fund which is always a good thing. I would like to be a resource or in some way help you with the work that your state is trying to do. Frank O'Brien, VP of State Gov't Relations at the American Property Casualty Insurance Association (APCIA), thanked the Committee for the opportunity to speak and stated that we have spent some time over the course of this meeting yesterday talking with the Commissioners regarding issues of availability and affordability. Later today, there will be a general session that will take a look at that topic as well. Availability and affordability issues are important and I don't have to tell you because you're seeing it in your legislatures and you're getting calls from your constituents, etc. The key to improving insurance affordability and availability is reducing overall losses. Mitigation of the type that has and is taking place in Alabama, legislation that has just recently passed in Kentucky is a key to making sure that availability and affordability issues can be resolved overtime. Mitigation prevents losses, prevents loss of life, prevents loss of property. It is just the right thing to do. The legislation that is before NCOIL right now provides a good basis to develop a model for the states to utilize. NCOIL is the place we believe to have that discussion and for NCOIL to play the role that it had displayed in previous years as the convener of insurance legislators on insurance issues. We think this particular draft is just that, a draft. It has some things that we think need to be fixed but it provides a good basis for moving forward and we look forward to working with NCOIL on this issue.

Wes Bissett, Senior Counsel at the Independent Insurance Agents and Brokers of America (IIABA), thanked the Committee for the opportunity to speak and stated that before I address this specific model, I do want to thank NCOIL for its recent focus on the hard market crisis that we find ourselves in. It's really an unparalleled crisis in recent years. It's hitting every part of the country, not just coasts and earthquake prone areas. And there are not a lot of great public policy responses that immediately address the hard market. But there are things you can do to help reduce losses and take unnecessary costs out of the system. This model is a great way in which you can go about doing that. You can stop certain claims from ever happening with a model like this. You're going to talk about a Model Law later this afternoon in the Financial Services Committee, the third-party litigation finance model, that would help I think also remove costs from the system. And we greatly appreciate the focus of NCOIL on the hard market right now. With regard to this proposal, we really thank Rep. Dunnigan for his work on this. We think this is a fantastic proposal. It's got two components you've

heard most about Section 3 already. Let me talk a little bit about that. The first component, Section 3, creates the grant program that you've heard the other speakers talk about. It would help and encourage consumers to retrofit and upgrade their roofs. It does have a proven track record in Alabama. Other states are picking up on the concept and already considering laws of their own. So, there is very much a need for a vetted Model Law in this area. The interest is there. States are acting. It's a great opportunity for NCOIL to lead. As you consider that particular section, we'd encourage this committee to consider perhaps adding a little additional meat to the bone. The proposal as drafted right now gives a significant amount of power and authority and discretion to Insurance Commissioners to design these programs as they see fit. And a certain amount of discretion is helpful. You want this to be a living and breathing program and not have to go in and change it statutorily all the time. But we do think in certain areas it would be helpful to be a little bit more specific such as how can grant dollars be used? What can grant dollars not be used on? What types of homes can receive grants like this? Can second homes or vacation homes receive grants like this? And what are the eligibility requirements that apply to contractors and evaluators? We think those are important elements.

Section 4 is the second component of the bill, and this addresses how consumers will be treated from an insurance perspective after they have installed a fortified roof. If the consumer takes an action that notably reduces the likelihood that they're going to have a claim, they will naturally expect that there will be some sort of insurance benefit that follows from that and that's what this section ensures. Companies tell us all of the time that they established the rates based on the potential for losses. They also tell us that the likelihood for a roof related loss drops significantly if a fortified roof is put into place. And so, all this section causes is it holds the insurer's feet to the fire to some degree. It says that a consumer that takes the steps that have been suggested by insurers now for several years that they can receive some corresponding benefit from that. This section is not prescriptive. That benefit could come in the form of a reduction in premiums and adjustment in the deductible or in other ways - it doesn't prescribe any particular dollar amount or percentage. It leaves all of those things to the insurer and they can take whatever action is warranted from an actuarial perspective. And if we're talking about incentives, we cannot establish a program that we say, "hey, consumers go out and put on this great fortified roof but you maybe won't get any sort of insurance benefit from that at the end". There's got to be something that comes from that and we think that leaving the discretion in the hands of the companies is appropriate but there will be some requirements to have a corresponding insurance benefit that stems from that. In terms of potential revisions to that section, we do encourage some revisions to subsection (c). We think it would be helpful to delete paragraph (c)(4), for example which imposes unnecessary paperwork requirements on consumers. And we're concerned that paragraph (c)(5) is a little bit inflexible. It could potentially make it difficult for insurers and agents to work with consumers to make sure that they get the discounts and credits that are warranted. Before I wrap up, there are a couple of related issues that I wanted to flag for you to think about. First, this proposal was sort of built on for very valid reasons the fantastic research and good standard setting work IBHS has done for years. They are the gold standard. You've heard from them in the past. But as states consider and enact laws of this nature it's going to be important for state policymakers to monitor the work of IBHS. They're going to be given considerable authority to set standards. They're going to have the power to approve or not approve contractors and evaluators

and you as policymakers are going to want to make sure that they're doing that work appropriately and not being inappropriately enriched as that happens.

Our focus in this area has peaked recently by what we view as a very troubling decision by IBHS. Until recently the IBHS had a database that all insurers and agents in the country could go on and see which properties had met this fortified roof standard. And it was helpful for my members to be able to look at that and ensure that their customers who had a fortified roof were getting the discounts or credits that were warranted. But what IBHS did in its infinite wisdom, and I say that as sarcastically as I possibly can, they decided that they would close off access to that database only to the insurance companies that pay dues to IBHS. And so, my members no longer have the ability to go on this website to see which homes have that fortified roof and it makes it harder for my members to serve their customers effectively and it's a private benefit to the members of IBHS now. It makes them look more like a trade association and deviates from their traditional nonprofit mission. We are encouraging IBHS to reconsider this decision and companies perhaps in this room or members of NCOIL that feel the same way that we do, we'd encourage them to weigh in. Secondly, I want to note that state mitigation grants of this nature are currently subject to federal taxation. There is legislation in Washington that would change that, the Disaster Mitigation and Tax Parity Act would eliminate that sort of taxation. We had over 1,000 insurance agents in DC this week lobbying on that bill trying to get more co-sponsors on it and it might be something that NCOIL would want to take a look at as it considers this model as well and as more states establish grant programs.

Jon Schnautz, VP of State Affairs at the National Association of Mutual Insurance Companies (NAMIC), thanked the Committee for the opportunity to speak and stated that to build on one of the points that was made earlier, this is a good example of talking about the answers before you've asked the questions. There's a definite tie in to the general session later about availability and affordability and we think particularly in the funding aspect this is one of the things that can be done at the state level to actually address some of the affordability and availability issues. And part of the reason for that is it's focused in the right area from our perspective and that is how do you mitigate? How do you deal with the underlying risk that is driving insurance rates? And we think this is a good example of the right focus. I also want to express some gratitude to Rep. Dunnigan and to NCOIL as when the mitigation discount issue was first brought up last year in regard to amendments potentially to the NCOIL building code model, we're in favor of resilience and we do appreciate that those two conversations were delinked. We urged NCOIL to go ahead and readopt the building code model with some improvements and that was done. And that's much appreciated. We had also at that time encouraged a couple things. One was looking at the direct funding issue for resilience that is in the model in front of you right now. So, thank you for that. And we also suggested that you look at the catastrophe and mitigation savings accounts idea and I think you're going to hear more about that at the panel later today as well. So, in terms of where to go from here? A few points. I guess the first one is please don't forget, even though it's already been readopted, about the crucial role of building codes here. In a sense, what we're talking about here is an enhancement going beyond the building code. But don't lose sight of the fact that 33 states in the country either do not have a statewide baseline building code or they do not enforce the one that they have. So, we have some work to do to go back to the building code to get to the best possible

baseline on which these kind of improvements can be made and we think it's important to keep that linkage there.

The second point on the model specifically and I think Mr. Bissett made some great points that we would echo on the specific issues that need to be considered and tweaked there. But another one is, and I think this is something all of you are familiar with as state legislators, don't forget about federal funding. The federal government, to its credit, in the last ten years or so has gotten more serious about front end resilience funding and that is in part because of losses through the flood insurance program and other issues where so much money is continually put into the back-end response and they have finally woken up to the idea of what if we do some of that upfront? Programs like the Building Resilient Infrastructure and Communities (BRIC) program. Those sorts of funds are already there. They can be used in limited fashion for these kinds of programs. They're very competitive. We have urged the government to expand that. I think that's a great thing for NCOIL to do is use that money to the extent that you can. I would also add one of the most important criteria there is having a statewide enforced building code if you want to be competitive. So again, to build that linkage in. Just to briefly pivot to the discounts and then I'll stop. So, this is obviously the part of the proposal that gives us the most concern but I will say we are very open to having this conversation. As an initial point, we would urge, and I think this is being followed, that the discount proposal be considered as part of a list of other items that you start with building codes, that you go to funding and that discounts is a follow on idea to that and that no one has the idea that you should go straight to the end and just do the discount. And we don't really have to hypothesize about what happens in that circumstance because Oklahoma did a discount without any of the rest of it and got somewhere in the neighborhood of a double-digit number of fortified homes out of it and that's not doing much. And Alabama did the opposite and showed actual results. So, we have many concerns about the discount, but the main point is if you do it alone it doesn't do anything and it is that simple in terms of the impact on the ground.

The other point I would make is mitigation discounts do already exist and there is already a market incentive for companies to use them because of the very fact that they do reduce the underlying risk. To Mr. Bissett's point about there should be an insurance benefit, I don't think we disagree with that conceptually. In some cases, of course, the insurance benefit could be the availability of insurance itself. We talked about availability, that is a real issue and I don't think we want to lose sight of that but to be clear, we're not suggesting that we don't think a well-structured discount can be part of this proposal. We think it can. Just keep those issues in mind. And we would encourage as much flexibility as possible in the way you structure it. Don't let it get in the way of companies still innovating and competing in this area. Don't let it turn into you do Y and you get X discount. And that applies across the entire market. And I think that's the approach we would prefer to avoid. The final point I want to make as it hasn't been addressed yet, when the model came up last year, I know one of Rep. Dunnigan's main concerns was wildfire. All of the proposals before you today are about wind and hail and that's because some states have sort of cracked the code we think on how to structure a program there and how to do discounts. The proposals you have today don't address wildfire and it is not as easy an issue to address. And one of the reasons for that is that, and I know you've heard about this last year, wildfire is a trickier peril. You can't do as much sort of cafeteria style mitigation and expect to get proportionate

benefits. If you look at the IBHS research you have to do it all if you really want to get the benefit. The second issue I would just briefly mention is community resilience there is a bigger deal. If I mitigate my home a lot against wildfire and my neighbors do nothing the benefit is much more attenuated than it is in the wind and hail world.

Rep. Matt Lehman (IN), past NCOIL President, stated that something Mr. Schnautz said really caught my attention talking about the loss mitigation and incentives and you said it could possibly get to availability itself. So, that's always been my concern on a lot of this technology is availability. Whether you give a discount or not, that can be debated. And I think you should. But, on the availability issue, and then you brought up wildfire at the end of this, if carriers are going to continue to use more technology on my house and now you're seeing tree scores where we can say, "you've got too many trees around your house." Are we going to get to where you are going to give me an incentive to cut down trees which would help mitigate fire? Have we been giving incentives on the coastal states when it comes to hurricane proofing homes? My biggest concern with all of this is are we going to begin to push people out of the market of availability? What if I can't get the grant? Because I'm going to have to put some of my own skin in the game, right? But I can't do that. So, I still have that asphalt roof. I still have five big trees around my house. Am I going to reach a point where availability itself becomes an issue?

Mr. Schnautz stated that fortunately, I don't think most of the country is at that point with the insurance market as a whole. But the idea that every company could write everywhere if certain mitigation was done I don't think is accurate. There are companies who simply cannot expand their risk profile in certain states for solvency reasons that things can be done about, but they're big picture things. There are things like this that we deal with underlying risk. I didn't want to leave the impression that a mitigation discount is always the end result. There may be companies for whom, if you do mitigation you get them to a point that their risk profile for that state changes and they can at least offer coverage. So, that's really the point I was trying to get to. I think those sort of concerns are there. The California market right now is a pretty good example. There is a real on the ground availability issue with the broad market that is hard to overestimate. I mean it's a real thing. Now across the country is that everywhere? No. And I hope it won't get there. But the impression I really wanted to leave is sometimes the benefit is just availability, just expanding the number of carriers who can actually write there in the first place.

Rep. Lehman stated that what I'm seeing right now in a hard market is it's usually what ushers in the restrictive market because it is an opportunity to say I won't write a house anymore that has X. Or I won't write a property that has Y. And so, if that becomes the standard I think we're really going to have an availability problem with a good portion of homes in the U.S. And Indiana is in a hail area. We've had some really bad hailstorms recently. But if we start to say, unless you have that kind of a roof we won't write you, that's where I think some of this has the potential to go. It hasn't gone there yet but I think it has the potential of going there and that's very concerning as a public policy maker.

Rep. Dennis Paul (TX) stated that I'm a structural engineer and actually practice on the coast. A couple of questions here and I think Mr. Schnautz you mentioned a little bit that

you're going to go beyond the building code. What does that mean? Mr. Schnautz stated that I was referring to the fortified designation as going beyond the code. Of course, in Texas you've got the WPI-8 process through the Texas Windstorm Insurance Association (TWIA) which is sort of a quasi-enhanced code because if you ever want to get into the wind market there, you've got to qualify for that. And so, that sort of acts as an unofficial, even in the unincorporated areas, enforced code in those barrier counties. But what I was specifically referring to is the fortified designation by its very nature is going beyond what a typical building code would be. Rep. Paul asked what is a fortified roof? What would you do that's different? The building code allows you to make sure you can go through the wind speed that's been determined by the code. What would you do beyond that? Mr. Schnautz stated that one of the other panelists can probably answer that better. I'm not going to be able to give you the technical specifications for what goes into making the roof fortified but it's essentially keeping it from blowing off, keeping it from being damaged by hail, all sorts of perils but all focused on wind and hail.

Mr. Powell stated that when we say fortified we're actually using that as a general term because there are actually three levels of fortified. And to your question, what is fortified and how is that beyond code if the minimum code protects against wind? Well, some of the components that go into the fortified program are things like waterproofing so even if you lose the shingles on your home your home still stays waterproof because of a couple of different technologies that can be applied. So, that's one particular element. Another one would be, along with severe convective storms especially, fortified protects your home against hail. So, although you're thinking of it from a wind perspective and the roof staying on it also is resilient to those impacts of the hail damaging the shingles so that they don't come off from the wind. So, those are just some of the elements. But like I said, there are three levels of fortified and actually two different fortified programs. There's one for hurricane and there's one for high wind so it's a little more complex than just fortified but we use fortified as kind of a general term.

Rep. Paul stated that I know there's a society that's running around trying to that you could get this certification. The other thing was as far as enforcement going on, you mentioned something about a statewide code enforcement or agency. The way it is in Texas, and I would imagine most states, local governments certified the code. Texas does have a minimum code but there's no enforcement. But the local communities also have their own code and it's usually stronger than with the state minimum is and they do enforce it. If you're out in the county somewhere that your county doesn't, there's no enforcement. So, you're suggesting that the only way to do this would be have statewide certification of the structure? As Mr. Schnautz mentioned, we have this WPI-8 process in Texas which is a convoluted thing but it still only tells you to build to the building code. So, how would you do enforcement of this? Mr. Powell stated that as part of the fortified certification there's actually a third-party evaluator that's involved that is trained to understand building construction and also the application of the fortified program to that particular structure. So, what you have is you have a third-party evaluator that will come in and evaluate that. Now, one thing that we did with the Strengthen Alabama Homes Program is we required building permits to be purchased for every construction project. So, now what you have is you have your building code officials that have a follow up if they so choose to enforce to make sure that at least the minimum code is met which it will be with fortified more than likely. So not only following

the contractors, but also the evaluators so there is a check and balance that's built into the process.

Sen. Mary Felzkowski (WI) stated that this is a grant program. I want to know why is it a grant program instead of a revolving loan fund? Because this is for private home ownership. And then why is there not an income or a sliding scale on this? Because we heard this is this going to apply to secondary homes. So, you're asking people whose homes may be already fortified to now cough up taxpayer dollars to fortify homes that may be not already fortified. So, why is this a grant program instead of a maybe low interest or revolving loan fund? Why did we go in this direction? And then why is there not a sliding income scale in this? Mr. Powell stated that a state could set it up as a revolving loan and we looked at a couple of initiatives. We partnered with the Federal Home Loan Bank at one time out of Atlanta. I think it really depends on looking at the source of funding and then the sustainability of the program. So, the Strengthen Alabama Homes Program does not use money from the Alabama general fund so it does not come out of the tax space. The program is mostly funded by the insurance industry. The state or at least the Department of Insurance receives fees that insurance companies pay like premium taxes and things like that. And legislatively we were able to gain authority to carve off just a portion of that to put that into this grant program. And we did that initially and also socialized this with the insurance industry and they were completely 100% on board with this. When you're able to mitigate a number of homes like we have in Alabama and you start seeing the market stabilize, you start seeing prices of the insurance coming down, companies coming and writing business, then we've effectively created some level of community resiliency in a lot of areas. And also the risk of that pool is reduced for those books of business so insurance companies are actually able to negotiate more favorable rates on their reinsurance. So there's a cascading effect to this.

Now as far as the sliding scale, we tried that. And what we found is that folks who could potentially receive more money than others would, and we actually had a sliding scale on this, so if you were economically challenged, you received a percentage. And for equitable reasons we based it on the U.S. Department of Housing and Urban Development (HUD) requirements for loans or for benefits. And what we found is that those that were most economically challenged did not have the free cash flow in the household to meet whatever gap cost that was created by mitigating the homes. So, if a home was $9,000 to mitigate and say we granted $7,500, that difference was just not available to those that were economically challenged. And conversely, for those that had the means to pay for the mitigation that applied for these grants perhaps they received $2,000 or $3,000 and in cases along the coast the deductible for a loss was less than that so they didn't want to fork out the additional $7,000 or $8,000. So, we wanted to make it equitable and just make it open to everyone without an income cap but we also limit it to $10,000 and the reason we did that was because the average household especially those for the lower incomes, it was costing about $9,200 to $9,300 so we were able to pay 100% for them and there was no out of pocket cost as far as the mitigation grant was concerned.

Rep. Linda Chaney (FL) stated that in 2022 we did the My Safe Florida Home Grant Program where the homeowner would put in a dollar and the state would give them two, up to $10,000 on the homesteaded property only for roofs, windows, doors. We added garage doors in the next session. Gave you a free inspection. No obligation. The program is doing well. We refunded it this session in 2024 and we added a My Safe

Florida condo pilot program because we have so many condominiums. Our biggest challenge with this program is the funding. There's a lot more need than funds but we're happy to help our homeowners. What's been reported is 70% of the homeowners who took advantage of it have either seen their insurance rates stabilize or decrease with an average savings of $1,000 a year. So, we're feeling good about it. We layered on top of that tax free holidays so tax free for any of these mitigation items like windows, doors, hurricane things. The feedback I'm getting and the question I have for you is because of the Federal Emergency Management Agency (FEMA) limitations on the work you can do on your home, 50% of the value of the property and our communities set their own look back rate. So, we have some communities with zero, some with one year and the beach communities have five years. So, that's limiting mitigation efforts and some homeowners have run into they get excited, they take the My Safe Florida home program, they've already done some things. Now they hit their FEMA cap and some of them have had a problem with their roof that they hadn't anticipated and then they want to go replace their roof and they're not allowed to do that. They've already hit their FEMA cap and now they're losing their insurance. So, my question is, are you hearing anything around the FEMA look backs and is it playing into this whole grant scenario? Mr. Powell stated that I've had a lot of dealings with FEMA and their funding requirements. And another thing that you're speaking to is also reflected in the benefit cost analysis that's done for qualifying for funds in Alabama. If we can solve the problem within the state we're going to do it within the state. So, looking at alternative ways to mitigate a home or to pay for mitigation is really the approach that we took in that case because if you're relying on the federal government for that, that's going to be a long, hard road to go down. And a couple of points on the mitigation money that comes from the federal government as well is that it's going to require a match and the question is, who's going to pay that match? And then also it's issued on a reimbursement basis. So, for the most part, the state's going to have to pay for it upfront. The contractor is not going to wait seven to ten years to get reimbursed for that money. Another thing that you could consider as an alternative is to consider maybe a roof endorsement where for a fee an insurance company can offer this endorsement and at the time of total loss of a roof and it has to be replaced, that is replaced with a fortified roof. Alabama came up with that concept years ago and received legislative authority to enact that. So, we have a roof endorsement and the only thing we did was basically state those terms and that also that it was to be issued at the time of the sale of policy or at first renewal.

Rep. Mark Tedford (OK) stated that my question is for Mr. Powell, I ask you to maybe expand on your comments of how Alabama has created the culture of fortified homes. I assume that this legislation can be seen as a pathway to where those in wind prone areas just voluntarily build fortified homes as the standard and that's the expectation irrespective of the credit. Is that what you're seeing in Alabama? And what were all the factors that went into building that culture? Mr. Powell stated that part of this is an education piece on the benefits of fortified and once people started understanding what fortified really is and it was demonstrated by us being able to put money into the grants and actually fortifying the homes after the storms damage assessments were done and you could see where there was real, tangible results. The President of IBHS, Roy Wright, he usually makes his comment he says that when people come up and ask him, “well how can you tell which homes are fortified and which homes are not?” And he says, “well, we color-coded them for you. The ones that have the roof on them, those are fortified. The ones that are blue are not.” So, as you educate people and you start

seeing the tangible results what you find is you find that communities will embrace this and Alabama does not have a statewide building code. But what has happened is that local jurisdictions have adopted the fortified standard as part of their jurisdictional building code. So, we're starting to see that grow throughout the state and I believe this year and even last year we've been pushing more toward a statewide building code that includes fortified as the roofing standard. Rep. Tedford stated that what's interesting to me is in states that have very high wind and hail deductibles, to me one of the benefits of the fortified homes is that the homeowner post claim if the roof sustains the wind event, then he doesn't have to pay the deductible, but his neighbors might. I very rarely hear that as a benefit. Are you seeing that as becoming a benefit in those areas? Mr. Powell replied yes.

Rep. Michael Sarge Pollock (KY) stated that I grew up thinking Oklahoma was Tornado Alley in our country. I think now it's Kentucky. We've actually had three tornadoes already this year touching down and causing damage. So, I echo Mr. O'Brien's comments, we have to do something and we did so in Kentucky. We worked with many of the panelists here today and we put some stuff together. I want to give a big shout out to my Insurance Commissioner, Sharon Clark. When we talk about funding, we designated $5million toward this pilot program to help contractors get certified, to help single homeowners look about getting that fortified roof just to find some way to offset these claims that we're seeing. A year ago in March, we had 70 mph winds that came all the way across Kentucky so we are looking at doing something and we did. And I want to thank everybody who's involved in making that happen. HB 256. We had to take action. And I just want to thank everybody involved in making that bill happen. I think we should look at this model and make it the best it can be and do some good here with it

Rep. Dunnigan stated that this has been an excellent discussion with a lot of good ideas. I appreciate Alabama and Florida and Kentucky sharing what they're doingand I'll be in touch with some of the presenters here and will continue to move forward. Rep. Bennett thanked Rep. Dunnigan for his work on the Model and stated that we will be discussing this throughout the year and hopefully we'll have something ready for consideration by the fall meeting in November. In the meantime, if you have any questions or comments please reach out to me, Rep.s Dunnigan, or the NCOIL staff.

CONTINUED DISCUSSION ON NCOIL CATALYTIC CONVERTER THEFT PREVENTION MODEL ACT/RESOLUTION IN SUPPORT OF STRENGTHENING STATE LAWS TO PREVENT CATALYTIC CONVERTER THEFT

Rep. Bennett stated that next on the agenda, we're going to continue our discussion on the Catalytic Converter Theft Prevention Model Act and also a resolution in support of strengthening state laws to prevent catalytic converter theft. We've been discussing this issue since the spring meeting of last year and during the interim Zoom meeting of this committee in February there was a discussion around whether the committee should proceed with the development of a model or instead develop a resolution. The idea behind a resolution is that as written now this legislation is more in the scope of criminal code as opposed to insurance code. So, we want to have a discussion about whether we want to move forward with the resolution or the Model Act. So that leads us to today. We have a decision to make on whether to move forward with the model or the

resolution. You can view the model on page 198 of your binders and the resolution is on page 204. And they're on the website and app as well. I'll turn things over to Rep. Tom Oliverson, M.D. (TX), NCOIL President, who's the sponsor of the Model.

Rep. Oliverson stated that I appreciate the opportunity to continue this discussion. As you referenced, during our interim meeting I think I made my point pretty clear about the importance of this model even though it may not necessarily go through and insurance committee. That is not unprecedented for an NCOIL model to do. The reality is just simply that we're spending a tremendous amount of time at this meeting talking about cost drivers and "hard markets" and property and casualty and everybody's looking for solutions and things that we can do to help lower the cost and increase the availability of insurance. And the fact of the matter is that catalytic converter theft across our states continues to be a cost driver in the property and casualty and automobile marketplace and so taking a strong position on the issue and making sure that there are appropriate criminal actions that are occurring that are deterring, this is something that we can do. We can't control insurance rates as far as what reinsurance would charge. We can't necessarily control the weather. But we can certainly deter criminal activity. And I think that we have to take the wins where we can get them. We have to look for things that we can point to that are cost drivers to the system and say that this is something that we can do to attempt to control insurance costs for our consumers and our state. I do understand that there are concerns with the fact that this model may not necessarily be laser focused on insurance. And so with respect to those concerns I am happy to offer an amendment which I believe you have before you that makes it slightly more insurance centric and hopefully that will be met with approval. But again, this is incredibly important and I would point out that we have this concept of an Advisory Commission that I've proposed in the amendment, this is actually very similar to the Deputy Darren Almendarez Act that we passed in Texas which is named in honor of a Harris County sheriff's deputy who was shot to death in the line of duty when he confronted a gang of organized criminals that were attempting to steal catalytic converters. So, there are tangible costs and there are lives being lost around our country with regards to this particular issue and I think we owe it to the insurance industry but also our law enforcement community to take a strong stance on this. So, I look forward to the discussion today. I just am firmly in support of the model and would like to see that move forward but obviously I respect the committee's decision either way.

Rep. Edmond Jordan (LA), NCOIL Secretary, stated that I also appreciate the peace offering that was just sent to us by Rep. Oliverson. Of course, I support the concept behind the model and in fact we've passed catalytic converter theft laws in Louisiana. However, I think because it falls outside the area of insurance, I think that the resolution still sends the strong message that Rep. Oliverson has spoken about. The other thing I would tell you is that I can tell you in my state of Louisiana, when I go to the insurance committee and I say that this is NCOIL model legislation I rarely have any opposition. It usually flies through. And I would imagine in most states that is the issue. I don't think that if I go to my Administration of General Criminal Justice Committee and say that this is an NCOIL model that is going to have the same effect. These bills either go through commerce committee or criminal justice committee and I'm speaking for Louisiana, it doesn't go through insurance. And part of my fear is that by stepping outside of our lane that we somehow diminish the effect that NCOIL model legislation has. And while I

know we've done this in limited occasions in the past I would not want to further that precedent by continuing to do it. I think the resolution sends a strong message of where NCOIL stands on this issue. I think it supports what the organization wants to do as far as sending that message. However, I'm like Rep. Oliverson in that I'm going to respect the will of this committee but I do think that the resolution accomplishes that goal while still keeping the brand of NCOIL intact.

Rep. Bennett stated that I appreciate both of you and your perspectives and I do want members of the committee to speak up and let us know what you think as to whether we go with the model or resolution.

Eric DeCampos, Senior 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 nonprofit organization that works with state and local law enforcement as well as member insurance companies to detect, prevent and deter insurance crimes. I'm here to speak in favor of the model. Over the last year, we've seen plenty of examples from insurers and law enforcement agencies attesting to the effectiveness of state legislation to help combat catalytic converter thefts. And just to give you an example, Georgia enacted a catalytic converter bill last year that went into effect on July 1st. When we're looking at catalytic converter thefts reported to NICB from the first half of 2023 and compare that to the second-half, the decrease was 72%. So, I really want to focus here that these types of bills do work and now is not the time for us to take our foot off the gas but rather to move forward with a model, not a resolution, which will provide important standards that will help address catalytic converter thefts and the impact that these thefts have on the insurance industry. As an example, the model improves record keeping requirements which provides investigators with more information they need for catalytic converter theft investigations. And the model has the potential to reduce costs to insurers and consumers alike who are faced with expensive vehicle repair bills in catalytic converter replacements. And so, I respectfully urge this committee to adopt this model. It is not unprecedented. We've seen examples in the past from predatory towing, airbag and different types of models that address insurance fraud, that address insurance crimes, and this is no different.

Rep. Chaney stated that Florida, we adopted a catalytic converter statute very similar to this one. Ours may even be a little tougher than this and the Sheriff's Association was very grateful that we did this. And it most definitely is tied to auto insurance rates which was one of the main drivers of the reason that we adopted this. And I would agree with Rep. Oliverson that this is definitely important to the insurance industry and to our constituents. I think they are much more concerned that we take action to reduce their auto insurance rates and I think they have zero concern about the NCOIL brand and I think taking action on the model is absolutely not only what we should do, but what we have an obligation to do for our constituents.

Del. Steve Westfall (WV) stated that I introduced this model in West Virginia. We already have some laws dealing with catalytic converter thefts and I introduced the part we did not have and it did not go to the Banking & Insurance Committee, it went through the Judiciary Committee. It was put on the agenda but was pulled when different people came and said, "hey, this is going too far, this will hinder our good recycling companies and we'll still have people at Walmart parking lots on Sunday night buying catalytic

converters." So I think we need a model act that all states can use. NCOIL is known in West Virginia, not just the banking & insurance committee because they hear enough from me about NCOIL model acts that every Delegate and Senator knows what NCOIL is. So, I think it needs to be a model act, not a resolution. I think that will have more teeth to it. I am not going to be there next year, but I think our vice chair will take this back and run it again and try to see if we do it better because it is a problem in West Virginia. It's a problem in all states. So, I think we need to have a model out there.

Rep. Brian Lampton (OH) stated that I agree with my colleagues. Rarely do we have an opportunity to pass legislation that provides downward pressure on insurance rates. Whether it goes to a criminal justice committee or insurance committee or judiciary committee, it's quite frankly, irrelevant. This is an insurance matter. Recently, when I first started and joined NCOIL, at my first meeting NCOIL passed distracted driving model legislation. I took that back to my state and because of that I was able to partner with a former law enforcement legislator and we were able to get that bill passed into law. I think this is extreme, very much similar to the distracted driving bill. It went through our criminal justice committee. It didn't go through insurance. So, I think we need to do the Model Act. It lends credibility and it did in our state with distracted driving. Right now we're carrying it through Ohio through a former Montgomery County sheriff who's running the bill. The bill in Ohio is much stronger than this one but I do encourage us to go with the Model Act. It will lend credibility and it needs to be nationwide for it to have a much larger effect because if we do it in Ohio, what's going to happen? These thefts are going to occur along the border. They'll go to other States and sell these things so if more states adopt the model legislation, it'll be much more difficult for the thefts to occur and to get these catalytic converters sold at a profit.

Sen. Lana Theis (MI) stated that I absolutely agree it is well within our scope that we address the issues that are crime and fraud that are related to cost drivers for insurance and I can't imagine that wouldn't be within our scope. So, I absolutely support passing a Model Act in this arena.

Rep. Bennett stated that I tend to agree with Rep. Jordan but it seems like the general consensus is that we should move forward with the model. So, I'll make that decision now and we'll move on. But I really do appreciate everyone engaging civilly on this issue.

DISCUSSION ON LIABILITY RELATED ISSUES WITHIN THE SHARING ECONOMY
Byron Wobeter, Associate General Counsel of Insurance at Airbnb, and Padma Purushothaman, Head of Product Development at Airbnb, thanked the Committee for the opportunity to speak. Mr. Wobeter stated that what we'd like to talk about is the proposed online marketplace guarantee Model Act and our host damage protection. Ms. Purushothaman is going to talk a little bit about Airbnb for those of you who are not familiar with our product and our platform. I'll talk a little bit about the program and how it works and then we'll talk a little bit about why we support the proposed Model Law. And with that, we'll move on to Padma. Ms. Purushothaman stated that Airbnb was born in 2007 when two designers decided to create this website called air bed and breakfast and decided to host their apartment to conference attendees coming to a design conference in San Francisco. This is the first apartment that was listed on Airbnb to support paying the rent for the house. The very first house on the platform. What had

its modest beginnings with that website and this listing has now grown to over eight million hosts across the entire globe offering their homes on the Airbnb Platform. Every day these hosts welcome millions of guests to their homes and allow them to connect with the local community in a more authentic way. In the U.S. alone, over the last year in 2023 we've had almost 22 million guests who are booked on the platform and had 36 million reservations. Obviously, for a platform of this scale to be able to manage and have these hosts and guests connect on a daily basis trust is an important element of the platform. Host damage protection is one program that offers trust on the platform. So, in 2011, three years into the Airbnb history, there was an infamous incident called the EJ incident that became viral on the newspapers. This host had listed their home on Airbnb and the home was trashed and burglarized by a guest who rented through the platform. Out of this incident was born the Host Damage Protection Program which is a guarantee of about $50,000 for any damage that was caused by a guest who rented through the platform to any of the belongings of the host home. This has now grown over the years and it has continued to protect the consumers and the communities since 2011. In addition to host damage protection, there are many other programs that Airbnb offers to connect hosts and guests to promote trust, transparency and authenticity. We do ID verification for guests, location verification of the homes, intelligence to detect and prevent parties. And as a combination of all of these, we are able to continue to promote these listings and enable hosts and guests to continue to connect with each other. And for guests, there is a unique and differentiated need for certain reservations they may need to want more privacy or a different set of locations or an extended set of amenities that the hotel might not offer. And so for these set of hosts, these set of guests and their reservations, Airbnb provides a unique value proposition which is something that we've highlighted in our latest ad campaign.

Mr. Wobeter stated that's what brings us here today. Ms. Purushothaman mentioned, this program is very important to us but I kind of want to give you all an idea of what is our host damage protection and then we'll talk a little bit about how it works. Our host damage protection is a limited incidental guarantee offered by Airbnb to its host as part of its terms of service. It guarantees the guest's obligation to pay those property damages that they cause to the host during the Airbnb stay. It's of course part of our terms of service and it's automatically included for every house. Now I can tell you all of that, but let's talk about an example here. When a guest goes on to our website, finds a place to stay, they sign our terms of service. Within that terms of service the guest agrees that they will pay for any damages they cause to the Airbnb listing and any damages to the belongings. They book the reservation. The host accepts it. And they go to the listing. On the host side, the host also agrees to the terms of service and as part of that terms of service these is the host damage protection guarantee. In the rare event that something happens, and it is incredibly rare that something does happen to belongings, the host and the guest can work on it together. So, essentially how it works as an example, the guest rents an Airbnb and drops a lamp during their stay. The host comes in after the stay to check out the place and they realize, "there's a lamp here that's been broken." They'll take a photo of the lamp, the price of the lamp and they'll put it on our platform. It's called a resolution center. That will go directly to the guest and at that point the host and guest can work it out. And in many cases the host and guests actually work it out and the guest can pay the host directly for that damage. It's only when the guest does not pay or doesn't respond that we can get involved. And what we will do is look at it and determine was the guest responsible? Yes or no. And if they

were, we would pay it under our terms. After we paid under the damage protection guarantee, we would then have the ability to collect from the guest. And we do that via various tools on the platform and we provide the appropriate notice to the guest and the appropriate documentation and evidence so that we can collect.

And so that's our host damage protection generally. Why do we support this proposed online marketplace guarantee model law - well, first and foremost, consumer protection. As Ms. Purushothaman mentioned, we are a community built on trust, on protecting our consumers, our hosts and our guests. The one big piece is transparency. In the model law, it's required that there are clear terms and disclosures on the guarantees that are out there that are provided by online marketplaces. Second, financial solvency. This ensures that the damages are paid. There is a requirement in there to either carry a contractual liability insurance policy or have the appropriate market capitalization or net worth so that damages can be paid and will be paid by these online marketplaces. State registration and fees - this gives the notice to regulators so that if there are issues they can go ahead and speak to the right people or the right online marketplace that's offering the guarantee. Enforcement - it allows regulators to enforce the provisions and ensure that the customers or consumer protections are in place and are being adhered to by the online marketplaces. And then finally, flexibility - it extends to many users of online marketplaces, both hosts and guests as well as other marketplaces out there beyond the rental of home marketplaces. And then finally, we think clarity is needed. We have had some questions from regulators and so we are strongly in support of getting clarity here so that we can continue to offer the online marketplace guarantee.

Matt Overturf, Regional VP, Ohio Valley-Mid Atlantic at the National Association of Mutual Insurance Companies (NAMIC) thanked the Committee for the opportunity to speak and stated that I will be very brief. While we're still reviewing the language that has been circulated on this topic, we do want to raise an initial concern of allowing a product that provides risk transfer like insurance under a different name to be exempt from the existing regulatory environment that all other insurance products are subject to. We look forward to learning more on this topic and continued engagement with both Airbnb and this committee in the coming months.

Rep. Jeff Keicher (IL) stated that I'm from Illinois and we've seen some of this happen in the vehicle sharing economy and I think one of my frustrations with the sharing economy is it all comes down to semantics and it seems like there's been a lot of exploited and unintended loopholes that many communities have suffered under and it's changed neighborhoods often displacing those that are systemically poor, like renters, and that type of thing. And I see this as potentially another loophole that sharing type organizations are trying to exploit because what we're really talking about here is we're talking about an insurance risk that we're not going to call it insurance. We're just going to let it slide through. I think that's a very slippery slope for any legislator to continue down and I urge caution because we are talking about a transfer of risk and that by definition is insurance. So, we need to be very careful in this space because we've seen so much manipulation of these loopholes by similar organizations.

Rep. Lehman stated that the question I have kind of goes to what NAMIC brought up and that is the fact that insurance is such a heavily regulated industry. So right now to sell an insurance product you have to be licensed. The carrier has to be approved by

the state and file your rates and everything else. My general question though is where is there a lack of coverage now? Because I remember when we did the whole sharing economy model with Uber several years ago I brought back the same issue with Airbnb and the industry said we really don't need anything on the Airbnb front because we already pay for all this. Because everybody has guests in their home throughout the year who break or damage something and either the homeowner policy covers that or I can go against their homeowner policy which covers the property damage. I think if you have a situation where there's damage and no one seems to know who or where, I don't know if that's an insurance issue because at the end of day even if I filed that claim under my homeowner policy or my commercial policy and just for disclosure, my daughter has an Airbnb here in Nashville and in the course of that she bought commercial insurance because you don't live there. So, that commercial policy is going to pay if there's damage to the property by that tenant. And if they subrogate against the tenants homeowner policy that's all in place now. So, I'm not sure what gap we're missing when it comes to claims other than it looks to me like it's a way I can add to the cost of an Airbnb. Why not offer this extra thing sort of like a life and health on an auto loan. But even then, you're still regulated by the state. And so as I think NAMIC said, we can continue to look at this, but I think the real thing for me is going to be how are you going to be regulated? And really what's the necessity of the product if it's already being covered elsewhere?

Mr. Wobeter stated that I think one thing is we don't have any deductible at all and so there's no threshold here. And for the most part these are household items. There are towels. There are small items, an average item will pay less than $300. So, many homeowners have deductibles that these wouldn't apply to. And then secondly, it is a different situation when as a homeowner carrier you generally have a primary obligation as a carrier to pay these out. I mean, this is a situation where the guest is paying a lot of these first and it's just backstopping that guest's obligation. Ms. Purushothaman stated that I just want to add that sometimes when we talk to hosts they've also expressed that they ultimately want the guests to take responsibility and I think with this platform, with this marketplace, they want to make sure that there is this dialogue and the conversation happens. And ultimately, they want us to follow up with them to let them know what eventually happened even if we ended up paying the host for them to go on and continue in a timely manner. Did we end up collecting with the guests? Or if they continued such sort of damages or offenses, are they still on the platform or are we taking actions against them?

Rep. Peggy Mayfield (IN) stated that I don't want to broaden the scope of this conversation because the agenda says liability issues but this sounds like it's just property damage issues. Is that correct? Mr. Wobeter replied yes. Rep. Mayfield stated so I won't ask the other question but it sounds like this is already part of the contract between Airbnb and the consumer and homeowner. I always caution as legislators that we don't insert ourselves in private contracts.

Rep. Mike McFall (MI) stated that why isn't it that you don't just offer an additional product yourself that the Airbnb host could purchase much like when you buy an airline ticket you can get coverage in case of emergencies and you have to cancel your ticket and it covers it. How come you can't just offer something that it could be an additional revenue stream for you actually instead of having us get involved. Ms. Purushothaman

stated that we've thought about it. The thing with offering products for purchase is there may be only a few hosts or few guests purchasing it and how do we manage to handle damages and ensure that the host can continue to host for other guests and continue to use the platform if they don't purchase it? Rep. McFall replied right, but you could offer it to the hosts. That way it's an additional coverage for them, or charge more or there's an additional fee for the person renting and you get a discount. I don't know, just something else instead of having us get involved. Ms. Purushothaman stated that I think we kind of always have viewed this as more of an obligation of the contract between the host and guests to be responsible and we do see 99.9% of the time there are no incidents and these incidents are so rare. And so for these kind of incidents that happen so rarely we don't want to impose the burden on the majority of the hosts and guests who have to pay more to purchase an additional policy and maintain them to manage such small risks on the platform.

Rep. Bennett thanked everyone for their comments and stated that my interpretation is that you're seeking from us model legislation that will provide clarity. You're not asking us to insert ourselves in the process. And as an insurance guy I echo Rep. Keicher's concerns and I know that Airbnb and short term rentals can have an effect in neighborhoods. I do think that issue is over here and the issue of the individual host and their property is over here. And I think that there are two legitimate conversations to have but not necessarily the same. And in my view, and I would hope that you can tell me if I'm wrong I am on this, the idea is Airbnb does require the hosts to carry insurance coverage that is already in place. The idea here is not so much when a window breaks and you need to file a claim on that but when an item in the place is destroyed or damaged, you want to be able to have an avenue by which the host is made whole that does not require them to file a claim. And again, the issue of one individual operating dozens of Airbnb's and kind of taking advantage of the platform and the process that's a conversation we should have and I don't want to put you on blast about that today. But over here on this side I'm imagining a mom and pop situation where they've got, like Rep. Lehman's daughter, a property and they just want to be able to be made whole without filing a claim, without having that effect on their coverage. Am I right in understanding that this is what you are seeking and this is just clarifying language and not that you're asking us to step in and create a new product or anything like that. Mr. Wobeter replied that's correct.

Rep. Bennett stated that I appreciate this conversation and I know that we'll be continuing it throughout the year. And then I also want to add that we had a conversation about this recently - here in Nashville, I rented an Airbnb and I was ironing a shirt and the iron ruined my shirt collar. So, the next morning I saw the two of you and I said, "I appreciate the conversation we had about making sure the host is made whole. Would you be open to making this language such that it goes both ways?" When you lose your phone in an Uber there is a way for you to get that back. How do we make sure that those who are staying in a hosted place are able to be made whole if something happens to their stuff? If they're damaged? You were eager to say, "Yes, we'd love for this to be able to go both ways." So, I wanted to make sure everyone on the committee and in the room knew where you all are on this and how open you are to

making sure that this is a pro consumer model both ways. So, thank you for this and I'm sure we'll be engaging in further conversations throughout the year[1].

ANY OTHER BUSINESS

Rep. David LeBoeuf (MA) stated that I'm hoping that this committee can consider in the future a larger dialogue around the use of aerial photography in homeowners insurance assessments. I know in my state we've had some issues where there isn't a clear appeal process if the insurance company misidentifies something on a roof. There were some major news stories where there were some solar panels on a roof and the aerial photography came over without the homeowners knowledge and they dropped the policy because they believed it was damage because whatever algorithmic assessment didn't pick up what the material on the roof was. There's also been some non-renewals that have been issued after aerial photography. And so I'm hoping we can have a larger dialogue on how that's affecting our States and how to make that work.

Rep. Bennett stated that I appreciate you bringing that to our attention and I look forward to having more conversations on that. I do have one other item of business – Rep. Oliverson has made it clear that he wants to make the affordability and availability of auto and homeowner insurance a priority, something that I really appreciate and would like to help with. But I wanted to make note of that because as a part of that effort, we'll be having a standing item on this committee agenda at our future meetings to provide updates from the NAIC on their P&C data call and other related issues that the NAIC is working on. So, I just wanted to make sure that I made that announcement and make it known that I look forward to working with Rep. Oliverson on this issue as I know all legislators are dealing with constituents who don't understand how insurance rates are established. But think that there's something that we can do about it. I love the conversation that we were having on fortified roofs because while I think a lot of folks think that legislators can wave a magic wand and fix this for everyone, it really is a challenge and we are obviously in an unprecedented hard market. So, finding ways to bring relief to consumers I think should be a priority.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Paul Utke (MN), NCOIL Treasurer, and seconded by Rep. Lehman, the Committee adjourned at 10:30 a.m.

[1] Frank O'Brien, VP of State Gov't Relations at the American Property Casualty Insurance Association (APCIA), submitted a witness slip in opposition to the proposed draft language.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
PROPERTY & CASUALTY INSURANCE COMMITTEE
INTERIM COMMITTEE MEETING – JUNE 14, 2024
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Property & Casualty Insurance Committee held an interim meeting via Zoom on Friday, June 14, 2024, at 12:00 P.M. (EST)

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

Other members of the Committee present were:

Sen. Dan McConchie (IL)
Rep. Matt Lehman (IN)
Rep. Peggy Mayfield (IN)
Rep. Deanna Frazier Gordon (KY)
Rep. Michael Sarge Pollock (KY)
Rep. Edmond Jordan (LA)
Sen. Paul Utke (MN)
Rep. Nelly Nicol (MT)
Asw. Pam Hunter (NY)
Rep. Tom Oliverson, M.D. (TX)
Rep. Jim Dunnigan (UT)

Other legislators present were:

Sen. Jesse Bjorkman (AK)
Rep. Jill Berry (CT)
Rep. Jim Gooch (KY)
Rep. Poppy Arford (ME)
Rep. Robert Merski (PA)

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 Rep. Jim Dunnigan (UT), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

CONSIDERATION OF NCOIL CATALYTIC CONVERTER THEFT PREVENTION MODEL ACT

Rep. Bennett thanked everyone for joining the meeting and stated that the purpose of today's meeting is for the Committee to conduct some business in advance of the meeting in July in Costa Mesa so the Committee is able to handle all the issues on that agenda in a timely manner. We have several items on today's agenda, the first being a model law that we'll be voting on, the Catalytic Converter Theft Prevention Model Act. If you'll recall, at our last meeting we kind of got consensus that that we were more interested in considering a model law rather than a resolution and so that's what we're

going to do now. I will turn things over to the sponsor of the model, Rep. Tom Oliverson, M.D. (TX) – NCOIL President.
Rep. Oliverson thanked Rep. Bennett for calling this meeting, and stated thanks to all my colleagues for being on here and giving us an opportunity to consider this. I think we've made a lot of progress on this. I think we've taken a lot of constructive feedback. It has morphed into something that I hope and I feel certainly is much more agreeable to a wider audience and sort of takes into account some of the concerns that were raised. I would point out that at our meeting in Nashville, as we were talking about the things that we as lawmakers could do to actually address the rising costs of property and casualty insurance, this was sort of one of the few things that was pointed out as well, you can't control the weather, you can't control inflation, and obviously driving behavior seems to be a little bit erratic post-COVID - but you certainly can address issues of theft. You can address building codes, and things like that. So this is one of those things that we can as a body say I know maybe it's not right in the middle of insurance policy, but from the standpoint of attempting to provide reasonable solutions to cost containment problems that we're all struggling with, dealing with issues of property theft that are certainly driving up the cost of insurance across all 50 states is definitely in our wheelhouse. And I think it would be a positive step for us as an organization to take a position on this. As I've said before, and I'll say it one more time, this isn't a victimless crime. And I know that we're not the criminal justice group, but in my home state, this Model is named after a Harris County sheriff's deputy who was shot to death by a gang of organized criminals that were perpetrating the majority of catalytic converter thefts in Houston. So, with that, I would like to adopt the Model and go through the process for that.

Eric DeCampos, Senior Director of Strategy, Policy & Gov't Affairs at the National Insurance Crime Bureau (NICB) thanked the Committee for the opportunity to speak and stated that NICB is a nonprofit organization that works with state and local law enforcement and insurance companies to detect, prevent and deter insurance and vehicle crimes, and that includes catalytic converter thefts. I just wanted to speak in support of the Model and emphasize that this Model will establish important standards that will help combat catalytic converter thefts. I do want to note that while we've seen the price of precious metals decrease recently, the theft has continued to persist and the impact on insurers and consumers is quite clear. In fact, I think many of us know and have seen the recent murder in Los Angeles of an actor who was killed by perpetrators attempting to steal the cattle converter from his vehicle. And so I wish to underscore again that now is not the time to take our foot off the gas pedal, but rather to move forward with this Model. And I also wish to remind this Committee of the effectiveness of state legislation already enacted in some jurisdictions in combating catalytic converter thefts as attested by both insurers and law enforcement alike. Thank you for the opportunity to speak and I urge your favorable vote on this Model.

Rep. Bennett asked Mr. DeCampos to specify some of the things he's seen regarding positive results of some of the legislation at the state level on this issue. Mr. DeCampos stated that we've seen catalytic converter thefts decrease in jurisdictions that have pursued catalytic converter theft legislation and we've seen various degrees of this from states that have pursued restrictions around transactions involving used attached catalytic converters to record keeping requirements. And we've also seen some insurers attest to the effectiveness of this as well and how catalytic converter thefts have been a

cost driver for insurance. And following the enactment of legislation we've seen that price tag or that cost decrease due to a decrease in the actual thefts of these devices.

Hearing no further questions or comments, upon a Motion made by Asw. Pam Hunter (NY), NCOIL Vice President, and seconded by Rep. Matt Lehman (IN), the Committee voted without objection to adopt the Model via a voice vote. Rep. Bennett thanked Rep. Oliverson and everyone who's contributed to the conversation. The Model will now be sent to the Executive Committee for final ratification in Costa Mesa.

CONTINUED DISCUSSION ON NCOIL STRENGHTEN HOMES PROGRAM MODEL ACT

Rep. Bennett stated that next on our agenda is a continued discussion on the NCOIL Strengthens Homes Program Model Act, sponsored by Rep. Jim Dunnigan (UT). We did discuss this briefly at our last meeting in Nashville and in the ensuing months the state of Oklahoma has passed similar legislation.

Rep. Dunnigan thanked everyone for joining the meeting and stated that I think it's very helpful to look at states who have stepped into the space that we're considering for the Model and see what we can glean and learn from them. And I'd like to share a little bit about what I like about Oklahoma. It fleshes the concept out and puts some more meat on the bone and provides some additional detail and guidance on how states might set up a type of program where they can assist homeowners in strengthening their homes and hardening their homes against natural disasters. And trying to do so in a way that it doesn't have a big drain on their general fund. So, a few of the things I'd like to highlight from the Oklahoma law is it requires the Department of Insurance to use its best efforts to obtain grants or funds from the federal government or other funding sources to help complement state funds. So, it doesn't just say we're only going to do state funds - let's look and see whatever money might be available elsewhere and use that. And then it also limits it to single family primary residences. We discussed this a little bit in Nashville. And then it also prioritizes the grants to those that are lower income and those that live in locations that are higher risk to catastrophic weather events.

And so it's focusing more on where it's really needed. And then it also sets up the program by way of a revolving fund financed by the grants and specifically designated funds. So, that's not an exhaustive list of everything that's in the Oklahoma law but those are some of the things that stood out to me. And so today I'm very interested in any feedback from on Oklahoma law and what if any of that should make its way into the current model. I'm looking forward to our July meeting because we're going to hear from the Oklahoma Insurance Commissioner, Glen Mulready and he's going to provide some details on what went into developing the law and give us some tips on what we should be looking for and be aware of in developing our model. There are a number of states that are looking at this issue and the National Association of Insurance Commissioners (NAIC) is looking at this issue as well and so I think it's important that we come to an agreement on what we want this to look like at our November meeting in San Antonio and we could take action there and have this model ready for 2025 legislative sessions.

Rep. Michael Sarge Pollock (KY) stated that I sponsored similar legislation in Kentucky this last session. We teamed up with Kentucky Insurance Commissioner Sharon Clark

and designated $5 million of unrestricted funds made-up from different insurance companies and other things. So, it's our insurance trust fund that we're using. It's kind of a pilot program for a two-year period. It also provides some funding for contractors to get certified to put on Fortified roofs. So, there's a lot of good things there to address the storms that we're seeing here in Kentucky. And so obviously I support the Model and would love to just share what we have in our Kentucky law that we passed to make this Model the best it could possibly be.
Rep. Lehman stated that as we move forward with these laws and models, is there any discussion with carriers? If we're going to incentivize me to build a less destructive house, how is that going to equate to a reduction in premiums? Will there be credits? If I put a roof on that's based on this, will I see a significant change in my insurance premium? I'm in favor of this but I also think that the other side of the table is if I spend the money to do this, what's it going to save me? If there's no savings from the insurance standpoint, will we get people incentivized to do it?

Rep. Bennett stated that Rep. Lehman's comment is a very good one, and stated that I remember having conversations here last year about whether to require premium discounts based on Fortified homes. Rep. Lehman stated that we hesitate when we talk about requiring discounts but I'd be interested in what the industry is saying.

Matt Overturf, Regional VP, Ohio Valley/Mid-Atlantic at the National Association of Mutual Insurance Companies (NAMIC), thanked the Committee for the opportunity to speak and stated that NAMIC appreciates the continued conversation around mitigation. This is something that we focus very heavily on in the States and in Washington DC in terms of incentivizing mitigation efforts. If you recall last year the Model started with just a mandatory discount and we had concerns with that and we really wanted to broaden the conversation to additional incentives and additional ways to do that in addition to the discount. The Kentucky law that Rep. Pollock mentioned did have an insurance discount mechanism to it in addition to the grant funds so as far as that's concerned, as we continue to trend towards additional options in ways to incentivize folks to mitigate we are certainly open to those. And I believe the mandatory discount piece continues to be a part of that conversation to Rep. Lehman's point. We appreciate the direction that this is going and look forward to further conversation in July.

Rep. Oliverson stated that to provide some information to what I just heard, we had a committee hearing in Texas on this very issue earlier this week. And to answer Rep. Lehman's questions, some things came up looking at the Alabama program that they have there. We had someone that came to testify and said that in the Alabama program, moving to an Insurance Institute for Business and Home Safety (IBHS) Fortified standard increases the value of the home on average by 9% which is more typically than the amount of money invested in getting to that standard. And because it gets certified, that's transferable so it's a permanent increase in the value to the property. They told us that in Alabama, on the windstorm coverage alone, the presence of the IBHS Fortified standard lowered the cost of windstorm premiums between 20% and 50% on average. So I just wanted to contribute that to the conversation.

Rep. Bennett stated that those are some incredible numbers and I hope that we're able to get into that a little bit more during the Summer Meeting.

DISCUSSION ON PROPOSED “TITLE ACCEPTANCE PILOT” FROM THE FEDERAL HOUSING FINANCE AGENCY (FHFA)

Rep. Bennett stated that included in the materials for this meeting is a letter that was sent by Rep. Oliverson to the Director of the FHFA expressing concerns about the agency's proposed “title acceptance pilot” which would permit title insurance obtainment requirements to be waived in certain transactions. I'll let Rep. Oliverson discuss this a bit more, but as you can see from the letter, there are a lot of concerns about this, mainly from the standpoint of federal intrusion on the state-based system of insurance.
Rep. Oliverson stated that I’ll just provide a little bit of commentary on this - this kind of hit us out of the blue. It was not on my radar screen until the Nashville meeting when it was presented by the title insurance industry. As you know, the title insurance product is the only insurance policy that you purchase that is good for as long as you own that home. And it essentially is there to protect you against a variety of issues resulting from ownership of that property and encroachments and things like that. The thing that particularly disturbed me about this proposal is that most of our states have a guaranty system that title insurers pay into whenever they sell a policy that essentially, in the event that something happens and there's a claim against the policy or there's fraud or any kind of wrongdoing, there's a guaranty system that steps that is run by the state that essentially makes the policyholder whole.

And so, I think the thing that really disturbed me more than anything about what is being attempted here is that none of these changes would be protected by any of the guaranty systems that exist in any of our states and so a person that purchased a home through this program would essentially be waiving or losing all of those lifelong protections and the guarantee that if there was a mistake made or there was fraud or some other kind of issue that there was a backstop where they would be made whole. So, it is a terrible encroachment. The only other thing I'll say is that when we investigated what we found out was that apparently this was sort of a hastily thrown out thing but I think it's a great example of a clear and present threat to the state-based system of insurance regulation. I'm hopeful that they will back off on this and if we can keep the pressure on them, hopefully we get up there at the end of this month during our fly-in and we can let our Members of Congress know about this and our opposition to this encroachment.

Dan Fichtler, Senior Advisor, Office of the Director, at the FHFA, thanked the Committee for the opportunity to speak and stated that I’m very glad to be part of this group because hearing some of this today I think there's some misconceptions about the pilot. It's actually unrelated to homeowners title insurance. It's purely about lenders title insurance policies. So, it has no impact on consumers. But let me back up. I'm with FHFA. I won't assume everybody knows who we are at FHFA. We're the regulator and the conservator of Fannie Mae and Freddie Mac who are government sponsored enterprises (GSE) whose mission is essentially to support liquidity in the secondary mortgage market. They buy mortgages, both single family and multifamily, from lenders all across the country. They issue mortgage-backed securities based off of those underlying mortgages. Essentially that takes capital from the global capital markets and brings it into domestic mortgage markets to support mortgage lenders.

One of the things that FHFA does in its oversight of both Fannie Mae and Freddie Mac is provide an annual basis we produce public scorecards on all those kind of things that we

would like to see Fannie and Freddie focused on over the course of the year. And I bring this up to highlight a couple points that have been there in the last couple of years. Scorecards that are relevant to this discussion and actually a much broader discussion than title insurance. So, we've asked them to do a couple of things. We've asked them to leverage data technology, other innovations to promote efficiency and cost savings in mortgage processes. And then a related note, we've asked them to explore opportunities to further sustainable home ownership through measures that positively influence affordability, including transaction costs in a manner that maintains safety and soundness. And really I'll bring that up to say those sort of directives are the basis for a lot of work that's underway across the federal government, but certainly within FHFA, in looking at mortgage closing costs and looking at whether there are ways that technology data innovation can be harnessed to bring down mortgage closing costs. I think folks are well aware there's a housing affordability challenge, some call it a crisis, throughout the country. And so trying to find ways to responsibly reduce the funds that prospective homeowners need to bring to the closing table in the form of closing costs is important because the higher those closing costs are the more it's a deterrent, particularly for first time homeowners.

This closing cost can cover a whole range of things. For example we've been doing quite a bit of work over the last several years on the appraisal front, home valuations, to leverage some new technology and data innovation there to bring down costs. Title insurance is obviously one important component of mortgage closing costs. So what we've asked, not just Fannie and Freddie, but of the industry others is, we're seeking ideas for ways to kind of meaningfully reduce the costs associated with providing title insurance. We've gotten several ideas, some from Fannie, Freddie, some from the industry, some from consumer advocates. It's been a really good process. One of those ideas essentially forms the basis of the pilot program we're discussing today. The main goal is really to test whether innovation and technological developments with respect to title search capabilities can lead to reduced costs without adding incremental risk. So it's really about sort of innovation in the way that title searches can be conducted and the models that are used as part of that process.

So, let me back up just a minute. So, what are the existing Fannie, Freddie requirements? They both have long standing requirements as it relates to title verification for every loan that they purchase. So, essentially what they do at its core is they say if you're a mortgage lender selling a loan to Fannie or Freddie, that lender has to rep and warrant that the loans are valid first liens, that they're free of title defects and the like. On top of that, and to further minimize the risk, they say, okay well, the lenders rep and warrant to this but they also in most cases generally speaking require the lender to get some sort of third party verification of that fact. And in the vast majority of cases that third party verification is a lenders title insurance policy. And I want to just differentiate here - the lenders title policy which travels with the loan versus the homeowners' title insurance policy which stays with the borrower as long as they're in that home. So, Fannie and Freddie don't have any requirements related to whether or not the homeowner purchases title insurance. That's the decision for the homeowner. What they do require, generally speaking, is that the lender get a lenders title policy as an additional means of protection behind that rep warrant. So, one last notable point I'll make about that distinction is even though the Fannie and Freddie requirements, the long-standing requirements have been for lenders title protection, a lenders policy, it is

the borrower who ultimately pays for that policy. That cost is passed through by the mortgage originator to the borrower in their closing costs. So let me sort of get to how that sort of comes to the title acceptance pilot. So, coming back to the goal of can improvements in title search capabilities meaningfully reduce costs in this space, sort of the crux of the pilot is this. So, what Fannie Mae would do is work with the third-party model providers, vendors and like to determine for a population of low risk refinance loans, in particular, whether they can determine which loans or the population of loans that are very unlikely to have unexpected title defects arise in the future. And there are several vendors that have been out in the industry working on sort of products, platforms, and algorithms to try to do this.

So, it's nothing new to Fannie or Freddie but what Fannie wants to do is work with some of these vendors to try to identify that population of loans and then for those loans that would be eligible for the pilot, essentially what happens is, I mentioned that Fannie requires the lender to rep and warrant clear title. So, what Fannie would be doing is relieving the lender of penalties associated with whether or not those reps and warrants are breached at a later date. So, if you think about the way it works today, the lender has to make this rep and warrant. If there's a title defect that's found at a later point and the lender doesn't address or can't address it, then the lender has to repurchase that loan from Fannie or Freddie. Which the lender doesn't want to do. That's a costly proposition to them. So, essentially what Fannie is proposing to do is to say, essentially a hold harmless provision for the lender, waiving that rep and warrant that the lender has to make. And by extension, if the lender does not need to make that rep and warrant, it obviates the need for the lender to go out and get the lenders title insurance policy. Now again, that's all unrelated to whether or not the homeowner chooses to purchase a homeowner's title insurance policy. Fannie would waive the rep and warrant for the lender and the requirement that the lender go out and get a lenders title insurance policy. So, outside of that, the process works kind of in the way it does today. You'd still have a settlement provider that does the title, there will be a title search process as part of this system, a right to determine if there's any encumbrances or title defects prior to the purchase. You have a settlement provider that is involved in the process at closing and then if there are any title issues that arise on the back end, those are addressed by Fannie Mae much in the way that they currently do for loans that are already in their real estate owned portfolio. Those are loans that are acquired due to foreclosure or things of that nature.

So, backing up, how does this get back to the stated goal of trying to put downward pressure on closing costs? Well, I mentioned that in pretty much all transactions the consumer is the one that pays for the lenders title insurance policy. And so, our expectation is if they're no longer on the hook for paying for that policy for these loans that would produce a savings of somewhere between $500 and $1,500 per loan depending on the type of loan, the jurisdiction you're in, lots of factors that go into the overall cost. Thinking about the scope, this would be during the pilot phase, limited to low-risk refinances. So, refinances where the loan to value ratio is below a certain a certain level probably in a handful of jurisdictions to test this out really to determine whether it works and determine whether the technology works, whether the process works from both the lenders perspective and the borrower's perspective. I would say just also thinking about scope, no lenders or vendors have actually been selected for this yet so we still have a ways to go. Fannie Mae is actually going to be putting out a

request for proposals for lenders to submit their proposals to be part of this in the next couple of weeks.

And I was a little disturbed by some of the comments earlier but it's going to be an open competitive process for vendors that would want to take part in this. The one other piece I just wanted to address quickly on some of the commentary from earlier - this pilot has been discussed in the public domain going back to last winter. In fact, our Director was doing her annual testimony before the House Financial Services Committee last May and received a bunch of questions about it. So, I would just respectfully push back both on the notion that something came through hastily. It's actually been something that's been discussed for well over a year now. The last thing I would say is, like most Fannie Mae or Freddie Mac pilots, part of the goal here is to test technology and test the lender processes in a small population of loans in a low risk population and determine what works. Maybe it'll work well, maybe it won't. And then from that point, look at the data to determine whether or not to move forward with this type of process for any other loans. Ed DeMarco, President of the Housing Policy Council (HPC) and former FHFA Director thanked the Committee for the opportunity to speak and stated that HPC is a trade association and our membership is some of the largest mortgage lenders, mortgage servicers, mortgage insurers, mortgage title companies in the country. I want to thank Mr. Fichtler for his remarks as I thought he did a nice job summarizing what FHFA is doing here. The things that he walked through are consistent with my understanding of how FHFA is approaching this. While I've got a different view about it, I thought he did a nice job presenting it. So, let me offer just a few thoughts here. So first, I want to start by recognizing and acknowledging the exclusive regulation of insurance granted to states including not just title insurance, but mortgage insurance. Unique from other financial institutions and products which have a mix of federal and state regulation, insurance is clearly a state regulated matter. But the GSE's, Fannie Mae and Freddie Mac, in this case are also unique. And what I want to start with is talking a little bit more about Fannie and Freddie and what makes them unique. So, let's start with what does it mean to be a GSE? Fannie Mae and Freddie Mac are just two of a handful of such entities. So, unlike all other corporations in the U.S., GSE's receive their corporate charter from Congress, not from the state government. Congress does this in order to secure a stable, targeted flow of credit to a particular sector. In the case of Fannie and Freddy, for residential mortgage finance. Now the GSE charter that Congress creates comes with certain benefits and constraints. The only companies that can get it are the companies that Congress creates. The benefits Congress grants include things such as tax exemptions, security law exemptions, and other benefits such as line of credit with the Treasury Department and special treatment of their financial obligations that make them more attractive to investors.

Now, in exchange for these benefits, Congress limits the corporate activities of a GSE to a specified market and market activity. In the case of Fannie and Freddy, they are tasked by Congress with creating a liquid secondary mortgage market in which eligible loans may be sold by lenders to investors, allowing lenders to recycle their capital to make more loans. Now, this package of benefits is very valuable and is only available to the GSE's. So, Congress also placed restraints on where and how those benefits may be used. And in particular in 2008 legislation Congress directed FHFA to use a process for new products and activities to make sure that any new product or activity of Fannie and Freddy is consistent with the intent of this framework. Now, the title acceptance

pilot announced in early March enables Fannie Mae to begin self-insuring title risk on a defined subset of refinance mortgages that FHFA deems to be low risk. As Mr. Fichtler went through, the purpose of the pilot is to test out a concept, but if it's successful, expand or make permanent its use. When the pilot was announced, HPC sent a letter to FHFA Director outlining our concerns, and I'd like to summarize them for you in just a moment. But I also say our letter detailed the important risk management functions of title insurers and title insurance. We pointed out that title insurers protect the integrity of the mortgage transaction and much of the work that they do is curative. That is, before the loan settles, their whole point is to try to identify any defects in title and cure it before you actually have a loan settlement. The title insurance component covers the remaining risk of what might have been hidden or wasn't discovered in the curative process. So, as I say, our letter to FHFA raises both process and risk management concerns. In the process area we described our concern that self-insuring title risk may exceed the GSE's authority to operate just in the secondary market, not the primary market. And we also described why we felt the pilot should trigger a new product review by FHFA which would have allowed for public notice and comment.

In the substance area, we discussed how the pilot encroaches Fannie Mae's beneficial status as the GSE to compete directly in a market already well served by private companies with private capital at stake and subject to a state regulatory regime.
We also pointed out how title insurers subject to state regulation, must satisfy prudential regulatory standards, including reserve requirements and it is not clear from the proposal what would be the corresponding prudential protections imposed on Fannie Mae to self-insure. We also speak to the issue of consumer impact and while the point was made that the title acceptance pilot is focused just on the lender policy, not on the borrower's policy, there's still some important potential impacts on the consumer that haven't been fully evaluated. For example, if the consumer looks and says well, the lender doesn't need a title policy, why do I, the consumer may decide to just not have title coverage. And the second is you're taking the lower risk. If indeed this works as planned and you take out the lower risk product, you're removing that revenue stream which then takes the higher risk loans that are left for the title insurance companies. And that's likely to raise the ultimate cost of title insurance down the road for these higher risk borrowers if you're taking the lower risk pool out of the insurance pool. So, I really think that all these issues could have received more thoughtful consideration had FHFA been more transparent about the details of the pilot in advance and put the concept out for public comment. That approach would allow an opportunity for all the issues discussed here both by HPC and by your organization to receive fuller consideration.

Elizabeth Blosser, VP of Gov't Affairs for the American Land Title Association (ALTA) thanked the Committee for the discussion and stated that I appreciated the comments on consumer protection from Mr. DeMarco. And the other thing I would just mention in the area of consumer protection is sort of borrower fraud or identity theft and things of that nature that could happen in a refinance that would leave a consumer with some coverage concerns so I'd just like to add that to the discussion.

Rep. Bennett thanked everyone for the conversation and stated that we're going to continue to monitor this issue and we'll have an update on where things stand with the pilot during the July meeting in Costa Mesa. In the meantime, if you have any questions, please reach out to me, Rep. Oliverson, or NCOIL staff.

OPPORTUNITY FOR COMMENT/DISCUSSION ON MODEL LAWS SCHEDULED FOR CONSIDERATION OF RE-ADOPTION AT 2024 NCOIL SUMMER MEETING

Rep. Bennett stated that last on our agenda is an opportunity to comment on the model laws scheduled for consideration of readoption at the NCOIL summer meeting. This committee has three model laws that are scheduled for consideration. As a reminder, per NCOIL bylaws all NCOIL model acts are scheduled to be considered for readoption every five years and if it's not readopted it sunsets. The three model laws scheduled for the summer meeting are: Model Act Regarding Use of Claims History Information – adopted 7/8/05; re-adopted 11/20/11; 12/13/19; Model Act Concerning State Interpretation of State Insurance Laws – adopted 7/13/19; and State Flood Disaster Mitigation and Relief Model Act – adopted 11/21/03; amended 7/13/08; re-adopted 7/13/19.

I note that these models will not be voted on for readoption today, but it's an opportunity for any comments and discussion in advance of the July meeting where the actual votes will take place. The July agenda won't allow time for additional discussion on these models so if you want to have any discussion, that should happen now. I do note by the time of the July meeting, we'll have information on which states have adopted these models so far.

Hearing no questions or comments, Rep. Bennett stated that if you have comments that you'd like considered by NCOIL, you can contact staff or Rep. Oliverson or myself.

ADJOURNMENT

Hearing no further business, upon a Motion made by Rep. Lehman and seconded by Asw. Hunter, the Committee adjourned at 1:30 p.m.

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CHIEF EXECUTIVE OFFICER: Thomas B. Considine

PRESIDENT: Rep. Tom Oliverson, TX
VICE PRESIDENT: Asw. Pamela Hunter, NY
TREASURER: Sen. Paul Utke, MN
SECRETARY: Rep. Edmond Jordan, LA

IMMEDIATE PAST PRESIDENT: Rep. Deborah Ferguson, AR

NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

Motor Vehicle Glass Model Act

Sponsored by Rep. Michael Sarge Pollock (KY)

Draft as of June 18, 2024. To be introduced and discussed during the Property & Casualty Insurance Committee on July 20, 2024.

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Section 1. Title

This Act shall be known as the [State] Motor Vehicle Glass Act.

Section 2. Definitions

As used in this Act, the following terms shall have the following meanings:

(A) "Advanced driver assistance system" means any motor vehicle electronic safety system, as outlined in the most recent version of SAE International's SAE J3016 Levels of Driving Automation, that is designed to support the driver and motor vehicle in a manner intended to:

(1) Increase motor vehicle safety; and
(2) Reduce losses associated with motor vehicle crashes.

(B) “Insurance Producer” means an individual or business entity required to be licensed under the laws of [State] to sell, solicit, or negotiate insurance or annuity contracts. "Insurance producer" includes agent, managing general agent, surplus lines broker, reinsurance intermediary broker and manager, rental vehicle agent and rental vehicle agent managing employee, and consultant.

(C) "Insured" means a person that is entitled, or may be entitled, to receive first-party benefits or payments under an insurance policy.

(D) "Motor vehicle glass" means the glass and non-glass parts associated with the replacement of the glass used in the windshield, doors, or windows.

(E) "Motor vehicle glass repair shop" means any person, including the person's employees and agents, that for consideration engages in the repair or replacement of damaged motor vehicle glass.

(F) “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.

(G) "Repair or replacement of damaged motor vehicle glass" includes:

(1) Inspecting, repairing, restoring, or replacing damaged motor vehicle glass; and
(2) Calibrating or recalibrating an advanced driver assistance system when an incident requires the replacement of damaged motor vehicle glass.

(H) "Rights or benefits under the policy" includes the insured's right to receive any and all post-loss benefits or payments available or payable under the policy, including but not limited to claim payments.

Section 3. Post-Loss Benefit Assignment

(A) An insured under a property and casualty insurance policy shall not, either prior to or after a claimed or covered loss, assign or otherwise transfer, in whole or in part, to any other person the insured's:

(1) Duties under the policy; or
(2) Rights or benefits under the policy.

(B) Any contract entered in violation of this section shall be void and unenforceable.

(C) Nothing in this section shall be construed to prohibit an insured from authorizing or directing payment to, or paying, a person for services, materials, or any other thing which may be, or is, covered under an insurance policy.

Section 4. Advanced Driver Assistance Systems

(A) Prior to contracting with an insured for a repair or replacement of damaged motor vehicle glass, a motor vehicle glass repair shop shall:

(1) Notify the insured:

(a) Whether the motor vehicle has an advanced driver assistance system;
(b) If the motor vehicle has an advanced driver assistance system:

(i) whether calibration or recalibration of the motor vehicle's advanced driver assistance system is required to make the advanced driver assistance system operable, and ensure that the repair or replacement of damaged motor vehicle glass is performed in a manner that meets the motor vehicle manufacturer's specifications.

(ii) Whether the motor vehicle glass repair shop can calibrate or recalibrate the advanced driver assistance system in a manner that meets the motor vehicle manufacturer's specifications; and

(iii) If the motor vehicle glass repair shop is not capable of performing a calibration or recalibration referenced in subdivision b. of this subparagraph, that the motor vehicle should be taken to the vehicle manufacturer's certified dealership or a qualified specialist capable of performing the calibration or recalibration.

(c) If calibration or recalibration of the motor vehicle's advanced driver assistance system is performed, that the motor vehicle glass repair shop will provide written notice to the insured:

(i) As to whether the calibration or recalibration was successful; and

(ii) If the calibration or recalibration was not successful, that the motor vehicle should be taken to the vehicle manufacturer's certified dealership or a qualified specialist capable of performing the calibration or recalibration.

Section 5. Motor Vehicle Glass Repair Claims and Practices

(A) A motor vehicle glass repair shop shall not contract with a person for a repair or replacement of damaged motor vehicle glass until:

(1) All of the following are satisfied:

(a) The person has made a first-party claim for the repair or replacement of damaged motor vehicle glass under a motor vehicle insurance policy;

(b) The motor vehicle glass repair shop has received a claim or referral number for the claim referenced under subparagraph 1. of this paragraph; and

(c) The requirements of Section (4) of this Act are satisfied; or

(2) The person either:

(a) States, in writing, that the person does not have first-party motor vehicle insurance coverage for the repair or replacement of damaged motor vehicle glass; or

(b) Declines, in writing, to make a first party claim for the repair or replacement of damaged motor vehicle glass under a motor vehicle insurance policy.

(B) A motor vehicle glass repair shop shall provide the insured an invoice, which shall, at a minimum, include:

(1) An estimate of the fees and costs that are anticipated to be charged to the insured by the motor vehicle glass repair shop for the repair or replacement of damaged motor vehicle glass;

(2) The shop's standard fees and costs for a repair or replacement of damaged motor vehicle glass; and

(3) Notice that the motor vehicle glass repair shop is prohibited under Section 6(2) of this Act from charging higher fees and costs to an insured for a repair or replacement of damaged motor vehicle glass than are reasonable and customarily charged in [State].

(C) A motor vehicle glass repair shop shall provide the insured upon completion of a repair or replacement of damaged motor vehicle glass:

(1) A receipt; and

(2) For any calibration or recalibration of an advanced driver assistance system, a notice that states whether the advanced driver assistance system is in working order.

Section 6. Prohibited Acts

(A) A motor vehicle glass repair shop, or any other person who is compensated for the solicitation of insurance claims, shall not offer a rebate, gift, gift card, cash, coupon, fee, prize, bonus, payment, incentive, inducement, or any other thing of value to any insured, insurance producer, or other person in exchange for directing or making a claim under a motor vehicle insurance policy for a repair or replacement of damaged motor vehicle glass.

(B) A motor vehicle glass repair shop shall not:

(1) Charge higher fees and costs to an insured for a repair or replacement of damaged motor vehicle glass than are reasonable and customarily charged in [State];
(2) Submit false, misleading, or incomplete documentation or information to an insured or an insured's insurer, including any agent of the insured or insurer, for a repair or replacement of damaged motor vehicle glass;

(3) With respect to an insured's claim, or potential claim, for a repair or replacement of damaged motor vehicle glass, do the following, which results, or would result, in a higher insurance payment or a change of insurance coverage status:

(a) Indicate that work was performed in a geographical area that was not the geographical area where the work occurred; or

(b) Advise an insured to falsify the date of damage;

(4) Falsely sign a work order or other insurance-related form relating to an insured's claim, or potential claim, for a repair or replacement of damaged motor vehicle glass;

(5) Misrepresent to an insured or the insured's insurer, including any agent of the insured or insurer, the price of a proposed repair or replacement of damaged motor vehicle glass;

(6) State that an insured's insurer has approved a repair or replacement of damaged motor vehicle glass without:

(a) Verifying coverage directly with, or obtaining approval directly from, the insurer or the insurer's agent; and

(b) Obtaining confirmation of the coverage or approval by facsimile, email, or other written or recorded communication;

(7) State that a repair or replacement of damaged motor vehicle glass will be paid for entirely by an insurer and at no cost to the insured unless the coverage has been verified by the insurer or the insurer's agent;

(8) With respect to an insured's claim, or potential claim, for a repair or replacement of damaged motor vehicle glass:

(a) Damage, or encourage an insured to damage, the motor vehicle in order to increase the scope of the repair or replacement of damaged motor vehicle glass;

(b) Perform work that is clearly and substantially beyond the level of work necessary to restore the motor vehicle to a safe pre-damaged condition in accordance with accepted or approved reasonable and customary techniques for the repair or replacement of damaged motor vehicle glass;

(c) Misrepresent the motor vehicle glass repair shop's relationship to an insurer or the insurer's agent; or

(d) Perform any other act that constitutes fraud or misrepresentation.

(C) Any notice or invoice required under this Act shall not be issued in any font size lesser than twelve (12) point font.

Section 7. Anti-Steering

(A) An insured that makes a first party claim for a repair or replacement of damaged motor vehicle glass under a motor vehicle insurance policy shall not be required to use a particular motor vehicle glass repair shop to receive claim payments or other benefits under the policy.

(B) This section shall not be construed to:

(1) Prohibit an insurer, insurance producer, insurance adjuster, or any person acting on behalf of an insurer, insurance producer, or insurance adjuster from providing an explanation to an insured of the coverage available, and any applicable liability limit, under any insurance policy.

(2) Prohibit an insurer from maintaining a network of motor vehicle glass repair shops; or

(3) Create a private cause of action.

Section 8. Presumption

It may be presumed that a motor vehicle glass repair shop is acting knowingly in violation of Section 6 if the motor vehicle glass repair shop engages in a regular and consistent pattern of the prohibited activity.

Section 9. Penalties

Drafting Note: Legislators may wish to consider provisions that establish rules that allow for [regulatory body] to be responsible for the administration and enforcement, including penalties, of all motor vehicle glass repair shops in [State].

Section 10. Application

This Act applies to insurance policies issued or renewed on or after the effective date.

Section 11. Effective Date

This Act is effective [xxxxxxxx].

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PRESIDENT: Rep. Tom Oliverson, TX
VICE PRESIDENT: Asw. Pamela Hunter, NY
TREASURER: Sen. Paul Utke, MN
SECRETARY: Rep. Edmond Jordan, LA

IMMEDIATE PAST PRESIDENT: Rep. Deborah Ferguson, AR

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 discussed by the NCOIL Property & Casualty Insurance Committee on July 20, 2024.

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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.

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SECRETARY: Rep. Edmond Jordan, LA

IMMEDIATE PAST PRESIDENT: Rep. Deborah Ferguson, AR

National Council of Insurance Legislators (NCOIL)

Online Marketplace Guarantees Model Act

***Sponsored by Rep. Brian Lampton (OH)**
***Draft as of June 18, 2024. To be discussed by the NCOIL Property & Casualty Insurance Committee on July 20, 2024.**

Table of Contents

Section 1. Title, Scope and Purposes

A. This Act shall be known and cited as the Online Marketplace Guarantees Act.

B. The purposes of this Act are to:

(1) Create a legal framework within which an online marketplace or its affiliates may offer or sell an online marketplace guarantee in this state;

(2) Protect consumers by promoting transparency, fairness and accountability related to online marketplace guarantees and placing the risk of innovation on the online marketplace providers rather than consumers;

(3) Encourage innovation in the marketing and development of more economical and effective means of providing an online marketplace guarantee; and

(4) Permit and encourage fair and effective competition among different providers.

Drafting Note: States wishing to allow providers to obtain insurance policies providing group or blanket liability insurance coverage, business interruption or similar coverages to platform users may add language to expressly allow such coverage within the scope of this Act.

Section 2. Definitions

As used in this Act:

A. ["Commissioner" means the commissioner of insurance of this state.]

Drafting Note: Insert the title of the chief insurance regulatory official wherever the term "commissioner" appears. If the state desires that online marketplace guarantees should instead be regulated by the state attorney general, a state should add language referencing to that effect to ensure the appropriate assignment of responsibilities.

B. "Online marketplace" means a person that meets each of the following criteria:

(1) Provides an online application, software, website, system or other medium through which a service is advertised or is offered to the public as available in this state.

(2) Provides, directly or indirectly, or maintains a platform for services by performing any of the following:

(a) Transmitting or otherwise communicating the offer or acceptance of a transaction between two platform users.

(b) Owning or operating the electronic infrastructure or technology that brings two or more platform users together.

(3) If engaged in the sale or offering of online marketplace guarantees, does so only in a manner that is ancillary to the conduct of its primary legitimate business or activity.

(4) Is not a local or state governmental entity or vendor.

C. "Online marketplace guarantee" means a contract or agreement issued in connection with an online marketplace, whether or not for a separate consideration, to guarantee a platform user's obligation to repair, replace or indemnify another platform user for any damages or loss of income arising out of use of the online marketplace, with or without additional provision for incidental payment of indemnity.

D. "Platform contract holder" means a platform user who is the beneficiary or holder of an online marketplace guarantee.

E. "Platform user" means a user of an online marketplace who is subject to the online marketplace's terms of service.

F. “Person” means an individual, partnership, corporation, incorporated or unincorporated association, joint stock company, reciprocal, syndicate or any similar entity or combination of entities acting in concert.

G. “Provider” means (i) an online marketplace or (ii) an affiliate or representative of an online marketplace, who issues, makes, provides, sells or offers to sell as well as administers, either directly or through a third party, an online marketplace guarantee.

H. “Reimbursement insurance policy” means a policy of insurance issued to a provider and pursuant to which the insurer agrees, for the benefit of platform contract holders, to discharge all of the obligations and liabilities of the provider under the terms of the online marketplace guarantee in the event of non-performance by the provider.

I. “Separate consideration” means a separately stated consideration paid to a provider for an online marketplace guarantee that is paid at the voluntary election of the person purchasing the online marketplace guarantee. Separate consideration does not include a revenue sharing agreement between the provider and platform user or any consideration collected by the online marketplace that is primarily related to the underlying service provided by the online marketplace.

Section 3. Requirements For Doing Business

A. An online marketplace guarantee shall not be issued, sold or offered for sale in this state unless the provider has:

(1) If sold for separate consideration, provided an electronic or written record of the purchase of the online marketplace guarantee to the platform contract holder;

(2) Made the online marketplace guarantee terms available on the provider’s website; and

(3) Complied with this Act.

B. All providers of online marketplace guarantees sold or offered in this state shall file a registration with the commissioner on a form and at a fee prescribed by the commissioner.

C. To ensure the faithful performance of a provider’s obligations to its platform contract holders, each provider who is obligated to a platform contract holder shall comply with at least one of the following requirements:

(1) Insure all online marketplace guarantees under a reimbursement insurance policy issued by an insurer authorized to transact insurance in this state or issued pursuant to [insert code section permitting surplus lines business].

(2) For at least 30 days in any 90-day period, maintain a market capitalization of at least $200 million on a securities exchange registered as a national securities

exchange or a securities market regulated under the Securities Exchange Act of 1934 (15 U.S.C. §§ 78 et seq.), as amended, as reported by such exchange at the close of each trading day.

(3) Maintain a net cash balance or net worth of at least $50 million. Upon request, the provider or provider's parent company shall provide the commissioner with financial statements to support such net cash balance or net worth. Financial statements may include, but are not limited to (i) a Form 10-K or Form S-1 filed with the U.S. Securities and Exchange Commission ("SEC") within the last calendar year, including any amendments thereto, or (ii) a copy of the company's audited financial statements with a reporting date within the last calendar year. If the provider's parent company's financial statements are provided to meet the provider's financial stability requirement, then the parent company shall agree to guarantee the obligations of the provider relating to online marketplace guarantees sold by the provider in this state.

Section 4. Online Marketplace Guarantees

A. Online marketplace guarantees do not constitute insurance and are not required to comply with any provision of the insurance laws of this state other than as expressly made applicable in this Chapter, provided the provider has registered with the commissioner as required by Section 3 of this Act.

B. The following activities by a provider or a provider's representative do not constitute the transaction of insurance and are likewise exempt from any licensing requirements under [cite to state insurance code]:

Drafting Note: The intent of this model is to exclude the transaction of online marketplace guarantees and these related activities from any state licensing requirements for insurance carriers or intermediaries that would otherwise apply

(1) Marketing, providing, selling or offering to sell online marketplace guarantees in compliance with this Act.

(2) Determining amounts payable under online marketplace guarantees, including, with respect to claims made by platform contract holders, (i) investigating, negotiating or administering settlement of claims, or (ii) applying the factual circumstances of the claim to the online marketplace guarantee's terms.

(3) Collecting separate consideration in connection with online marketplace guarantees.

C. A provider may (i) charge separate consideration for an online marketplace guarantee and (ii) provide varying levels of service and functionality depending on whether a platform user has paid separate consideration. Any separate consideration collected for online marketplace guarantees shall not be subject to premium taxes.

D. Nothing in this Act shall be construed to limit a provider's rights to seek recourse from a platform user to the extent of any contractual obligation by any means permitted under an online marketplace's terms of service.

E. An online marketplace guarantee may set a minimum threshold amount of damages that limit amounts payable to a platform contract holder provided that such minimum threshold amount is disclosed pursuant to Section 6.F of this Act.

Section 5. Reimbursement Insurance Policy

A. Reimbursement insurance policies insuring online marketplace guarantees sold or offered in this state shall clearly state that, upon failure of the provider to perform under the online marketplace guarantee, the insurer that issued the policy shall pay on behalf of the provider any sums the provider is obligated to pay according to such online marketplace guarantee.

B. A reimbursement insurance policy shall be subject to the laws and regulations governing termination and non-renewal of insurance policies in this state or with [citation to specific statute]. The termination of a reimbursement insurance policy shall not reduce the issuer's responsibility for online marketplace guarantees issued by providers prior to the effective date of the termination.

C. For purposes of [insert citation to the law that obligates an insurer for the acts of its agents, including the collection of moneys not forwarded] a provider is considered to be the agent of the insurer which issued the reimbursement insurance policy. The insurer retains the right to seek indemnification or subrogation from the provider if the insurer pays or is obligated to pay sums to the platform contract holder that the provider was obligated to pay under the online marketplace guarantee. This Act does not prevent or limit the insurer's right in this regard.

Section 6. Consumer Protection Disclosures

A. Online marketplace guarantees issued, sold or offered for sale in this state shall be written in clear, understandable language and conspicuously disclose the requirements in this section, as applicable.

B. Online marketplace guarantees insured under a reimbursement insurance policy pursuant to Section 3.C(1) of this Act shall contain a statement in substantially the following form: "Obligations of the provider under this online marketplace guarantee are guaranteed under a reimbursement insurance policy. If the provider fails to pay or provide service on a claim within one hundred and eighty (180) days after proof of loss has been filed, the platform contract holder is entitled to make a claim directly against the insurance company subject to the terms of the policy."

C. Online marketplace guarantees not insured under a reimbursement insurance policy pursuant to Section 3.C(1) of this Act shall contain a statement in substantially the

following form: “Obligations of the provider under this online marketplace guarantee are not covered under a reimbursement insurance policy and are backed only by the provider (issuer).”

D. Online marketplace guarantees shall identify each provider obligated to provide payment for claims under the contract or otherwise involved in the contract’s issuance or sale.

E. If sold for separate consideration, online marketplace guarantees shall conspicuously state the total purchase price and the terms under which the online marketplace guarantee is sold prior to the sale.

F. Online marketplace guarantees shall conspicuously state the existence and amount of any damage recovery minimum threshold.

G. Online marketplace guarantees shall specify the services to be provided and any limitations, exceptions or exclusions.

H. Online marketplace guarantees shall state any terms, restrictions or conditions, including conditions governing transferability or conditions governing termination of the online marketplace guarantees by the platform contract holder. The provider of the online marketplace guarantee shall mail or email a written notice to the platform contract holder within thirty (30) days of the date of termination.

I. Online marketplace guarantees sold for separate consideration shall clearly and conspicuously state, at the time of sale, the applicable cancellation and refund policy.

J. Online marketplace guarantees shall include a statement in substantially the following form: “This agreement is not an insurance contract.”

Section 7. Prohibited Acts

A. A provider shall not make, permit or cause to be made any false or misleading statement, or deliberately omit any material statement that would be considered misleading if omitted, in connection with the sale, offer to sell or advertisement of an online marketplace guarantee.

B. If an online marketplace guarantee is offered for separate consideration, a provider shall not require the purchase of an online marketplace guarantee as a condition of the use of the online marketplace’s platform.

Section 8. Enforcement Provisions

A. When necessary or appropriate to enforce the provisions of this Act and the commissioner’s regulations and orders, and to protect platform contract holders in this state, the commissioner may take action under [insert citation to general enforcement power of commissioner].

B. A person aggrieved by an order issued under this Section 8 may request a hearing before the commissioner pursuant to [insert citation to statutes concerning hearings before the commissioner]. Pending such hearing and the decision by the commissioner, the commissioner shall suspend the effective date of any such order.

Section 9. Authority to Develop Regulations

The commissioner may promulgate regulations that are not inconsistent with and are necessary to administer and enforce the provisions of this Act, including regulations related to recordkeeping by providers.

Section 10. Separability Provision

If any provision of this Act, or the application of the provision to any person or circumstances, shall be held invalid, the remainder of this Act, and the application of the provision to any person or circumstances other than those as to which it is held invalid, shall not be affected.

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SECRETARY: Asm. Kevin Cahill, NY

IMMEDIATE PAST PRESIDENTS:
Sen. Jason Rapert, AR
Sen. Travis Holdman, IN

National Council of Insurance Legislators (NCOIL)

Model Act Concerning Interpretation of State Insurance Laws

Sponsored by Rep. Joseph Fischer (KY)

Adopted by the Property & Casualty Insurance Committee on July 12th, 2019 and the Executive Committee on July 13th, 2019

To be considered for re-adoption during the Property & Casualty Insurance Committee meeting on July 20, 2024.

Section 1. Title

This Act shall be known as the "Model Act Concerning Interpretation of [State] Insurance Laws."

Section 2. Interpretation of [State] Insurance Laws

A statement of the law in the American Law Institute's Restatement of the Law, Liability Insurance does not constitute the law or public policy of this state if the statement of the law is inconsistent or in conflict with:

(1) The Constitution of the United States or of this state;

(2) A statute of this state;

(3) This state's case law precedent; or

(4) Other common law that may have been adopted by this state.

Section 3. Effective Date

This Act shall take effect immediately

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IMMEDIATE PAST PRESIDENTS:
Sen. Jason Rapert, AR
Sen. Travis Holdman, IN

NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

Model Act Regarding the Use of Insurance Claims History Information in Homeowners and Personal Lines Residential Property Insurance

Adopted by the NCOIL Property-Casualty Insurance Committee on July 8, 2005. Amended and adopted by the NCOIL Executive Committee on July 8, 2005. Readopted by the NCOIL Property & Casualty Insurance Committee on November 18, 2011 and by the NCOIL Executive Committee on November 20, 2011. Readopted by the NCOIL Property & Casualty Insurance Committee and Executive Committee on December 13th, 2019

Sponsored by Sen. David Bates, RI; Rep. Dan Tripp, SC; and Rep. Rich Golick, GA

To be considered for re-adoption during the Property & Casualty Insurance Committee meeting on July 20, 2024.

Table of Contents

Section 1. Short Title

This Act may be called the *Model Act Regarding the Use of Insurance Claims History Information* in Homeowners and Personal Lines Residential Property Insurance.

Section 2. Purpose

The purpose of this Act is to regulate the use of claims history information for homeowners and personal lines residential property insurance and provide certain consumer protections with respect to the use of such information.

> *[Drafting Note: In certain respects, this model does not address or restrict the manner in which an insurer may respond to the claims of existing policyholders. Many states already regulate the treatment of existing policyholders, and any jurisdictions that wish to address the issue will need to do so independently.]*

Section 3. Definitions

A. "Adverse Action" means a denial or cancellation of, an increase in any charge for, or a reduction or other adverse or unfavorable change in the terms of coverage or amount of any insurance, existing or applied for, in connection with the underwriting of homeowners and personal lines residential property insurance.

B. "Claim" means a request to an insurer for payment of a benefit by an insured or third-party. A mere report of loss or a question relating to coverage shall not constitute a claim.

C. "Claims history report" means information provided by a claims history report provider to an insurer, insurance producer, or other authorized party regarding the claims history or loss experience of natural persons or properties, including reports generated from or by the APLUS Property Database and the Comprehensive Loss Underwriting Exchange (CLUE).

D. "Claims history report provider" means any person that regularly engages in the practice of assembling, collecting, or disseminating information regarding the individual claims history of natural persons or properties for the primary purpose of providing such information to insurers, insurance producers, or other authorized parties for underwriting or rating. Government institutions, insurers, and insurance producers shall not be considered "claims history report providers."

E. "Consumer" means an insured or an applicant for insurance coverage.

F. "Inquiry" means a telephone call and other communication made to an insurer regarding the terms, conditions, or coverage afforded under an insurance contract that does not result in a claim, including questions concerning whether a policy will cover a loss or the process for filing a claim. An "inquiry" under this Act shall not be considered a "claim" for purposes of [*insert reference to State Unfair Trade Practices Act*].

G. "Insurer" means an insurance company authorized to do business in this state.

Section 4. Use of Claims History Information Generally

A. An insurer that uses insurance claims history or loss experience information to underwrite or rate risks shall not deny, cancel or non-renew homeowners or personal lines residential property insurance coverage, or establish rates for such coverages, based solely on the claims history or loss experience of a previous owner of the property to be insured.

B. Failure of an insurer, within 30 days of binding coverage, to act upon the information contained in a claims history report shall preclude the insurer from declining homeowners or personal lines residential property insurance coverage or terminating a binder of such coverage based on that information. This subsection shall not apply if the insurer has commenced a further investigation, inspection, or other review of the property to be insured as a result of information contained in the report within the 30-day period and the investigation, inspection, or other review has not yet concluded. The requirements of this subsection shall also not apply to the renewal of an insurance policy.

C. When a consumer applies for homeowners or personal lines residential property insurance, an insurer may not consider or take an adverse action based upon information contained in a claims history report that is more than five (5) years old.

D. Notwithstanding subsections (A) and (B), an insurer may deny, cancel or non-renew homeowners or personal lines residential property insurance coverage, or establish rates for such coverages based on the known condition or use of the premises or due to fraudulent acts of the consumer

Section 5. Use of Inquiries and Other Information

A. An insurer shall not deny, cancel or non-renew homeowners or personal lines residential property insurance coverage, or establish insurance rates for such coverages, based in whole or in part on inquiries made by any consumer to an insurer.

B. An insurer shall not deny, cancel, or non-renew homeowners or personal lines residential property insurance coverage, or establish rates for such coverages, based in whole or in part on claims that have been closed without payment to or on behalf of an insured or third-party, unless 1) more than one such incident occurred within the previous three years or 2) the claim closed without payment affects the nature of the risk and is predictive of future loss.

C. Notwithstanding subsections (A) and (B), an insurer may deny, cancel or non-renew homeowners or personal lines residential property insurance coverage, or establish insurance rates for such coverages, based upon the known condition or use of the premises or due to fraudulent acts of the consumer.

Section 6. Dispute Resolution and Error Correction

If it is determined through the dispute resolution process set forth in the federal Fair Credit Reporting Act, 15 USC 1681i(a)(5), that the claims history information of an insured or property was incorrect or incomplete and if a homeowners and personal lines residential property insurer receives notice of such determination from either the consumer reporting agency or from the insured, the insurer shall re-underwrite and re-rate the consumer within 30 days of receiving the notice. After re-underwriting or re-rating the insured, the insurer shall make any adjustments necessary, consistent with its underwriting and rating guidelines. If an insurer determines that the insured has overpaid premium, the insurer shall refund to the insured the amount of overpayment calculated back to the shorter of either the last 12 months of coverage or the actual policy period.

Section 7. Disclosure to Insurance Consumers

A. If an insurer writing homeowners or personal lines residential property insurance uses claims history or loss experience in underwriting or rating, the insurer shall disclose, either on the insurance application or at the time the insurance application is taken, that it may obtain claims history or loss experience information in connection with such application. Such disclosure may be oral, written, or in electronic form. Such disclosure must explain the ways in which the insurer uses claims history or loss experience information, whether the claims history of the applicant and/or property to be insured will be reviewed, and whether future claims incurred by the applicant will be reported to a claims history report provider.

B. If a homeowners or personal lines residential property insurer takes an adverse action based upon the claims history report of a consumer or property, the insurer must meet the notice requirements of this subsection. Such insurer shall:

1. Provide notification to the consumer that an adverse action has been taken, in accordance with the requirements of the federal Fair Credit Reporting Act, if applicable.

2. Provide notification, upon request, to the consumer identifying the claim information that resulted in the adverse action. An insurer may comply with this paragraph by providing the requisite disclosure and claims information in any declination, nonrenewal, premium increase or surcharge, adverse action, or other notice required under other applicable law.

Section 8. Treatment of Certain Information

A. A homeowners or personal lines residential property insurer shall not disclose or submit to any claims history report provider or any other consumer reporting agency that an inquiry was made to the insurer by a consumer.

B. A claims history report provider shall not knowingly provide an insurer, insurance

producer, or any other person with a claims history report that discloses that an inquiry was made to an insurer by a consumer.

Section 9. Disclosures by Claims History Report Providers

A claims history report provider must disclose the codes, classifications, and guidelines utilized in its claims history reports to the Department of Insurance, upon request.

Section 10. Severability

If any section, paragraph, sentence, clause, phrase, or any part of this Act passed is declared invalid, the remaining sections, paragraphs, sentences, clauses, phrases, or parts thereof shall be in no manner affected and shall remain in full force and effect.

Section 11. Effective Date

This Act shall take effect on [*insert date*], applying to homeowners and personal lines residential property insurance policies either written to be effective or renewed on or after 9 months from the effective date of the bill.

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NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

State Flood Disaster Mitigation and Relief Model Act

Amended by the NCOIL Property-Casualty Insurance Committee on July 11, 2008, and Executive Committee on July 13, 2008.
Originally adopted by the NCOIL Property-Casualty Insurance and Executive Committees on November 21, 2003. Re-adopted by the NCOIL Property & Casualty Insurance Committee on July 12, 2019 and by the Executive Committee on July 13, 2019.

To be considered for re-adoption during the Property & Casualty Insurance Committee meeting on July 20, 2024.

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Section 1. Purpose

The legislature finds that unforeseen periodic flood disasters cause personal hardship and economic distress, requiring substantial disaster relief that strains limited state resources. In order to provide a sustainable system to provide disaster relief, the U.S. Congress has established the National Flood Insurance Program (NFIP), which provides flood insurance in conjunction with the private insurance industry. The legislature further finds the viability of this essential program requires the participation of state and local governments to mitigate the hazard and lower the magnitude of the potential disasters.

This Act develops a multifaceted state program of insurance producer and realtor education; local floodplain zoning; mandatory purchase of flood insurance by, and notification by lenders to, property owners in a floodplain; property owner self-certification of compliance; and other measures to improve floodplain management and hazard mitigation.

Section 2. Short Title

This act may be called the State Flood Disaster Mitigation and Relief Model Act.

PART I. FLOOD INSURANCE COVERAGE AND NOTICE

Sec. 1. Flood insurance purchase and compliance requirements and escrow accounts

(a) Requirement of State officers/agencies. After 60 days following the passage of this Act, no state officer or agency shall approve any financial assistance for acquisition or

construction purposes for use in any area that has been identified by the Director of the Federal Emergency Management Agency (FEMA) or designee as an area having special flood hazards and in which the sale of flood insurance has been made available under the National Flood Insurance Act, 42 U.S.C. Chapter 50, unless the building or mobile home and any personal property to which such financial assistance relates is covered by flood insurance in an amount at least equal to its development or project cost (less estimated land cost) or to the maximum limit of coverage made available with respect to the particular type of property under the National Flood Insurance Act, 42 U.S.C. Chapter 50, whichever is less. If the financial assistance provided is in the form of a loan or an insurance or guaranty of a loan, the amount of flood insurance required need not exceed the outstanding principal balance of the loan and need not be required beyond the term of the loan. The requirement of maintaining flood insurance shall apply during the life of the property, regardless of transfer of ownership of such property.

(b) Requirement for mortgage loans.

(1) Regulated lending institutions. Each [State entity for lending regulation] shall by regulation direct regulated lending institutions not to make, increase, extend, or renew any loan secured by improved real estate or a mobile home located or to be located in an area that has been identified by the Director as an area having special flood hazards and in which flood insurance has been made available under the National Flood Insurance Act, 42 U.S.C. Chapter 50, unless the building or mobile home and any personal property securing such loan is covered for the term of the loan by flood insurance in an amount at least equal to the outstanding principal balance of the loan or the maximum limit of coverage made available under the Act with respect to the particular type of property, whichever is less.

(2) Applicability

(A) Existing coverage. Except as provided in subdivision (b)(1), this subsection shall apply [three months] after the effective date of this Act.

(B) New coverage. This subsection shall apply only with respect to any loan made, increased, extended, or renewed after the expiration of the one-year period beginning [three months] after the effective date of this Act.

(3) Small loans. Notwithstanding any other provision of this Sec. 1, subsections (a) and (b) of this section shall not apply to any loan having

(A) an original outstanding principal balance of $5,000 or less; and

(B) a repayment term of one year or less.

(c) Escrow of flood insurance payments.

(1) Regulated lending institutions. Each [State entity for lending regulation] shall by regulation require that, if a regulated lending institution requires the escrowing of taxes, insurance premiums, fees, or any other charges for a loan secured by residential improved real estate or a mobile home, then all premiums and fees for flood insurance under the National Flood Insurance Act, 42 U.S.C. Chapter 50 for the real estate or mobile home shall be paid to the regulated lending institution or other servicer for the loan in a manner sufficient to make payments as due for the duration of the loan. Upon receipt of the premiums, the regulated lending institution or servicer of the loan shall deposit the premiums in an escrow account on behalf of the borrower. Upon receipt of a notice from the [State entity for

lending regulation] or the provider of the insurance that insurance premiums are due, the regulated lending institution or servicer shall pay from the escrow account to the provider of the insurance the amount of insurance premiums owed.

(2) “Residential improved real estate” defined. For purposes of this subsection, the term “residential improved real estate” means improved real estate for which the improvement is a residential building.

(3) Applicability. This subsection shall apply only with respect to any loan made, increased, extended, or renewed after [one year following the passage of this Act].

(d) Placement of flood insurance by lender.

(1) Notification to borrower of lack of coverage. If, at the time of origination or at any time during the term of a loan secured by improved real estate or by a mobile home located in an area that has been identified by the Director (at the time of the origination of the loan or at any time during the term of the loan) as an area having special flood hazards and in which flood insurance is available under the National Flood Insurance Act, 42 U.S.C. Chapter 50, the lender or servicer for the loan determines that the building or mobile home and any personal property securing the loan is not covered by flood insurance or is covered by such insurance in an amount less than the amount required for the property pursuant to subdivision (b)(1), (2), or (3) of this Sec. 1, the lender or servicer shall notify the borrower under the loan that the borrower should obtain, at the borrower's expense, an amount of flood insurance for the building or mobile home and such personal property that is not less than the amount under subdivision (b)(1) of this Sec.1, for the term of the loan.

(2) Purchase of coverage on behalf of borrower. If the borrower fails to purchase such flood insurance within 45 days after notification under subdivision (d)(1), the lender or servicer for the loan shall purchase the insurance on behalf of the borrower and may charge the borrower for the cost of premiums and fees incurred by the lender or servicer for the loan in purchasing the insurance.

(3) Review of determination regarding required purchase.

(A) In general. The borrower and lender for a loan secured by improved real estate or a mobile home may jointly request the Director to review a determination of whether the building or mobile home is located in an area having special flood hazards. Such request shall be supported by technical information relating to the improved real estate or mobile home. Not later than 45 days after the Director receives the request, the Director shall review the determination and provide to the borrower and the lender a letter stating whether or not the building or mobile home is in an area having special flood hazards. The determination of the Director shall be final.

(B) Effect of determination. Any person to whom a borrower provides a letter issued by the Director pursuant to subdivision (d)(3)(A), stating that the building or mobile home securing the loan of the borrower is not in an area having special flood hazards, shall have no obligation under this title to require the purchase of flood insurance for such building or mobile home during the period determined by the Director, which shall be

specified in the letter and shall begin on the date on which such letter is provided.

(C) Effect of failure to respond. If a request under subdivision (d)(3)(A) is made in connection with the origination of a loan and the Director fails to provide a letter under subdivision (d)(3)(A) before the later of either (i) the expiration of the 45-day period under such subdivision, or (ii) the closing of the loan, no person shall have an obligation under this title to require the purchase of flood insurance for the building or mobile home securing the loan until such letter is provided.

(4) Applicability. This subsection (d) shall apply to all loans outstanding on or after [three months following the passage of this Act].

(e) Civil monetary penalties for failure to require flood insurance or to notify.

(1) Civil monetary penalties against regulated lenders. Any regulated lending institution that is found to have a pattern or practice of committing violations under subdivision (e)(2) (below) shall be assessed a civil penalty by the [appropriate State entity for lending regulation] in the amount provided under subdivision (e)(4) (below).

(2) Lender violations. The violations referred to in subdivision (e)(1) shall include:

(A) making, increasing, extending, or renewing loans in violation of:

(i) the regulations issued pursuant to subsection (b) of this Sec. 1;

(ii) the escrow requirements under subsection (c) of this Sec. 1; or

(iii) the notice requirements under Sec. 2 of this Part (below); or

(B) failure to provide notice or purchase flood insurance coverage in violation of subsection (e) of this section.

(3) Notice and hearing. A penalty under this subsection (e) may be issued only after notice and an opportunity for a hearing on the record.

(4) Amount. A civil monetary penalty under this subsection may not exceed $350 for each violation cited under subdivision (e)(2). The total amount of penalties assessed under this subsection against any single regulated lending institution or enterprise during any calendar year may not exceed $100,000.

(5) Lender compliance. Notwithstanding any State or local law, for purposes of this subsection (e), any regulated lending institution that purchases flood insurance or renews a contract for flood insurance on behalf of or as an agent of a borrower of a loan for which flood insurance is required shall be considered to have complied with the regulations issued under subsection (b) of this Sec. 1.

(6) Effect of transfer on liability. Any sale or other transfer of a loan by a regulated lending institution that has committed a violation under subdivision (e)(1), which occurs subsequent to the violation, shall not affect the liability of the transferring lender with respect to any penalty under this subsection. A lender shall not be liable for any violations relating to a loan committed by another regulated lending institution that previously held the loan.

(7) Deposit of penalties. Any penalties collected under this subsection shall be paid into the Hazard Mitigation and Floodplain Management Account established in Sec. 4 of Part III of this Act. [Drafting note: This money could be targeted for floodplain mapping.]

(8) Additional penalties. Any penalty under this subsection shall be in addition to any civil remedy or criminal penalty otherwise available.

(9) Statute of limitations. No penalty may be imposed under this subsection after the expiration of the [four-year period] beginning on the date of the occurrence of the violation for which the penalty is authorized under this subsection.

(f) Other actions to remedy pattern of noncompliance.

(1) Authority of State entities for lending regulation. A [State entity for lending] regulation may require a regulated lending institution to take such remedial actions as are necessary to ensure that the regulated lending institution complies with the requirements of the National Flood Insurance Program if the State agency for lending regulation makes a determination under subdivision (f)(2) (below) regarding the regulated lending institution.

(2) Determination of violations. A determination under this subdivision shall be a finding that:

(A) the regulated lending institution has engaged in a pattern and practice of noncompliance in violation of the regulations issued pursuant to subsection (b), (c), or (d) of this Sec. 1 or the notice requirements under Sec. 2 of this Part; and

(B) the regulated lending institution has not demonstrated measurable improvement in compliance despite the assessment of civil monetary penalties under subsection (e) of this Sec. 1.

(g) Fee for determining location. Notwithstanding any other Federal or State law, any person who makes a loan secured by improved real estate or a mobile home or any servicer for such a loan may charge a reasonable fee for the costs of determining whether the building or mobile home securing the loan is located in an area having special flood hazards, but only in accordance with the following requirements:

(1) Borrower fee. The borrower under such a loan may be charged the fee, but only if the determination:

(A) is made pursuant to the making, increasing, extending, or renewing of the loan that is initiated by the borrower;

(B) is made pursuant to a revision or updating under 42 U.S.C. 4101(f) of the floodplain areas and flood-risk zones or publication of a notice or compendia under subsection (h) or (i) of 42 U.S.C. 4101(h) or (i) that affects the area in which the improved real estate or mobile home securing the loan is located or that, in the determination of the Director, may reasonably be considered to require a determination under this subsection; or

(C) results in the purchase of flood insurance coverage pursuant to the requirement under subdivision (d)(2) of this Sec. 1.

(2) Purchaser or transferee fee. The purchaser or transferee of such a loan may be charged the fee in the case of sale or transfer of the loan.

Sec. 2. Notice requirements

(a) Notification of special flood hazards.

(1) Regulated lending institutions. Each [State entity for lending regulation] shall by regulation require regulated lending institutions, as a condition of making, increasing, extending, or renewing any loan secured by improved real estate or a mobile home that the regulated lending institution determines is located or is to

be located in an area that has been identified by the Director under 42 U.S.C. Chapter 50 as an area having special flood hazards, to notify the purchaser or lessee (or to obtain satisfactory assurances that the seller or lessor has notified the purchaser or lessee) and the servicer of the loan of such special flood hazards, in writing, a reasonable period in advance of the signing of the purchase agreement, lease, or other documents involved in the transaction. The regulations also shall require that the regulated lending institution retain a record of the receipt of the notices by the purchaser or lessee and the servicer.

(2) Contents of notice. Written notification required under this subsection (a) shall include:

(A) a warning, in a form to be established by the [State entity for lending regulation], stating that the building on the improved real estate securing the loan is located, or the mobile home securing the loan is or is to be located, in an area having special flood hazards;

(B) a description of the flood insurance purchase requirements under section 102(b) of the Flood Disaster Protection Act, 42 U.S.C. Chapter 50;

(C) a statement that flood insurance coverage may be purchased under the National Flood Insurance Program and also is available from private insurers; and

(D) any other information that the [State entity for lending regulation] considers necessary to carry out the purposes of the National Flood Insurance Program.

(b) Notification of change of servicer.

(1) Lending institutions. Each [State entity for lending regulation] shall by regulation require regulated lending institutions, in connection with the making, increasing, extending, renewing, selling, or transferring any loan described in subdivision (b)(1) of this Sec. 1, to notify, in writing, the [State entity for lending regulation] of the servicer of the loan during the term of the loan. Such institutions shall also notify the [State entity for lending regulation] of any change in the servicer of the loan, not later than 60 days after the effective date of such change. The regulations under this subsection shall provide that, upon any change in the servicing of a loan, the duty to provide notification under this subsection shall transfer to the transferee servicer of the loan.

(c) Notification of expiration of insurance. The [State entity for lending regulation] shall, not less than 45 days before the expiration of any contract for flood insurance under this chapter, issue notice of such expiration by first-class mail to the owner of the property covered by the contract, the servicer of any loan secured by the property covered by the contract, and (if known to the [State entity for lending regulation]) the owner of the loan.

Sec. 3. Rules; report

(a) The [State entity for lending regulation] is authorized to adopt rules to implement this Part I.

(b) The [State entity for lending regulation] shall submit a report to the legislature on the implementation of this Part I and on compliance with the rules one year after passage.

PART II. FLOODPLAIN REGULATION

Sec. 1. Purposes

The purposes of this Part are to:

(1) Minimize the extent of floods by preventing obstructions that inhibit water flow and increase flood height and damage.

(2) Prevent and minimize loss of life, injuries, property damage, and other losses in flood hazard areas.

(3) Promote the public health, safety, and welfare of citizens of the State in flood hazard areas.

Sec. 2. Definitions

(a) As used in this Part:

(1) “Agency” means the state agency in charge of floodplain regulation
(2) “Artificial obstruction” means any obstruction to the flow of water in a stream that is not a natural obstruction, including any that, while not a significant obstruction in itself, is capable of accumulating debris and thereby reducing the flood-carrying capacity of the stream.
(3) “Base flood” or “100-year flood” means a flood that has a one percent (1%) chance of being equaled or exceeded in any given year. The term “base flood” is used in the National Flood Insurance Program to indicate the minimum level of flooding to be addressed by a community in its floodplain management regulations.
(4) “Base floodplain” or “100-year floodplain” means that area subject to a one percent (1%) or greater chance of flooding in any given year, as shown on the current floodplain maps prepared pursuant to the National Flood Insurance Program or approved by the Agency.
(5) “Flood hazard area” means the area designated by a local government, pursuant to this Part, as an area where development must be regulated to prevent damage from flooding. The flood hazard area must include and may exceed the base floodplain.
(6) “Local government” means any county or city.
(7) “Lowest floor,” when used in reference to a structure, means the lowest enclosed area, including a basement, of the structure. An unfinished or flood-resistant enclosed area, other than a basement, that is usable solely for parking vehicles, building access, or storage is not a lowest floor.
(8) “Natural obstruction” includes any rock, tree, gravel, or other natural matter that is an obstruction and has been located within the 100-year floodplain by a nonhuman cause.
(9) “Secretary” means the Secretary of the Agency.
(10) “Stream” means a watercourse that collects surface runoff from an area of one square mile or greater.
(11) “Structure” means a walled or roofed building, including a mobile home and a gas or liquid storage tank.

(b) As used in this Part, the terms "artificial obstruction" and "structure" do not include any of the following:

(1) An electric generation, distribution, or transmission facility.

(2) A gas pipeline or gas transmission or distribution facility, including a compressor station or related facility.

(3) A water treatment or distribution facility, including a pump station.

(4) A wastewater collection or treatment facility, including a lift station.

(5) Processing equipment used in connection with a mining operation.

Sec. 3. Regulation of flood hazard areas; prohibited uses

(a) Powers of local government. A local government may adopt ordinances to regulate uses in flood hazard areas and may grant permits for the use of flood hazard areas that are consistent with the requirements of this Part II.

(b) Allowable uses. The following uses may be made of flood hazard areas without a permit issued under this Part, provided that these uses comply with local land-use ordinances and any other applicable laws or regulations:

(1) General farming, pasture, outdoor plant nurseries, horticulture, forestry, mining, wildlife sanctuary, game farm, and other similar agricultural, wildlife, and related uses;

(2) Ground-level loading areas, parking areas, rotary aircraft ports and other similar ground-level area uses;

(3) Lawns, gardens, play areas and other similar uses;

(4) Golf courses, tennis courts, driving ranges, archery ranges, picnic grounds, parks, hiking or horseback riding trails, open space, and other similar private and public recreational uses.

(5) Land application of waste at agronomic rates consistent with an approved animal waste–management plan.

(6) Land application of septage consistent with a permit issued by the State permit authority.

(c) Prohibited uses. New solid waste disposal facilities, hazardous waste management facilities, salvage yards, and chemical storage facilities are prohibited in the 100-year floodplain except at authorized under Sec. 4(b) (below).

Sec. 4. Minimum standards for ordinances; variances for prohibited uses

(a) A flood-hazard prevention ordinance adopted by a county or city pursuant to this Part shall, at a minimum:

(1) Meet the requirements for participation in the National Flood Insurance Program and of this Sec. 4.

(2) Prohibit new solid waste disposal facilities, hazardous waste management facilities, salvage yards, and chemical storage facilities in the 100-year floodplain except as authorized under subsection (b) of this Sec. 4.

(3) Provide that a structure or tank for chemical or fuel storage incidental to a use that is allowed under this Sec. 4 or to the operation of a water treatment plant or wastewater treatment facility may be located in a 100-year floodplain only if the

structure or tank is either elevated above base-flood elevation or designed to be watertight with walls substantially impermeable to the passage of water and with structural components capable of resisting hydrostatic and hydrodynamic loads and the effects of buoyancy.

(b) Variances. A flood-hazard prevention ordinance may include a procedure for granting variances for uses prohibited under Sec. 3(c). A county or city shall notify the Secretary of its intention to grant a variance at least 30 days prior to granting the variance. A county or city may grant a variance upon finding that all of the following apply:

(1) The use serves a critical need in the community.

(2) No feasible location exists for the location of the use outside the 100-year floodplain.

(3) The lowest floor of any structure is elevated above the base-flood elevation or is designed to be watertight with walls substantially impermeable to the passage of water and with structural components capable of resisting hydrostatic and hydrodynamic loads and the effects of buoyancy.

(4) The use complies with all other applicable laws and regulations.

Sec. 5. Acquisition of existing structures

A local government may acquire, by purchase, exchange, or condemnation an existing structure located in a flood hazard area in the area regulated by the local government if the local government determines that the acquisition is necessary to prevent damage from flooding. The procedure in all condemnation proceedings pursuant to this Sec. 5 shall conform as nearly as possible to the procedure provided in [State statute reference].

Sec. 6. Delineation of flood hazard areas and 100-year floodplains; powers of the Agency; powers of local governments and of the Agency

(a) Use of additional resources. For the purpose of delineating a flood hazard area and evaluating the possibility of flood damages, a local government may:

(1) Request technical assistance from the competent State and federal agencies, including the Army Corps. of Engineers, the Natural Resources Conservation Service, the Federal Emergency Management Agency (FEMA), the Department of Public Safety, and the U.S. Geological Survey, or successor agencies.

(2) Utilize the reports and data supplied by federal and state agencies as the basis for the exercise by local ordinance or resolution of the powers and responsibilities conferred on responsible local governments by this Part II.

(b) Powers of the Agency. The Agency shall provide advice and assistance to any local government having responsibilities under this Part. In exercising this function, the Agency may furnish manuals, suggested standards, plans, and other technical data; conduct training programs; give advice and assistance with respect to delineation of flood hazard areas and the development of appropriate ordinances; and provide any other advice and assistance that the Agency deems appropriate. The Agency shall send a copy of every rule adopted to implement this Part to the governing body of each local government in the State.

(c) Delineation using maps and descriptions. A local government may delineate any flood hazard area subject to its regulation by showing it on a map or drawing, by a written description, or any combination thereof, to be designated appropriately and filed permanently with the clerk of superior court and with the register of deeds in the county where the land lies. A local government also may delineate a flood hazard area by reference to a map prepared pursuant to the National Flood Insurance Program. Alterations in the lines delineated shall be indicated by appropriate entries upon or addition to the appropriate map, drawing, or description. Entries or additions shall be made by or under the direction of the clerk of superior court. Photographic, typed, or other copies of the map, drawing, or description, certified by the clerk of superior court, shall be admitted in evidence in all courts and shall have the same force and effect as would the original map or description. A local government may provide for the redrawing of any map. A redrawn map shall supersede for all purposes the earlier map or maps that it is designated to replace upon the filing and approval thereof as designated and provided above.

(d) Preparation of maps. The Agency may prepare a floodplain map that identifies the 100- year floodplain and base-flood elevations for an area for the purposes of this Part II if all of the following conditions apply:

(1) The 100-year floodplain and base-flood elevations for the area are not identified on a floodplain map prepared pursuant to the National Flood Insurance Program within the previous five years.

(2) The Agency determines that the 100-year floodplain and the base-flood elevations for the area need to be identified and the use of the area regulated in accordance with the requirements of this Part II in order to prevent damage from flooding.

(3) The Agency prepares the floodplain map in accordance with the federal standards required for maps to be accepted for use in administering the National Flood Insurance Program.

(e) Notice. Prior to preparing a floodplain map pursuant to subsection (d) of this Sec. 6, the Agency shall advise each local government whose jurisdiction includes a portion of the area to be mapped.

(f) Upon completing a floodplain map pursuant to subsection (d) of this Sec. 6, the Agency shall both:

(1) Provide copies of the floodplain map to every local government whose jurisdiction includes a portion of the 100-year floodplain identified on the floodplain map.

(2) Submit the floodplain map to the Federal Emergency Management Agency for approval for use in administering the National Flood Insurance Program.

(g) Responsibility upon approval of map. Upon approval by the Federal Emergency Management Agency of a floodplain map prepared pursuant to subsection (d) of this Sec. 6 for use in administering the National Flood Insurance Program, it shall be the responsibility of each local government whose jurisdiction includes a portion of the 100-year floodplain identified in the floodplain map to incorporate the revised map into its floodplain ordinance.

Sec. 7. Procedures in issuing permits

(a) Considerations. A local government may establish application forms and require maps, plans, and other information necessary for the issuance of permits in a manner consonant with the objectives of this Part II. For this purpose a local government may take into account anticipated development in the foreseeable future that may be adversely affected by the obstruction, as well as existing development. A local government shall consider the danger that a proposed artificial obstruction in a stream may pose to life and property by:

(1) Water that may be backed up or diverted by the obstruction.

(2) The danger that the obstruction will be swept downstream to the injury of others.

(3) The injury or damage at the site of the obstruction itself.

(b) Ordinances. In prescribing standards and requirements for the issuance of permits under this Part II and in issuing permits, local governments shall enact ordinances.

(c) Issuance of permits. The local governing body is hereby empowered to adopt regulations it may deem necessary concerning the form, time, and manner of submission of applications for permits under this Part II. These regulations may provide for the issuance of permits under this Part by the local [governing body], as prescribed by the governing body. Every final decision granting or denying a permit under this Part shall be subject to review by the superior court of the county, with the right of jury trial at the election of the party seeking review. Pending the final disposition of an appeal, no action shall be taken that would be unlawful in the absence of a permit issued under this Part.

Sec. 8. Violations and penalties

(a) Violations. Any willful violation of this Part II or of any ordinance adopted (or of the provisions of any permit issued) under the authority of this Part shall constitute a [indicate level of crime] misdemeanor.

(1) A local government may use all of the remedies available for the enforcement of ordinances to enforce an ordinance adopted pursuant to this Part II.

(b) Failure to remedy. Failure to remove any artificial obstruction or enlargement or replacement thereof, that violates this Part or any ordinance adopted (or the provision of any permit issued) under the authority of this Part, shall constitute a separate violation of this Part for each day that the failure continues after written notice from the county board of commissioners or governing body of a city.

(c) Other proceedings. In addition to or in lieu of other remedies, the local governing body may institute any appropriate action or proceeding to restrain or prevent any violation of this Part II or of any ordinance adopted (or of the provisions of any permit issued) under the authority of this Part, or to require any person, firm, or corporation that has committed a violation to remove a violating obstruction or restore the conditions existing before the placement of the obstruction.

Sec. 9. Other approvals required

(a) Approvals required under separate statutes. The granting of a permit under the provisions of this Part II shall in no way affect any other type of approval required by any other statute or ordinance of the State or any political subdivision of the State, or of the United States, but shall be construed as an added requirement.

(b) Permits for construction. No permit for the construction of any structure to be located within a flood-hazard area shall be granted by a political subdivision unless the applicant has first obtained the permit required by any local ordinance adopted pursuant to this Part.

Sec. 10. Floodplain management

The provisions of this Part II shall not preclude the imposition by responsible local governments of land-use controls and other regulations in the interest of floodplain management for the 100-year floodplain.

PART III. FLOODPLAIN MANAGEMENT AND HAZARD MITIGATION

Sec. 1. Zoning restrictions in floodplain

(a) Definition. As used in this Sec. 1, “floodplain” means that area of a municipality located within the real or theoretical limits of the base flood or base flood for a critical activity, as determined by the Federal Emergency Management Agency in its flood insurance study or flood insurance–rate map for the municipality, prepared pursuant to the National Flood Insurance Program (44 C.F.R. Part 59 et seq.).

(b) Restrictions upon revising zoning requirements. Whenever a municipality, pursuant to the National Flood Insurance Program (44 C.F.R. Part 59 et seq.), is required to revise its zoning regulation or any other ordinance regulating a proposed building, structure, development, or use located in a floodplain, the revision shall provide for restrictions for flood storage and conveyance of water for floodplains that are not tidally influenced as follows:

(1) Within a designated floodplain, all encroachments (including fill, new construction, substantial improvements to existing structures, and any other development) are prohibited unless the applicant provides certification to the commission by a registered professional engineer that such encroachment shall not result in any increase in base-flood elevation;

(2) The water-holding capacity of the floodplain shall (A) not be reduced by any form of development unless such reduction is compensated for by deepening or widening the floodplain, (B) be on-site, unless adjacent property owners grant easements, (C) be within the same hydraulic reach and a volume not previously used for flood storage, (D) be hydraulically comparable and incrementally equal to the theoretical volume of flood water at each elevation, up to and including the 100-year flood elevation, which would be displaced by the proposed project, and (E) have an unrestricted hydraulic connection to the same waterway or water body; and

(3) Any work within adjacent land subject to flooding, including work to provide

compensatory storage, shall not restrict flows resulting in increased flood stage or velocity.

(c) Additional restrictions. Notwithstanding the provisions of subsection (b) of this Sec. 1, a municipality may adopt more stringent restrictions for flood storage and conveyance of water for floodplains that are not tidally influenced.

Sec. 2. Creation of plan by Secretary

The Secretary of the [State agency in charge of flood regulations], after consultation with all appropriate State, regional and local agencies and other appropriate persons shall, prior to [set date], (1) complete a revision of the existing plan and enlarge it to include policies relating to risks associated with natural hazards, including, but not limited to, flooding, high winds, and wildfires; (2) identify the potential impacts of natural hazards on infrastructure and property; and (3) make recommendations for the siting of future infrastructure and property development to minimize the use of areas prone to natural hazards, including, but not limited to, flooding, high winds, and wildfires.

Sec. 3. Plan of conservation and development

At least once every ten years, the [local entity in charge of planning] shall prepare or amend and shall adopt a plan of conservation and development for the municipality. Following adoption, the [local entity in charge of planning] shall regularly review and maintain such plan. The [local entity in charge of planning] may adopt such geographical, functional, or other amendments to the plan or parts of the plan, in accordance with the provisions of this Sec. 3, as it deems necessary. The [local entity in charge of planning] may, at any time, prepare, amend, and adopt plans for the redevelopment and improvement of districts or neighborhoods that, in its judgment, contain special problems or opportunities or show a trend toward lower land values. The [local entity in charge of planning] shall identify the potential impacts of natural hazards on infrastructure and property and shall prepare, adopt, and amend plans for the siting of future infrastructure and property development to minimize the use of areas prone to natural hazards, including, but not limited to, flooding, high winds, and wildfires.

Sec. 4. Hazard mitigation and floodplain management account

(a) General. There is established an account to be known as the “Hazard Mitigation and Floodplain Management Account.” Any balance remaining in the account at the end of any fiscal year shall be carried forward in the account for the fiscal year next succeeding. The account shall be available to the [State entity in charge of environmental protection] for the purposes of Sec.s 3 to 7, inclusive, of this Part III.

(b) Funding. The State shall increase the fee for land use permits [or similar fee] and dedicate proceeds of the increase to the Hazard Mitigation and Floodplain Management Account.

Sec. 5. Definitions

As used in Sec.s 6 to 9, inclusive, of this Part III:

(a) “Hazard mitigation” means activities that include, but are not limited to, actions taken to reduce or eliminate long-term risk to human life, infrastructure, and property resulting from natural hazards including, but not limited to, flooding, high winds, and wildfires; and

(b) “Floodplain management” means activities that include, but are not limited to, actions taken to retain the existing capacity of designated floodplain areas to store and convey flood waters.

Sec. 6. Hazard mitigation and floodplain management grant program

(a) Purposes and applications. The [State entity in charge of environmental protection] shall establish and administer a hazard mitigation and floodplain management grant program to reimburse municipalities for costs incurred in the reduction or elimination of long-term risks to human life, infrastructure and property from natural hazards, including, but not limited to, flooding, high winds and wildfires, and in the retention of present capacity of designated floodplain areas to store and convey flood waters. Application for a grant shall be made in writing to the commissioner in such form as the [State entity] may prescribe and shall include a description of the purpose, objectives, and budget of the activities to be funded by the grant. The chief executive officer of the municipality applying for the grant may designate the town planner, director of public works, police chief, fire chief, or emergency management director as the agent to make the application.

(b) Awarding of grants; notice of program. The [State entity in charge of environmental protection] shall establish, by rules, relative priorities for the approval of grants under this Sec. 6. Such priorities may take into account the differing needs of municipalities, the need for consistency and equity in the distribution of grant awards, and the extent to which particular projects may advance the purposes of this section. The [State entity] may establish further criteria for the approval of grants under this Sec. 6 and shall develop and disseminate a pamphlet that describes the evaluation process for grant applications. In awarding grants under this section, the [State entity] shall consult with any person the commissioner deems necessary.

(c) Allocation of moneys. The [State entity] shall allocate not less than 60 percent of the moneys in the Hazard Mitigation and Floodplain Management Account in any fiscal year for grants under this section.

Sec. 7. Grants to municipalities for planning

(a) Effective date. On and after [insert date], the [State entity in charge of environmental protection] shall make grants to municipalities from the Hazard Mitigation and Floodplain Management Account, established under Sec. 4 of Part III of this Act, for hazard mitigation and floodplain management.

(b) Conditions of repayment. If the [State entity] finds that any grant awarded pursuant to this section is being used for other purposes or to supplant a previous source of funds, the commissioner may require repayment.

(c) Specific purposes. The [State entity] shall allocate moneys in the Hazard Mitigation and Floodplain Management Account, established under Sec. 4 of Part III of this Act, for (1) the preparation or revision of hazard mitigation plans by municipalities; (2) the preparation or revision of municipal plans of conservation and development that include the identification of the potential impacts of natural hazards, including, but not limited to, flooding, high winds, and wildfires; (3) reimbursement of costs associated with participation in the community rating system of the National Flood Insurance Program; (4) the execution of hazard mitigation projects by municipalities in accordance with approved hazard mitigation plans; and (5) costs for administering and providing financial assistance for the hazard mitigation and floodplain management grant program established under Sec. 6 of Part III of this Act.

(d) Submission of report. Annually, the [State entity] shall submit a report describing the activities performed with the allocated moneys for the preceding fiscal year to the joint standing committees of the General Assembly having cognizance of matters relating to planning and development and the environment.

Sec. 8. Municipal report

(a) Each municipality that receives a grant from the Hazard Mitigation and Floodplain Management Account, established under Sec. 4 of Part III of this Act, shall submit a report to the [State entity in charge of environmental protection], in such form as the [State entity] prescribes, not later than September first of the fiscal year following the year such grant was received. Such report shall contain a description of activities paid for with financial assistance under the grant. The chief executive officer of a municipality that receives a grant from the Hazard Mitigation and Floodplain Management Account may designate the town planner, director of public works, police chief, fire chief, or emergency management director of that municipality as the agent to make such report.

(b) Report of [State entity in charge of environmental protection]. On or before [insert date], and annually thereafter, the [State entity in charge of environmental protection] shall submit a report on grants made under Sec.s 6 and 7 of Part III of this Act for the preceding fiscal year to the joint standing committees of the General Assembly having cognizance of matters relating to planning and development and the environment. Each such report shall include: (1) a description of the grants made, including the amount, purposes, and the municipalities to which they were made; (2) a summary of the activities for which the Department of Environmental Protection used the moneys allocated to it under Sec. 6 of Part III of this Act; and (3) any findings or recommendations concerning the operation and effectiveness of the grant program.

Sec. 9. Model ordinance

The [State entity in charge of environmental protection] shall develop guidelines to be used by municipalities in revising ordinances restricting flood storage and conveyance of water for floodplains that are not tidally influenced. Such guidelines shall include, but not be limited to, a model ordinance that may be used by municipalities to comply with the provisions of Sec. 1 of this Part III. The commissioner shall make the guidelines available to the public.

Sec. 10. Regulations

The [State entity in charge of environmental protection] shall adopt regulations to implement the provisions of this Part III.

PART IV. MISCELLANEOUS PROVISIONS REGARDING PARTICIPATION

Sec. 1. Insurance producer qualification; continuing education

The [State entity for regulating insurance] shall require:

(1) Pre-licensing requirement. The [State entity for regulating insurance] shall require all resident insurance producer applicants to demonstrate satisfactory knowledge and understanding of flood insurance and the National Flood Insurance Program, as determined by the [State entity for regulating insurance] in order to qualify for licensure.

(2) Continuing education requirement for existing licensees. The [State entity for regulating insurance] shall require resident insurance producers licensed on [the bill's effective date] to complete a basic or advanced continuing education course related to flood insurance and the National Flood Insurance Program before [a date certain at least two years from the bill's effective date]. The course may be online or instructor-led and shall be approved by the [State entity for regulating insurance]. Completion of the course will provide the licensee with continuing education credits as determined by the [State entity for regulating insurance].

Sec. 2. Insurance adjuster qualification; education

The [State entity for regulating insurance] shall require:

(1) Insurance-adjuster license applicants to demonstrate satisfactory knowledge and understanding of flood insurance, as determined by the [State entity for regulating insurance], in order to qualify; and
(2) An applicant for an insurance-adjuster license renewal to complete at least two hours of continuing educational programs in flood insurance every two years.

Sec. 3. Real estate broker and salesperson qualification; education

The [State entity for regulating the licensing of real estate brokers and salespersons] shall require:

(1) applicants for real-estate broker or salesperson licensing to demonstrate satisfactory knowledge and understanding of flood insurance, as determined by the [State entity for regulating the licensing of real estate brokers and salespersons], in order to qualify; and
(2) an applicant for real-estate broker or salesperson license renewal to complete at least two hours of continuing educational programs in flood insurance every two years.

Sec. 4. Disclosure of real estate flood propensity

The [State entity in charge of consumer protection or the State Real Estate Commission, as the case may be] shall, by regulations, require a written residential disclosure report to be provided to a real estate buyer that is to include information concerning flood propensity. [If a state already has a required form for disclosure, this provision could be added to it.]

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EXECUTIVE COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
EXECUTIVE COMMITTEE
2024 NCOIL SPRING MEETING – NASHVILLE, TN
APRIL 14, 2024
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Executive Committee met at the Sheraton Grand Nashville Downtown Hotel in Nashville, TN on Sunday April 14, 2024 at 10:45 AM (CST).

NCOIL President, Representative Tom Oliverson, M.D. (TX), Chair of the Committee, presided.

Other members of the committee present:

Rep. Deborah Ferguson, DDS (AR)
Rep. Matt Lehman (IN)
Rep. Michael "Sarge" Pollock (KY)
Rep. Edmond Jordan (LA)
Rep. David LeBoeuf (MA)
Sen. Paul Utke (MN)
Sen. Bob Hackett (OH)
Sen. George Lang (OH)
Rep. Forrest Bennett (OK)
Rep. Jim Dunnigan (UT)

Other legislators present were:

Sen. Justin Boyd (AR)
Sen. Michael Webber (MI)
Rep. Nelly Nicol (MT)
Sen. Natasha Marcus (NC)
Rep. Brian Lampton (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. Michael "Sarge" Pollock (KY), and seconded by Rep. Deborah Ferguson, DDS (AR), NCOIL Immediate Past President, the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a motion made by Sen. George Lang (OH) and seconded by Rep. Forrest Bennett (OK) the Committee voted without objection by way of a voice vote to approve the minutes of the Committee's November 18, 2023 meeting in Columbus, OH.

FUTURE MEETING LOCATIONS

Rep. Oliverson stated that looking ahead to the rest of 2024, the Summer Meeting will be in Costa Mesa, CA from July 17th-20th and the Annual Meeting will be in San Antonio, TX from November 21st – 24th. The Annual Meeting will also start with the 3rd Annual NCOIL Open Golf Outing to benefit the Insurance Legislators Foundation (ILF) Scholarship Fund. For 2025, the Spring Meeting will be in Charleston, SC from April 24th – 27th, the Summer Meeting will be in Chicago, IL from July 16th – 19th, and the Annual Meeting will be in Atlanta, GA from November 12th – 15th.

ADMINISTRATION

Will Melofchik, NCOIL General Counsel, stated that there were 367 total registrants for the Spring Meeting including 73 legislators from 31 states and of that number there were 17 first time attendee legislators from 13 states. Additionally, 8 Insurance Commissioners participated with 16 total insurance departments represented.

Mr. Melofchik gave the 2024 unaudited financials through March 31st showing revenue of $263,329 and expenses of $167,966 leading to a surplus of $95,363. He also stated that while a non-profit, particularly one the size of NCOIL is not covered by auditor rotation requirements, NCOIL did solicit a bid for a new auditor as it's a best practice and one firm, EisnerAmper, submitted a competitive bid and we retained them for the 2023 NCOIL & ILF audits.

CONSENT CALENDAR

Rep. Oliverson 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 Joint State-Federal Relations & International Insurance Issues Committee adopted a Resolution Reaffirming Support for the U.S. State Based System of Insurance Regulation in Response to Growing Federal Encroachment.

- The Life Insurance & Financial Planning Committee re-adopted the NCOIL Model Unclaimed Life Insurance Benefits Act, for the full 5 year cycle, and re-adopted the NCOIL Life Settlements Model Act until the next NCOIL Meeting in July while proposed amendments to the Model are discussed and developed.

- The Health Insurance & Long Term Care Issues Committee adopted the NCOIL Medical Loss Ratios for Dental (DLR) Health Care Services Plans Model Act, and re-adopted the NCOIL Healthcare Cost Transparency Model Act, with a technical amendment, for the full 5 year cycle.

- The Property & Casualty Insurance Committee adopted the NCOIL Public Adjuster Professional Standards Reform Model Law.

- The Audit Committee agreed to retain EisnerAmper for the 2023 audits of NCOIL and ILF.

Rep. Oliverson asked if any Committee member wanted anything removed from the consent calendar. Hearing no such requests, upon a motion made by Rep. David LeBoeuf (MA) and seconded by Rep. Ferguson, the Committee voted to adopt the consent calendar without objection by way of a voice vote.

NEW EXECUTIVE COMMITTEE MEMBERS

Rep. Oliverson 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. Bill Sutton (KS), Chair of the Kansas House Insurance Committee, and Rep. Brian Lampton (OH), Chair of the Ohio House Insurance Committee, should be added to the NCOIL Executive Committee.

Rep. Oliverson then asked if anyone else would like to make any nominations to the Executive Committee.

Rep. Ferguson stated she would like to nominate Sen. Justin Boyd (AR).

Rep. Matt Lehman (IN) stated he would like to nominate Sen. Michael Webber (MI).

Upon a motion made by Rep. Ferguson and seconded by Rep. Lehman, the Committee voted without objection by way of a voice vote to add Rep. Sutton, Rep. Lampton, Sen. Boyd, and Sen. Webber to the Executive Committee.

OTHER SESSIONS

Rep. Oliverson stated that the Institutes Griffith Foundation held a legislator luncheon during which Jim Hilliard, Associate Professor of Instruction at the Fox School of Business at Temple University gave a great presentation titled “Reinsurance: Exploring Fundamentals & Considering Linkages to Insurance Pricing.” The Institutes Griffth Foundation also hosted a legislator breakfast during which Bryant Walker Smith, Associate Professor at the University of South Carolina School of Law gave an interesting presentation titled “Autonomous Vehicles: Evolution and Impact on Insurance Frameworks.”

There were also two interesting and timely general sessions including: “The Latest on Weight Loss Drugs: A Discussion on Access, Cost, and Coverage”, and “Affordability and Availability Crises in the Auto and Home Insurance Markets: How Did We Get Here and How Do We Fix It?”

Our Keynote Speaker was Professor Benjamin Barton, Distinguished Professor at the University of Tennessee College of Law who gave a tremendous keynote address talking about the composition and history of the U.S. Supreme Court.

RESOLUTION HONORING REP. RICHARD SMITH (GA)

Rep. Oliverson stated that Rep. Richard Smith (GA), former NCOIL Executive Committee Member passed away suddenly earlier this year. Rep. Oliverson stated that he would like to offer a Resolution in Honor of his decades of public service in Georgia and at NCOIL. Rep. Oliverson said that he got to know Rep. Smith when he was just coming into NCOIL and really enjoyed his contributions and leadership and was deeply saddened to hear of his passing.

Rep. Oliverson then asked the Committee if anyone would like to say a few words.

Rep. Lehman said he knew Rep. Smith for quite a while, and he was certainly an NCOIL Leader and he will be missed not only by his family and colleagues in Georgia but also by everyone at NCOIL.

Upon a motion made by Rep. Lehman and seconded by Sen. Bob Hackett (OH), the Committee voted unanimously to adopt the Resolution by way of a voice vote.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Bennett and seconded by Rep. Pollock, the Committee adjourned at 11:15 a.m.

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CHIEF EXECUTIVE OFFICER:
Thomas B. Considine

PRESIDENT: Rep. Tom Oliverson, TX
VICE PRESIDENT: Asw. Pamela Hunter, NY
TREASURER: Sen. Paul Utke, MN
SECRETARY: Rep. Edmond Jordan, LA

National Council of Insurance Legislators (NCOIL)

Catalytic Converter Theft Prevention Model Act

Adopted by the NCOIL Property & Casualty Insurance Committee on June 14, 2024. To be placed on the Executive Committee's agenda for final ratification on July 20, 2024.

Rep. Tom Oliverson, M.D. (TX) – NCOIL President - Sponsor

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 Insurance [or similar].

(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 Advisory Committee

(a) The Department may establish a Catalytic Converter Advisory Committee ("Committee") to advise the Department on matters related to catalytic converter theft and its impact on the insurance industry.

(b) The Committee shall be composed of 12 members appointed by the Commissioner as follows:

(1) A representative from the Department;

(2) A representative from an insurance company authorized to issue motor vehicle coverage in this state;

(3) A licensed new or used motor vehicle dealer;

(4) A licensed used motor vehicle parts dealer;

(5) A registered secondary metals recycler; and

(6) One representative from each of the following:

(A) The motor vehicle rental industry;

(B) The State Association of Chiefs of Police;

(C) The State Sheriffs' Association;

(D) The State District Attorneys Association;

(E) The National Insurance Crime Bureau; and

(F) A consumer protection group.

(c) The advisory committee shall elect a presiding officer from among its members to serve a two-year term. A member may serve more than one term as presiding officer.

(d) The advisory committee shall meet annually and at the call of the presiding officer or the Commissioner.

(e) An advisory committee member is not entitled to compensation or reimbursement of expenses.

Section 4. 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 5. 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 6. 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 7. 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 8. 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 9. 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 10. 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 11. Enactment

This Act shall take effect and be in force from and after [XXXX].