30 DAY MATERIALS AND GENERAL SCHEDULE
NCOIL ANNUAL MEETING
NOVEMBER 21 - 24, 2024

As of November 12, 2024, and Subject to Change

The Westin Riverwalk Hotel

San Antonio, Texas

San Antonio, Texas
November 21 - 24, 2024
SCHEDULE

****Note: There will be a room (El Rincon on the lobby level) available throughout the duration of the conference for informal meetings. Attendees should feel free to meet with legislators there throughout the meeting.****

THURSDAY, NOVEMBER 21ST

NCOIL Open Insurance Legislators Foundation Scholarship Golf Outing	12:30 p.m.
Alternative Activity to Golf Outing --- TopGolf ***Please reach out to Pat Gilbert at pgilbert@ncoil.org if interested in attending. Space is limited.***	1:30 p.m.
Welcome Reception at The Alamo	6:15 p.m. - 7:45 p.m.

FRIDAY, NOVEMBER 22ND

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.

Health Insurance & Long Term Care Issues Committee	10:00 a.m.	-	11:30 a.m.
General Session NCOIL Special Series on Preventive Medicine Part 2: Food as Medicine and Advancing a Healthy America	11:30 a.m.	-	1:15 p.m.
The Institutes Griffith Foundation Legislator Luncheon Cyber Risk: Are There Risks Beyond Ransomware? ***Open to Public Policymakers and Staff Only***	1:15 p.m.	-	2:15 p.m.
Workers' Compensation Insurance Committee	2:15 p.m.	-	3:30 p.m.
Networking Break	3:30 p.m.	-	3:45 p.m.
Life Insurance & Financial Planning Committee	3:45 p.m.	-	5:00 p.m.
Adjournment	5:00 p.m.		
Nominating Committee (Members Only)	5:15 p.m.		
Reception Honoring Cmsr. Tom Considine, NCOIL CEO ***Open to All Attendees***	6:00 p.m.	-	7:30 p.m.

SATURDAY, NOVEMBER 23RD

Registration *Exhibits Open: 8:00 a.m. – 5:00 p.m.*	8:00 a.m.	-	5:00 p.m.
General Session ERISA at 50: An Important Standard Setter or Roadblock to State Healthcare Innovations?	9:15 a.m.	-	10:45 a.m.
Networking Break	10:45 a.m.	-	11:00 a.m.
NCOIL – NAIC Dialogue	11:00 a.m.	-	12:15 p.m.
Luncheon with Keynote Address	12:15 p.m.	-	1:45 p.m.

General Session Does SCOTUS' *Chevron* Repeal Mean a Rebirth For State Regulation?	1:45 p.m.	-	3:15 p.m.
Networking Break	3:15 p.m.	-	3:30 p.m.
Financial Services & Multi-Lines Issues Committee	3:30 p.m.	-	5:00 p.m.
Budget Committee	5:00 p.m.	-	5:30 p.m.
Adjournment	5:30 p.m.		

SUNDAY, NOVEMBER 24TH

*****Attendees are Welcome to Dress Casually on the Final Day of the Meeting*****

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 Captives in Perspective: Benefits, Questions, and Strategic Considerations ***Open to Public Policymakers and Staff Only***	8:00 a.m.	-	9:00 a.m.
Joint State-Federal Relations & International Insurance Issues Committee	9:00 a.m.	-	10:15 a.m.
Networking Break	10:15 a.m.	-	10:30 a.m.
Property & Casualty Insurance Committee	10:30 a.m.	-	12:15 p.m.
Executive Committee	12:15 p.m.	-	12:45 p.m.

Please note all speakers listed are scheduled to speak as of November 12, 2024. There will be modifications between now and the start of the Meeting.

Note: There will be a room (El Rincon on the lobby level) available throughout the duration of the conference for informal meetings. Attendees should feel free to meet with legislators there throughout the meeting.

Attendees are Welcome to Dress Casually on the Final Day of the Meeting

Thursday, November 21, 2024

NCOIL Open Insurance Legislators Foundation (ILF) Scholarship Golf Outing
Thursday, November 21, 2024
12:30 p.m.

Alternative Activity to Golf Outing --- TopGolf
Thursday, November 21, 2024
1:30 p.m.
*****Please reach out to Pat Gilbert at pgilbert@ncoil.org if interested in attending. Space is limited.*****

Welcome Reception at The Alamo
Thursday, November 21, 2024
6:15 p.m. – 7:45 p.m.

Friday, November 22, 2024

Welcome Breakfast
Friday, November 22, 2024
8:15 a.m. – 9:45 a.m.

1.) **Sponsor's Welcome**
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**
    -Comments from NCOIL General Counsel
5.) Any Other Business
6.) Adjournment

First Time Attendee Legislator & Staff Meeting
Friday, November 22, 2024
9:45 a.m. – 10:00 a.m.

First Time Attendee Interested Party Meeting
Friday, November 22, 2024
9:45 a.m. – 10:00 a.m.

Networking Break
Friday, November 22, 2024
9:45 a.m. – 10:00 a.m.

Health Insurance & Long Term Care Issues Committee
Friday, November 22, 2024
10:00 a.m. – 11:30 a.m.

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

1.) Call to Order/Roll Call/Approval of July 18, 2024 Committee Meeting Minutes
2.) Consideration of NCOIL Value Based Purchasing Model Act
Sen. Mary Felzkowski (WI) – Sponsor
JP Wieske, VP of State Affairs – Campaign for Transformative Therapies
3.) Continued Discussion on NCOIL Improving Affordability for Patients Model Act
Rep. Deborah Ferguson, DDS (AR), NCOIL Immediate Past President;
Rep. Tom Oliverson, M.D. (TX), NCOIL President – Sponsors
Karen Davenport, Senior Research Fellow – Center on Health Insurance Reforms, McCourt School of Public Policy – Georgetown University
John Hawkins, President/CEO – Texas Hospital Association
4.) Discussion on Developments in Vision Care Services Legislation
Tommy Lucas, O.D., Director of Advocacy – Texas Optometric Ass'n
Jon Pederson, O.D., State Gov't Relations – American Optometric Ass'n
Lisa Anne Hurt-Forsythe, VP of Gov't Affairs – National Ass'n of Vision Care Plans (NAVCP)
5.) Presentation on the Prior Authorization Reform Landscape
Emily Carroll, Senior Legislative Attorney – American Medical Association (AMA)
Miranda Motter, Senior VP, State Affairs & Policy – America's Health Insurance Plans (AHIP)
6.) Introduction of Hearing Aide Classification Model Law Concept
Rep. Deanna Frazier Gordon (KY)
7.) Any Other Business
8.) Adjournment

General Session
Friday, November 22, 2024
NCOIL Special Series on Preventive Medicine
Part 2: Food as Medicine and Advancing a Healthy America
11:30 a.m. – 1:15 p.m.

Moderator: Sen. Justin Boyd (AR)

Sharon Lamberton
Deputy VP of State Policy & External Outreach
PhRMA

Greg Thompson
President
Wellpoint Texas

Brenda Gleason
President
M2 Health Care Consulting

Martha Roherty
Executive Director
ADvancing States

Barbara Kowalcyk, Ph.D.
Associate Professor & Director of Institute for Food Safety & Nutrition Security
Milken Institute School of Public Health

The Institutes Griffith Foundation Legislator Luncheon
Cyber Risk: Are There Risks Beyond Ransomware?
Friday, November 22, 2024
1:15 p.m. – 2:15 p.m.
*****Open to Public Policymakers and Staff Only*****

Scott Shackelford, Ph.D.
Provost Professor of Business Law & Ethics
Indiana University Kelley School of Business

Workers' Compensation Insurance Committee
Friday, November 22, 2024
2:15 p.m. – 3:30 p.m.

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

1.) Call to Order/Roll Call/Approval of July 19, 2024 Committee Meeting Minutes
2.) Perspectives From the Bench on Structured Settlements
    The Honorable Victor S. Lopez, New Mexico District Court Judge, 2nd Judicial District, Bernalillo County
    Susan Stauss, Member, Cozen O'Connor (on behalf of the National Structured Settlement Trade Association NSSTA))
    The Honorable Omar Maldonado, Hidalgo County (TX) Court Judge
3.) Presentation on the State of Work Comp Coverage for Mental Injuries
    Michael Duff, Professor – St. Louis University School of Law
4.) Presentation on the Texas Workers' Compensation Insurance System
    The Hon. Jeff Nelson, Commissioner – Texas Dep't of Insurance Division of Workers' Compensation
5.) Any Other Business
6.) Adjournment

Networking Break
Friday, November 22, 2024
3:30 p.m. – 3:45 p.m.

Life Insurance & Financial Planning Committee
Friday, November 22, 2024
3:45 p.m. – 5:00 p.m.

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

1.) Call to Order/Roll Call/Approval of July 19, 2024 Committee Meeting Minutes
2.) Presentation on Wellness Program Innovations in the Long Term Care Insurance Marketplace
    Michael Gugig, U.S. General Counsel – Assured Allies
3.) Presentation on LexisNexis Risk Solutions' 2024 Life Insurance Mortality Risk Management Study
    Patrick Sugent, VP of Data Science, Insurance Data Solutions – LexisNexis Risk Solutions
4.) Consideration of Proposed Amendments to NCOIL Life Settlements Model Act
    Rep. Forrest Bennett (OK) – Sponsor
5.) Update on Interstate Insurance Product Regulation Commission (IIPRC) Activities
    Karen Schutter, Executive Director - IIPRC
6.) Update on Resolution in Favor of Encouraging a Redesign and the Use of Lifetime Income Investment Solutions in Defined Contribution Plans
    TIAA Representative
7.) Any Other Business
8.) Adjournment

Nominating Committee (Members Only)
Friday, November 22, 2024
5:15 p.m.

Reception Honoring Cmsr. Tom Considine, NCOIL CEO
Friday, November 22, 2024
6:00 p.m. – 7:30 p.m.
*****Open to All Attendees*****

Saturday, November 23, 2024

General Session
ERISA at 50: An Important Standard Setter or Roadblock to State Healthcare Innovations?
Saturday, November 23, 2024
9:15 a.m. – 10:45 a.m.

Moderator: Sen. Bob Hackett (OH)

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

Katy Johnson
Senior Counsel, Health Policy
The American Benefits Council (ABC)

Carmel Shachar
Asst. Clinical Professor of Law
Faculty Director, Health Law & Policy Clinic
Center for Health Law & Policy Innovation
Harvard Law School

Randall Markarian, D.M.D.
Chair
American Dental Association's Special Committee on ERISA

Networking Break
Saturday, November 23, 2024
10:45 a.m. – 11:00 a.m.

NCOIL – NAIC Dialogue
Saturday, November 23, 2024
11:00 a.m. – 12:15 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 July 19, 2024 Committee Meeting Minutes
2.) Recap of NAIC's 2024 Fall National Meeting
3.) NAIC's Securities Valuation Office (SVO) Activities
    a.) Recap of NCOIL Visit to SVO Offices
    b.) Discussion on NAIC's "Framework for Regulation of Insurer Investments", Including Request for Proposal for Credit Rating Provider Due Diligence

4.) Update on NAIC's Property & Casualty Insurance Market Intelligence Data Call
5.) Update on Development of NAIC's Data Privacy Protection Model Law
6.) Update on Work of NAIC's Long Term Care Actuarial (B) Working Group
7.) Any Other Business
8.) Adjournment

Luncheon with Keynote Address
Saturday, November 23, 2024
12:15 p.m. – 1:45 p.m.

General Session
Saturday, November 23, 2024
Does SCOTUS' *Chevron* Repeal Mean a Rebirth for State Regulation?
1:45 p.m. – 3:15 p.m.

Moderator: Rep. Brenda Carter (MI)

Michelle Long
Senior Policy Analyst, Patient & Consumer Protections
KFF

Jack Beermann
Philip S. Beck Professor of Law
Boston University School of Law

Craig Green
Charles Klein Professor of Law & Gov't
Temple University School of Law

The Hon. Greg Serio
Former Superintendent of the NY Dep't of Financial Services
Partner - Park Strategies, LLC

Networking Break
Saturday, November 23, 2024
3:15 p.m. – 3:30 p.m.

Financial Services & Multi-Lines Issues Committee
Saturday, November 23, 2024
3:30 p.m. – 5:00 p.m.

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

1.) Call to Order/Roll Call/Approval of July 18, 2024 and September 20, 2024 Committee Meeting Minutes
2.) Consideration of Re-adoption of NCOIL Insurance Fraud Model Act: Originally Adopted 7/28/95; Readopted 11/16/01, 11/19/04, 11/22/09, 7/13/19
3.) Presentation on Inflation's Impact on the Insurance Market – Where Are We Now and Where Are We Headed?
    Edward Lukco, Instructor of Insurance and Risk Management – Ohio Dominican University
4.) Consideration of NCOIL Earned Wage Access Model Act
    Asw. Pam Hunter (NY), NCOIL Vice President – Sponsor
    EarnIn Representative
    Financial Technology Association (FTA) Representative
    American Fintech Council (AFC) Representative
5.) Consideration of NCOIL Transparency in Third Party Litigation Financing Model Act
    Rep. Matt Lehman (IN) – Sponsor; Del. Steve Westfall (WV) – Co-sponsor
    Hilary Segura, VP & Counsel, State Gov't Relations – American Property Casualty Insurance Ass'n (APCIA)
    National Ass'n of Mutual Insurance Companies (NAMIC) Representative
6.) Any Other Business
7.) Adjournment

Budget Committee
Saturday, November 23, 2024
5:00 p.m. – 5:30 p.m.

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

1.) Call to Order/Roll Call/Approval of July 17, 2024 Committee Meeting Minutes
2.) Consideration of 2025 Budget
3.) Any Other Business
4.) Adjournment

Sunday, November 24, 2024

*****Attendees are Welcome to Dress Casually on the Final Day of the Meeting*****

The Institutes Griffith Foundation Legislator Breakfast
Captives in Perspective: Benefits, Questions, and Strategic Considerations
Sunday, November 24, 2024
8:00 a.m. – 9:00 a.m.

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

Rob Hoyt, Ph.D.
Chair & Professor of Risk Management & Insurance
University of Georgia, Terry College of Business

Joint State-Federal Relations & International Insurance Issues Committee
Sunday, November 24, 2024
9:00 a.m. – 10:15 a.m.

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

1.) Call to Order/Roll Call/Approval of July 18, 2024 Committee Meeting minutes
2.) Consideration of NCOIL Model Act in Support of Mental Health Wellness Exams
    Rep. Rachel Roberts (KY) – Sponsor
    David Lloyd, Chief Policy Officer – Inseparable
3.) Consideration of 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 Ass'n (ABA)
    Paul Martin, VP of State Affairs – National Ass'n of Mutual Insurance Companies (NAMIC)
4.) Presentation on Patent Practices in the Prescription Drug Marketplace
    Wayne Brough, Resident Senior Fellow, Technology & Innovations – The R Street Institute
5.) Any Other Business
6.) Adjournment

Networking Break
Sunday, November 24, 2024
10:15 a.m. – 10:30 a.m.

Property & Casualty Insurance Committee
Sunday, November 24, 2024
10:30 a.m. – 12:15 p.m.

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

1.) Call to Order/Roll Call/Approval of July 20, 2024 and October 7, 2024 Committee Meeting Minutes
2.) Consideration of NCOIL Strengthen Homes Program Model Act
   Rep. Jim Dunnigan (UT) – Sponsor; Rep. Matthew Gambill (GA) – Co-sponsor
   Hilary Segura, VP & Counsel, State Gov't Relations – American Property Casualty Insurance Ass'n (APCIA)
   Wes Bissett, Senior Counsel – Independent Insurance Agents & Brokers of America (IIABA)
   Paul Martin, VP of State Affairs – National Ass'n of Mutual Insurance Companies (NAMIC)
3.) Consideration of NCOIL Online Marketplace Guarantees Model Act
   Rep. Brian Lampton (OH) – Sponsor; Rep. Forrest Bennett (OK) – Co-sponsor
   Byron Wobeter, Associate General Counsel – AirBnb
   Brad Nail – Converge Public Strategies
   Hilary Segura – APCIA
   NAMIC Representative
4.) Discussion on NCOIL Model Act Regarding Insurers' Use of Aerial Images
   Rep. David LeBouef (MA); Rep. Brian Lampton (OH) – Sponsors
   Joel Laucher, Program Specialist – United Policyholders
   Susan Bow, General Counsel – Cape Analytics
   Hilary Segura – APCIA
   Wes Bisset – IIABA
   Tony Cotto, Director of Auto & Underwriting Policy - NAMIC
5.) Continued Discussion and Potential Consideration of NCOIL Motor Vehicle Glass Model Act
   Rep. Michael Sarge Pollock (KY) – Sponsor

Eric DeCampos, Senior Director, Gov't Affairs – National Insurance Crime Bureau
Paul Martin – NAMIC

6.) Any Other Business
7.) Adjournment

Executive Committee
Sunday, November 24, 2024
12:15 p.m. – 12:45 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 July 20, 2024 Committee Meeting Minutes
2.) Future Meeting Locations
3.) Administration
    a.) Meeting Report
    b.) Receipt of Financials
    c.) Consideration of Auditor
4.) Consent Calendar
5.) Other Sessions
    a.) The Institutes Griffith Foundation Legislator Sessions
    b.) General Sessions
    c.) Featured Speakers
6.) Nominating Committee Report/Election of Officers
7.) Any Other Business
8.) Adjournment

HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE MATERIALS

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)

Value Based Purchasing Model Act

Sponsored by Sen. Mary Felzkowski (WI)

Draft as of March 13, 2024. To be discussed and considered during the meeting of the NCOIL Health Insurance & Long Term Care Issues Committee on November 22~~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.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
2024 NCOIL SUMMER MEETING – COSTA MESA, CALIFORNIA
JULY 18, 2024
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee met at The Westin South Coast Plaza Hotel in Costa Mesa, California on Thursday, July 18, 2024 at 2:00 p.m.

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

Other members of the Committee present were:

Rep. Deborah Ferguson, DDS (AR)
Sen. Dafna Michaelson Jenet (CO)
Sen. Larry Walker (GA)
Rep. Rod Furniss (ID)
Rep. Matt Lehman (IN)
Rep. Cherlynn Stevenson (KY)
Rep. Edmond Jordan (LA)
Rep. Brenda Carter (MI)
Sen. Lana Theis (MI)
Sen. Michael Webber (MI)
Sen. Paul Utke (MN)
Sen. Jerry Klein (ND)
Asm. Jarett Gandolfo (NY)
Sen. Bob Hackett (OH)
Rep. Ellyn Hefner (OK)
Rep. Tom Oliverson, M.D. (TX)
Sen. Mary Felzkowski (WI)

Other legislators present were:

Rep. David Silvers (FL)
Rep. Joseph Gullett (GA)
Rep. Martin Momtahan (GA)
Rep. Matt Lockett (KY)
Rep. Dennis Bamburg (LA)
Rep. Gabe Firment (LA)
Sen. Franklin Foil (LA)
Rep. Brian Glorioso (LA)
Rep. Chance Henry (LA)
Rep. Shaun Mena (LA)
Sen. Kirk Talbot (LA)
Sen. Bill Wheat (LA)
Sen. Arthur Ellis (MD)
Sen. Kevin Hertel (MI)
Sen. Jeff Howe (MN)
Rep. Bob Titus (MO)
Sen. Waler Michel (MS)
Sen. Brian Rhodes (MS)
Sen. Joseph Thomas (MS)
Asm. Alex Bores (NY)
Rep. Greg Scott (PA)
Sen. Patty Kuderer (WA)
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. Jerry Klein (ND), and seconded by Sen. Bob Hackett (OH), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Sen. Hackett and seconded by Rep. Edmond Jordan (LA), NCOIL Secretary, the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's April 14, 2024 meeting.

CONTINUED DISCUSSION ON SITE-NEUTRAL PAYMENT REFORMS

Rep. Dunnigan stated that at our last meeting in April we had a good discussion on this topic that we're going to address again now. And recently we've had some draft model language shared with us and it's been distributed before you. The language that's before you is simply a rough draft and for now, it's really meant to just start the conversation and get the discussion going and continue what we did in April. We're not intending to take any action on this item today and not this year. If we do it will be next year. So, at this point I'm going to turn it over to Rep. Deborah Ferguson, DDS (AR), NCOIL Immediate Past President, and she's agreed to sponsor the language for introductory purposes.

Rep. Ferguson stated that I wanted to make sure that I got this model started now as most of you know I will be leaving the legislature at the end of December. So, I wanted to make sure we got the process started and then I have already talked to some people about taking over as sponsor since I will no longer be a legislator. I don't want to preempt anything the speakers are going to say but really, the goal of this is to save healthcare costs and to save money for patients and to create a fairer process for private providers who are competing with hospitals in an outpatient setting where the exact same procedure is being done at drastically different costs.

Randi Chapman, Managing Director of State Affairs at the Blue Cross Blue Shield Association (BCBSA), thanked the Committee for the opportunity to speak and stated that I really appreciate the willingness to continue this conversation about healthcare affordability for consumers. And of course, you all know BCBSA and our companies as well. I'm sure many of you have a blue card in your pocket or your wallet or purse right now but I wanted to say that our mission is simple. We want everyone to have access to high quality affordable healthcare and that's why we're here to talk about that today. So over the last 20 years, the U.S. has made really great strides in expanding access to health insurance and nearly 92% of Americans have coverage right now. And that's a historic high. But where we need to continue to work is with regard to healthcare costs. Those costs continue to grow and they threaten affordability for American families and businesses. And the reason for this affordability crisis is clear, rising prices for healthcare services driven by higher healthcare spending. And that's why BCBSA developed our affordability policy platform last year which you see a snippet of here on

the slide. These policy solutions, if implemented in total, would save patients, seniors and taxpayers $767 billion over the next 10 years. And the draft language that you see that we're talking about today focuses on policy solutions found under the first prong of that platform. The prices for our healthcare services have significantly increased and that's due in part to the trend of big hospitals and health systems acquiring physician practices and that often results in reduced provider competition and excess cost and those excess costs can show up for consumers as facility fee charges which fuels the post-acquisition service cost disparities that we discussed this past spring. Excess costs also show up as higher cost sharing for consumers due to inappropriate billing practices.

So, let's break this down a little bit. What are facility fees? On its face, a facility fee is meant to compensate hospitals for standby capacity required for emergency department and inpatient services. And when we talked about this at the spring meeting, hospitals provide 24/7 care and emergency service to all who need it regardless of their ability to pay. And that requires personnel to be at the ready and able to handle high acuity in merchant inpatient services needed by patients who come to the hospital. And to be clear, the model is not about that. We aren't talking about inpatient overnight hospital care or emergency rooms. We're talking about hospital facility fees being charged to consumers who receive routine diagnostic outpatient services off the hospital campus. So, how do facility fees show up for American consumers? Well often it seems as these headlines indicate, that they are unexpected and unwanted. I've seen facility fees described as a cover charge for just walking in the door. Or even recently as a hospital resort fee kind of like the hotel resort fees that we have to pay even if you don't use the services. And these fees show up for common outpatient services. They show up even for telehealth services, where there's no facility involved. They raise costs for services that used to cost less for consumers and they hit patients across the country from Seattle to Mississippi where it counts, in their wallets. This model proposes reasonable limits on facility fees in three areas. Those fees shouldn't be collected for services provided at off campus locations for outpatient services using evaluation and management codes or for services provided via telehealth. So seven states, as you'll see on this map, have enacted or are considering bills to limit the imposition of facility fees. The National Academy of State Health Policy (NASHP) tracks this issue across the country and has identified 16 laws in 12 states that have been enacted. NASHP also has its own facility fee model language that some legislators have looked to in order inform their efforts in states.

And I want to spend a little time talking about campus and how that's defined in the language and then this concept of on campus versus off campus. So, the model language uses the Centers for Medicare & Medicaid Services (CMS) definition of campus and that's used in many federal and state laws and regulations. And it sets the on campus parameters at 250 yards around the hospital's main buildings. This is again the same definition used in several state facility fee limitation bills including bills in Colorado and Connecticut, but not limited to those. So, let's consider a couple of examples of what on and off campus might look like under the CMS definition. So, this diagram can provide some perspective on how that's practically applied. So, it might be hard to see, but if you see there's a blue line around the hospital in the middle and the two little buildings on the side there. So, you can have the situation where there's a

hospital, there's one main building and then perhaps there are a couple of facilities on the outside of those buildings, but still within that 250 yard radius. So, that's considered on campus. And then the two building figures that you see outside of that blue circle those would be considered off campus as they're outside of that 250 yard radius, as defined under the CMS definition of campus. And we have another example here where you might have a health system that has four main buildings or five or sometimes the hospital systems have buildings across a state or across an area. I used to live in Maryland and I think of Johns Hopkins that has one big hospital in Baltimore but then there are several hospitals around the state of Maryland that Johns Hopkins owns. And they are full-on hospitals but in a case like that you would have the 250 yard radius around each main building and that's how you would classify what is on campus versus what facilities are off campus. So, the proposed language also requires certain notice provisions to ensure that consumers and patients are empowered with knowledge that a facility fee might be charged and also of the grievance dispute and fee waiver processes, if any. The language also requires hospitals and health systems to clearly identify facility fees in healthcare bills.

And moving on to the second prong of the model, this addresses the need for honest or appropriate billing and reimbursement that will ensure consumers are not paying higher copays and cost shares. Patient cost share should not be in some instances, based on the hospital rate, but should instead be based on the appropriate outpatient provider rate which is lower than the hospital rate. And the bottom line here, and this is kind of behind the scenes back-end stuff, but if we can help payers properly identify where a service is taking place then the correct and appropriate consumer cost sharing can be applied and appropriate reimbursement rate can be applied. One way to do that is to compel hospitals and health systems to have separate National Provider Identifiers (NPI's) for off campus facilities, those that are outside of that 250 yard radius, and to use place of service codes on claim forms. And so the NPI is the National Provider Identifier number. This is a ten-digit number that CMS assigns to providers and practitioners. And what that allows payers to do again it designates where a service took place so a payor is not in a position of paying hospital reimbursement rates for services that actually happened in a doctor's office. And again, there's a pretty significant disparity in what those rates can be depending on the services as we discussed in the spring. And so with that I will wrap up and again, I do want to thank Rep. Ferguson for the support and the entire NCOIL membership for willingness to discuss this important issue. And I look forward to working with you all to help improve affordability for patients.

Francis Gibson, CEO of the Utah Hospital Association, thanked the Committee for the opportunity to speak and stated that for 14 years I was a state legislator so I understand where you're at in some of the many challenges that you have even though you're from different states and I bet many of the challenges are the same. I would like to just share a little bit about my career background for a moment. You might know of the various areas in healthcare that I've served in my career. The first three years of my career I grew up in Texas. I worked in College Station in a primary care administrator. We had a women's clinic, pediatric clinic and HIV and AIDS clinic. A Special Supplemental Nutrition Program for Women, Infants and Children (WIC) program. And the majority of the patients that we served were either Medicaid or low income or noninsured.

Following that I moved to Utah and for 15 years I served as an ambulatory surgery center developer and creator owner. And I understood what it meant to be able to run an ambulatory surgery center and actually competed against hospitals for 15 years. For the last 12 years, I've served as a hospital CEO and running the day-to-day operations of two different hospitals in a regional operator for a bigger tertiary care center as well. And I served as a state legislator in the Utah State Legislature, four years as the Majority Leader, four years as the majority whip, and as various different committee chairs as well. As a legislator sitting through various committee hearings over those 13 years I saw many PowerPoint presentations and I would like to just kind of not use a PowerPoint today and just speak about some of the challenges that hospitals have and my experiences as an ambulatory surgery center person and then in my experiences as a legislator as well and just kind of speak from the heart if I may.

Today I hope to share a little bit of my experience working in these settings while representing nearly 7,000 hospitals in the U.S as I sit here representing the American Hospital Association (AHA) though I work in Utah. Every day in a hospital, there are hundreds or even thousands of inputs that arrive daily in that facility depending on the size of the hospital that are required to make hospitals work. When hospitals successfully function, they serve the communities and your constituents across this country very well. Each of these inputs are a cost and cannot be avoided and the costs continue to rise year after year. You're probably thinking what are some of those costs? Surgical, medical supplies, pharmaceuticals, med gas, food and beverage, cleaning supplies, medical devices, imaging equipment. And the most important are the caregivers themselves with nearly seven million caregivers in the U.S. that work at hospitals. All of these things, and hundreds of more, cost money. Many of the companies that supply such inputs at hospitals are from publicly traded companies. What happens every quarter with a publicly traded company? Earnings reports are due and made public, and every shareholder or investor wants a bigger return on their investment. Thus, prices are moved accordingly to achieve a greater return. Medical device companies, pharmaceutical companies - all of these different things continue to rise every single year. Hospitals are the last stop for care. No one wakes up in the morning and says, “I get to go to the hospital. I'm so excited to be there.” Nobody does that. I can think of only one person who's excited to go to the hospital, a mother waiting to give birth. I know that you've heard that there are places in the hospital that are required to be open 24/7. Well, this is true. Emergency rooms, infusion services, lab departments, rehab services, med surge floors are all critical for the comprehensive care for patients. And they make very little, if anything, to cover the cost to run those units. Every hospital or health system that I know of have been actively working to lower the cost of care while raising the outcomes to patients. Quality measures, which are federally mandated and measured by CMS, are strict regulatory requirements that are required of hospitals to ensure great quality. I know you've heard that enacting some sort of site neutral payment system will lower the cost of healthcare to patients. As I mentioned earlier, the costs continue to rise in hospitals while reimbursement for services continue to decrease both from commercial payers and government payers. Many of our commercial payers are publicly traded companies. There needs to be a return on their investment.

And how do they do that? They're able to shift costs. When certain services within hospitals are more profitable than others those profits are taken and they move to the areas which are not meeting their costs. This is not unique. Insurance companies, both property & casualty and health insurers, shift costs as well. When we have healthy patients who continue to pay their premiums and they do not use them, those costs are shifted to the higher cost patients, maybe a cancer patient, terminally ill patient. That happens all the time. It does happen in hospitals as well. For nearly 15 years of my career, I worked and led and developed ambulatory surgery centers (ASCs). I would partner with surgeons and would declare the ASC as an extension of their office within the bounds of stark laws. And they would partner with these ASC's and then drive patients to the ASC's for services. Patients would then be taken care of and care would be at a cheaper cost than in the hospital. And I would use this mantra with Rep. Dunnigan when we served together - “hey, we are cheaper than hospitals. Why aren’t we driving more care there?” However, patient selection in these facilities is very important. If you're obese, if you're a diabetic, if you have a cardiology problem or any other medical comorbidity that we consider you at risk, those patients are not taken to surgery centers. Those are shifted to the hospital. Why? Because hospitals have the ability to take care of those comorbidities and those other risky issues. And at what cost? It costs more to take care of sicker patients and that's why hospitals are there. ASC's are not required to have the same services. They are not required to have many of the different things that hospitals are required to have. So, taking care of a sick patient is not beneficial to the business model of an ASC. I developed, ran and operated ASC’s for 15 years. I did not want to see Medicaid patients. I did not want to see patients who can't have any other source to pay. Or patients that may potentially run risk of complication. I know that this bill that we're talking about is focused on facility fees. As an ASC, I charged a facility fee. Physician offices charge facility fees. So, just being able to say that hospitals cannot charge facility fees, I would broaden that if that is the direction of this committee to say no one can. I think it is appropriate to charge the fees to take care of the patients for what needs to happen. But please don't be confused, ASCs and other off-site centers do charge facility fees.

Finally, I understand the hard work you do as legislators as I used to be in your shoes. I would hear about healthcare costs rising all the time and what things can be done. I was blessed to serve in the highest leadership positions in the Utah House of Representatives. I know that you're all looking to lower those healthcare costs and healthcare is expensive. And I agree we need to find ways to lower those costs. I'm asking that you look at the cost in its entirety. When was the last time any of your insurance premiums went down? How about your constituents and businesses? Publicly traded companies like device manufacturers, PhRMA, and some insurance plans who supply the needed inputs into a hospital daily have never showed up and said I'd like to lower the cost of those supplies for the hospital today - I think we've been charging you too much, can we lower those costs? It's never happened. The nearly seven million hospital caregivers nationwide have never went to their bosses or the hospitals and said, “You know what I don't need to raise this year. I think we're making enough money.” It's never happened. Many hospitals in this company operate on a low single digit profit margin. Some are barely breaking even, while health insurance companies who do not lower premiums have double digit profit margins. Device

manufacturers and especially PhRMA continue to have double digit profit margins. Hospitals are needed in your communities to serve those folks who are sick. Hospitals are a major employer in your communities. Site neutral payment reform will negatively impact hospitals and hospitals will close. Probably not in every community, but is that hospital closed in your state or in your community? Maybe. If we're going to look at cost cutting, I'm asking that you look at everything. Can you assure that the payers and the savings that may come from this legislation or any other site neutral legislation that may be discussed nationally or within your states go directly to the very people that cause you to raise the question? Those payments will hit hospital pocketbooks immediately. Will they be translated into lower premiums for the people that you represent? Just saying that I'm not going to raise your premiums is not a cost savings. Because these companies are making money today. If you're going to enact something to save the $766 million will that translate into a lower premium for our folks? I just want to thank you for your time. You sit in very difficult shoes. You're going to try to draft model legislation that could potentially be drafted in the various states that you go back into. But these are questions that should be asked. I know that every state has a Hospital Association. Many of you may have met with your Hospital Association leaders. And if you've not I would encourage you to do so and understand what are facility fees in my state? I'm not here to talk about what may happen in New Jersey or Nebraska or California. I don't know all of that. But I can tell you it is very difficult to be able to run hospitals. And to see the continued decline in reimbursement built from government commercial payers while every other input increases, there are tough decisions. We ask that the AHA be part of drafting a bill on these issues from its inception.

Rep. Ferguson stated to Ms. Chapman to please address that we're not talking about getting rid of facility fees across the board, right? My husband's a radiologist, for instance, and he charges a facility fee because we own the facility and a professional fee because we have very expensive radiology equipment. So, those outpatient centers would be able to continue to charge a facility fee. I think you might explain the facility fee removal and who that is being removed for. And just on another note with health care inflation at over 3% even if we don't raise premiums for insurance, we save consumers money because it's very difficult for all of us to keep up with the health inflation. But please address the facility fee and I told you all this before my husband does a echocardiogram and he can do it in his office for $264. And you go to the hospital outpatient center and it's $6,000. So, I mean that's the differential we're talking about. And I completely support acute care in hospitals. I understand all that, and I'm for them continuing their disparity and fees. But when we're talking about similar facilities, if we're talking about apples and apples I think that's a different matter. Please explain the facility fee so that we understand that we're not eliminating the facility fee.

Ms. Chapman stated that's exactly right. I think the example that you raised again, going back to our presentation in the spring is just that what we see and I'll get to the answer to your question, but just to reiterate what we see is, you have a hospital or health system that purchases a physician's office and then what happens is due to fees or due to reimbursement coding the services that are provided in the doctor's office goes up exponentially. And so, what happens is consumers in effect are being saddled with the extra cost after this acquisition takes place. But this doesn't all deal with facility fees in

certain circumstances. And so, we're talking about healthcare services that are provided at off campus locations and we talked about the definition of campus. We're talking about outpatient services using evaluation and management codes. And then we're talking about outpatient services using the evaluation and management codes that are provided via telehealth. And so again there are many instances where the facility fees are appropriate and do make sense because of the type of care that's provided at the facility.

Rep. Tom Oliverson, M.D. (TX), NCOIL President, stated that I appreciate the panelists being here and having this conversation. Like Rep. Ferguson, I also have a direct connection to the healthcare industry so I see this at the ground level and as an anesthesiologist I've worked in many surgery centers. The thing I hope everybody else gets out of this is there is a fundamental disconnect happening here in that we're charging the facility fee in a doctor's office for a service that essentially 20 years ago the same exact service was provided with no facility fee of any kind. And the kind and quality of the service that's being provided hasn't changed at all. It's just another source of revenue. It's another way to monetize essentially for no additional benefit we're adding an additional cost to the system. And we talk about healthcare costs going up, healthcare costs staying the same. It stands to reason that if you add a charge where previously there was no charge, that's going to increase costs. The second thing is that this type of financial arrangement which is typically happening through, at least in my state, our larger we use the term not-for-profit but really it's tax-exempt hospital systems where they're building a brand new tower essentially every year with the excess revenue that they have in order to keep their tax exempt status I guess. But the problem is that these physician practices that are purchased by these hospital systems now the hospital system owns the patient’s medical record and the patients care. So, it's not just that there's an additional fee being charged, but now there's complete vertical consolidation in the patients care pathway where the patient is essentially trapped into having to use that hospital system for every additional ancillary service that they may require because their physician has a contract requirement as being an employee of that facility now being paid by that facility and doing well financially, having a lot less overhead and headaches, a whole other conversation. Now every MRI has to be done at the hospital whereas before it could be done at the outpatient imaging center for less than half the cost. Every lab has to be done there. Every physical therapy appointment has to be there. So really, the game here and I hate to use the word game but really the overarching theme is not just the facility fee itself it's control of the physicians, referral patterns and the ability of the patient once they're seeing a patient in that system to never be able to escape to find value anywhere else in the system, which is essentially completely the antithesis of what we've been working so hard for in hospital price transparency and other transparency measures where we're trying to give patients the right to compete in the right to shop.

My question is this is just like the conversation that we've had in the past. In my impression, when we talk about doing away with healthcare facilities ability to go after a patient for collections an unpaid bill and now that patient's going to be sued in order to pay that bill. Medical debt is actually one of the leading causes of bankruptcy in America and yet it always seems to me that the defense mechanism that's employed or the

reason that we have to have this is that the hospitals are barely scraping by and so they need the ability to be able to sue patients who are unable to meet their financial obligations. While at the same time, we as state lawmakers are dumping copious buckets of money into these systems for disproportionately under resourced care and all of these other buckets of state supported funds which are supposed to be taking care of these very things and I guess I have to ask is it really that tough out there? Because as a doctor sort of seeing it from the inside it doesn't seem to me like anyone's hurting. In fact, it seems to me like everywhere I turn, there's a parking lot being converted into a brand new building with 500 more shiny new beds and the new MRI scanner being bought every month. And it just doesn't compute. So, I guess where is the disconnect that I'm not seeing there in terms of are we really with the exception of rural hospitals, where I understand that is a special bucket, but that has more to do with payer mix and the fact that there just aren't that many patients. But not where I live. Not in the Houston area. I don't see a lot of facilities going out of business because they can't charge a facility fee for something that was essentially provided in the office 20 years ago with no facility fee. And so I guess where's the problem? What are we missing here? That's my question.

Mr. Gibson stated that I grew up in Houston my whole life, so I'm very familiar with the area where you work. There are lots of things in your comments to address. I heard lots of things about physician practices. Many physician practices because reimbursement is going so low, they are joining health systems because now they can get a solid set salary. They know what that means. But in order to run that practice there's a cost there. Are the facility fees that are charged inside those practices for dermatology or whatever other office procedures may be done? Possibly. And I'm not going to say that's not true because it probably is true in many places but in some places it's not. I think to exclude a free standing facility that may be outside the 250 yards but is independent from charging a facility fee, how would that be any different from charging a facility fee or the inability to charge a facility fee for a building that's outside the 250 yard marker? I think if we're going to compete, that should all be the same. If reimbursement is going to be the same there should be the ability to charge that facility or no one charge the facility fee. That's the crux of it. Just because there's an investment there and you need to recruit that by charging facility fee that same investment is made by whoever the owner is whether it be a hospital system or whether it be a group of radiologists who put together a freestanding imaging center. So, if a facility fee is not important, then facility fees shouldn't be important. We shouldn't charge it to anyone. The disconnect, Rep. Oliverson, I don't know what that means. I do know that there are costs inherent in running physician practices and they should be looked at when a physician chooses to join a system. There are certain rules there that he or she chose when they came into that system. We talked about the direct ability of patients in ASC's all the time. Why do they direct patients to ASC's? They're only three reasons a surgeon takes a procedure to a surgery center. Number one, he's an owner and he's financially vested. Number two, he's an owner and he's financially vested. Number three, he's an owner and he's financially vested. That would be an easy way to say it. But from practicing I would say number one, he's financially invested. Number two, our continuity of care. He gets the same surgical staff every time. And number three,

typically turnover times are easier and faster. Those are the three reasons why they go to a surgery center.

That being said, number one, he is financial invested and there is a return on that investment. So, in some ways, there's a perverse incentive to be able to take them over there. The other two reasons, I would never argue about those and that is turnover times and continuity you get the same surgical staff every time you go. And you, being the anesthesiologist and working in ASC's you see that every day. And I could speak with you all day long because that's what I did for a long time. I don't know what the discount is, I'm not going to pretend to know that. But I will tell you, the example that Rep. Ferguson used of the big difference in price, that's stupid. I don't know what that looks like. I would love to be able to see what that looks like. I would love to see the Arkansas Hospital Association sit down with you and you share that with them if you have not already and let them talk and understand what that looks like. That seems to be way out of bounds. There may be a difference in rates but I would argue that your lower rate cited is probably just the professional fee to have it done because by the time the facility fee is tacked on that disparity is not going to be that big. Rep. Ferguson stated that is the global fee. Mr. Gibson stated that's a great deal.

Sen. Mary Felzkowski (WI) stated that this is directed towards Mr. Gibson. You sit there as a previous lawmaker and say we have a hard road ahead of us to try to get in line with healthcare costs. But I think as a legislator and insurance agent before that, "if" can also be the biggest word in the dictionary. If there was transparency in pricing. If hospital systems voluntarily were upfront with costs to consumers and we saw the patient mix. We saw the payer mix. It would be a little easier I think for the legislators in all 50 states to kind of come to terms with what was actually happening. But with the secrecy in pricing that we see in our systems it's very hard to have sympathy when we are watching our constituents not going to the doctor, delaying care because they're more afraid of the debt than the diagnosis. And it always comes back to what other major purchase do you make where you have no idea the cost is until the bill is sent to you? No one across the U.S. wants to see our hospitals go under or not have them make a fair return on the investment that they have but until that transparency is evident, it's just really hard as a lawmaker to make a lot of those decisions and that's why I think you see legislation like this. And until the AHA steps up and come to terms with that transparency I think you're going to see more and more legislation like this.

Mr. Gibson stated that's a great point and I think one of the things that concerns me is what does that transparency look like? There are states that already have transparency legislation on the books that have to show what that looks like - an MRI's this much, an ACL is this much. An ACL is a good example, I may quote you $4,500 for an ACL. We get into the operating room and an ACL typically the first choice would be to possibly harvest something from your hamstring. I've seen it happen before where a hamstring is in very bad shape. We go to the back of the operating room and they take that hamstring and they re-stretch it and make it tight and they reinsert it in your knee. If you have a bad hamstring though and we can't harvest that, I quoted you $4,500 but now I'm going to do something different, something artificial which is an additional $4,000 or $5,000 and you've been under anesthesia longer than anticipated. And now that bill

goes from $4,500 initially to an $11,000 quote. Or I can quote you a straight vaginal delivery $6,500 for example. All of a sudden you get in there and something is going wrong and we have to do a C-section. But the only thing the patient remembers is the $4,500 quote. Or the only thing they may understand is that $6,500. And then the trouble to collect becomes different. I'm not saying that we can't do more with regards to transparency and pricing but what I am saying is that not every quote may wind up being the same because of the different variables that may go into in order to treat you. Sen. Felzkowski stated that I don't disagree with you, but that's a standard. I don't want to compare getting my roof repair to having surgery but if I have rotten sheeting now that $18,000 quote for my roof is no longer $18,000. I don't think that the American public is that naïve. I would give the American public much more credit than that because we do quotes all the time in this world.

Rep. Ferguson stated that I knew this would probably be a little contentious when I brought it forward but the bigger question for me is how we got here. I know that doesn't solve the problem but I'm not sure how CMS ever decided that this was a good way to support hospitals as a permanent payment modality and in making patients pay more and consolidating private practice to get vertical with hospitals. But I look forward to the discussion and someone else sponsoring the language in the future.

Rep. Dunnigan thanked everyone for their comments and stated that if anyone has additional comments or ideas that you'd like considered for this model you can send it to myself, Rep. Ferguson or NCOIL staff.

CONTINUED DISCUSSION ON NCOIL VALUE BASED PURCHASING MODEL ACT

Rep. Dunnigan stated that next on our agenda is a continued discussion on the NCOIL Value Based Purchasing Model Act (Model). You can view the model act on page 79 in your binders and on the website and the app. And before we hear from our speakers I want to turn to Sen. Felzkowski, sponsor of the Model.

Sen. Felzkowski stated that we introduced this model very briefly at our last meeting in Nashville in April and I look forward to continuing the discussion today. I sponsored a nearly identical piece of legislation in my home state of Wisconsin and the concept here is very straightforward as it simply creates authority for states to enter into a value-based purchasing agreement with a drug manufacturer. The speakers we have here today will provide us with some information as to what exactly a value-based purchasing agreement is and how it works but what we're looking at here is the fact that while our medical treatments continue to advance, the cost of those treatments are extremely high, and these types of purchasing agreements can be used as a tool for the state to ensure that the cost of treatment is based on the value provided to the patient. I'll stop there so we can hear from our speakers but I obviously support this model and encourage my colleagues to do so as well and hopefully we can have something ready for consideration at a November meeting.

JP Wieske, VP of State Affairs at the Campaign for Transformative Therapies (CTT), thanked the Committee for the opportunity to speak and stated that CTT is a group that

is looking for solutions to this cost problems that we see. This may be the most important slide you see. This tells you what is coming. What is coming is an explosion. On the good side we have gene therapies that are going to change the way patients interact with their diseases. And there may be durable cures for it. On the other hand, there are really significant financing issues we'll get into in a little bit. Medicaid will have to cover these treatments. Under federal rules, these high costs would leave the potential to significantly limit access. This Model is one of many possible solutions to this explosion that's coming. To highlight here, spinal muscular atrophy, hemophilia, sickle cell disease all have gene therapies that potentially have a cure that are available on the market as we speak now. Now the cost of these therapies, at least in the case of hemophilia are $2 to $3 million dollars for a treatment. It's a one time treatment and it promises that the patient will functionally no longer be a hemophiliac. There are 30 gene therapies so far that have been approved. There are 56 currently in clinical trials. We expect more than 60 by 2030. And there are over 2,000 in development across the country. So, these are coming. They are going to be expensive and they're going to change the way medicine works. It's important to understand when we look at financing for Medicaid there are a couple of ways Medicaid looks at specific drugs and medical treatments. Access is one of their key drivers. We're aware of one state that has effectively maneuvered to ensure gene therapies will not be available through their state Medicaid department. It's technically available, but you would never get through to it as they also use utilization review, managed care, pharmacy benefit managers (PBM) contracting issues and a number of other preferred drug lists.

When you're looking at these you also have a national standard as far as what Medicaid pays for the drug. So, there is a minimum standard that attaches. These rebates that we're talking about are on top of that minimum standard. So, this does not change that and states are free to do whatever they want to do with it or not but the existing rebate structure continues. Value based payments are intended to align the incentives in the correct way. So, you negotiate with Medicaid, the drug company negotiates on access and they agree to a rebate if the drug is not effective. Now, if you have really broad patient access and you have a rebate structure your rebates will outpace, and the drug company will no longer be able to make a profit because that's not effective under the terms. And the same thing for Medicaid. They want to have access and they want to limit cost. But this ensures that their interests are the same as the drug, they're perfectly aligned from a structure standpoint. And this is what we're talking about and my colleague will talk a little bit more about Medicaid but we believe that state policymakers need solutions that balance both the access and the costs.

Michael Heifetz, Principal at Infinite Policy Solutions and former Wisconsin Medicaid Director, thanked the Committee for the opportunity to speak and stated that I was also a former state budget director and CEO of a Medicaid health plan for a time as well. And I also worked in a provider based integrated health system so I've been on pretty much every side of the payer provider component here and this just becomes a larger and larger issue as we go. A quick summary of what these are. It's really a contractual arrangement between the manufacturer and the Medicaid program. So again, it's voluntary. As Sen. Felzkowski indicated, the model simply allows states to pursue this. It doesn't require them to do so. So, it essentially then rolls into a contractual

arrangement where they would mutually agree to the terms, the definitions, the access components of it and the measurements for success or what is deemed as not success. So you can see those boxes there. The medium sized box on the right is very important because terminology is often mixed in this realm. So, you'll hear outcomes based performance, pay for performance, alternative payment arrangements and a number of things. You'll hear value-based care. Things like that that also crossover into other realms. So, just keep that in mind as we go but it's really at its essence a contractual agreement. So, for patients with rare disease, this can be very important to them because it can increase access. So, part of why the manufacturing community and I'm not saying it is the whole of the manufacturing community, but some members of the manufacturing community are pursuing these or are in favor of the ability to pursue these to address the access issue and to really battle through some of the components that my colleague just mentioned on how treatments can be restricted or limited or analyzed and delayed through some of those other utilization mechanisms that are common in Medicaid programs from the payer side.

So that's a large piece of this is that the manufacturer then knows that the patients who need this will get that access without those steps in between that are often costly to fight through and often difficult for patients to address. So, the other side of that is reducing the wasteful spending that comes from treatments that aren't helping or simply getting at a return on investment in a crass way on using some of these newer therapies that have some incredible impacts. In some cases, they monetarily work out very favorably for the payer side. In some cases they don't. But obviously they have massive impact on the patients and their families and their lives going forward. My colleague mentioned sickle cell. The average patient, according to some studies, with sickle cell disease only lives into their low 50s. And that's a dynamic that has to be thought of through all of this. So, as we talk about statistics and clinical studies and all these things that sound pretty lofty and remove the patient, really in some cases, we have to think about what that really means to the patient. Obviously, we have providers here on this committee today so that won't be lost here but sometimes when we talk about it, it sounds a little insensitive and it's not meant to be that way because these are massive patient impacts that we're talking about.

As mentioned, it's a contract between the two parties. It's addressing access and cost and the risk structure and we're ensuring through that contractual mechanism that these treatments are going to the right patients. Patients that are likely to succeed. Patients that generally without me getting overly clinical since I'm not a clinician, but patients that resemble the clinical testing that the treatment went through to gain approval from the federal folks and the regulators. So, there's that component of it and then there's the tracking and the data gathering of the success or not success of these treatments. So, it can be helpful in that public policy realm as well. Some of these are approved with different clinical trial results. Some of them are extremely successful on a percentage basis and some of them a little less so. So, that dynamic does come into play and it's measured. And how it's measured is determined through that contractual arrangement. And again, we love this balancing meme, I guess you could call it or logo. But anyway, these are aimed at ensuring the access issues and balancing that with the cost. And as my colleague mentioned, states will have to pay for these through the Medicaid

programs. This gives them a mechanism to at least manage that cost and give it some accountability that the manufacturers previously typically have not come forward with. So, it's not going to balance a Medicaid budget per se but it's going to pay for the performance of the product of the treatment and if it's not working as intended, then there will be a payback of some kind. That's a broad term. It will be spelled out contractually and there will be some transparency in that regard.

You can see up here all of the 24 states that have state plan amendments which is a relatively simple process that states file for their Medicaid programs to the federal government for approval. These are turned around relatively quickly by the federal government. They're very familiar given that it's 24 states. I think California was the most recent. We know of others that are exploring the issue. Wisconsin is soon to be filing its state plan amendment with the feds. We're hopeful of it. And it's giving flexibility in this regard. So, in some cases we have seen where legislation is needed for a state Medicaid agency to move forward with these. In other places the state Medicaid agency has its own independent authority in that regard but sometimes wants legislation so that there is full buy in and transparency of the process. But we've done this roadshow for a while, my colleague and I, and the 24 states, it used to be 13 then 16, then 18, and it is clearly growing as states explore this. And again, that doesn't mean every state is doing it but they want that authority, and they want to be able to talk to the manufacturers about how to approach this. Anecdotally, when I was Medicaid director, there was only one of these treatments around for spinal muscular atrophy. It was SPINRAZA. And it was at that point a one off for us from a clinical and a financial dynamic. It was about $500,000 to $750,000 but we only had two to three members in the Medicaid program that would have been eligible for it from a clinical perspective. So, in a $9 billion combined federal and state funds budget that $1 or $3 million would not have really caused us a major problem but when you look at the numbers that my colleague presented earlier, it becomes entirely different with sickle cell being $3 million or something in that neighborhood and having a much larger population of patients. You can do the math pretty quickly and then all of a sudden all of you as appropriators have a different dilemma in front of you besides the normal Medicaid dilemmas that you have in front of you. So, it's a significant issue. I was in a position where we didn't have to really debate it because it wasn't yet this advanced and I certainly did not want to play clinician or higher and say yes or no on my own. So, we were able to say yes but this dynamic gets more difficult as more of these come out and the price is what it is today. So, the volume is significant and that's really why this legislation is here. A few years ago it may not have been necessary and today it's a different world in this regard.

Rep. Ferguson asked if the eligibility process could be explained. Is there a national criterion or are all states doing the same thing for the same diseases? Who establishes those? Mr. Wieske stated that we expect there are a few states that have agreements in play. It is going to be literally a one-off agreement for each drug. It's a separate agreement and separate eligibility requirements. There are issues like tracking of the specific outcome. So, for example, for somebody who's a hemophilia you may have a pretty clear tracking whether or not they need to go continue on factor so that's a pretty easy one. Others may be a little bit more complicated because it's more of a systemic issue that may not be as clear. So, we expect that it's going to be a one off relationship

for each contract, each drug manufacturer will have to negotiate with each Medicaid agency for that. We do expect that by and large there'll be some, once they get agreement with a couple of states it will be a little bit more cookie cutter, but the agreements will differ on a drug to drug basis.

Sen. Paul Utke (MN), NCOIL Treasurer, stated that on the slides you had the outcome based reimbursements. Can you give us a couple examples or an example of how that's affected things. I would guess you you've got to have results or they don't get paid or they get a lower payment or how does that work and what have we seen? Mr. Wieske stated that one of the manufacturers that we were working with inside CTT, as it includes manufacturers, insurers and others and patient groups, but one of the manufacturers is offering contracts for one of the hemophilia drugs where if there's a failure in the first year they expect they're going to rebate back the entire cost of the drug which is $2 to $3 million. And then the second year there'll be a smaller percentage. The third year there'll be a little bit smaller percentage as they move on and maybe it's a five year or a ten year outset. But they will be rebating some portion of it back depending on what it does.

Sen. Arthur Ellis (MD) stated that you have a chart up there with all the states and it's color-coded. You said 24 states have this agreement and California was listed and it was the same color code as Maryland and Maryland was not in there so is that intentional or accidental? Mr. Wieske stated that was because California was late in the process and my computer skills were unable to re-color California in time. Sen. Ellis stated that I'm also really interested in the issue of social equity and when you talk about the cost for these very expensive cures I was sitting here and with the example used about when the population is so much higher and the treatment price will be cost prohibitive I said I bet you will say sickle cell and you did say sickle cell. And so that feeds into what a lot of my constituents say that when it comes to treating in certain populations the product becomes a problem. So, I know Johns Hopkins and others have come up with a cure for sickle cell and they're close to it and the cost is there and the issue is how we pay for it. And so you stated the problem, but what is the possible solution to take care of that problem and do you think it's bigger than we can handle?

Mr. Heifetz stated that globally, it may be larger than we're prepared to handle at the moment but I don't know that we're unable to handle it forever, so to speak. I'm trying to illustrate that when you have this many coming it becomes a much more difficult problem financially. For sickle cell, again, it's a more common of a rare disease, so to speak. So these kind of outcome based arrangements can address it. It means you as a legislator and appropriator can say, "Look, we do need to finance these. This needs to be a priority in our Medicaid program and in our state budget." But at the same time, if these very expensive treatments are not working as we think they should or as clinically as we think they should, then there will be some repercussions from the manufacturer. So, it helps balance out that dynamic of just cost with another side of that equation. Today, it's largely just a cost and hopefully all of these treatments work. Or it's difficult to get them as a patient and as a family because of prior authorization, other utilization reviews and other mechanisms. So, this type of arrangement gets at that and removes some of those hurdles potentially so that your constituents and others can receive the treatment

and your constituents statistically, it's just very difficult in the publicly paid healthcare programs to get some of these treatments. And the data on life expectancy that I mentioned earlier is pretty harsh. So, this can address a lot of that while still getting at that cost component but I think underlying your point is there's still a significant financial commitment that will have to be made in the short term and perhaps in the long term. Again, this is meant to balance that out, with the point being access so that you don't have to have this kind of debate routinely and that your constituents and others around the country, whether it's sickle cell or hemophilia or something else can get the treatments that their physicians and providers thinks will benefit them the most. Mr. Wieske stated that and the other bit here I think is important to remember is that these are horrific diseases in a lot of cases. There are significant issues and it might be in the short term that the adoption will take some time to trust the system for the gene therapies that will lead to a better result and so part of this as well is going to be proving that they in fact work and that they are in fact effective and that is of the interest of the drug manufacturer as well. They'll have data to prove that it is in fact effective, safe, and it in fact works. So, that's a piece of this as well.

Sen. Felzkowski thanked everyone for their comments and stated that I would like everybody to really take a serious look at this so that we can aim for considering it in November. Rep. Dunnigan stated that if anyone has any questions or comments, please reach out to me, Sen. Felzkowski, or NCOIL staff.

PRESENTATION ON POLICIES TO SUPPORT MATERNAL HEALTH

Amy Chen, Senior Attorney at the National Health Law Program (NHLP), thanked the Committee for the opportunity to speak and stated that I'll be sharing a little bit about state efforts to expand access to doula care. So, a little bit first about my organization for those who might not be familiar, we're a national nonprofit law firm that works to protect health rights for all and improve health access, health equity and quality of services, especially for low income and underserved individuals and families. We do our work through litigation, policy, advocacy and education. We have offices here in California where I'm based, North Carolina and Washington. DC. And we work closely with legal aid attorneys and health advocates across the 50 states as well as in Washington DC. I've been working on reproductive health law and policy at NHLP for almost 10 years now and prior to NHLP I worked as a legal aid attorney providing direct legal services to low income clients in and around Oakland, California. So, first of all, what is a doula? Just to provide some background information about what doulas are and what doula care is. Doulas are birth workers who provide health education, advocacy and physical and emotional support through different aspects of reproductive health. Doulas can provide care before, during, and after childbirth as well as support during miscarriage, stillbirth and abortion. Doulas do not provide medical care. They do not replace medical providers such as physicians, midwives and nurses. Rather, doulas provides support in places and in contexts where medical providers do not and ideally, supplements the care provided by a pregnant person's medical care team.

So, as you all probably know, the U.S. is in the midst of a maternal mortality crisis. New Centers for Disease Control and Prevention (CDC) data released just last year found the

maternal death rate in the U.S. rose again in 2021 with the rates of maternal death among black, pregnant and birthing people 2.6 times or more than twice as high as those of white pregnant and birthing people. Meanwhile, extensive research supports the proposition that doula care increases positive health outcomes. Pregnant and birthing people receiving doula care have been found to have improved health outcomes for both themselves and their infants including higher breastfeeding initiation rates, fewer low birth weight babies and lower rates of cesarean births. Doulas can also help reduce the impacts of racism and racial bias in healthcare settings by providing individually tailored culturally appropriate and patient centered care and advocacy. While doulas alone are not the solution to addressing America's maternal mortality crisis, they do offer one critical intervention. So, just a quick personal side, I have three kids. I had doulas at all three of my pregnancies, and I'm so grateful to my doulas for having supported me through my own pregnancies and also during my labor and delivery. At the same time when I returned to my work as a legal aid attorney after my parental leave it was really obvious to me how much my own legal aid clients could benefit from doula services but how painfully few of them could actually afford them. All of my clients as a legal aid attorney, they were on California's Medicaid program so very few of them could actually afford the $1,500 to $2,000 that was then the standard rate for doula services in the San Francisco Bay area. The rates for doula care across the country vary, but in most places the market rate for doula care is at least $1,000 and in many places is easily upwards of $2,000 to $3,000. At the same time, we know that low income, pregnant and birthing people are higher risk for poor birth outcomes and as I mentioned earlier, because of the high cost are less likely to be able to afford doula care out of pocket.

Meanwhile, Medicaid covers up to half of all births nationally so an intervention, such as doula care for pregnant and postpartum Medicaid enrollees really has the potential to make a tremendous impact on maternal and infant health across the country. So, my organization’s doula Medicaid project, which was launched in May 2019, seeks to improve health outcomes and address inequities in maternal health by ensuring that all pregnant and postpartum people who want access to a doula can have one. Our starting point in this work is expanding access to sustainable, equitable and inclusive programs for Medicaid coverage for doula care.
You can read more about our work on the website at the link below on the bottom of this slide. Suffice to say that we provide technical assistance, information sharing and other support to doula policy advocates and other stakeholders across the country. Our ultimate goal is to help identify and overcome barriers to sustainable equitable and inclusive programs for Medicaid coverage for doula care. We are also creating published resources and manage multiple avenues to share state and regional updates. My organization’s focus is on expanding access to full spectrum doula care which includes doula support not just for prenatal, postpartum and labor and delivery but for all the ways in which your pregnancy can end including abortion, miscarriage and stillbirth. Lastly, I want to note that at NHLP we're lawyers, we’re researchers and policy advocates. We do not have any doulas on our team. So, we've sought to do our work in partnership and with the guidance of community doula groups, doula collectives and individual doulas, especially doulas representing groups most impacted by disparities in care. So, I also have a map as of July 2024 there's currently a total of 44 States and Washington, DC that have taken some action towards Medicaid coverage of doula care

including either direct implementation or some adjacent action aimed at ultimately implementing Medicaid reimbursement. There are 15 states plus Washington, DC that have already implemented coverage so those are the states that you see on the map with the red stars. Another 14 states are in process, those are the yellow stars. And a lot of these states with the yellow stars will be implementing coverage later this year, some early next year. And then another 16 states, the blue stars have taken some other adjacent option. For example, state funded doula pilot programs, creation of doula advisory boards or doula advisory committees or recruiting other mechanisms for doulas to be certified by the state. 2023 saw four states rolling out Medicaid coverage for doula care: Michigan, California, Oklahoma and Massachusetts. 2024 thus far, we've seen three states, New York, Kansas and Colorado implementing coverage. I do have New Mexico marked as having implemented coverage with the red star but that was a little bit premature. They don't yet have an approved state plan amendment (SPA), they just have the proposed SPA that is currently out. And the Colorado star should also be red. I just found out last week that they implemented coverage on July 1 and I did not have time to change my slides.

So, how are states implementing coverage? Perhaps the most common way the states implement coverage is through just straight up legislation requiring coverage of doula care as a Medicaid benefit, typically followed by an SPA. Legislation has also sometimes been used to create, as I mentioned earlier, doula advisory boards or doula advisory committees, something along the road to ultimate implementation of full Medicaid coverage for doula care. Other states have started with the legislation and even in situations where that legislation is not passed, sometimes they nonetheless have implemented Medicaid coverage for doula care. Oftentimes, the state Medicaid agency will kind of take it upon themselves. Doula care can also be added as a benefit through the state budget or funding initiatives. So, for example, here in California, doula care was initially included as part of SB-65, our California Omnibus maternal health bill. But then it was later included in the Governor's 2021 to 2022 budget and so that piece was taken out of the legislation since it had already been funded in the budget. And the last slide as I mentioned earlier, state Medicaid agencies can also decide to include doula care as a Medicaid benefit on their own. So, for example, in Michigan, there was legislation introduced in 2020. The legislation did not pass, but it did launch discussions in the Department of Health and Human Services and that department did end up adding doula care as a new benefit on their own in 2022. So, just a couple of trends to watch. First of all, I am seeing a growing number of states being really more thoughtful about achieving a sustainable and equitable reimbursement rate for doulas. This follows Rhode Island implementing a $1,500 Medicaid reimbursement rate starting in July 2022 and Oregon implementing a $1,500 reimbursement rate after languishing for many years at a reimbursement rate of $350. California just this year recently implemented a new doula Medicaid reimbursement rate of $3,100. This is for the entire package of services. And in 2023, both Minnesota and Nevada increased their reimbursement rates to $2,000 and $1,500, respectively. Second, I'm seeing an increase in efforts to expand access to doula care in the private insurance context as well. So, at present, there's only one state, Rhode Island, that requires private health insurance plans to cover doula care which they passed as a requirement in 2021 alongside the Medicaid coverage for doula care requirement. Last year, in 2023, Louisiana passed legislation to expand doula care

in the private insurance context. And also, in 2023 Utah passed legislation to include doula coverage and access to birth centers specifically for state employees.

And in April of this year Virginia's Governor signed into law SB 118, which will also require private insurance coverage of doula care. So, they're still in process. And then thirdly, in terms of trends, many of the states that have implemented or are implementing Medicaid coverage for doula care have also seen the growth or emergence of doula groups, co-ops, associations that are really self-organizing to help alleviate some of the burden that entails to become a Medicaid provider. There's obviously a lot of bureaucracy, paperwork, billing challenges, coding that's involved with Medicaid billing and reimbursement and many doulas were new to Medicaid as a system are just really finding that they're needing support not just to navigate the system, but also to be successful in seeking reimbursement as Medicaid providers. Lastly, just a couple of recommendations I wanted to share that I am currently working on in a document distilling a series of best practices that have come from our work over the years with doulas and advocates across the country. I think there should have been a link to my sort of draft version of the best practices document in the meeting materials. If you didn't get it, you can e-mail me. There's my e-mail address on the slide. Second, I really encourage legislators, doulas, policy advocates, agency staff, those that will be implementing Medicaid coverage for doula care to really make sure that at every step in the process community-based doula groups who are already serving low income and Medicaid enrollees are really front and center in crafting the policy language and determining how it's implemented. Some state Medicaid agencies and health plans have really struggled on this piece, not for lack of intent, but in some cases just lack of experience working in real partnership with stakeholders. This is really a new relationship for many of those involved and it's also no small task to figure out how to incorporate a brand new category of provider. And lastly, don’t reinvent the wheel - follow what's happening not just in your state, but in other states. For example, there are five states that have implemented statewide standing recommendations for doula services: Michigan, California, Massachusetts, Minnesota, New York. These standing recommendations state that any Medicaid enrollee who's pregnant or was pregnant within the past year would benefit from receiving doula services and it obviates the need for Medicaid enrollees to obtain specific recommendations from licensed Medicaid providers on an individual basis. This was something that had not been done before Michigan issued their statewide standing recommendation but once they did it, other states learned from that effort.

Ms. Chapman stated that I just wanted to highlight that BCBSA recently launched a report on postpartum care to amplify our efforts to raise awareness about maternal health care and maternal health inequities and when it was mentioned to me that there was interest here at NCOIL in talking about maternal health we were really excited to hear that and we hope this conversation continues. You should have a copy of the report available online in the materials and if not please let me know and I'll make sure you get it. In short, this report demonstrates that the risk of childbirth does not end at delivery. There are many dangerous and unexpected birth complications or health related events that are categorized or called severe maternal morbidity. And those events can take place during labor and delivery as well as during the postpartum period,

which is considered six weeks after giving birth. And these events have sometimes long-lasting consequences and even death. Our research shows that as many as one third of all severe maternal mortality events occurred during that postpartum period and black patients are at much higher risk of experiencing these events even more so than their white and Latina counterparts, even after the delivery of the child. So again, I just want to reiterate, we do have that report available and I hope that we'll continue discussing these issues here at NCOIL.

Rep. Ellyn Hefner (OK) thanked the speakers and stated that I think we need to put more time towards this topic. I know the statistics are not getting any better for moms that have babies. We're not finished after we have them and doulas are such a great way to help moms connect. We bring up Medicaid and I would love to ask how many in here have applied for Medicaid? I have a child with a disability and it's one barrier after another and so I think that we need doulas. I'm working on community healthcare legislation for designation so we can pay them because it's more than just wanting them or needing them, which our moms need. It's workforce, we're not paying them enough to do the job of taking care of a mom who's carrying kids, who may need that help to access doctors. In Oklahoma, we do have it set up but we just don't have the payment system there that gets them to where they need to. We have very few doctors that are OBGYN's that are in our rural areas and we have some urban challenges as well that are the same as rural. So, I'm so happy that you're bringing this here to give us all this great information. I do wish that we could spend some more time on what our individual states could do to help moms that need that extra care because it's not a one and done as we all know. I appreciate NCOIL bringing this up and as Rep. Oliverson said earlier today, preventative care is the best and if we have doulas at the beginning we know that we will have better outcomes so we won't be paying for certain things later in our budgets in our states. Some of the statistics about maternal morbidity cited are awful and we need to get those better and this is one of those preventative things that can really help save some mom’s lives.

Rep. Greg Scott (PA) stated that I just wanted to acknowledge the committee for bringing this issue up. This is an issue that hits close to home for me personally. I know that there's a lot to be said around adding Medicaid for those services and we've done that in Pennsylvania and Pennsylvania like the rest of the country, we have a maternal mortality crisis. But with everything I try and look at it through an equity lens and when America has a cold, the black community gets the flu. In Pennsylvania black women are 3.5 times as likely to die for what should be the most joyous event of their lives, bringing another human being into this earth. And so we've taken an all hands on deck approach to this issue in Pennsylvania. A few of my colleagues have created the Pennsylvania Black Maternal Health Caucus which really shined a light on this issue. We got the Governor to pay attention to it by bringing his wife to a few clinics to showcase this issue. We got some real dollars in our budget last year to study this issue. Those studies are in the process of being evaluated and the Governor directed our Health and Human Services Dep’t to have Medicaid accept it. We also have legislation for Medicaid as well as for private insurance to cover doula care. My question to you is really about what about the other postpartum care that data shows works for example, postpartum mental health services. Sending moms home with a blood pressure kit to check blood

pressure a couple times a day. What about neonatal kits? Where are we seeing other states around the country with adding those things in legislation? I know some of the insurance companies are sending them home from their wellness perspective but where are we at with that kind of stuff?

Rep. Oliverson stated that he really appreciated the presentations and stated that if $3,000 for doula services is what is being sought, I think that's more than double what the OBGYNS make in California from the Medicaid system. Ms. Chen stated that in California, the reimbursement rate for doulas is now $3,100. Rep. Oliverson stated that the OBGYN gets $1,300 and that doesn't seem proportional to me. Can you explain that? Ms. Chen stated that I think what would be helpful is I have some resources on our doula Medicaid project website that I can share but I think you really have to think of the scope of work that a doula does is very different. A doula is not providing medical care, not providing medical services and so what that means is that the time that a doula spends with a pregnant patient is very different. The type of work and care they're providing is very different. As I mentioned earlier, I have three kids. I love my OBGYN, and she spent about maybe 15 to 20 minutes with me at each of those prenatal appointments. She was there kind of at the end during labor and delivery when the baby was coming out. My doula came for a number of prenatal and postpartum appointments, 60 to 90 minutes for each of those appointments. She came to my house when I started having contractions hours before I went to the hospital, stayed with me during my entire labor and delivery, stayed with me after the baby was born and I was trying to figure out breastfeeding, stayed with me during that very early immediate postpartum recovery period. And not until I was settled this is hours after did she go home. And then there were a couple of additional postpartum appointments that were again about 60 to 90 minutes each. So I think if you think about the scope of services that's important. I know just looking at the $3,100 versus $1,500 is different and the training is obviously different, but I think you really have to think about the nature of the care and the scope of care.

PRESENTATION ON BILLING PRACTICES IN THE GROUND AMBULANCE SERVICE INDUSTRY

Nadia Stovicek, Research Fellow at the Center on Health Insurance Reforms at the McCourt School of Public Policy at Georgetown University, thanked the Committee for the opportunity to speak and stated that I'm also a former legislative staffer so I have a sincere appreciation for all the work you're doing here today. Today I'll be talking about the No Surprises Act (NSA) and what states and the federal government are doing to protect consumers from being balanced billed when using ground ambulances. And I also would be remiss if I didn't thank our sponsors Arnold Ventures and the Commonwealth Fund for supporting this project. The NSA is a federal law that protects consumers with private insurance from being balance billed or facing a surprise bill. A balanced bill is when the provider bills the patient for the balance due, the difference between the provider's charge and how much the insurer is willing to pay. The NSA bans balance billing for out of network costs in emergency situations when using an air ambulance or receiving care at an in-network facility but using an out of network provider and it went into effect two years ago. While it's still relatively new, a recent study of ours

found that it is by and large accomplishing the goal of protecting consumers from having to pay out of network costs for an emergency situation or when they expect to only receive in network care. It also removes consumers from any dispute between the cost of care between the provider and the insurer. If there's a disagreement on the billed charge, then the provider's insurers have to use an independent dispute resolution (IDR) process to agree on a price. But a major gap in the NSA is that ground ambulances are not protected despite them being crucial in emergency situations.

So, why is it important to fill the ground ambulance gap? Many of us can probably recall a time when we or a loved one had to call 911 for an ambulance because of an emergency health situation. With time being of the essence, it would make sense that consumers are eager for the quickest ambulance ride to take them to the hospital. But in emergencies, consumers often don't have time to determine if a provider is in network and they often don't even have a choice in a provider. On top of that contracting as an in network provider is an administrative burden for ground ambulances. Carriers also struggle to contract with providers for various reasons such as inability to reach an agreement or being unable to contact someone who handles the contract negotiations. Thus, it is common for ground ambulances to be out of network. But we know that ground ambulances don't just transport people to the hospital. They can administer crucial life support depending on the level of EMS staff, treat patients on site without needing to bring them to the hospital, and move patients in between facilities. Currently, providers do not get reimbursed for these treat no transport cases. So, how many people arrive to the ER via ground ambulance? Well, 10% of ER visits by privately insured people are by ambulance which is about three million people annually. There is a significant patient affordability issue with ground ambulance costs. A recent poll found that about a quarter of people have decided not to use an ambulance because of the fear of cost. And data from 2021 found that one third of insured patients cannot afford a surprise medical bill of $1,000 or more and almost half of insured patients cannot pay an emergency expense over $400 without borrowing money or selling assets. This puts the burden of balance billing on consumers who are more likely to incur medical debt as a result which could have lasting consequences. Ambulance providers also struggled to recoup the costs for their services. Washington State collected data on what type of ground ambulance coverage exists for consumers with private insurance. As we can see in this table for Washington, insurers are more likely to cover emergency transport but leave out other forms of care. The majority of ambulances are publicly owned. The ground ambulance industry consists of small operations connected to a town's fire department to completely privatize ambulances that a local government outsources care to. This chart shows with the lighter blue color on the right that public sector ground ambulance agencies provide almost two thirds of ground ambulance rides. This is significant since state and local regulation and the high rates of publicly operated ground ambulances were reportedly two reasons that Congress did not include ground ambulances in the NSA. As the table shows, 85% of emergency transports are delivered out of network meaning that emergency care is mostly likely out of network and 28% of those transports can result in a surprise bill. We see in this slide here the breakdown of charges for a ground ambulance ride from data from 2017. The bill charged for a public sector ambulance is more than $1,000. The allowed amount is what insurance pays. Insurance is willing to pay almost 80% of that amount and

consumer paid $207 in cost sharing. But if insurers do not pay the allowed amount, the consumer could have to cover the potential surprise bill on top of cost sharing. This makes a total out of pocket cost unaffordable for the majority of Americans.

I know I've just whipped up a lot of information and thrown it at you guys and I wanted to pause and reflect on what I just covered. I know that the ground ambulance rides are not covered by the NSA but it is likely for these rides to be out of network and unaffordable for consumers. Now, we'll talk about what states are doing to protect consumers from ground ambulance balance billing charges. I'd also want to mention that while federal regulations would cover a lot more people, it's still very important for states to pass protections to ensure that some people can be covered now. As many of you know, states have been taking action before and after the NSA to protect consumers from surprise ambulance bills and four states this year, Indiana, Mississippi, Oklahoma and Washington all passed laws. Here's a bunch of information on how states differ on consumer protections and rate reimbursement in these laws. So let me break down this information for you because I know it can seem overwhelming. As you can see on the box on the left all of the states that have ground ambulance protections protect consumers from surprise bills but some only cover emergency services and others only offer protection space on the ownership type of the ground ambulance. I'll skip through specific examples for the sake of time. Now, I'll talk about rate reimbursement guidance. So, while states all have some form of rate reimbursement guidance, some provide more detailed guidance than others. As you can see on the slide there are a variety of factors to consider for creating state-based ground ambulance protections. States can decide to include coverage based on if the provider's public or private. If the ground ambulance is used in emergency and non-emergency situations. If coverage exists for interfacility transport and treat but no transport cases. And states would also have to consider if they would like to forgo a negotiation process like IDR and if so, how would they like to set up a reimbursement rate. Ultimately from a consumer perspective the broader the coverage, the better it is. A federal advisory committee called the Ground Ambulance and Patient Billing Committee will publish its report to Congress to prevent ground ambulance balance billing soon. This committee was created as part of the NSA to develop a solution for federal ground ambulance protections. The Committee voted on recommendations but have yet to send the report to Congress but we're hoping that it's going to happen soon, maybe by the end of the month.

Since only the federal government can regulate self-funded employer sponsored insurance, where 65% of workers in the U.S. get their coverage, federal coverage would cover a lot more people. So, let's go through the recommendations very quickly. Consumers would be protected from balance billing for emergency transports responding to 911 calls and interfacility transports. Both public and private providers will be covered, as well as treat no transport cases. The most a consumer would pay out of pocket would be the lesser of $100 or 10% of the payment rate which is a far cry from the $260 average cost sharing charge many consumers currently experience with the potential surprise bill of $734 for private sector transport. Unlike the NSA's approach to payment, the federal Committee agreed on specific reimbursement standards to inform payment amounts similar to what many states have done. Thinking through the prospects for expanding protections to ground ambulances we know federal action could

significantly increase the number of consumers protected from ground ambulance balance billing and it has a lot of bipartisan support but it is unlikely that the federal government will act on these recommendations in the short term. Unfortunately, it's hard for Congress to pass much in general these days which is why continued state action is still so valuable and to consider the breadth of services covered. Eighteen states have already taken action and this is crucial for the consumers who are covered under state regulated insurance. So, what can states do going forward? They don't need to wait on the federal government to take action. They can look out for the federal committee report, which would be out soon and consider how to best protect consumers and include specific rate reimbursement guidance on their bills. That concludes my presentation. I've included my contact information and I'd also like to offer the services of the Center on Health Insurance Reforms for any states who are looking to consider introducing bills on ground ambulance balance billing protections.

Sen. Ellis thanked Ms. Stovicek for the presentation and stated that I'm trying to keep up with your acronyms - the NSA is the No Surprises Act? Ms. Stovicek replied yes. Sen. Ellis asked if that is a state initiative or federal? Ms .Stovicek replied it's a federal initiative. Sen. Ellis asked if the law passed. Ms. Stovicek replied it did pass in 2022 to protect consumers from having to pay the difference between what the provider charges and what insurance is willing to pay. Sen. Ellis asked if states are taking additional action. Ms. Stovicek replied yes some states have taken additional action and they're able to if the state goes above and beyond what the federal regulations are, they're able to supersede that. But the significant point of the NSA is that they didn't cover ground ambulance protections even though that's a very common way for consumers to be balance billed, i.e. pay the difference between what the provider is charging and what the insurance is willing to pay. Sen. Ellis stated so if any actions need to be taken with ground ambulances it's up to the states because the NSA did not cover ground ambulance? Ms. Stovicek replied yes, and the government is trying to work on it through this committee I mentioned.

Rep. Scott asked if the NSA mainly covered hospitals and doctor's visits? Ms. Stovicek replied yes. Rep. Scott stated so the object here is that if you add ground ambulances about to the balance billing protections then that would help. When people have implemented these in these states, where are these volunteer EMS services making up that shortfall? Is there also a line item when you add these balance billing bans for them to come up with this money? And is there a rate structure in place to display the amount of these things ahead of time? Ms. Stovicek stated that it doesn't seem like there's been a huge differentiation in terms of what providers are getting paid eventually because right now there's no standard for what providers are being paid. And with a lot of state legislation, there's specific guidance on that but otherwise a lot of these services are just out of network so they have out of network charges. Rep. Scott stated where I come from, the majority of our ambulances are provided by volunteer services by a wide swath of the state. We have very minimal pockets where there's full time career staff, especially government run full career staff and so the question ultimately is how do we pay for this, especially with banning the balance billing. A lot of them they make up their money from the balance billing. Ms. Stovicek replied that is a great question and she will look into it further.

Rep. Dunnigan thanked everyone and stated that this issue is a valid concern for me. In Utah worked on surprise billing for a number of years and the federal level finally stepped up in the space but they didn't cover ground ambulances.

ANY OTHER BUSINESS

Rep. Dunnigan stated that we have one more item of business under other business. Julian Roberts, President & CEO of the American Association of Payors and Administrators and Networks (AAPAN) will provide some brief remarks.

Mr. Roberts thanked the Committee for the opportunity to speak about an access to care issue in regards to hearing healthcare. In August of 2022, the U.S. Food and Drug Administration (FDA) promulgated regulatory changes establishing over the counter hearing aids as a new category of medical devices while classifying non over the counter hearing aids as a prescription or medical devices. So previously there was no need for a prescription for hearing aids and now there is a new prescription requirement for non over the counter hearing aids. This has created a lot of confusion in the various states as to who can write the prescription for these and who cannot. Approximately 20 states have passed legislation to provide clarification to ensure audiologists and hearing aid specialists can both prescribe non over the counter hearing aids. I might also add that in these 20 states where we passed legislation it was passed with both payers and providers supporting these bills which is kind of a rarity. We look forward to further discussions on this issue at future meetings.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Utke and seconded by Rep. Lehman, the Committee adjourned at 3:45 p.m.

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SECRETARY: Rep. Edmond Jordan, LA

IMMEDIATE PAST PRESIDENT: Rep. Deborah Ferguson, AR

National Council of Insurance Legislators (NCOIL

Improving Affordability for Patients Model Act

Sponsored by Rep. Deborah Ferguson, DDS (AR), NCOIL Immediate Past President, and Rep. Tom Oliverson, M.D. (TX), NCOIL President

Draft as of September 16, 2024. To be discussed during the Health Insurance & Long Term Care Issues Committee on November 22, 2024.

Table of Contents

Section 1. Purpose and Intent

The purpose of this Act is to prohibit healthcare facilities, including hospitals, from imposing facility fees for outpatient services and to require healthcare facilities to accurately bill for services provided at hospital-owned facilities. Such reforms will address escalating healthcare costs and improve the affordability of healthcare benefits for consumers.

***Drafting Note**: States may consider including this Act in the State's Public Health, Health and Safety, or Health Care Code section, or its Commercial or Consumer Affairs Code section. States may also consider placing the prohibition, billing, and reporting requirements of the Act in a health-related code section while making violations of the Act an unfair trade practice under the State's unfair trade practices provision. States*

should consider existing statutes that provide sufficient authority to promulgate the provisions of this Act in a regulation format and provide sufficient enforcement authority.

Section 2: Facility Fees

A. Definitions. For purposes of this [section 2]:
Drafting Note*: States should review existing authority and align these definitions with other state-specific definitions, as appropriate, including Commissioner, Director, or Superintendent.*

(1) "Affiliated with" means:

(a) employed by a hospital or health system; or

(b) under a professional services agreement, faculty agreement, or management agreement with a hospital or health system that permits the hospital or health system to bill on behalf of the affiliated entity.

(2) "Campus" has the meaning set forth in section 413.65(a)(2) of title 42 of the Code of Federal Regulations (or successor regulations).

Drafting Note*: Campus means the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office, to be part of the provider's campus. 42 CFR 413.65(a)(2). States should review existing state definitions of campus that should be used.*

(3) "Facility fee" means any fee a hospital, healthcare facility, or health system charges or bills for outpatient hospital, healthcare facility, or health system services that is:

(a) intended to compensate the hospital, healthcare facility, or health system for its operational expenses; and

(b) separate and distinct from fees charged or billed by a healthcare facility for healthcare services.

(4) "Healthcare facility" has the meaning set forth in [state code] and includes hospitals and [entities that are separately licensed].

(5) "Healthcare provider" means any person, group, professional corporation, or other organization that is licensed or otherwise authorized in this state to furnish a healthcare

service or provides the services of such individuals, groups, corporations, or organization, including but not limited to a medical clinic, a medical group, a home health care agency, a health infusion center, an urgent care center, and an emergent care center.

(6) "Healthcare services" means healthcare related items, services or products rendered or furnished by a provider within the scope of the provider's license, [certification], or legal authorization for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease. The term includes, but is not limited to, durable medical equipment, infusion, imaging, hospital, medical, surgical, and pharmaceutical services or products.

(7) "Health system" has the meaning set forth in [state code].

(8) "Hospital" means a hospital currently licensed [or certified] under [state code].

(9) "Off-campus location" means any location that is not located:

(a) on the campus as defined in this section; or

(b) within the distance described in such definition of campus.

(10) "Outpatient hospital services" means any healthcare services that are furnished by a healthcare provider affiliated with or owned by a hospital, healthcare facility or health system and are furnished without an overnight stay at a hospital, healthcare facility or health system.

B. Prohibition on facility fees:

(1) A healthcare provider, healthcare facility, or health system shall not charge, bill, or collect a facility fee directly from a patient, [insurer/carrier], or [health benefit plan] for healthcare services provided in an off-campus location.

Drafting Note*: A state should use the state-specific term for a health insurance issuer and a group health plan. Consider including "as defined in [state code]" as necessary.*

(2) A healthcare provider, healthcare facility, or health system shall not charge, bill, or collect a facility fee from a patient, [insurer/carrier], or [health benefit plan] for outpatient services billed using evaluation and management (E/M) Current Procedural Terminology (CPT) codes, even if such services are provided on a hospital's campus.

(3) A healthcare provider, healthcare facility, or health system shall not charge, bill, or collect a facility fee from a patient, [insurer/carrier], or [health benefit plan] for outpatient services billed using evaluation and management (E/M) CPT codes when such services

are provided via real-time audio and/or visual interactive telecommunications [or appropriate state code reference to telehealth services.]

Drafting Note*: A state may consider referencing Medicare for telehealth; e.g., telehealth as that term is described in section 1834(m) of the Social Security Act of 1934.*

(4) A healthcare facility that is newly affiliated with or owned by a hospital or health system on or after [date], shall not charge, bill, or collect a facility fee from a patient, [insurer/carrier], or [health benefit plan] for services described in paragraph (1) through (3) of this subsection B, without regard to whether the healthcare facility is designated [under state law, regulation, guidance] as a hospital.

Drafting Note: *A state may consider the interplay of other state payment requirements here.*

C. Transparency on facility fees

(1) A healthcare provider affiliated with or owned by a hospital or health system that charges a facility fee that is not prohibited by subsection (B) shall:

> (a) provide notice in plain language to patients that a facility fee may be charged, indicate in the notice the range of the facility fees that could be charged, and require the healthcare provider to provide the notice to a patient at the time an appointment is scheduled and again at the time the healthcare services are rendered;
>
> (b) provide notice of [any state required billing grievance process] and [any free/reduced cost care programs available];
>
> (c) provide notice of the fee waiver process described in paragraph (C)(5); and
>
> (d) post a sign, in English and [at least the 15 languages most commonly spoken by individuals with limited English proficiency in the State and must be provided in alternate formats for individuals with disabilities who require auxiliary aids and services to ensure effective communication] and that is plainly visible and located in the area within the facility where an individual seeking care registers or checks in, that states that the patient may be charged a facility fee in addition to the cost of the healthcare service. The sign must also include a location within the facility where a patient may inquire about facility fees, an online location where information about facility fees may be found, and a toll-free phone number that the patient may call to inquire about facility fees.

***Drafting Note**: The reference to 15 language most commonly spoken and auxiliary aids is the July 2022 requirement applicable to entities that receive federal financial assistance from the Department of Health and Human Services (the section 1557 rules), and which applies to most hospitals and health care facilities already. States may consider cross referencing directly to the federal regulatory provision: subsection 92.11(b) of title 42 of the Code of Federal Regulations (or successor regulations), but note that the section 1557 rules have been, and are expected to continue to be, subject to litigation, so the substantive requirements in the cross-reference may be vacated or materially changed.*

(e) Provide to a patient a standardized bill that:

(I) includes itemized charges for each healthcare service;

(II) specifically identifies any facility fee;

(III)identifies specific charges that have been billed to insurance or other payer types for healthcare services; and

(IV)includes contact information for filing an appeal with the healthcare provider to contest charges.

(2) The healthcare provider shall provide the required notice and standardized bill in a clear manner and, to the extent practicable, in the patient's preferred language.
(3) A healthcare facility that is newly affiliated with or owned by a hospital or health system on or after [date], shall provide written notice to each patient receiving services from such facility. In addition, the healthcare facility must provide the notice to any patient that received services from the healthcare facility in the past 12 months. The notice must include:

(a) the name, business address, and phone number of the hospital or health system that is the purchaser of the facility or with whom the facility is affiliated;

(b) a statement that, beginning on or after the date of the acquisition or affiliation, the facility bills, or is likely to bill, patients a facility fee that may be in addition to and separate from any professional fee billed by a healthcare provider at the facility;

(c) a statement that the healthcare facility cannot impose, or attempt to hold the patient liable for, any facility fee prior to the date of the acquisition or affiliation with the hospital or health system that is the purchaser of the facility or with whom the facility is affiliated; and

(d) a statement that prior to seeking services at the facility, a patient covered by a [health insurance policy or health benefit plan] should contact the patient's [health insurer or plan] for additional information regarding the facility's facility fees, including the patient's potential financial liability, if any, for the facility fees.

Drafting Note*: States should conform health insurance policy and health benefit plan to state's defined terms.*

(4) A hospital, healthcare facility, or health system shall not collect a facility fee for healthcare services provided by a healthcare provider affiliated with or owned by a hospital or health system that is subject to any provisions of this section from the date of the transaction until at least thirty days after the written notice required pursuant to subsection (C)(3) of this section is mailed to the patient.

(5) Facility Fee Waiver Process. Each hospital, healthcare facility, and health system shall create a process by which patients may receive a waiver from, or reduced cost for, any facility fee charged to that patient that is not prohibited by subsection (B). Such process shall provide a minimum of 30 days for a patient to request a waiver or reduced fee, shall be provided in the patient's preferred language, and with any auxiliary aids necessary to ensure that the patient is able to fully access the waiver process. The [Department/Commission] shall issue rules implementing this waiver process, along with best practices and a model process, within [X days/weeks/months] of the passage of this [provision / Act].

D. Annual Reporting:

(1) Each hospital, healthcare facility, and health system shall submit a report annually to [the Department/Commission] concerning facility fees charged or billed during the preceding calendar year. The report shall be in such format as [Department/Commission] may specify. The [Department/Commission] shall publish the information reported on publicly accessible website designated by the [Department/Commission].

Drafting Note*: States should consider the appropriate state agency with the authority to oversee this requirement.*

(2) Reporting Requirements. Such report shall include, without limitation, the following information:

(a) The name and full address of each facility owned or operated by the hospital or health system that provides services for which a facility fee is charged or billed;

(b) The number of patient visits at each such hospital-based facility for which a facility fee was charged or billed;

(c) The number of patient waiver requests, with the number approved, the number denied, and the average amount and percentage of fee waived;

(d) The number of patient appeals as described in Section (C)(1)(e)(iv) of this act, with the number approved and the number denied;

(e) The number, total amount, and range of allowable facility fees paid at each such facility by Medicare, Medicaid, private insurance, and by individuals;

(f) For each hospital-based facility and for the hospital or health system as a whole, the total amount billed and the total revenue received from facility fees;

(g) The top ten procedures or services, identified by current procedural terminology (CPT) category I codes, provided by the hospital or health system overall that generated the greatest amount of facility fee gross revenue, the volume each of these ten procedures or services and gross and net revenue totals, for each such procedure or service, and, for each such procedure or service, the total net amount of revenue received by the hospital or health system derived from facility fees;

(h) The top 10 procedures or services, identified by current procedural terminology (CPT) category I codes, based on patient volume, provided by the hospital or health system overall for which facility fees are billed or charged [based on patient volume], including the gross and net revenue totals received for each such procedure or service; and

(i) Any other information related to facility fees that the [Department/Commission] may require.

Section 3. Honest Billing

A. Applicability. This [section 3] applies to all healthcare facilities, including but not limited to hospitals, and includes the ultimate parent company of a health system, and all health carriers licensed in this State.

B. Definitions. As used in this [section 3]

Drafting Note*: States should modify to include definitions or cross-references with state law, as appropriate. Note that the definitions of healthcare facility, healthcare services, health system, and off-campus location, are intended to be the same as under the facility*

fee section. If both provisions are adopted in the same act, the definition sections for facility fees and honest billing may be merged and overlapping definitions omitted.

(1) "Campus" has the meaning set forth in section 413.65(a)(2) of title 42 of the Code of Federal Regulations (or successor regulations).

***Drafting Note**: Campus means the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office, to be part of the provider's campus. 42 CFR 413.65(a)(2). States should review existing state definitions of campus that should be used.*

(2) "Covered person" means a policyholder, subscriber, enrollee or other individual, including a dependent of the policyholder or subscriber, participating in a health benefit plan [as defined in the state's code], including Multiple Employer Welfare Arrangements (MEWAs) but excluding limited benefit health plans, accident or indemnity plans, excepted benefit dental and vision plans, and short-term limited duration health plans.

***Drafting Note**: States should consider excluding, by reference to state law, all HIPAA "excepted benefits" from "health benefit plan" for purposes of this Section.*

(3) "Healthcare facility" has the meaning set forth in [state code] and includes hospitals and [entities that are separately licensed].

(4) "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance,
health benefits, or health services.

***Drafting Note**: A state should consider cross-referencing the appropriate definition of "health carrier" or "insurer" here and, if changed here, should make the same change throughout the provision. States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.*

(5) "Healthcare services" means healthcare related items, products, or services rendered or furnished by a provider within the scope of the provider's license, [certification], or legal authorization for the diagnosis, prevention, treatment, cure or relief of a health

condition, illness, injury or disease. The term includes, without limitation, durable medical equipment, infusion, imaging, hospital, medical, surgical, and pharmaceutical services or products. For purposes of this section, the amount of any bill submitted to a health carrier with the expectation of payment (in whole or in part) is considered to be a bill for "healthcare services."

(6) "Health system" has the meaning set forth in [state code].

(7) "National Provider Identifier" or "NPI" means the standard, unique health identifier for health care providers that is issued by the National Plan and Provider Enumeration System in accordance with title 45, Part 162 of the Code of Federal Regulations.

(8) "Off-campus location" means any location that is not located:

(a) on the campus as defined in this section; or

(b) within the distance described in such definition of campus.

C. National Provider Identifier. Irrespective of 42 CFR section 162.410(a)(1), each off-campus location of a healthcare facility must apply for, obtain, and use, on all claims filed after [date] for reimbursement or payment for healthcare items or services provided in that off-campus location, a unique NPI that is distinct from the NPI used by the campus of the facility and any other off-campus location of the facility.

D. Billing Requirements.

(1) A healthcare facility subject to this [section 5], with respect to healthcare services furnished to a covered person at an off-campus location, shall submit a claim for such healthcare services to a health carrier, and may not hold the covered person liable for such healthcare services, unless those healthcare services are billed:

(a) using the separate unique NPI established for such off-campus location; and

(b) on a U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) 1500 form or its successor form, or a Health Insurance Portability and Accountability Act (HIPAA) X12 837P standard electronic claims transaction (or a successor transaction or form).

(2) A health carrier is not responsible to reimburse claims for healthcare items and services furnished to a covered person at an off-campus location if claims are not billed pursuant to this subsection.

(3) A covered person, with respect to healthcare services at an off-campus location furnished by a healthcare facility subject to this [section 5] and billed in compliance with this subsection, shall be responsible for paying only the cost-sharing required by their health benefit plan. A covered person is not responsible for and may not be held liable by such healthcare facility to pay amounts in addition to the cost-sharing required by their health carrier.

D. Revalidation. A healthcare facility, healthcare provider, or other entity applying for revalidation as a healthcare provider under [state law] shall demonstrate that it has obtained one or more NPIs as required by this section as a condition of receiving revalidation, and upon receiving revalidation, shall use its unique NPI on every claim for payment in the manner required by this Act.

Drafting Note*: A state should use the appropriate terminology in its laws or regulations (e.g., re-certification, approval, licensure, etc.) The intent is to require that a facility demonstrate its compliance with this Act as a condition to continue to provide services in the state.*

E. Hold Harmless. Any healthcare facility or its designee that does not bill for professional healthcare items or services rendered to a covered person at an off-campus location as required by this Act may not hold the covered person liable to pay for such healthcare items and services. A violation of this section constitutes a violation of the [state's consumer protection act] subject to enforcement by the attorney general.

Section 6. Regulatory Authorization.

The [appropriate state entity] shall promulgate regulations necessary to implement this Act, specify the format and content of reports, and impose penalties for noncompliance.

Section 7: Enforcement Mechanisms.

Drafting Note*: A state should ensure that enforcement authority is clearly vested and harmonized with any grant of regulatory oversight or investigative authority. Enforcement mechanisms may include vesting enforcement authority with the state's Attorney General in addition to, or in lieu of, the Departmental authority outlined below. Similarly, a state may grant general authority to refer to the [appropriate state agency regulating healthcare systems] any entity violating this Act.*

A. Any violation of any provision of this Act shall constitute an unfair trade practice pursuant to [section for state unfair trade practices statute].

B. The [Department/Commission] shall, after [any applicable state requirement for notice and hearing], impose any or all of the following, separately or in combination, on any healthcare provider or healthcare facility violating any of the provisions of this Act

(1) an administrative penalty of not less than $1,000 per occurrence;

(2) probationary status, suspension, revocation, or denial of the issuance of, or renewal of, professional licensure or [a Certificate of Public Authority or similar certificate];

(3) conditional issuance of, or renewal of, [state required license, certificate, etc.];

(4) require increased cost-reduction benchmarks under [state cost benchmarking law];

(5) referral to the attorney general for investigation.

C. The [Department/Commission] may audit any healthcare facility or healthcare provider for compliance with the requirements of this Act. Until the expiration of [four (4)] years after the furnishing of any services for which a facility fee was charged, billed, or collected, each health care provider shall make available, upon written request of the [Department/Commission], copies of any books, documents, records, or data that are necessary for the purposes of completing the audit.

D. The [Department/Commission] shall recover from any healthcare facility or healthcare provider reasonable investigative fees and costs incurred if a violation of this Act is found through inquiry, investigation, or audit.

E. The [Department/Commission] shall publish the results of all audits conducted under this section and shall require any healthcare facility or healthcare provider that is found to be in violation of any provision of this Act to publish on the main page of its public website an account, including the amount of any penalties, conditions on licensure or any other penalty, regarding its violation and the steps it has taken to correct its violation.

Section 8. Severability.

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 9. Effective Date.
This Act shall be effective for healthcare claims submitted on or after [insert date].

Texas HB 1696 - https://capitol.texas.gov/tlodocs/88R/billtext/pdf/HB01696F.pdf#navpanes=0 – and Oklahoma HB 1979 - http://webserver1.lsb.state.ok.us/cf_pdf/2023-24%20ENR/hB/HB1979%20ENR.PDF – will serve as the basis for discussion for the topic "Discussion on Developments in Vision Care Services Legislation."

Kentucky SB 58 - https://apps.legislature.ky.gov/law/acts/23RS/documents/0053.pdf - will serve as the basis for the topic "Introduction of Hearing Aide Classification Model Law Concept."

WORKERS' COMPENSATION INSURANCE COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
WORKERS' COMPENSATION INSURANCE COMMITTEE
2024 NCOIL SUMMER MEETING – COSTA MESA, CALIFORNIA
JULY 19, 2024
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Workers' Compensation Insurance Committee met at The Westin South Coast Plaza Hotel in Costa Mesa, California on Friday, July 19, 2024 at 9:00 a.m.

Senator Lana Theis (MI), Chair of the Committee, presided.

Other members of the Committee present were:

Sen. Larry Walker (GA)
Rep. Matt Lehman (IN)
Rep. Michael Meredith (KY)
Rep. Michael "Sarge" Pollock (KY)
Rep. Brenda Carter (MI)
Sen. Paul Utke (MN)
Rep. Nelly Nicol (MT)
Sen. Jerry Klein (ND)
Sen. Bob Hackett (OH)
Rep. Mark Tedford (OK)
Rep. Tom Oliverson, M.D. (TX)

Other legislators present were:

Sen. Dafna Michaelson Jenet (CO)
Rep. Joseph Gullett (GA)
Rep. Rod Furniss (ID)
Rep. Matt Lockett (KY)
Rep. Dennis Bamburg (LA)
Sen. J. Adam Bass (LA)
Sen. Royce Duplessis (LA)
Rep. Jason Hughes (LA)
Rep. Shaun Mena (LA)
Sen. Kirk Talbot (LA)
Sen. Bill Wheat (LA)
Sen. Arthur Ellis (MD)
Sen. Jeff Howe (MN)
Rep. Bob Titus (MO)
Sen. Joseph Thomas (MS)
Rep. Forrest Bennett (OK)
Sen. Mary Felzkowski (WI)
Del. Walter Hall (WV)

Also in attendance were:

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

QUORUM

Upon a Motion made by Rep. Michael "Sarge" Pollock (KY) and seconded by Sen. Bob Hackett (OH) the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Mark Tedford (OK) and seconded by Rep. Brenda Carter (MI), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's April 12, 2024 meeting.

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

Jeff Eddinger, Senior Division Executive at the National Council on Compensation Insurance (NCCI) stated let me just start off by saying that the state of the workers' compensation system is very strong. In fact, the state of the workers compensation system has been strong for many years. As you will see, and I think once I go through some of this information with you, I'm hoping you'll agree, we feel that the workers' compensation system will continue to be strong for the foreseeable future.

One way of measuring the strength of the workers' compensation system is by looking at the combined ratio which is simply the ratio of the claims that are paid out relative to the premiums that are taken in and the expenses that go along with that. You're looking here at a 20-year history of calendar year combined ratios. The latest combined ratio is 86%, up 2% from the previous year which basically means a 14% underwriting profit for the latest year. This is 7 straight years of the combined ratio being less than 90% percent and 10 straight years of underwriting profits. These are the components that would go into the combined ratio. As I mentioned, the loss ratio, underwriting expenses, and loss adjustment expense. Most of the components are staying very stable. Just the loss ratio ticking up slightly. But again, this is the 7th straight year of loss ratios being under 50% for workers' compensation.

This just shows the gain on insurance transactions. The latest year being 9% on investments, a bit below the long-term average of 11% percent. But when you combine the return on investments with that 14% underwriting profit, you're looking at a pretax operating gain of 23%, down slightly from the previous year of 25% percent but still well above the long-term average of 13%.

Workers' compensation profitability has to be driven by the premiums that are taken in and workers' compensation premiums are based on employment and what those workers are paid in payroll times the rate that is charged by insurance companies gets you the written premium. The one thing that you would notice here is that during the pandemic the premiums did drop off due to slowdowns in employment that we all know about and remember, but for the latest year we're looking at combined premium between private carriers and the state funds of $48 billion dollars and you can see they're basically back to the 2018 pre-COVID premium levels.

Premium is impacted by the payrolls that are paid to workers and for the latest year, the payrolls growth has been very strong with two things contributing to that. We see here a 6% increase in payrolls for the latest year being driven by a 4% increase in the wages that are being paid and a 2% increase just in the level of employment alone. The wage rate is pretty consistent across lots of different job classifications. The employment

changes vary a little bit. There is strong growth in leisure and hospitality but not strong growth or even shrinkage and transportation and warehousing. So, it's been a very small change to the overall premium for workers' compensation. I just talked about very robust growth in payroll. But the offsetting part of that has been what has happened to the loss costs or the rates that are being charged. We're seeing almost an exact offsetting between those two things. There are some other factors, which I won't get into, that slightly are driving up the overall premium but for the most part, staying relatively stable.

This shows what NCCI has been doing to the loss cost levels in our states. So, for 2024, most of our jurisdictions we've been filing lost cost decreases and overall, that has added up to a -9% in the loss cost level in our states. And the previous year, it was about -7%. This just shows for all the states where NCCI makes a filing last year the changes in loss costs varied from -0.5% in Virginia to -19% in Maine. But all those filings were for decreases in the loss costs. It's also helpful to look at the residual market at this stage only because it can tell us how the health of the market is going because the residual market is where you would have to find coverage if you could not find coverage written voluntarily and there have been times in the early 2000s, where the size of the residual market was fairly large, over $1 billion. The last year the the size of the market is $700 million down from about $800 million the year before. And that basically translates to a 5% assigned risk market share which is very manageable. This is telling us that 95% of the time based on premium coverage is being able to be found written voluntarily so the market is competitive.

So, that was premium. Now, it's helpful to look at the loss side of it, the claims payments that are going out. The first thing that we like to look at is what we call claim frequency, which is just another way of saying the number of workers that are injured relative to how many workers are on the job. For this 20-year history, most of the time we have seen the claim frequency drop from the from the previous year and the latest year, the claim frequency decreased by 8%, almost twice the annual average of about 3-4%.This is good news, showing us that workplaces continue to get safer, and injuries continue to go down relative to employment. The other side of a claim payment is once a worker is injured, what is happening to the average claim payments for both the medical component of the claim and what we call the indemnity or the wage replacement part of the claim. What we term medical claim severity is the average medical cost for each lost time claim. We are seeing there that in the latest year the average medical component went up about 2% and the previous year about 3.5%. So, we've been living in the last couple of years a high inflation environment where things like our groceries and some of our other insurance costs, like car insurance and things are going up at quite a higher rate than we're used to. But in workers' compensation, when we compare the medical average cost per claim, it has been tracking relatively close to the wage levels and relatively close to what we term kind of a medical Consumer Price Index (CPI). So, not exactly what we usually think of as a CPI, but we call it here, personal healthcare price index.

One of the reasons that the medical costs in workers' compensation have not gone up as much as you would think things go up in the general economy is that almost all states have medical fee schedules in place where the amounts that are paid for certain things are set up by statute. And that helps to control how much cost increase there is for medical in workers' compensation. Then on the indemnity, the wage replacement side. When a worker is injured, they get a certain percentage of their wages. So, you would think that as wages increase, then the indemnity claims severity would increase as well and it has been. So, the last 2 years up 7% and then another 5%. But again, when you compare that increase over time in indemnity versus wage inflation, it actually has increased much slower than wage inflation. Overall, when you add those two things together, the overall claim severities have been going up about 3%. I'm going to call that a pretty moderate increase in the amount of those payments.

So, let me just recap some of the things that we've seen here. The lowest combined ratios that we've seen in decades, under a 100 and now under 90 for 7 years in a row. A very slight change or increase in the written premium driven by strong growth in employment, strong wage growth, but we see loss cost decreases which are kind of offsetting that. Those loss cost decreases are being driven by safer workplaces. So, claim frequency decreasing. And then moderate increases in the average cost per claim. And that is putting us in this environment where NCCI has been filing and expects to file decreases in the loss costs as the claim payments do not keep up with the increased premium as payrolls increase.

Rep. Matt Lehman (IN) stated a question that was not on your presentation, but it's an issue that we've had, and I've tried to work on this in Indiana is with experience modifications. We've had two situations now where someone had a claim, a large claim, not at fault in an auto accident, but it was work related. It hits their modification because it hits their workers' comp. They paid about $60,000 in additional premium over the three years of their experience modification increase. It took five years to finally get subrogation. They got their subrogation, and no one is going back and recalculating the modification. So, what we found is there is really no mandate that you have to recalculate the mod. Well, the concern was that the carrier got all their money back, but how did the insurer, who paid out the additional $60,000 on an experience modification that was not their fault, they didn't get their money back. Has NCCI ever looked at putting some standard in place that says if you are successful with subrogation within so many years you have to go back and recalculate their mod and refund them back any money that you collected?

Mr. Eddingner said it's an interesting scenario. I'm not aware of the time period, like you say, there is a time period where you can revise the data for up to a certain amount of time, but after a certain amount of time, I'm not aware if you can go back and do that. So, it is an interesting issue.

Rep. Lehman stated we tried to do this legislatively in Indiana, but there's always two parts of this. The other part was experience modifications driven by your claims and a

lot of public contracts and large contracts will not allow you to even bid a project if your mod is over 1. So, you have some people who are very sophisticated, they're very large contractors and they're presented with a $10,000 loss and they look at that and go if I calculated that into my mod, I'm going to have 1.02 modification, let's just pay that claim. And it's not that they're not allowed to, they can pay their own claim, but they have to disclose it which in fact could hit their mod. But they're doing this and I think it's tainting the modification process. So, we've tried to take out the bid requirement and then part of that was also with the recalculation of the mods. We hear from the carriers that they already do this, but they'll do it like back two years. So, in this case, the trucking company lost $60,000 and would have gotten about $25,000 back while the company was made whole. My only concern is we're making the carrier whole through subrogation. There's no time frame on subrogation. I could be successful 7 years from now and get my money back. Now that's money I didn't get interest on, etcetera. But I got all of what I paid out back and the individual who I paid that mod did not get that. That's something I guess I'd like to see NCCI maybe give some guidance to.

Mr. Eddinger said that we have been vocal and published in saying that the mod should not be used for those types of things, whether someone gets a contract. A mod over 1 does not necessarily mean that that is a bad employer or a bad risk. And so, we have tried to put some numbers behind that and some theory behind that as to why you can have a mod above 1. That is something I think if it can be handled legislatively to not allow that, we would be behind.

Rep. Tedford stated one observation that I had on this is the fact that the loss costs have been dropping over the last couple of years. It has made, in my opinion, the e-mods more sensitive to claims and now you're getting a higher mod from the same claim that you would have gotten a couple years ago and it has made these contractors that have been under these type of provisions where they have to keep their mod under one very sensitive to that. So, you're saying that you would support any type of initiatives to prohibit that type of arrangement in a contract? Mr. Eddinger stated obviously we're not lobbyists, but we have published information on our website saying that the mod should not be necessarily misused for those types of purposes. That there are reasons why a mod above one is perfectly acceptable. And the other thing I will say is when loss costs decrease, it doesn't necessarily mean that now the mods are getting bigger. I mean everything adjusts along with it. So, that the experience mods overall should remain about the same even during a decrease in loss cost environment.

Rep. Lehman said a follow up to that is as they go through this process of recalculating things like that, one of the things that we've looked at from a claim standpoint and I'd like to know if you have data behind this. As you went through the fact that, and Indiana is no exception, we've lowered rates the last I think 11 years, create some disruptions of the market, but it's good. However, the one thing we did do 11 years ago was we capped reimbursement to hospitals because they had no fee schedules. And there were some of them that were 800 – 900% of Medicare. We capped everything at 200% of Medicare

and things dropped like a rock. So, on some of these the rates or the premiums are the losses are going down, how much of it is better loss control, which there is, and how much of it is what states have implemented in some form of fee schedules? And do you know many states have a fee schedule on workers' comp? Mr. Eddinger said out of 38 states where NCCI files a loss cost, I would say roughly 36. I'm just going to throw that out there, like almost every state has some kind of fee schedule. There might be one or two that don't. When you look at the decreases that we're filing, very rarely is it due to a new fee schedule or you know, a large change. I think those changes are made all the time, we call them more tweaks here and there. But those things are not necessarily driving the decreases that we see here. It's really the experience itself.

Rep. Brenda Carter (MI) stated it's my understanding that NCCI provides a fair system of data to everybody involved. I want to know if this data is being given to the general workforce. In other words, health care providers, insurers, and even some injured workers in the system. What kind of system do you have for an output? So, everybody knows the end result of your analysis. I applaud the data, it's very good. Now I need to know if the workers are getting this data. Mr. Eddinger said the question is we get a lot of data, do we give it back? I would say, what I would call raw data, no, we do not collect data and provide raw data back to workers or to insurance departments, but obviously summarized data that you see here or even data used in research we provide back. But, it's important to keep that that information secure and private because a lot of that information is private information.

Rep. Carter said but just a general overview of what we have here, is that disseminated to average workers? Mr. Eddinger said yes, this information, by the way, we finished up our annual meeting in May where the results become available and we present that information to almost 1,000 industry people and as soon as that information is presented at our meeting, it is posted on our website where anybody can access it. You don't need a login, you don't need to pay any money. That information a lot of other useful information is available on our website to everyone.

PRESENTATION ON WORKERS' COMPENSATION PREMIUM FRAUD IN THE CONSTRUCTION INDUSTRY

Matt Capece, Representative of the General President at the United Brotherhood of Carpenters & Joiners of America thanked the Committee for the opportunity to speak and stated this issue of illegal employment practices in the construction industry is something I've been tracking since back in 1989. If any theme comes out from this presentation, I hope you understand that the status quo that we are facing in the construction industry with workers' compensation premium fraud is unsustainable and I'm hoping that this is a beginning of a conversation with NCOIL. So, how does this happen? How does a construction labor provider operating through a shell company identity that claims 4 workers at $43,000 of payroll in 15 months get 450 certificates of

insurance issued to it by an insurance broker? How does this company make $11 million in 15 months without the insurer knowing anything about it. How does this happen? A labor provider that operated out of Tennessee into Colorado and up through Pennsylvania was finally arrested in the State of Tennessee for workers' compensation premium fraud. And when the investigators talked to him, they asked him, "well, do you ever declare your full payroll at the beginning of a policy term? What do you put down in the application?" He said, "I never tell them what my real payroll is going to be." And then he was asked, "well, what do you do when it's time to renew your policy, when the audit comes around?" And he simply said, "I just don't answer the phone. I don't set up an audit. And I just go to another insurance broker and get another policy." How does this happen? We're facing an issue in the construction industry where law abiding employers are being squeezed out of markets because they're not engaged in unlawful practices that lower their labor costs that allow them to underbid law-abiding employers.

So, what are some of the numbers? A study was done by the Coalition Against Insurance Fraud and the United Brotherhood of Carpenters as a member, of fraud in the construction industry and claim of fraud is a problem. It's a $9 billion dollar problem. But employer premium fraud is a $25 billion dollar problem. It's much, much more severe. And unfortunately, it seems like claimant fraud gets the bulk of the attention. Now in the construction industry, the premium fraud loss numbers to insurers are at a staggering $5 billion dollars a year. Now this is not just a loss of premiums to insurers. This is a loss in premiums to the administration of state workers' compensation systems. Because a lot of our systems in the states are funded by assessments on premiums. In the State of Tennessee alone, that state loses $13 million a year to fund the administration of its workers' compensation system and their Tennessee Occupational Safety and Health Administration and uninsured employers fund.

How do the contractors do it? Now the picture you see on the slide is intentional. There is a thought, an assumption, that the illegal part of the construction industry is isolated to the single-family home construction. Well, home residential construction is probably the worst of it. But what we are seeing extends to military bases, hospitals, public schools, universities, legislative office buildings, luxury condominium towers. And we're seeing this in every phase of the construction industry, every type of project, in every state in the Union. And I'm going to run through the fraud scheme and as you'll see this isn't a case where you have people that are confused about definitions of employment. This is organized crime. The construction industry is what we're calling a fissured industry, they're layers, as you know of contractors and subcontractors.

You have general contractors and owners who hire specialty subcontractors that actually do the hands on work, the excavating, the pile driving, the electrical, the HVAC, painting and flooring. And what we're seeing is a lot of these specialty subcontractors are now getting their labor through subcontract labor providers, labor brokers. And at times, these labor brokers will operate through a shell company identity. The labor brokers will 1099 misclassify the workforce. But most of the time, for every one worker that gets a

1099 who should get a W-2, two are being paid off the books. So, this is just out and out fraud. So, the specialty subcontractor will use a labor broker to supplement its labor force and it will act, if you apply your employment laws in your states, you will see that those specialty subcontractors are just as much an employer of the labor brokers workforce as the labor broker. Oftentimes, the labor broker simply recruits the labor and pays them. Especially, subcontractors who will be doing the daily supervision, even transferring from job site to job site, could even fire them and have some impact on the wages that they're paid. And in the cash pay system, you could put into this flow chart the use of check cashing stores or bunny service businesses. And a fair question that has to be asked, is the cash pay system we're seeing growing in the construction industry a way for organized crime to wash dollars? And we have seen a case of a member of a New York City crime family going down to Florida and opening a check cashing store that was being used in this type of organized crime scheme.

Now as you can imagine, workers' compensation costs are very expensive in the construction industry and those specialty subcontractors realize an incredible decrease in their labor costs which allows them to underbid law-abiding employers. And on these job sites that I've mentioned, we have seen some of the largest general contractors, construction managers, and specialty subcontractors in the country, where these types of schemes are occurring on their projects. As you can imagine there's a cornucopia of laws being violated, not just workers' comp premium fraud, but tax fraud, child labor, immigration. The system is very, very good for hiding the employment of undocumented labor that's easily exploitable. We see money laundering, mail fraud, wire fraud, labor trafficking, child labor and conspiracy charges. If you don't believe that this is a problem, take a look at this. The Financial Crimes Enforcement Network which is a part of the US Treasury Department, has issued a notice to banks and other financial institutions like check cashing stores that they need to start sending suspicious activity reports to them when they see suspicious transactions being undertaken by construction contractors because of the high degree of tax fraud and workers compensation premium fraud that they're seeing in the construction industry.

Every year, the US Department of Treasury issues a national money laundering risk assessment report. The construction industry has been cited as being prone to child labor trafficking and for tax evasion and workers' compensation premium fraud. Something I failed to mention when I got to that chart is that $450 number in some of the more sophisticated schemes like we see in Florida, once that Certificate of Insurance (COI) is issued, that shell company labor broker operation will rent it out to other labor brokers in the region. So, this is how insurers that think it's on the risk for four people for $43,000 worth of payroll is actually on the risk for hundreds of people with millions of dollars of payroll happening. The bad guys know what the insurers do and don't do and they're driving a truck through the opening. So, some changes needed, and we have some suggestions on what the insurance industry should be doing to play more of a role of not seeing itself being taken advantage of and stopping this problem. One thing they

could do is they could start tracking the COI's being issued by their insurance brokers. This way they could catch the fraud before it becomes too large.

Right now, there is no tracking, and I don't know if I need to explain this to you, you probably already understand that COIs lack integrity and they could be easily forged. We think these insurance certificates should have some indication of the payroll being paid, being declared, because these certificates are used as a shield against liability for those upper tier contractors. They say I got this COI. I'm covered right? Everything looks fine to me. Now, when law enforcement comes around, they are focusing on that labor broker shell company operation. They're not pushing up the contract chain any of the accountability and that's why this problem is mushrooming. Because right now when law enforcement gets involved, they are disrupting the fraud scheme, they are not dismantling it. And those upper tier specialty subcontractors simply get another law-breaking labor broker to fill its shoes or that labor broker will change its shell company identity and keep on rolling. And the COI's play a role in this. So, it would be good if the COIs had some payroll amount on them. If they always had classification codes for the type of work being performed and for safeguards to prevent forgery. And how about putting a QR code on them so and so a company that's getting these certificates in order to verify that they're actually real can use the QR code to go someplace and see that yeah, it's a real certificate because we also have a problem with employers of upper tier contractors getting fake COIs or getting a COI and the policy was terminated by the holders of the certificate.

Other impactful reforms. We think insurers should ask their contractors coming in for policies, well, how do you get your labor? And since the use of labor brokers increase risk, if you're going to use a labor broker you should pay a higher premium. Also, they should start tracking bad employers. Why was that guy in Tennessee able for a decade to get another policy? Because insurers don't track bad employers. I broke my foot working for the carpenters union back in the late 90's and I'm sure if I got injured again, the insurer can go into the ISO and see that I had a previous injury. But there's no tracking of bad employers. And something else that's not on the slide that needs to be mentioned because these slides are focusing in on internal stuff. Externally to improve enforcement, we think there should be a grant funding mechanism to state district attorneys to pick up these cases. Because right now we're not seeing enough meaningful criminal enforcement. And they have a very good system in California for that.

Rep. Tedford stated when I heard your scenario it triggered me a little bit because I've seen exactly what you've talked about here. Some of the comments and some of the fixes as far as the certificates of insurance, is that certificate that you're requesting being sent that has a payroll was that from the insurance broker or the labor broker, so to speak or all certificates of insurance through the industry? Mr. Capece said when the specialty subcontractor wants to see a COI, the labor broker will get the COI from its insurance broker and give it to the drywall contractor or concrete contractor is that you're

asking? Rep. Tedford said what I'm trying to make a distinction from is who is sending this certificate is it the insurance brokers who is sending the certificate who's not going to have necessary knowledge about the payroll unless given it by the underlying contractor themselves. So, what I'm suggesting is if the fraud is coming from specifically labor brokers, are you suggesting just those handling the insurance for labor brokers are to do that? Or just for throughout the industry as a whole to list payroll on certificates of insurance? Mr. Capece stated if you want to focus just on the construction industry, that would be a good thing to list the payroll. And insurance brokers have been arrested as part of these schemes. Unfortunately, there is a crop of insurance brokers that do this as part of their business, get involved in these schemes as part of their business.

Rep. Tedford said do you know if there is among the property & casualty insurance industry, a discussion or a push to create a database of contractors who are refusing to respond to audit? Mr. Capece responded no but it should be looked at. And on the QR code thing. These fixes, this is stuff I'm not making up. I've been doing presentations like this for about a decade. This is stuff I'm hearing and the audit side as well as from insurers.

Sen. Arthur Ellis (MD) stated this past session I was the primary sponsor on legislation to attack one part of this problem. Going in, I had a lot of support from the unions and by the time we got to the hearing, only one union showed up to testify because the word went out to not show up to testify against this bill. This is a huge problem, wage staff, premiums in this space with wage brokers and the contractors. It seemed like there was a fear among the unions to really go in and be forceful and supporting legislators who want to attack this problem. Have you seen that particular aspect of what I saw? And if you have, what do you think are the reasons behind it? Mr. Capece said I can't speak for other labor organizations. I know I've been hired specifically to focus on this issue. And I know our carpenter regional councils are focused on this issue. And if you're looking for a friend to tackle this problem. We're all in. So, contact us. This is an existential problem for us. When you see contractors working on legislative office buildings and this is happening. You know, something is terribly wrong.

Rep. Carter stated I come from the labor movement, and this is disturbing to me to hear that this is going on. What kind of effort is being made to make sure that the workers understand what's going on? Because they're impacted by these premium hikes and these shell games, ghost policies and everything else impacts their safety. And safety is number one. What efforts being made to make sure that the worker understands what's going? Mr. Capece said we are on thousands of construction sites a week talking to workers and we talk about this to the workforce. And I know we're doing our darndest and we have lots of public information available on this for employers to look at and workers. We have Spanish versions of what's on our websites. We're out there spreading the word.

Sen. Larry Walker (GA) stated in Georgia, and I don't know if this is nationwide or not, you can go on our State Board of Workers' Compensation's website and verify workers'

comp coverage by doing a search on the name of the employer. And it's real time. A certificate is just a snapshot in time, as you know, and policy could cancel the next day. I think we endeavor to let the certificate holder know but that's very hard to do. But this is a real time verification of coverage. It seems to me at that point it's on the insurance carrier to do a good audit and verify payrolls. I think in Georgia the carriers ought to ask for 1099s and all that stuff when they do their audit and if the company, the insurer is going to be just totally fraudulent and be a criminal about it and dishonest I don't know how much you can do. Even if you legislate stuff, you can't legislate people, you know, are going to break the law no matter what you do. But the labor unions in Georgia are very much pushing for the type of things you're talking about, and I have discussions with them every session. But I think our system in Georgia is working pretty well. There could be more surprise type audits on companies from maybe the Department of Labor or something to see if they're just totally violating all kind of laws as far as whether they're considering their people, you know, independent contractors or employees and we have kind of a seven point thing to look at and determine whether they're an employee or not.

Mr. Capece said if for instance our suggestion that the insurers be notified of the number of certificates going out would certainly queue them up a lot earlier. And I hate to say it, and please don't take offense but Georgia is one of the worst places for this problem in the country. And the enforcement level of the law in this regard not just in Georgia, but in other states it hasn't proven to be very effective. The status quo is unsustainable for the law abiding part of the industry.

PRESENTATION ON DEVELOPMENTS IN THE CALIFORNIA WORKERS' COMPENSATION INSURANCE MARKETPLACE

Rena David, Senior Vice-President, Research & Operations, CFO And Treasurer at the California Workers' Compensation Institute (CWCI) stated I'll be focusing today primarily on trends we've been seeing in pharmaceuticals and 5 years out what the impact has been since the adoption of the California formulary. I'm going to start just by describing a little bit about CWCI. We are a nonprofit research institute and our goal is to improve the California workers' compensation system. You can see we've been around since 1964, so I guess we haven't accomplished that yet. I also wanted to make you aware of our website where we have both public and member only research on a variety of topics I'll be getting into. As legislators and your staff, you are welcome to give us a call and get copies of our member only research. We like to support the legislative efforts even if it's not just in California. So, you're welcome to come there. We also have a repository of all regulatory activity that's taking place in California, every round of hearings and comments. And that's open to the public. So, you're welcome to go there just to see how California has approached different topics.

We also have on our website research that we've done recently and back in years. What we focus on is claim reporting activity, trends in average payment, and medical treatment. In particular over the last year, we've done research on inpatient utilization.

Especially the shift of spinal surgery and major joint replacement from the inpatient to the outpatient setting and I'm not sure if that happens countrywide, but it's quite accelerated in the last couple of years in California. We also conducted a major study on cumulative trauma claims. Which my understanding is a California issue, but I invite you to look at that report. We also often look at regulatory or legislative change and try to measure the impact some of which I'll be talking about today on individual proposed legislation and then our new medical legal fee schedule.

With that as background, let's go ahead and go into the California formulary. In October of 2014, the institute did a study where we modeled California utilization against two existing formularies. The Texas formulary and the Washington State formulary and just measured what the impact would be had California had that into effect. Both were based on national direct NDC which is a particular identifier for a drug that even includes manufacturer. With Texas they allowed more drugs into their formulary and with Washington, they were quite exclusive, really eliminating many drugs that typically weren't used for workers comp injuries as well as some higher priced drugs. The conclusion from both analyses was that there could be quite an impact of a formulary for California and not necessarily just related for that reason from our report, but also from other stakeholders. In 2015, AB 1124 was passed that proposed or mandated the implementation of a statewide formulary for workers' comp and we had two intended goals. The primary one was to ensure that the medications provided followed our treatment guidelines and were evidence based. It also intended to assist with frequency, duration and strength along with the appropriateness of the drug and you'll see I'm not sure if it quite addresses those areas. And then the second intent was to reduce friction costs associated with the provision of pharmaceuticals in terms of UR independent medical review with the hope of reducing both the costs and delays associated with that.

So, some of the key aspects of the formulary, the primary one I'm going to be discussing a fair amount today, is that it is not based on that National Drug Code (NDC) that gives you manufacturer frequency, strength and dose. It's based on just the drug ingredient name. So, it is not as specific as the Texas and Washington formularies. To be on the formulary, it needs to be mentioned in our medical treatment utilization schedule which is our treatment guidelines for California. And then once they're in there, the drugs are either exempt from utilization review based on the drug ingredient or nonexempt. Then we have everything else that's not on the formulary. In the traditional group health world, if it's not on the formulary you'd really have to go through quite an appeal process to prescribe that drug, the initial thing would be not to reimburse it. But in this system, the only difference between not listed and nonexempt drugs they both have to go through prospective UR. But for not listed because they are not part of the treatment guidelines, theoretically, the request needs to bring with it the evidence that this is needed for the patient and so higher level of requirement to get approved. The first few days of treatment has some exemptions to UR as well as perioperative drugs. So, what do we see five years out? In green is the share of utilization that was for exempt drugs and then in kind of the gold color is this year for nonexempt drugs. You can see since the

implementation in 2018, we really saw a trend of shift between the use of exempt drugs and nonexempt drugs. Not listed stayed pretty flat going down a little bit. So, ultimately, the goal of exempting more activity through UR was achieved. Now there are other factors that come into play on the shift. But I'll talk about that in a moment.

When you look at the payment side, you can see that the share of dollars for nonexempt drugs went down as the share for exempt went up and the exempt tend to be lower price drugs generally. But you can see that the brownish line there where it says not listed, even though they only represented 12% of the volume in 2023, they represented 45% of the total drug spend in that year. So, those drugs that are really not in the treatment guidelines and in theory shouldn't be part of treatment, they do represent still a large portion of the dollars. As we look at drug utilization in general by drug group, we've seen a tremendous change in the mix of drugs prescribed. Opioids were at one time almost 45 - 50%, of the utilization. It's now down to about 30%. So, a tremendous change and really the treatment has shifted from opioids to anti-inflammatories.

I'm going to take a little side note here on our fee schedule in California. In 2004 there were reforms to have workers' comp payments be based on the Medi-Cal fee schedule, which is our Medicaid program in California. That caused a considerable drop in the average unit price paid for any given drug. They also allowed for generic substitution unless the prescriber said dispensed as written. And it had some limits on repackaged drugs. Then in 2012 they put caps on pharmaceuticals dispensed by physicians and actually, pending right now our new set of regulations to adopt some additional changes that Medi-Cal made in terms of a two-tier dispensing fee and other ways of pricing the drugs. I bring this up because in many formularies there's a dual purpose. First of all, just having only a certain set of drugs being prescribed as appropriate drugs. But it's also to limit costs where if you have the same drug from different manufacturers with same efficacy but different pricing, you would only want to prescribe the lower priced drugs. That's true of group health and other workers' comp systems, where price is a factor in the formulary. In California that's not the case. It's strictly the ingredient and because it's not NDC based, there is no tie between choosing what's on the formulary and a lower versus higher price drug doing the same thing. We've done several studies on high-cost drugs within the system, this slide is an example of anti-inflammatories. Of them there are certain drugs that are just 1% of the volume but represent that first drug 33% of the anti-inflammatory costs. This is an exempt drug, and it has the same efficacy as any anti-inflammatory. It's just it's not part of the Medi-Cal fee schedule and therefore it has gone from a $169 to about $1,500 a script. Pricing again is not part of the California formulary. It is impacted by the fee schedule, but there are a lot of loopholes in this category especially in dermatological and we looked at other drug groups as well. So, you can see more of our studies on that.

Back to the trends we've been seeing in pharmaceutical treatment. It's just incredible every time I see this graph, that tremendous change in practice in the use of opioids. We were again up to the almost the 50% level back in the early 2010's and now we're

down to 5% of indemnity claims having opioids as part of the treatment plan. The same is true of the number of scripts people get once they start using opioids as well as the strength of those opioids. We think whether that is actually due to the formulary and the fact that opioids were nonexempt and really demanded more scrutiny perhaps than before or just the general trends and treatment. I think it's probably both. But clearly this trend in drops in opioid use continues. And we'll show you some statewide data across pairs in a moment.

Back to the second intent of the legislation. It was to reduce friction costs. We did see an immediate drop in the number of disputes going to the independent medical review process after the implementation of the formulary, about 30% of the UR denials go to independent medical review in California. And again, there was an immediate effect. The fact that not listed drugs can go through as well limits how much that can go down. Also, the share pharmaceuticals within the independent medical review process went from 50% of the disputes to 33%. All along for the last from 2005 through 2023, we've seen that once a pharmaceutical request goes to the independent medical review over 90% of the time, really throughout the time period, those requests have been upheld by the independent medical reviewer. And just another point is that opioids as a share of pharmaceuticals has also dropped over the time period. So, I'm going to end with a discussion of some research we've just embarked in on using the statewide PDMP which is it's a monitoring program for controlled substances. Through this data, we're able to look at use of opioids across payers and we are especially interested in looking at well are people stopping opioid use in the workers' comp area and getting it through group health or other means? So, when we see the drops and workers' comp, do we also see it in other areas? We're just starting the research. We'll have this published probably in the next few months. But I just wanted to go through a few statistics here.

Again, using statewide data, not just our own database you can see the tremendous change in the opioid use in California for workers' comp and then comparing that to total California. Including group health, you know, California is about 1 - 2% of the medical activity in California. But you can see that all payers in all sectors opioid uses dropped 30% from 2017 to 2022. But for workers' comp, the reduction has been even greater. Almost double that. When we look at that by the acuity of the patient whether they just need it for a short time, a middle timer on chronic use, again, tremendous drops for all payers, but more so in comp. And then here is just the start of our look at overlaps.

In 2017 data we found, unfortunately for the same date of service, we found about an 8% overlap in the days on opioids from between, you know, somewhere workers' comp only and then other payers they were also receiving pharmaceuticals or opioids for that same day for that same patient. So, that has dropped down to about 3.5% in 2022. But it's something we'll be looking at and it's the PDMP itself is supposed to prevent overlapping treatment, but even if it was just the transition period between workers comp coverage and other, it does seem to be that people are having treatment paid for in the

comp system and then again additional opioid treatment from these other payers. We'll have more on that over the next course of the next couple of months.

In conclusion after the formulary was implemented, there's definitely a shift in patterns from drugs exempt to drugs exempt from UR from the nonexempt categories and just the tremendous change in practice with the decline in opioids. I think we have to think it was somewhat accelerated by the implementation of the formulary and perhaps the higher scrutiny to those opioid prescriptions. And then in general, we're seeing it across all payers this drop in opioids. And in our prior research, we did find and especially for less acute treatment like low back pain, the introduction of opioids actually worsened the outcomes for the injured workers. Also, we did see the decline in independent medical review that the legislation had hoped for. And just another, again, if you don't have a formulary and you're thinking of implementing it, when it's not based on NDC, there's very little controls you can do over price. Over the especially within the same category, the same efficacy. If you're not setting the restrictions or the view on a specific drug based on the manufacturer and the dose and all of that, it just limits how much it can be used for cost controls in addition to just efficacy.

Rep. Lehman asked has there been any study done as to what's been the impact of medical marijuana in that space of opioid and pain management? Ms. David stated this is a difficult issue. We did do a kind of a study of marijuana laws across the states, but because marijuana has been a controlled substance, I think it's Class 4 if I have that right. It can't be studied in a clinical setting and even the studies that were done in the past had to use like three strains that were developed by the National Institutes of Health. Also, because we can't use the banking system to pay for marijuana even though it's legal in California. It's not legal federally for a bank to be used in the payment of it. We just are restricted on how much we can use. There has been some research on methadone. I think some of the research abilities have been loosened up in recent years. If a payer is even paying for marijuana for particular patients that is really going to show up in our data as just a cash payment reimbursement to an individual worker and we can't identify it in the administrative data because it doesn't have a fee schedule and isn't identifiable because of those federal laws. So, it would be great to measure, and hopefully that will change in the future.

Rep. Lehman said I think it would because in Indiana we do not have medical marijuana do not have recreational, we are an island. Ohio, just expanded, Michigan's expanded, Illinois expanded. Kentucky, I think is medical only. But I would say work comp becomes the issue because I'm a border community so I'm 6 miles to Ohio line. I can have somebody who has a legal prescription, even now can use it recreationally, they get injured in Indiana. It's illegal. They could lose their job. I don't know how we're going to manage this data around opioid and pain management when you're seeing more and more of pain management go the route of medical marijuana. And yet, as a schedule one drug federally, and then I think they're moving to take that off the schedule one so you can begin to do these studies, but I think it's marijuana sometimes really

tipping the scale when it comes to workers' comp. To the extent we just don't know. Ms. David said I would say that just the combination of Advil and Tylenol instead of opioids has become more of the practice norm even after surgery. And I think that alone has proven to be at least equally effective. With marijuana, I think the other challenge is to have it be regulated, it's a little bit less able to control the quality is my understanding. So, I think those will all be the challenges, but I think that definitely is in theory something that needs to be studied for pain management. I think there hasn't been enough study to say whether that's true or not. That it's an effective treatment.

CONSIDERATION OF RE-ADOPTION OF NCOIL WORKERS' COMPENSATION DRUG FORMULARY MODEL LAW

Sen. Theis stated last on our agenda is the consideration of the readoption of the NCOIL Workers' Compensation Drug Formulary Model Law. You can view the model in your blinders on page 163 and on the website and app. Per NCOIL bylaws, all model laws must be readopted every 5 years or else they sunset. This model or something substantially similar to it has been adopted in 11 states.

Brian Allen, VP of Gov't Affairs at Enlyte Pharmacy Solutions thanked the Committee and stated I have about almost 40 years of experience in the insurance world and workers' comp, the last 20 years spent advocating around the country for workers' comp issues primarily around pharmacy and medical care to injured workers. I am a former State Representative in Utah so although I am a recovering politician, I'll be remarkably brief. I just want to just enlist your support for reauthorizing the Model Law. About a third of the states have adopted some form of a formulary. We are very supportive of that. We have seen in our own data, and I'll echo what Ms. David said, that we see a reduction of opioid use. We also see just an overall reduction of drug use. And which we think is important. And one of the goals that I think should be in any workers comp system is that we're delivering the right care at the right time for the right reasons. And a formulary as it relates to pharmacy care does that. And there are things that you can do with the formulary to help reduce some of what we see as outlier abuses. Like for example, in Texas, which introduced its formulary and was going along really well. We suddenly started to see an increase in very expensive topical creams. We were seeing bills for $14,000 or $15,000 for a month supply of a topical cream. Which is ridiculous for something that you can probably buy at the local drug store for $20.

We were able to use the formulary to implement some restrictions to make sure that the prior authorization is required. There's some checks and balances that happen up front before that happens. So, there's some very positive things that come from using a formulary and it's kind of funny we're here advocating for this because we make our money when a drug is dispensed, but yet formularies actually reduce the number of drugs that get dispensed so, we're sort of cannibalizing our own business. But the reality of it is just the right thing to do. I mean, the bottom line is it does save costs, if it's done appropriately, you can save costs. But the bottom line is on a drug formulary,

you're doing the right thing for the injured worker. And we think that's important. And we support that. And we urge your support for the readoption of this model law.

Hearing no further questions or comments, upon a motion made by Rep. Carter and seconded by Rep. Michael Meredith (KY), the Committee voted without objection by way of a voice vote to readopt the Model.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Walker and seconded by Rep. Nelly Nicol (MT), the Committee adjourned at 10:30 am.

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National Council of Insurance Legislators (NCOIL)

Model State Structured Settlement Protection Act

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

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

To be discussed during the agenda topic "Perspectives From the Bench on Structured Settlements."

SECTION 1. TITLE.

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

SECTION 2. DEFINITIONS.

For purposes of this Act--

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 3. REGISTRATION REQUIRED

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

(b) (1) An applicant's initial registration application shall be submitted on a form prescribed by the [appropriate state agency], and shall include a sworn certification by an owner, officer, director, or manager of the applicant, if the

applicant is an [entity, not a natural person], or by the applicant if the applicant is [an individual, a natural person], certifying that the applicant has secured a surety bond, or has been issued a letter of credit, or has posted a cash bond in the amount of $50,000.00, relative to its business as a structured settlement purchase company in this state. The surety bond, letter of credit, or cash bond is intended to protect payees who do business with a structured settlement purchase company.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

> (i) Pursue or complete a transfer with a payee without complying with all applicable provisions of this Act.
>
> (ii) Refuse or fail to fund a transfer after court approval of the transfer.
>
> (iii) Acquire structured settlement payment rights from a payee without complying with all applicable provisions of this Act, including, without limitation, obtaining court approval of the transfer in accordance with this Act.

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

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

> (A) A commission or finder's fee to a person who is a structured settlement purchase company or is an employee of a structured settlement purchase company;
>
> (B) To third parties any routine transfer expenses, including, without limitation, court filing fees, escrow fees, lien recordation fees, judgment and lien search fees, attorney's fees and other similar types of fees relating to a transfer; and
>
> (C) A reasonable referral fee to an attorney, certified public accountant, actuary, licensed insurance agent or other licensed professional adviser in connection with a transfer.

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

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

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

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

transfer that is the subject of the pending structured settlement transfer proceeding.

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

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

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

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

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

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

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

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

SECTION 5. REQUIRED DISCLOSURES TO PAYEE.

Not less than three (3) days prior to the date on which a payee signs a transfer agreement,

the transferee shall provide to the payee a separate disclosure statement, in bold type no smaller than 14 points, setting forth —

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

(b) the aggregate amount of such payments;

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

(d) the gross advance amount;

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

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

(g) the net advance amount;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) The structured settlement obligor and the annuity issuer may rely on the court [or responsible administrative authority] order approving the transfer in redirecting periodic payments to an assignee or transferee in accordance with the order approving the transfer and shall, as to all parties except the transferee or an assignee designated by the transferee, be discharged and released from any and all

liability for the redirected payments; and such discharge and release shall not be affected by the failure of any party to the transfer to comply with this chapter or with the court [or responsible administrative authority] order approving the transfer.

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

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

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

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

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

SECTION 8. PROCEDURE FOR APPROVAL OF TRANSFERS.

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

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

(c) A timely hearing shall be held on an application for approval of a transfer of structured settlement payment rights. The payee shall appear in person at the hearing

unless the court [or responsible administrative authority] determines that good cause exists to excuse the payee from appearing in person.

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

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

(ii) a copy of the transfer agreement;

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

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

(v) A summary of:

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

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

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

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

SECTION 9. GENERAL PROVISIONS; CONSTRUCTION.

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

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

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

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

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

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

(g) Nothing contained in this Act shall be construed to authorize any transfer of structured settlement payment rights in contravention of any applicable law or to imply

that any transfer under a transfer agreement entered into prior to the effective date of this Act is valid or invalid.

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

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

LIFE INSURANCE & FINANCIAL PLANNING COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
LIFE INSURANCE & FINANCIAL PLANNING COMMITTEE
2024 NCOIL SUMMER MEETING – COSTA MESA, CALIFORNIA
JULY 19, 2024
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Life Insurance & Financial Planning Committee met at The Westin South Coast Plaza Hotel in Costa Mesa, California on Friday, July 19, 2024 at 3:00 p.m.

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

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Rep. Rod Furniss (ID)
Rep. Brenda Carter (MI)
Sen. Michael Webber (MI)
Rep. Bob Titus (MO)
Sen. Walter Michel (MS)
Sen. Joseph Thomas (MS)
Asm. Jarett Gandolfo (NY)
Sen. Bob Hackett (OH)
Rep. Ellyn Hefner (OK)
Rep. Tom Oliverson, M.D. (TX)
Rep. Jim Dunnigan (UT)
Del. Walter Hall (WV)

Other legislators present were:

Sen. Larry Walker (GA)
Sen. Arthur Ellis (MD)
Sen. Jeff Howe (MN)
Sen. Paul Utke (MN)
Asm. Alex Bores (NY)
Rep. Forrest Bennett (OK)
Rep. Mark Tedford (OK)

Also in attendance were:

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

QUORUM

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

MINUTES

Upon a Motion made by Rep. Bob Titus (MO) and seconded by Rep. Brenda Carter (MI), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's April 12, 2024 meeting.

PRESENTATION ON RETIREMENT SECURITY BILL OF RIGHTS

Sen. Klein stated that we're going to start today with a presentation on a Retirement Security Bill of Rights. You have also received a draft resolution in favor of encouraging a redesign on the use of lifetime income investment solutions in defined contribution plans which is before you. There currently isn't the sponsor attached to the resolution, but it's been drafted by Teachers Insurance and Annuity Association of America (TIAA) for discussion purposes, and we hope it will be developed throughout this current year.

Brendan McCarthy, Senior Managing Director, TIAA, thanked the Committee for their time. For background, I think most are probably familiar with the firm, but TIAA is the largest insurer in the US, based on AUM we are the largest provider of guaranteed in-plan lifetime income, and we are the fourth largest provider of retirement plans. What I want to talk about today is a little bit about some of the challenges that are facing the US retirement system. And specifically, the need for lifetime income. So, the goal of any retirement plan in the US is to replace 80% of preretirement income and to do that through a combination of both Social Security and a retirement plan.

Unfortunately, that is out of reach for a significant percentage of Americans today. You'll see here three of the major challenges, we like to call them gaps, facing the U.S. retirement system. They are the coverage gap, the savings gap, and the lifetime income gap. Coverage gap is access to employer sponsored retirement plans. Today, 57 million Americans still do not have access to an employer sponsored retirement plan or a workplace retirement plan. This is something that a number of the states have already started to take action on, and we've seen that through these mandatory state IRA's. In fact, California in 2018 I believe started CalSavers Mandatory IRA and a number of other states have done that and even more so have it in process. Those have been a success. You can look at some of the numbers, but know that the numbers that you see, the states that have enacted legislation on the Mandatory IRA, they have seen the highest increase in 401K sales. It's almost a gold rush if you're in the small market 401K. So, there are small employers and they're looking at those and saying I don't want to do that, I could actually do a 401K plan it's easier. And so, it is driving business and that one is working and it's working at the state level.

Next is the savings gap. When employees do have access to a retirement plan, they are unfortunately not saving enough. So, people in their 40s with somewhere in the range of 2 to 5 years' experience at an employer on average have only $38,000 sitting in their retirement plan or their 401K plan. So, employees are not saving enough. There's some legislation at the federal level that I'll talk about that's addressing that gap.

Last what we want to talk about today is the lifetime income gap. 60% of non-retiree Americans think they will not have enough income in retirement. I can tell you this is massive in the private sector. Only 12% of Americans that worked in the private sector have access to guaranteed income. In 1975, that number was 70%. So, guaranteed income has all but gone away in the corporate private sector 401K plans. There is a

massive boom right now for that to come back with both products and retirement plan providers starting to build to support guaranteed income through 401K plans.

There are some other risks that are out there in the retirement system. First, is longevity risk. Americans are living longer today, and the risk keeps increasing that Americans are going to outlive their retirement savings. This is sometimes masked too. We say when you're looking at longevity risk in the retirement industry you don't want to look at just U.S. life expectancy data. When you are looking at it from the view of a retirement plan, you are concerned with those that have reached age 65. The unfortunate statistic out there is that 30% of Americans today do not reach age 65. So, they skew that U.S. life expectancy number. When you're dealing with a retirement plan you want to look at those that are reaching age 65. And for those that reach age 65 today, there is a 46% chance that one out of a couple will reach age 95 or longer. For an individual, it's a 25% chance of living to age 95 or longer. So, there's an increased risk that Americans are going to outlive their retirement savings.

You also have market risk. In 2008 to 2009, we saw a 47% drop in the US equity market between October and March of 2009. That drop was so significant that if you remember at the time Congress held hearings to look into U.S. retirement plans and specifically target date funds. They were saying how were Americans that were this close to retirement losing this much of their retirement savings? So, you have that market risk and that's something that can be addressed with lifetime income. Also increased cognitive decline. One third of Americans aged 65 or older have mild cognitive impairment or dementia. And last is inflation risk. We've seen that probably more evident the last couple of years. That is something that reduces their spending power, their purchasing power in retirement.

As mentioned, Congress at the federal level has been addressing this. There has been an unprecedented amount of retirement legislation passed in the last 4 years. Over 120 provisions through two acts. First was the Secure Act passed in December of 2019 and then there was the Secure Act 2.0, which was passed in December of 2022. The provisions in these bills were designed to hit those three gaps. Number one was the access gap, there's a number of tax credits there that encouraged small employers to start 401K plans. Second was to help with the savings aspect. Defined contribution plans or 401K plans going forward, are required to have auto enrollment and auto increase. You're automatically enrolled in the plan and your amount that is deducted is automatically increased each year. Now, at any point an employee always has the option to opt out, but you're defaulting them in so that their own behavior does not work against them.

Third is lifetime income. There were safe harbor provisions passed in the Secure Act that made it easier for defined contribution plan sponsors, ERISA fiduciary plan sponsors, or employers to utilize annuities inside of 401K plans and any other ERISA sponsored plan. That legislation was passed in 2019 and what it has led to is the retirement plan providers out there, the ones who administered these retirement plans,

building the technology. And that's now going into production to offer guaranteed income as well as the product manufacturers can now offer guaranteed income through what we like to call the default fund. Now the impact of this on the states or the impact of not incorporating lifetime income, not addressing these measures, equates to $334 billion in increased aggregate spending at the state level. In fact, when you combine state and federal, it's estimated to be upwards of $1.3 trillion in additional expenditures that this will result in.

So why lifetime income? First are employees. Employees are looking for lifetime income. I think most have, if you saw the UAW negotiations, saw a demand to bring back that guaranteed lifetime income. 78% of respondents to an Employee Benefit Research Institute (EBRI) survey responded saying that they were looking for lifetime income. 75% said that they prefer income stability in retirement over principal preservation. Plan sponsors like an ERISA fiduciary plan sponsor incorporating guaranteed income can help increase the risk return profile of the retirement plan that you offer. And last is it allows for the potential of increased spending. Adding guaranteed lifetime income generates 29% more in annual spending ability from one's retirement savings and reduces downside risk by 33%. The spending piece, and we are seeing this and we're hearing it more and more from financial advisors and you may be dealing with this yourself, when you do not have enough guaranteed income, you tend not to spend. In fact, we hear from financial advisors that people's biggest regret was they had too much money. They're now in a position where they're not able to enjoy it. They wish they'd taken that trip with the family and now they can't go back in time and redo things. That is because people without guaranteed income are worried about outliving it. I will just say, personally, I live up in New England, I'm from Massachusetts. My father is 79 years old and I get a call every winter from my mom to come over and try to convince him to turn the heat on. He tries to go to Thanksgiving before turning the heat on in the house. It's that level and the driver of that is he is worried about running out of savings. He does not have guaranteed income. So, that is often known when you have it as a license to spend. If you know you are covered and as long as you live, you're not going to run out of income to cover your essential living needs, you are way more likely to spend in retirement.

I talked about the technology earlier and this year this is one of the hottest things in the retirement industry is now this ability to provide guaranteed income through a retirement plan, through a defined contribution plan. I mentioned TIAA is, the fourth largest provider of lifetime income. We've always had the technology and the ability; we've been providing guaranteed lifetime income through defined contribution plan since 1918. Our competitors out there, both Fidelity and M Power, number two and number one with state plans, have both earlier this year announced that they have added lifetime income, M Power actually is offering our lifetime income offering. Alight is number three and they're in the process of building it. So, the technology is there now for this to be delivered. The other thing is this can be delivered simply. It's not complex. These solutions are being embedded inside of the default target date funds. So that investment

that they are being defaulted into inside of the defined contribution plan works the same way it always did. But now you can convert a portion of your retirement savings. You don't just have a balance. You still have that same balance, but you can now convert a portion of it into a retirement income. One other part on this, there are a number of solutions in the market now that do not necessarily need to increase costs. In fact, some of these income solutions could actually lower the overall cost of the retirement plan. Additionally having it increases income in retirement rather than a lot of people today who rely simply on a 4% withdrawal rule.

So, what can states do? I know we have the draft resolution in front of you, please reach out to us. We'd love to work with you on that. But on your state retirement plan, number one is just ensure that your employees, state employees are participating in the plan. Sometimes it requires additional promotion of it and other marketing to just make sure and other kind of structural designs to make sure they're participating in the plan.

Second is driving adequate savings. You want people saving 12-15% of their retirement plan and you can do that through auto escalations we mentioned earlier. Offering core investments including lifetime income. Again, now you can get those target date funds that all of your state plans most likely have as their default fund. You can get them where they actually embed the guaranteed income inside. Last is driving employee engagement. This is viewed as a benefit enhancement. You may now have an addition to your DB plan. You've got additional supplemental guaranteed income so that you can meet that 80% desired income replacement. Some of the states here, you'll see that have already taken this on, New York, North Dakota, Rhode Island, and South Carolina have all moved forward with lifetime income options inside of their defined contribution plan.

So again, in terms of what to do, we have the draft resolution. Take it back. This is meant to be a guide for you. But I would just take a look at your state's retirement plan offering. See how much lifetime income is being generated by the defined benefit plan, is it enough? And with your defined contribution plans, is there enough for that 80% income ratio? If the typical DB plan doesn't offer enough, can you then include that? Can you easily get to that 80% by incorporating that into the defined contribution plan? Whether it's the deferred comp 457 or whether it's a hybrid or state DC plan. Again, happy to help everyone here on this. I'll take questions. Also, feel free to reach out to me on LinkedIn. It's Brenden McCarthy, TIAA, you'll find me pretty easily out there if we can help in any way. So, thank you for your time.

Sen. Bob Hackett (OH) stated this what I do for a living and I've done it for many, many years. And we manage a lot of monies. We have five public plans in Ohio. They're all defined benefit plans, even though you have some options that you can do different things. The problem is its healthcare and there's nothing in a high revised code. When I was a State Representative, we brought the plans into compliance which we needed to do. But it was the board of directors of the five public plans that created the problem. And a teacher for example, in our STRS, it's a teachers retirement system, they can

retire at any time in 30 years so many teachers started at 20 and 21, are going to retire at 50, 51. The problem is what is the cost of healthcare to get them to Medicare that is the problem on the plans.

And we have no responsibility or authority or anything on healthcare. It's the five public plans that did that. I see what you did and I understand what you did. But there's a cost to everything. I mean, you used how bad the market dropped in ’08 and ’09, but you didn't put how much the market has come back since then. You know that I mean, and how much the market jumped. You know you could do from 2000 to 2002, where the market dropped. But the market usually comes back. And so, I only ask this to be fair. The problem of the guaranteed lifetime income is the cost of it. You got to do it right. And you know that. And I know that. It has to be done right. And we have to be careful that we don't use annuities completely in a situation like that. Annuities, the commission on annuities, is extremely high and the cost is there. So, we have to be careful on how we do this. And you know that as much as anybody knows that.

Mr. McCarthy said you're absolutely accurate. In 2008 to 2009, the danger was not those that just experienced that drop and stayed in the plan, it was the number that exchanged out that thought this market's going to zero and then they missed the bounce back. So, that 47% for a number of Americans was even worse.

Sen. Hackett stated it came back strongly. And that's why the consumer a lot of times chases the market and you and I know that is completely wrong. So, I'm not a just a pension representative, I’m an investment advisor. So, I can give pension advice to people and say you don't buy it to sell it when the market drops under that scenario. I just warn you a little, because it isn't always a solution of having the guaranteed income. The solution is getting people to put more money away. The problem is healthcare and in the private sector we don't have defined benefit plans. Only in the state-run systems are there defined benefit plans or some of the maybe major corporations. But even they've gotten away from it. Well, I just want you to be careful to the people in here. Mr. McCarthy said I appreciate that. While this can't solve for healthcare, it can help a little towards it. That is a larger issue without a doubt. I will say on cost, there is a number of different solutions. But there are solutions out there that do not increase the cost that can actually lower the cost.

PRESENTATION ON TRANSAMERICA’S CENTER FOR RETIREMENT STUDIES ANNUAL RETIREMENT SURVEY

Sen. Klein stated that next on the agenda is a presentation on the Transamerica Center for Retirement Studies Annual Retirement Survey. And once again, we'll hold our questions until the end.

Catherine Collinson, CEO and President of the Transamerica Institute and Transamerica Center for Retirement Studies (TCRS) thanked the Committee for having her. I'd like to spend our time together talking about a survey report we released just last month, it's

called The Multigenerational Workforce: Life, Work, & Retirement. This report is based on a survey of more than 5,700 workers of for profit companies. And I don't usually do this in my presentations, but I have to add this little footnote. We did not inquire about political affiliation, so I cannot answer any questions on that. We engaged Harris Poll, which is one of the largest online panel survey firms in the country. So, this is a nationally represented survey. And these are our findings.

A quick note, we're a nonprofit private foundation that is funded by Transamerica and our Retirement Survey which I'm talking about is one of the largest and longest running of its kind. Mr. McCarthy touched on longevity and one of the things that we're all seeing in our research and our society is people have the potential and are living longer than we've seen ever before. And this has tremendous implications for how we live, how we work, how we retire. We view successful retirement as the combination of healthy aging and financial security. In many ways, they are two sides of the same coin. When we ask workers how long they were planning to live to, and it's an awkward question because a lot of people don't think about that if they're not actuaries, 1 in 7 are planning to live to a 100 or older. The median age of those who provided a number is 88 and then of course 34% are not sure.

I'm going to start with the health side of the question and then take a deeper dive into what's happening with retirement savings and retirement security. The good news is 3 in 4 workers have close relationships with family and friends and are happy and enjoying life. And this is probably some of the best news that we see in the survey when we look at overall, sort of what we call positive feelings, as well as indicators of distress. I've covered the positive. I've got a notate some of the indicators of distress. We see high percentages of people saying that they're having difficulty making ends meet. And that number is especially high for GenZ, the youngest generation in the workforce.

We also see among GenZ and to a lesser extent, millennials, is many are feeling anxious and depressed. And in GenZ, the youngest generation, we see very high percentages of them saying they often feel isolated and lonely. So, we are seeing a social isolation and the effects on mental health in the Surgeon General's report on the loneliness epidemic. I think this is something that we really need to pay attention to because it affects their quality of life. It affects their health. It affects their productivity. And their ability to save for retirement. I'm going to just touch on most workers are in good or excellent health. We inquire about healthy behaviors that they are engaging in on a consistent basis. Everything from the basics of eating healthy, exercising regularly, getting plenty of sleep. And we see more than half are doing those, at least the first couple of things. And then there's other things people could be doing to protect their health that they're not engaging in. You can see the percentages, not seeking medical care when needed, not keeping up with routine physicals and health screenings. As well as only 38% or indicate they are avoiding harmful substances which in the question we say EG, cigarettes, alcohol, drugs. Older workers tend to be taking care of themselves better than younger workers. But still, you know, what I see here is a role for public

health. That our education campaigns are always going to be a work in progress. And for current generations as well as for future.

Now we're going to shift gears to retirement. One of the things that we've seen in our survey, and I've also been involved in global retirement research, is in the US people love retirement. We have positive word associations where workers are twice as likely to cite one or more positive word associations than negative word associations. And it's really something that people strive for, save for, and look forward to. And in the spirit of longevity, the workforce is already rethinking their time in the workforce relative to retirement. And something that we've seen in the survey for a good 15 years now, our work and retirement are no longer mutually exclusive in the minds of workers. They're envisioning a gradual transition versus an all or nothing work full time one day and never again the next.

Almost half expect to retire after age 65 or are not planning to retire. And when we look at older generations, of course, many baby boomers are already doing that. In GenX, far more than half are looking to work beyond traditional retirement age. And then across the board, among generations, more than half say they plan to continue working at least part time in retirement. They want to do so for both financial reasons as well as healthy aging reasons. It's probably not surprising that 4 in 5 cite one or more financial reasons. But almost, it's almost as many 78% are citing healthy aging related reasons ranging from being active, keeping their brain alert, having a sense of purpose, enjoying what they do.

However, the kicker is this. Will there be employment opportunities for them? And are they being proactive enough so that they can continue to work as long as they want and need? But fewer than 6 in 10 say they're focused on staying healthy so they can continue working. Particularly concerning to me only half of workers say they're keeping their jobs skills up to date. We know the world of work is moving very, very quickly right now. And if we don't all strive to keep our jobs skills up to date, we're at a big risk of getting left behind. And then, as you say, fewer than three in ten are networking and meeting new people. Which are essential for getting leads on job opportunities and even having an understanding of what employers are looking for.

Workers also face competing financial priorities. Some good news is when we ask about current financial priorities, the highest response rate is on saving for retirement. Again, this finding is skewed towards millennials, GenX, and baby boomers. Whereas GenZ many are saying that they're just getting by to cover basic living expenses.

Another thing I want to point out about GenZ in our research and this is an emerging trend and is something that we're starting to see sort of ooze through the data. And that is when we ask this series of financial priorities among GenZ, 1 in 5, 20%, said supporting their parents. Which is suggesting that absent adequate savings of older generations, the burden is starting to fall on their adult children who at are point in their life where they’re trying to build their own financial base to carry them through their

working years. Good news and again, these are employed workers of for profit companies. 4 in 5 are saving for retirement, either through their employer's plan or outside of the workforce. And the savings rate is 4 out of 5 for millennials, GenX, and baby boomers. But a really exciting proportion of GenZ, 71%, say they're already saving for retirement which is remarkable.

However, that takes us to something along the lines of what Mr. McCarthy touched on. Only 20% of workers are very confident they're going to be able to fully retire with a comfortable lifestyle. And this is something that we see across all four generations to a greater or lesser extent. Their greatest retirement fears and I'll add the older workers who are closer to retirement are more likely to have fears than younger workers when retirement is a bit further away. But the biggies are outliving their savings and investments, anxiety about the future of Social Security, as well as health issues later in life and the potential need for long-term care. We did have an outlier in the findings generationally that caught me by surprise. One of the options that's not cited by all that many if when we look at the numbers in their totality is 4 in 10 GenZ cited feeling isolated and lonely as one of their greatest retirement fears. Which just sort of reinforces that we've got to pay close attention to the mental health of the younger generation.

Expected primary source of retirement income which I've laid out here. We asked workers about all their expected sources of retirement income and then what will be your primary source of retirement income? These are the overall findings, there's some big results generationally. Whereas baby boomers are far more likely to cite Social Security as their primary source of retirement income, other generations are more likely to indicate income from 401K's, 403B's and IRA's.

One thing I want to touch on because this is such a central topic today is retirement plan coverage. And we ask workers in the survey which of the following retirement benefits are offered to you personally by your employer? And we can see that a high percentage, 3 in 4 are offered a 401K or similar plan, some sort of employee funded means to save for retirement in the workplace. And because there is so much focus on closing the coverage gap, we had to pay really close attention to who is not covered. What we see in our research is it is typically workers of the smallest companies, part-time workers, and lower income workers. Across large companies, the access rates are very high.

One thing I'm really enthusiastic about and is indicative of how the defined contribution system is working is we're seeing emerging super savers. So, among workers offered a 401K or similar plan, we see very high rates of participation, 4 in 5. And then when we ask how much of their salary they're contributing to the plan, the median among those participating is 10%. And Gen Z, and this is the second year in a row that we've seen this, is really high percentages among Gen Z workers who are taking advantage of the retirement plans. How this relates to household retirement savings, and again, this is of all workers regardless of their offer to plan or not and we ask about savings in total household retirement accounts. We can see that Gen Z is getting a strong start whereas millennials, having saved $50,000, these are estimated medians, are making progress.

Gen X and boomers I'm very worried about. Generation X, it's hard to believe the first Gen Xers are going to start turning 60 next year and all indicators are many are behind in their savings.

A few opportunities I wanted to point out to strengthen savings. One is financial literacy. Only 21% of workers say they have a lot of working knowledge about personal finances. And then another one I just want to focus on for a second is many, many workers are saving, but we're seeing a high percentage tapping into their savings before retirement by taking a loan, hardship withdrawal, and or early withdrawal, 35%. And those percentages are pretty high across the four generations including the youngest savers, Gen Z. It seems like they haven't saved long enough to have to need to dip into their savings, but we see it happening.

I'm going to wrap this up with just a couple more sets of insights. We asked workers their priorities for the President and Congress to help people have a financially secure retirement. And what comes to the top of the list, and we've asked this question in prior surveys, is strengthening our social safety nets especially as it relates to Social Security and Medicare. People are really counting on those. And this is also reflective of sort of the broader ecosystem if we think about successful retirement, being healthy, aging, and financial security. There is a pretty high response rate on ensuring our workers have access to retirement benefits in the workplace or retirement plans in the workplace.

But it's interesting to see where it stands relative to some of the other priorities. So, my five key takeaways for you based on our survey findings, is first of all public policy is absolutely essential for fostering an environment that's conducive for successful retirement. The second takeaway is workers understand the importance of saving for retirement, but many are still at risk of falling short. The next is to create an environment where everyone can be successful. We need to ensure they have the tools and education and know how to be successful. Number four, we lean heavily on employers as a very important conduit for offering not only employment, jobs, education, training, but also very important benefits, health, retirement and other benefits. We lean on them a lot. We also have to recognize some care about it a whole lot more than others. And then there's some employers that may be just too small or not stable that just don't have the wherewithal. And so, we've got to find ways to help those employees or bring those employees into the system that may not have the same level of benefits. And then finally, to strengthen our retirement system, in addition to enhancing 401K's defined contribution plans, and other types of retirement savings. We also have to pay close attention to our safety nets. And that's it. Thank you.

Sen. Klein thanked Ms. Collinson for her presentation and stated as I listen to this, there's a lot of things if you retired 10 years ago, you would have thought where the inflation period was that, we're fine. You know, that was one thing that came to mind as I've gotten older. And I'm not suggesting people go back to run for the legislature so they have a part time job. But, you know, those are things that everybody is being faced with. And I think the literacy issue is another thing where I think the user, there's a lot of

fun stuff out there to buy and saving money is probably something that we don't instill in them enough to understand. It seems like statistically it's coming. But I think we still have a ways to go. Is there anything in there suggesting the young people are doing a better job?

Ms. Collinson stated well, especially if they're offered the chance to save for retirement in the workplace, they're doing a terrific job. And I touched on the 4 out of 5 who are saving either in the workplace or outside of work. A really exciting development for me is this, of the Boomers who are saving, they started at age 35. When we look at the youngest generation in the workforce, Gen Z, the median age is 20. That has added an entire 15 years to their savings and investment horizon. So, if they can stay focused and not tap into their savings, they can really take advantage of that trajectory.

Rep. Forrest Bennett (OK) stated I add to my client list Gen Z and millennials, because my colleague, the Chairman talked about young folks having fun things to buy and things like that. I just want to offer a different perspective. And I'm sure, you know, I'm sure that's true in many circles. But there are also extraordinary challenges, as we all know, for the youngest generation and for millennials. Our housing stock is not where it needs to be, our ability to save, to begin to save is difficult. And I just like to push back on that idea sometimes not that I think you meant anything by it, but that it's not for lack of a desire to save and be able to buy things like a house that can help you create generational wealth, that kind of thing.

And I think it behooves us all as policymakers to look at that housing stock, cost of healthcare, wages. I love this organization because what we really do get at the heart of some of these things, but this all exists in the context that other areas of public policy are not necessarily ideal for the consumer either. So, I do wonder in your research, if you've noticed where people are prioritizing. I saw the need to strengthen social safety net and I wonder how much money folks are spending in that respect that they could be putting back as a result of not having some of those sort of safety net tools that that previous generations have been able to have. Whether that's mortgage assistance or that's care for the elderly. I have an aging mother who needs additional care now and we are struggling to find a way to pay for that. I'm 34 and I'm spending some of my money doing that as opposed to putting it away. So, I wonder what advice you might have for us. More specifically, in where we would prioritize it. As many of us and many of our state legislatures don't have endless amounts of money. But where is the best place to put that money if we have to choose?

Ms. Collinson stated that's a great question and a couple of other things, I just feel compelled to say about younger generations and Gen Z. And this goes back to when I was growing up and I'd hear my grandparents say "kids these days". That it was almost universal because I hear my friends saying it now, I'm like what are you saying? And what we see in the research is especially with millennials, that was the first generation that we really saw high rates of student debt. We certainly see that with Generation Z. In prior waves when we asked about employment effects of the pandemic, they were

more likely to be laid off or furloughed and that was a setback for them. Where they're at now generationally, they're more likely to be just getting by to make ends meet. And they're hustling, a high percentage have two or more jobs and a high percentage have side hustles. What's coming out of the data is they have a very, very strong work ethic and also, a pretty high percentage it's at least one in three are either serving or have been serving as caregivers.

So, I'm really happy you brought that up. Across the four generations right now Millennials take the top spot as the caregiving generation. Gen. Z's not far behind them. And if we think about public policy somewhere that could really help is support for family caregivers. Because if they're working in caregiving, 4 in 5 are making adjustments to their employment which could, effect their employability, their future raises, their own career development, and their own ability to save for retirement. And affordable housing is very top of mind for everybody, but especially for the younger generations wondering if they're going to be able to afford it.

Sen. Justin Boyd (AR) said this might be more of a comment or just an educational point than a question. But just a reminder, if you have a child who isn't even 18 yet, he or she can go to work, pay virtually no taxes, invest that in a Roth IRA, and let that grow for years, decades, and virtually pay no taxes ever. So, that's just something again, a lot of it is what are we doing to help taxpayers understand the system that we have in place and encouraging mom and dad to work with those kids.

Rep. Tedford stated I'm curious of the data on Gen Z and millennials whether that willingness to invest more is due to a paradigm shift in their trust in Social Security being there when they retire?

Ms. Collinson stated I believe it is. I believe that's a big part of it. One of the things that we saw and we've seen over the years with millennials and if we just think timing wise, is they were entering the workforce right about the time the financial crisis was hitting, many were still living at home with their parents and they saw what was happening with their parents and part of just being part of family units because it was such an extremely difficult time. They've heard concerns about Social Security probably as long as they can remember, but there's also something that money and finance has captured their imagination. And I think in many ways it's access to 401K's and the ability to save. For years when we ask workers how frequently they talk about saving and investing and planning for retirement, millennials are twice as likely as boomers, the generation that's retiring or getting close to it, to say they frequently discuss it. So, millennials have a new money mindset that I think is a really good thing that could help them. And we're also seeing that bubble up with Gen Z as well.

DISCUSSION ON PROPOSED AMENDMENTS TO NCOIL LIFE SETTLEMENTS MODEL ACT

Sen. Klein stated the next agenda item is discussion and proposed amendments to NCOIL Life Settlements Model Act. We had a good discussion on some amendments at

the last meeting in April. Since then, we've had Rep. Bennett sign on to sponsor some amendments. Before we go any further, I'll turn things over to him for some brief comments.

Rep. Bennett stated I'm happy to sponsor the amendments and you can find them on your binders on page 253, 256 and 258. They're the parts that are underlined. Basically, they can be broken down into two categories, one being modernizing the model by allowing for electronic communications in certain circumstances which I think benefits both carriers and individuals by saving paper and cost and also trees. So, it's pretty self-serving, considering my name is Forrest. And the other is focusing on whether agents should be prohibited from disclosing the options of a life settlement when a client comes to them thinking about dropping their insurance. I've appreciated the conversations that have gone on between the folks that are involved in this and their efforts to reach a compromise. So, because they are still having a conversation, I'm asking that we not have a vote on the amendments today as it seems that the conversations are progressing in a positive way. But we may be able to have a vote on this in November. To that end, I would request, Mr. Chairman that we have a conversation about this during any interim meetings that may occur between now and the fall meeting. I appreciate the input that everybody's provided so far, and I look forward to continuing to work with everybody to make this happen.

Josh May, Chief Legal Officer at Coventry thanked the Committee for the opportunity to speak and stated I'm here on behalf of the Life Insurance Settlement Association (LISA) this afternoon, LISA represents life settlement brokers and ife settlement providers. Overall, we believe this has been a very successful model act and we're pleased that it will be readopted. We also think that after 17 years, there are a few items that should be addressed and refreshed. As our sponsor said we put those items into two or three categories. The first is electronic communications and signatures. We don't think this is very controversial. They should be accepted, some carriers still require snail mail, which adds significant time and inconvenience for consumers to what is already a lengthy and relatively complex transaction. So, we're asking that carriers be required to accept electronically signed documents and accept electronic requests for things like verifications of coverage and policy illustrations. We deal with this on a daily basis in the industry and think it's a practical and pro-consumer change.

A second bucket that wasn't mentioned previously is to change some of the carrier response times. We'd like to move from 30 days to 21 days in a couple of situations. And also impose a 21 day deadline for the first time for carriers to respond to requests to change the ownership of the policy. We think consumers should be able to have their transactions completed on a timely basis. And this will go a long way towards helping make that happen. The third category relates to insures that prohibit their agents from discussing the life settlement option. It's a small minority of carriers, but we believe it's anti-consumer and should change. To be clear we're not asking insurers to advertise or promote life settlements. Simply, we want them to allow their agents to speak about the

life settlement option if he or she chooses to do so because they think it's in the consumer's interest. I understand this is the most controversial change. And as I've said, we've had productive discussions with the American Council of Life Insurers (ACLI) and plan to continue those discussions to work towards a mutually agreeable solution.

Jill Rickard Regional VP, State Relations at ACLI said thank you, Mr. Chair, I'll just be very brief. We have had, like Josh said, some good conversations about this. He also mentioned the most controversial is the producer disclosure requirement which along with the other two provisions at this point ACLI does oppose, absent what we view as evidence of consumer harm in the marketplace. But in the spirit of continuing discussions and compromise we have agreed to take some proposals from LISA back to our members in the next couple of months prior to the interim meeting and hope to come to a compromise, if possible, on the less controversial provisions particularly E-notification.

Sen. Klein stated for those of you in the audience who were here 20 years ago when we battled through this and then we went to our states and once again worked through this, it's like reopening this can of worms. That was certainly an interesting time at NCOIL and certainly in our own legislatures. Once again, this is model legislation. Each state can adopt things as they see fit and approach these issues from their own state perspective. Rep. Bennett stated I just want to reiterate my appreciation to everybody that's been involved in for being as amicable as possible and helping me get caught up to speed on this issue in the first place. And I do genuinely look forward to additional conversations and hope that we can come to an agreement on everything. Hearing no further questions or comments, upon a motion made by Rep. Bennett and seconded by Sen. Boyd, the Committee voted without objection by way of a voice vote to readopt the Model until the November meeting.

UPDATE ON LITIGATION SURROUNDING THE U.S. DEPARTMENT OF LABOR FIDUCIARY RULE

Sen. Klein said as some of you know, the US Department of Labor finalized its new fiduciary rule which essentially mirrored a rule from several years ago that was ultimately struck down by the federal court system. NCOIL opposed both rules on the grounds that the rule is an encroachment on the state-based system and insurance. For this current rule there's a lot of activity in the courts and in Congress. Two lawsuits have been filed by insurance trade groups in Federal District Court. There's also a bill in Congress that is headed for a vote that would prevent the DOL from spending any funds to implement the rule. NCOIL will continue to monitor that activity and we hope that the rule will ultimately be struck down as it was several years ago.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Utke and seconded by Rep. Lehman, the Committee adjourned at 4:30 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.***
****Re-adopted by NCOIL Life Insurance & Financial Planning Committee on July 19, 2024 and NCOIL Executive Committee on July 20, 2024 until NCOIL Annual Meeting in November while proposed amendments are discussed.***

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

****To be discussed and considered during the Life Insurance & Financial Planning Committee's meeting on November 22, 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.]

Section 10. Disclosure to Insurer

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 submitted by a Provider, settlement broker, or life insurance producer not later than thirty calendar days of the date the request is received. <u>The insurer shall accept an original or facsimile or electronically delivered copy of such request for verification of coverage and any</u>

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. 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.

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, 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.

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.

Drafting Note: Nothing in these Sections prohibits a life insurer from requiring a specific method or mode of e-signature or e-delivery in common commercial use to authenticate the authorization of an Owner or Insured.

Resolution in Favor of Encouraging a Redesign and the Use of Lifetime Income Investment Solutions in Defined Contribution Plans

To be discussed during the Life Insurance & Financial Planning Committee meeting on November 22, 2024.

Many American workers are facing a retirement savings and income challenge. Almost 57 million Americans don't have access to a workplace retirement plan to help them start saving (*1). Worker sentiment also reflects the challenges of retiring with dignity. Seventy-one percent of nonretired adults are at least moderately worried about being able to fund their retirement (*2). These challenges include a lack of guaranteed retirement income covering employees' essential expenses and insufficient overall savings to provide and generate enough retirement income.

If current trends continue, inadequate retirement savings will cost states $334.3 billion in aggregate increased spending by 2040, and $1.3 trillion in state and federal expenditures combined (*3).

State governments have an important role to play in promoting and helping workers achieve greater retirement security which contributes to sound state fiscal policy. States should understand how much, if any, lifetime income their respective retirement plans provide employees and consider whether their plan is providing enough retirement income. The goal should be to provide employees 80% of their pre-retirement income.

WHEREAS, there is a retirement crisis today for American workers, including state employees, and

WHEREAS, the retirement crisis is heightened due to a lack of or shortage of lifetime income in the retirement plans of millions of American workers, and

WHEREAS, there is an opportunity today for employers of all sizes in the private and public sector to include lifetime income investment solutions for their employees; and

WHEREAS, there is an opportunity today for employers to educate, encourage and facilitate utilization of lifetime income investment solutions by their employees; and

WHEREAS, to help mitigate our nation's growing retirement crisis, state policymakers and retirement plan sponsors have tools at their disposal, including auto-enrolling eligible workers into their respective primary and/or supplemental retirement plans; and

WHEREAS, according to research institutions like the Center for Retirement Research at Boston College (*4), the Brookings Institute (*5) and financial services firms (*6), employees in a defined contribution plan and the plan sponsor, should contribute a shared

amount of at least 10-15% of the employees' salary to ensure an adequate amount to retire comfortably. If an employee is not enrolled in social security, an additional 6-12% contribution may ensure retirement income adequacy; and

NOW, THEREFORE, BE IT RESOLVED, to help workers gain access to an adequate amount of lifetime income, state policy makers should conduct a study to analyze and quantify the current amount of income the typical worker might receive in their respective retirement plans. This includes the income created by the defined benefit, defined contribution and/or deferred compensation plans; and

NOW, THEREFORE, BE IT FURTHER RESOLVED, for those employees in a defined benefit plan, the employer and employee should contribute the actuarial required contribution rate as prescribed by the retirement plan's Board of Directors and/or their actuary; and

NOW, THEREFORE, BE IT FURTHER RESOLVED, to help employees ensure they are on track for a dignified and secure retirement, sponsors should provide advice and guidance services, tools and solutions to employees and encourage employees to utilize those services, tools and solutions; and

NOW, THEREFORE, BE IT FURTHER RESOLVED to provide additional lifetime income to supplement any pension benefits received by an employee, sponsors should include an in-plan lifetime income solution as part of the available investments in a defined contribution or deferred compensation plan; and

AND BE IT FINALLY RESOLVED, copies of this resolution should be provided to the members of state legislative insurance, retirement, and banking committees, and the chief financial services and insurance regulators.

*1: Wharton Pension Research Council. March 2022
*2: *Americans' Outlook for Their Retirement Has Worsened,* Gallup, May 25, 2003
*3: State and Federal Impacts of Insufficient Retirement Savings, National Conference of State Legislatures, July 17, 2023.
*4: *How Much Should People Save*, Center for Retirement Research at Boston College, Alicia H. Munnell, Anthony Webb, and Wenliang Hou, July 2014.
*5: The new math of saving for retirement may boil down to this one, absurdly simple rule (brookings.edu)
*6: How much should I save for retirement? – Empower

MATERIALS FOR GENERAL SESSION – ERISA AT 50: AN IMPORTANT STANDARD SETTER OR ROADBLOCK TO STATE HEALTHCARE INNOVATIONS?

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National Council of Insurance Legislators (NCOIL)

ERISA Preemption- Health Reform Waiver Proposal

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29 U.S.C. § 1144 (***Amendments re: Waiver indicated by underline***)

(a) Supersedure; effective date

Except as provided in subsections (b) and (f) of this section, the provisions of this subchapter and subchapter III shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2) (A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 1136 of this title.

(4) Subsection (a) shall not apply to any generally applicable criminal law of a State.

(5) (A) Except as provided in subparagraph (B), subsection (a) shall not apply to the Hawaii Prepaid Health Care Act (Haw.Rev.Stat. §§ 393-1 through 393-51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a)--

(i) any State tax law relating to employee benefit plans, or

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent they govern matters which are governed by the provisions of such parts 1 and 4, shall supersede the Hawaii Prepaid Health Care Act (as in effect on or after January 14, 1983), but the Secretary may enter into cooperative arrangements under this paragraph and section 1136 of this title with officials of the State of Hawaii to assist them in effectuating the policies of provisions of such Act which are superseded by such parts 1 and 4 and the preceding sections of this part.

(6) (A) Notwithstanding any other provision of this section—

(i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides—

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this subchapter, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this subchapter.

(B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements which are not fully insured. Any such exemption may be granted with respect to any arrangement or class of arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of section 1002(1) and section 1003 of this title necessary to be considered an employee welfare benefit plan to which this subchapter applies.

(C) Nothing in subparagraph (A) shall affect the manner or extent to which the provisions of this subchapter apply to an employee welfare benefit plan which is not a multiple employer welfare arrangement and which is a plan, fund, or program participating in, subscribing to, or otherwise using a multiple employer welfare arrangement to fund or administer benefits to such plan's participants and beneficiaries.

(D) For purposes of this paragraph, a multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State.

(7) Subsection (a) shall not apply to qualified domestic relations orders (within the meaning of section 1056(d)(3)(B)(i) of this title), qualified medical child support orders (within the meaning of section 1169(a)(2)(A) of this title), and the provisions of law referred to in section 1169(a)(2)(B)(ii) of this title to the extent they apply to qualified medical child support orders.

(8) Subsection (a) of this section shall not be construed to preclude any State cause of action—

(A) with respect to which the State exercises its acquired rights under section 1169(b)(3) of this title with respect to a group health plan (as defined in section 1167(1) of this title), or

(B) for recoupment of payment with respect to items or services pursuant to a State plan for medical assistance approved under title XIX of the Social Security Act which would not have been payable if such acquired rights had been executed before payment with respect to such items or services by the group health plan.

(9) For additional provisions relating to group health plans, see section 1191 of this title.

(c) Definitions

For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

(3) The term "group health plan" includes any "employee welfare benefit plan" as defined in section 1002(1) of this title which is established or maintained by an employer, an employee organization, or both, that provides medical care for participants or their dependents directly or through insurance, reimbursement, or otherwise.

(4) The term "Secretary" means the Secretary of Labor.

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of the United States prohibited

Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(b) of this title) or any rule or regulation issued under any such law.

(e) Automatic contribution arrangements

(1) Notwithstanding any other provision of this section, this subchapter shall supersede any law of a State which would directly or indirectly prohibit or restrict the inclusion in any plan of an automatic contribution arrangement. The Secretary

may prescribe regulations which would establish minimum standards that such an arrangement would be required to satisfy in order for this subsection to apply in the case of such arrangement.

(2) For purposes of this subsection, the term "automatic contribution arrangement" means an arrangement—

(A) under which a participant may elect to have the plan sponsor make payments as contributions under the plan on behalf of the participant, or to the participant directly in cash,

(B) under which a participant is treated as having elected to have the plan sponsor make such contributions in an amount equal to a uniform percentage of compensation provided under the plan until the participant specifically elects not to have such contributions made (or specifically elects to have such contributions made at a different percentage), and

(C) under which such contributions are invested in accordance with regulations prescribed by the Secretary under section 1104(c)(5) of this title.

(3) (A) The plan administrator of an automatic contribution arrangement shall, within a reasonable period before such plan year, provide to each participant to whom the arrangement applies for such plan year notice of the participant's rights and obligations under the arrangement which--

(i) is sufficiently accurate and comprehensive to apprise the participant of such rights and obligations, and

(ii) is written in a manner calculated to be understood by the average participant to whom the arrangement applies.

(B) A notice shall not be treated as meeting the requirements of subparagraph (A) with respect to a participant unless—

(i) the notice includes an explanation of the participant's right under the arrangement not to have elective contributions made on the participant's behalf (or to elect to have such contributions made at a different percentage),

(ii) the participant has a reasonable period of time, after receipt of the notice described in clause (i) and before the first elective contribution is made, to make such election, and

(iii) the notice explains how contributions made under the arrangement will be invested in the absence of any investment election by the participant.

(f) Waiver for state flexibility. A State may apply to the Secretary for the waiver of section 1144(a) or section 1144(b)(2)(B) of this Part or both provisions as applied to State laws implicating group health plans defined in section 1144(c)(3).

(1) Such application shall--

(A) be filed at such time and in such manner as the Secretary may require;

(B) contain such information as the Secretary may require, including--

(i) a description of the State law or laws which would fall within the scope of the requested waiver, and

(ii) the requested waiver's likely impact on group health plans operating within the State; and

(C) refer to any related waiver applications submitted by the State under 42 U.S.C. § 18052, titles XVIII, XIX, and XXI of the Social Security Act [42 U.S.C. 1395 et seq., 1396 et seq., 1397aa et seq.], or any other Federal law relating to the provision of health care items or services.

(2) Waiver consideration and transparency.

(A) In general. An application for a waiver under this section shall be considered by the Secretary in accordance with the regulations described in subparagraph (B).

(B) Regulations. The Secretary shall promulgate regulations relating to waivers under this section that provide--

(i) a process for public notice and comment at the State level, including public hearings, sufficient to ensure a meaningful level of public input; and

(ii) a process for providing public notice and comment after the application is received by the Secretary, that is sufficient to ensure a meaningful level of public input and that does not impose requirements that are in addition to, or duplicative of, requirements

imposed under the Administrative Procedures Act, or requirements that are unreasonable or unnecessarily burdensome with respect to State compliance.

(C) Report. The Secretary shall annually report to Congress concerning actions taken by the Secretary with respect to applications for waivers under this section.

(3) Scope of waiver. The Secretary may not waive under this section any Federal law or requirement that is not within the authority of the Secretary.

(4) Determinations by Secretary.

(A) Time for determination.

The Secretary shall make a determination under subsection (f)(1) not later than 180 days after the receipt of an application from a State under such subsection.

(B) Effect of determination.

(i) Granting of waivers. If the Secretary determines to grant a waiver under subsection (f)(1), the Secretary shall notify the State involved of such determination and the terms and effectiveness of such waiver.

(ii) Denial of waiver. If the Secretary determines a waiver should not be granted under subsection (f)(1), the Secretary shall notify the State involved, and the appropriate committees of Congress of such determination and the reasons for the denial.

(5) Term of waiver. The Secretary may limit the duration of a waiver granted under section (f)(1) to not less than 5 years. If the Secretary grants a waiver with a limited duration, the State may request continuation of such waiver on the expiration of the initial term.

NCOIL – NAIC DIALOGUE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
NCOIL – NAIC DIALOGUE COMMITTEE
2024 NCOIL SUMMER MEETING – COSTA MESA, CALIFORNIA
JULY 19, 2024
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) NCOIL – NAIC Dialogue Committee met at The Westin South Coast Plaza Hotel in Costa Mesa, California on Friday, July 19, 2024 at 10:45 a.m.

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

Other members of the Committee present were:

Rep. Deborah Ferguson, DDS (AR)
Rep. Rod Furniss (ID)
Sen. Dan McConchie (IL)
Rep. Matt Lehman (IN)
Rep. Cherlynn Stevenson (KY)
Sen. Kirk Talbot (LA)
Rep. Brenda Carter (MI)
Sen. Lana Theis (MI)
Sen. Michael Webber (MI)
Sen. Paul Utke (MN)
Rep. Bob Titus (MO)
Rep. Nelly Nicol (MT)
Sen. Jerry Klein (NY)
Asw. Pam Hunter (NY)
Sen. Bob Hackett (OH)
Rep. Ellyn Hefner (OK)

Other legislators present were:

Sen. Dafna Michaelson Jenet (CO)
Rep. David Silvers (FL)
Rep. Joseph Gullet (GA)
Rep. Martin Momtahan (GA)
Sen. Jared Carpenter (KY)
Rep. Matt Lockett (KY)
Rep. Michael Meredith (KY)
Rep. Rachel Roberts (KY)
Sen. Royce Duplesis (LA)
Rep. Gabe Firment (LA)
Rep. Brian Glorioso (LA)
Rep. Chance henry (LA)
Rep. Jason Hughes (LA)
Rep. Shaun Mena (LA)
Sen. Arthur Ellis (MD)
Sen. Jeff Howe (MN)
Sen. Walter Michel (MS)
Asm. Alex Bores (NY)
Rep. Greg Scott (PA)
Sen. Roger Picard (RI)
Sen. Patty Kuderer (WA)
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. Deborah Ferguson, DDS (AR), and seconded by Rep. Brenda Carter (MI), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Carter 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 April 12, 2024 meeting.

INTRODUCTORY REMARKS

Rep. Oliverson stated that before we get started I just want to say how truly grateful I am to see so many Commissioners here at the table joining us. We consider you at NCOIL to be an integral part of what we do here and I know a lot of the members being able to work with our commissioners and thinking about issues and policies and ideas and working through these matters collaboratively is really critical for us to actually make the right decisions legislatively. It requires working with you and your departments and understanding what you're seeing on the ground and how things are actually working and so I'm tremendously grateful. I remember my first NCOIL meeting, I think we had three Commissioners or maybe four around the table and so I'm just really grateful to see you all here and I would I think before we dive, we have several legislators here who are attending their first NCOIL meeting so it would be beneficial for everyone to introduce themselves: Colorado Commissioner Mike Conway; Georgia Commissioner John King; Idaho Director Dean Cameron; Indiana Commissioner Amy Beard; Kansas Commissioner Vickie Schmidt; Oklahoma Commissioner Glen Mulready; and Pennsylvania Commissioner Mike Humphreys.

RECAP OF NCOIL AND NAIC D.C. FLY-INS

Rep. Oliverson stated that the first thing on the agenda deals with NCOIL having its ninth consecutive Washington DC fly in June. And I know that the NAIC conducted its annual fly in in May so we were reinforcing hopefully some of the same things at the fly-ins. And I know from our perspective, we found the Members of Congress and their staffs to be very receptive and generally very supportive of the state based system of insurance regulation. I met with a number of Members on both sides of the aisle and their staff that were equally concerned about some of the things that have been cropping up in various federal agencies, most particularly with regards to the "Title Acceptance Pilot" from the Federal Housing Finance Agency (FHFA) which in my opinion, at least in my state, title insurance is literally the one area of insurance that we never have an issue with. If there's an area of insurance that works fairly flawlessly in Texas, other than workers comp, it's title insurance. And now we're having this federal encroachment and on that area but I found that people on the Hill were very receptive to our concerns. And we actually did succeed in getting the support of Congressman Pete Sessions at our visit to

introduce legislation at the federal level which would create an Employee Retirement Income Security Act of 1974 (ERISA) waiver process where we would just like a like a 1332 waiver or an 1115 waiver it would give states the ability to approach U.S. Department of Labor (DOL) and say for purposes of continuity, there's this small area of ERISA health plans that seems to be in direct conflict with the way the rest of our marketplace is going and we believe we have the authority. Do you agree? If so, could we regulate this under your supervision? And so, we're very excited about that and we look forward to hopefully getting your support on that moving forward. And we know the wheels of Congress grind very slowly but we're hopeful that they will move forward. Dir. Cameron stated that first, we want to say thank you for the opportunity to be here with you and to have this dialogue and we have really appreciated how the relationship between the NAIC and NCOIL has developed and continues to develop in large part thanks to your own leadership of Rep. Matt Lehman (IN), past NCOIL President, Cmsr. Tom Considine, NCOIL CEO, and everybody else. I don't mean to exclude anybody. We really appreciate your support. First and foremost, our state based regulatory system, we know that's the best way to govern insurance. We know that's the best way to protect our consumers in our states, our constituents and your constituents. We know that gives us the ability to be laboratories of innovation and to try different things and we know that is best suited for not only us regulators, but for you as lawmakers to be able to have that. And we continually see federal encroachment in a number of areas. You mentioned title insurance, but the list is pretty long. That continues to take place and of course we continue to push back. We held our fly in in May and we had 35 jurisdictions that attended in that week. We had an international forum the week before so we had some jurisdictions that came a week early and did sort of their private visits with Members of Congress and staff members the week before. But overall, on our fly in we had 35 jurisdictions and 144 different visits that were very informative. We want Members of Congress to be able to reach out to us and you as they have issues or questions about insurance proposals. There are many proposals that you guys push for that we support and that we were on the same page. Disaster mitigation was probably at the top of the list for us as we all are continuing to deal with a tightened property insurance market and try and figure out ways to make coverage available and affordable for consumers who are trying to buy it.

And the Disaster Mitigation and Tax Parity Act of 2023, Senate Bill 1953 and House Bill 4070, which is a bipartisan bill, we support it and we talked about it. And of course, you guys also discussed flood insurance reforms, as did we. There were a number of other proposals we discussed and I want to touch on just a couple of others in the interest of time. As insurance commissioners, we have been long advocating for voting membership on the Financial Stability Oversight Council (FSOC). We have a member, Rhode Island Commissioner Beth Dwyer, who has been a participant but she's a non-voting member. We're pleased to say that this administration nominated Commissioner Gordon Ito from Hawaii to be on FSOC. Unfortunately, it means he has to give up his role as commissioner in order to be an FSOC voting member but we're grateful to have somebody with insurance understanding and background serving on FSOC along with Cmsr. Dwyer. So, to the extent you helped us that way, we appreciate it. Also, a huge issue besides the property insurance issue is protection of our seniors from financial abuse. And we are very supportive of trying to have that protection. I think most of you

know that we regulate most forms of insurance. We regulate Medicare. We don't regulate Medicare supplement plans. We don't get to regulate Medicare Advantage plans. We have been pushing Congress to give us that authority because we feel like those plans aren't being adequately watched over and there are financial abuses going on with seniors in that aspect and it goes beyond that. We appreciate your support in protecting policyholders when insurers fail and unfortunately, that happens from time to time. We also appreciate your support in combating improper health insurance marketing that's been taking place. We also appreciate your support in opposing federal preemption of state data privacy and cybersecurity and artificial intelligence protections. We feel like that should happen at the state level through the NAIC and we feel like you should have a big say in what that looks like in your state. And we also appreciate your support and ask for your continued support in opposing federal preemption of states in the Liability Risk Retention Act. There's been an effort to try and expand that Act that's already in place and we're pushing back on that and we appreciate your support. We appreciate collaborating with you and working through these challenging issues that all of our states are facing in various degrees.

Rep. Oliverson stated that I love the idea of continuing to work in tandem and I think the more times that these folks at the federal level hear from us at the state level the better. The repetition is beneficial and I know that's something that we've talked about prioritizing trying to increase our turn out in our representation at the fly in and getting it to a much bigger place to where we actually have lawmakers essentially from every state represented. I would love to work with you and make sure that we're always comparing notes on these things ahead of time so that when feasible, I think we can go up and reemphasize things, especially if you're going in May and we're going in June. I think it's good for us to basically remind them of what you said on these issues because we're going to be in alignment and I think the more times they hear it the better.

UPDATE ON DEVELOPMENT OF NAIC'S DATA PRIVACY PROTECTION MODEL LAW

Rep. Oliverson stated that speaking of data privacy, we're going to get an update on the development of the NAIC's Data Privacy Model Law. For the benefit of everybody in the room, last year the NAIC began efforts to try and develop a new consumer data privacy protection model law. There were concerns raised throughout the process and so those efforts were paused and the NAIC sort of started from scratch. And we understand that you've had a working group that has had multiple meetings and decisions are being made and so we're looking forward to hearing an update on what the working group is doing.

Cmsr. Beard stated that as you just mentioned, the privacy protections (H) working group has been around for a couple of years now. So, it was appointed in 2019 and was charged with researching and looking into reviewing state laws about the collection, the use, and just how information is gathered in connection with insurance transactions. So, that working group was also charged with making recommendations as needed in conjunction with NAIC models. Currently right now there are two NAIC models that primarily address privacy concerns. The first one is the NAIC Insurance Information and

Privacy Protection Model Act, which is model 670. It was approved in 1980 following the federal enactment of the Fair Credit Reporting Act in 1970 and the Federal Privacy Act in 1974. And then the other model that exists right now is the NAIC Privacy of Consumer Financial and Health Information Regulation - that's model 672. And that was approved in 2000 to implement the requirements set forth in title five of the Gramm-Leach-Bliley Act. These two models have been a pretty effective regulatory framework for consumer privacy protections but there's been a lot of business developments, technology has evolved. We've seen artificial intelligence, machine learning, accelerated underwriting, algorithms with rating models being presented. And so, the working group determined that it either needed to amend and modernize the existing models or start from scratch and develop a new Model Law.

As you mentioned, at the NAIC summer 2022 national meeting the executive committee approved the request for a new model law development and that was to draft the insurance consumer privacy protection Model Law. Which is number 674. So, I've thrown multiple numbers at you, we've got two existing models, 670, 672 and then 674 was approved to be started on in 2022. Throughout 2023, the Privacy Protection working group held meetings and met with interested parties and exposed two drafts of Model 674 but ultimately, there was no consensus. And so, each committee approved the working groups request this year to extend and and kind of pause the drafting of Model 674. So, all of that being said we've had a transition of leadership. So, there's new leadership of the privacy protections working group this year and in 2024, we reconsidered whether we want to continue down the road of using Model 670 or updating and revising the NAIC privacy models, 670 and 672. On June 12th of this year we held an open group call, and we took a roll call vote and decided to pause on drafting 674 indefinitely and to continue revising existing Model 672. And some of the thought behind that is 672 has been adopted by all the States so we think it's an existing framework that can be built upon to modernize what those consumer protections are right now in the privacy world. We also held an open call on July 10th, and we announced that we would begin the drafting process on Model 672 and we really wanted to emphasize transparency, open dialogue and I really want to emphasize how much we want to hear from you all and Indiana is chairing the new Privacy Protections working group and our Co-chair is Illinois and a lot of you have worked on privacy models in your state to pass them. And then, of course, whatever we're working on right now at the NAIC we can't implement in our states without you all so we definitely want this to be a collaborative process working with industry, consumer groups and NCOIL as we discuss what protections we want to provide next. So, between now and the open call in Chicago in August we are going to talk with fellow regulators about what consumer protections we want to see, overarching themes, and kind of group those privacy protections into workable groups that we can work on the drafts of updating Model 672. And then we'll break apart into working groups going forward.

Rep. Oliverson stated that we do appreciate the collaborative nature of what you're doing. Regarding the decision to do 672 instead of 674, was the thought process that since that was already adopted that it wouldn't require passage of new legislation? But if I heard you correctly it sounds like even the reworking of 672 may require additional legislative lifting on our part, is that correct? Cmsr. Beard stated, yes. It wouldn't be

done in a vacuum at the NAIC with just the insurance commissioners. We thought it would be a good foundational framework that 672 has already been adopted by every state so it's a good starting point but we will still need everybody's input and work on the passage at the state level of updates to the model.

Rep. Oliverson asked if it would be useful to you if NCOIL designated an ad hoc working group of NCOIL members to participate in your calls so that whenever you're having these meetings, you could have a few lawmakers who are interested in this issue that are essentially on the call with you and then reporting back to us as to what's been happening. Cmsr. Beard stated that I would welcome any input from NCOIL. I think these open calls are a great forum as we get industry on them, we have consumer groups on them so if we've got legislative voices on them, that helps too. And then of course working off the calls and just having discussions and dialogues, it's always helpful as well and then bringing things to the forum on the calls to be transparent is always helpful. So, I think we want this to be as collaborative as possible so any input that you have, we welcome.

Rep. Oliverson stated that if anybody has any comments on this particular issue just raise your hand or let NCOIL staff know that you want to speak. And if you're interested in this topic and you think this is important, please see me or NCOIL staff at the conclusion of this meeting and I'm going to go ahead and create a small working group to work with Cmsr. Beard to make sure that we're providing that legislative input as these models are being developed.

Rep. Lehman stated that I couldn't agree with you more and I've had some conversations with Cmsr. Beard about these issues. When you talk about data privacy you can go all the way back to when this whole thing started talking about credit scoring. Collecting that credit data was always the concern but now we heard yesterday in the aerial photography space of privacy, we're going to get deeper into artificial intelligence. So, I think there's a bit of a I don't want to say a collision course, there may be a bit of a blending over the next couple of years really, the issue of artificial intelligence and data privacy. So, I think that long term it's good if we kind of start not from scratch but to start with 672 as our basis and move forward. I think we can bring a lot to the table as legislators and I would like to be a part of that.

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

Rep. Oliverson stated that for those who aren't aware, the NAIC has an organization within it called the Securities Valuation Office (SVO), which looks at the financial stability of investments that insurers are making and seeks to provide some objective non conflicted independent guidance to NAIC Commissioners in terms of the strength of investments and things like that. Recently, there's been a discussion that has generated a tremendous amount of interest here at NCOIL regarding some changes or expansion of scope, I guess you could say in terms of how the SVO conducts its duties and what its duties are. And I know that you have been working on this and I want to say before we

get into this that I think all of us at NCOIL are deeply appreciative of the fact that the NAIC has listened to us as lawmakers and has taken our suggestions and has been very open with us in terms of the direction that this is going and has been responsive to some of the concerns that have been raised in terms of where is this going and what does this lead to. There are some issues with the current proposal said to fall into three basic buckets: due process and appellate issues rights for those entities that the ratings are being challenged for; unintended consequences in the macroeconomy; misguided financial incentives for the SVO. My understanding is that there was a work group call recently and I want to hear your perspectives on this because what I'm hearing and what I think other members here are hearing is that proposal sort of was pushed out of committee maybe even without a recorded vote and that essentially, there's still some ongoing issues that need to be looked at and resolved. I was given a list of proposed suggestions and things that people are still concerned about like the ability of a commissioner in a state that would be impacted by an SVO's decision to essentially have the authority to override or essentially say I don't want that rating right now and I want to be involved in the process with the SVO and I essentially have that authority on a state by state basis to participate in whatever review process the SVO is engaged in.

Cmsr. Mulready stated that very briefly for those that are new, the SVO is an arm of the NAIC based in New York City. They really are there to assist the regulators in our financial areas. The overriding concern for us is the financial stability and solvency of companies. And so, with these different investments, how do those rank if you will, within risk-based capital and the valuation and the liquidity and the risk and that sort of thing. So, that is their role. And in fact I had a very recent, very specific example where we had a company that was in supervision and they needed some money and they sent us notification that they had $5 million in investments in one of the U.S. territories in the bank there. Well, what do we do with that as far as what exactly is that investment? And I will tell you, watching the SVO work and this was literally 30 days ago to evaluate that quickly and respond back to us very quickly because we needed that to happen quickly because they needed capital immediately for us not to take further action. But determine what that was and how liquid was that and that sort of thing and so literally within one week's time they had that information back to us with full documentation that we could then present to them why that was not acceptable or that was not admissible as an asset for them. So just a quick personal example there from literally 30 days ago. That said, thank you to NCOIL for being engaged with this and Cmsr. Dwyer previously was chair of the NAIC's E committee but she was elected NAIC secretary-treasurer and now the Chair is Cmsr. Nathan Houdek of Wisconsin. And I know Cmsr. Dwyer addressed this issue at a prior NCOIL meeting and then Cmsr. Houdek did at the last NCOIL meeting in April. The issue that this is trying to address is the E Committee is trying to come up with some solutions on when there is an investment that maybe we've got double rating agencies that have quite a difference in how it is rated, what do we do with that and how do we make sure that there's not some, I've used this example of my three sons that have recently gone through or are in college and that conversation at the fraternity house about I got to take this course and which Professor is going to give me the easiest grade on that? How do we look out for that? And so maybe a poor example, but that's the general concern. Or a rating comes in and just seems very inconsistent. What do we do with that?

And so that's the genesis of this really. And so typically on over 80% of these ratings, we just take those and they do not get looked at. And so, part of the concern is what we would call blind reliance on those credit agencies, on those ratings. And maybe we should utilize the SVO's risk analysis capabilities to sort of have a little bit more informed reliance on some of those ratings. Currently, there's no mechanism for that. There's no mechanism for a regulator to look into that or check into that and we don't have the resources and capabilities that they do at the SVO office. So, that's what we're trying to address for very specific situations. I will tell you that if you've heard conversations about sort of a three-tranche difference, if there's a three-tranche difference that's when we will step in and that wasn't arbitrary as that three tranche difference is because there's a 100% difference in risk-based capital required on that three-tranche difference and so that's how that was selected and it would be used on a very limited basis. It was originally exposed in May of 2023. We've been working through that. At our most recent national meeting we worked on things as far as the level of transparency and the oversight of the SVO's discretion and I will say I was handed this document just as I sat down here as far as some concerns and some changes that may need to be made but I think most all of those have already been done or are in my mind have been done ultimately. And I'll just make this statement, the domestic regulator has 100% total control over that period and so they will be involved if there is a challenge and the rating agency will be involved. The SVO will be involved. The domestic regulator will be involved. But again, ultimately the total control and ultimate say lies with the domestic regulator as to how that impacts that individual insurer. So that does stay with the domestic regulator.

The other thing is as far as the market impact, there is no intent that this would be an evaluation or a review of total classes of investment. This will be the investment specific, not looking at certain security structures or asset classes. These will be individualized issues. And then also as far as the financial incentives, the SVO I'll say this, those rating agencies that are out there that we're utilizing for more than 80% of that business, we can't afford to do what they're doing. We would have to staff up into a crazy amount of staffing. We've got about 50 employees up there in New York now but we would have to staff up unbelievably to make that happen. So, they play a really critical role for us and overseeing that solvency. So, we being the NAIC, there's something that actually I initiated because as this conversation was coming up here at NCOIL way back I realized I didn't know a lot of detail about what they did up there in that New York office. And as I asked around I realized I was not the only one amongst my colleagues who didn't know much about exactly what they did there. I knew very generally, that's all. So we did a trip up there on May 29th and we sat in a room like this with about maybe 40 of us and kind of learned in a lot more detail what they're doing and what this proposal is doing and is not doing. So, it was super helpful. Along those lines I know we are working on right now nailing down a date to have the NCOIL officers at least go and do the same thing that they would have a little fly in to New York so that you can ask the questions there and be in person and hear from the folks that are doing that. So, I think that would be super helpful as well. I don't think a date has actually been set there but we've been working on it. The work continues on this proposal. I will tell you that it's going to be a very slow and methodical process. Even when the ultimate

decision is made, we're talking a year or two before that's fully implemented. And so, we have taken comments. We have a call next week, a regulator only call, to review the comments that have come in. It will then be sent out for exposure again, probably pretty quickly prior to our summer meeting. I know the intent was to get it out there at least 30 days in advance of our summer meeting. But that will be an additional comment period. Then we'll head into our summer meeting from there.
Rep. Oliverson stated that I've said before that my biggest concern with this goes back to my own personal experience with the American Medical Association (AMA) and how they got in the business of publishing code books and suddenly that became lucrative and that ended up being the only thing they actually really cared about was publishing code books. And so, what I think I'm hearing you say is that the SVO essentially serves at the pleasure of the state regulator, and they do not initiate, nor do they get involved in reviewing or rating existing ratings, unless you ask them to. They're not out there essentially rating every product whether you want them to or not. Because to me, that would be a big difference between being a fact checker, which is what I hear you saying, and being a market participant which is what I think the fear is, is are they functioning autonomously and essentially out there rating everything and essentially competing against the private market providing their own rating system? Or are they waiting to be called by the state regulator saying, “we have some concerns here. Can you guys take a look at that?” And I was handed the same document as you, but it talks about the state regulators should have to initiate that process. The SVO shouldn't be out there doing that on their own. And furthermore, they shouldn't be slapping an under review label on a company's ratings unless they were asked to do so by the state’s regulator in that state. So, I'm just curious because that's what I thought I heard you say. Is that kind of how the process works? Or are they autonomously out there constantly rating everybody whether you asked them to or not?

Cmsr. Mulready stated that's a great question and the answer is yes and no. And I'll clarify. And that is absolutely not, they're not reviewing even close to every investment out there. Like I said, 80% or more is reliance on those credit rating agencies. However, they will be utilized for our purposes to flag some things that they see. It may be something that they flag, they come to us we move forward with this challenge and look at that. But they will be the ones sort of boots on the ground if you will flagging some things. Now, it can also come from us as well. Even like it just did with me and this most recent example. But that really is unrelated to what we're doing here. So, it’s sort of like a triage but it does not have to be initiated by the regulator. They may flag something and then we would be involved in that going forward. Rep. Oliverson stated but when they flag something, do they bring it to that state regulator and then say “Hey, we've noticed this. Would you like us to do something further?” And then they have to get permission before they do anything else? Or do they just sort of do it on their own?
Cmsr. Mulready stated that yes, it would be flagged and then there will be a process with the subgroup of the E committee that involves the domestic regulator, I guess the domestic regular absolutely at that point could say we don't need that. They will have that final control but the process would work for it to move forward. And as far as the public under review status, I don't know of any mechanism that would signify that as being under review of something. That would be to a private regulator only scenario.

Rep. Oliverson stated that to me it seems like that literally would be the best mechanism to defend against what my main concern is which is that essentially this just becomes the money tree in the background printing money. Essentially they have to either go to you as the state Commissioner and say, “hey, we saw something, would you like for us to take a look at this? What do you think?” Or you call them and say, “Hey, I'm worried about what this company's assets are. This is some funny business stuff here. And I'm not sure I trust this rating. Can you take a look at that?” And I feel like as long as they're essentially having to work through the individual state’s Commissioner to make those decisions then they can't function autonomously which I think makes a lot of us that have some anxiety about this feel more comfortable that they're actually working with you on a state by state basis essentially as that fact checker which is what my understanding is that's what this whole thing is about is we want to have a fact checker that we can trust, which is great. Cmsr. Mulready stated that's a great way to put it.

Sen. Lana Theis (MI) stated that my concerns aren't exactly the same as I am concerned about the due process issues. I'm concerned about their ability to appeal. I'm concerned about the unintended consequences. I would love to know whether or not the authority to do what it is that the SVO is doing is statutory. Because I'm actually interested in the Chevron implications of what I see as a significant expansion of authority within the SVO. But also, I am extraordinarily concerned, even with our commissioner’s oversight. The U.S. Securities and Exchange Commission (SEC) is already heavily regulating this area. It's not like there's only one organization that's looking at this and doing the ratings. And you’re detrimentally relying on a singular organization that's looking at the ratings. There are many of them from which you can compare and I understand absolutely you shouldn't just take it on blind faith. But is this actually the best approach? And do you even have the statutory authority to do it in the first place given the changes? Cmsr. Mulready stated that my response to that would be that I think we have that authority as we're doing it today. This isn't really any different than what we're doing today as far as determining what the value is from a financial stability and risk based capital standpoint and how that counts in the financial equation. That's what we do today.

Sen. Theis stated yes, to a certain extent. But you're expanding it significantly and that's where we've had some debate as to whether or not there was an expansion on this. I'm willing to participate at a future time in discussions but I just I want to express my concerns and then also just because you've been doing it doesn't mean you had the authority to do it to begin with. Cmsr. Mulready stated that I would say that is one of our main roles. From a statutory standpoint, it’s the financial oversight of those carriers and what sort of investments they're making and to ensure that they have the financial wherewithal in the event of a claim to fulfill the contract that they have with their policyholders. That is one of our main roles. Also, I would raise consumer protection and I think all we're doing here is utilizing another tool to make sure that is being done well. Sen. Theis stated that's where I disagree about whether or not it's an expansion, this additional tool and how you're approaching it. So, how is it that you define what a good investment looks like? Who's the one who should be saying what that is? And then whether or not they're participating in it, those are all different questions. And I understand where you are coming from, absolutely oversight needs to exist. Absolutely,

they need to be investing well. Who is it that's determining what a safe investment is and how is the question?

Rep. Brenda Carter (MI) stated that I also share a lot of the concerns that I've heard here today. I attend the NAIC conferences whenever I can and I appreciate the work that the NAIC does but when it comes to taking away the authority of state regulators, I work very closely with our regulators in the state of Michigan and I am deeply concerned about any type of possible relationship breaking because of statutory and non-statutory issues that we may not have looked at as unintended consequences. I heard a lot of good conversation here today. I think I heard you say the states would still have their autonomy and they will have the direct decision making on ratings. I appreciate that very much. And I will be at your next meeting in Chicago. I implore that you look at unintended consequences because that is what sneaks in behind and by the time it mushrooms up it's too late.

Cmsr. Schmidt stated that we have broad regulatory authority over this and the statutes in my state are very broad about that. I think what is missing in my state is the expertise. I don't have people on my staff that have the expertise. And if the SVO is one place we can go, or we can hire outside consultants that are no different in some respects and in my mind, I need help. Some of these investments are incredibly complex. And I have said before that they are five steps ahead of the regulator. Always. We're trying to play catch up all the time. But I do want to go back to when Cmsr. Beard talked about the privacy data working group calls and those types of things The same thing applies to all of our committees. If you want to be alerted to our calls when they happen, we have public calls all the time. And we ask for interested parties and maybe we should add a thing in our scripts about interested legislators. I'll be happy to do that. We're trying to be as transparent as possible. And as Cmsr. Mulready said It's going to take at least another year or two to finalize this. It is a long process to finalize things at the NAIC and sometimes it seems so long but it is a very methodical that we are doing this and I can't think of a person with a better temperament than Cmsr. Houdek to chair the E committee. It has several steps to go through. We're not trying to rush anyone. There'll be a 30 day comment period when the next draft comes out and I am 100% sure that will not proceed without more changes and more comments and that's what we want. So, please know that your concerns are very valid. All of the concerns we've heard today are very valid and we need to take that back. I'm not qualified to answer those questions on statutory authority and if we're going outside of our regulatory authority but I know that we have people that can speak to that and we want you to become comfortable with it before we move on. I really appreciate the dialogue.

Cmsr. Conway stated that to address some of the issues that have been brought up, I think it is important for everybody to understand that everything that the NAIC does, they do with our approval. We're a membership organization. So, anything that the SVO ultimately ends up doing will only be done because the members direct them to do that. And I just want to make sure that we really drive the point home about the domestic regulator and make sure that everybody understands what we're talking about with the domestic regulator. We're structured at the NAIC to really rely on each other from a financial solvency regulatory standpoint and the reason we do that is because we want

to make sure that we're being robust in our regulation and the solvency of companies but we also don't want to require companies to have 56 different regulators going in and looking at their solvency issues. So, we structure ourselves that way so that the domestic regulator really does have the ultimate authority and approval for everything related to the solvency of a company. So, when Cmsr. Mulready says that the domestic regulator is going to be the one that carries the stick or doesn't carry the stick on this issue or any other issue related to solvency that's what we're talking about. It's going to be that domestic regulator that ultimately is going to make the decision as to whatever happens. And I do think that we absolutely do have this authority as we sit here today. We're talking about the solvency of companies. We have robust, very broad regulatory authority when it comes to solvency of companies and regulating the solvency of companies. I do think this is just another tool in the toolbox to make sure that we're doing our jobs well and that we understand what we're doing.

Rep. Oliverson stated that I just want to clarify one thing before we move on - all matters concerning what the SVO is doing, they're not operating essentially in a silo on their own. Whatever decisions are made essentially have to go through that state's commissioner. What I heard you say is they can come to you and say we've done some crunching of numbers, we have some concerns about the ratings that have been applied to this company, here's what we have, would you like us to investigate further? They still have to get your permission to move forward and essentially you as the regulator have the authority to either say thank you let's work on this or shut them down completely and just say, “yeah, we're done with this. Let's move on. They're not operating on their own.” And I think if we're worried about them being a challenger in the marketplace and a market participant, having to work through our state regulator and actually having permission to take action to really do anything and having to work through you is an important check and balance in that marketplace. So, I just want to clarify that's what I think I heard you guys say but I just want to be clear that's actually how it works. Cmsr. Mulready replied, yes - everything the SVO does is at our direction and our ultimate control.

UPDATE ON WORK OF NAIC RELATED TO ARTIFICIAL INTELLIGENCE

Rep. Oliverson stated that the NAIC has had a working group looking at the role of artificial intelligence and insurance and I think there was some discussion early on that maybe there would be a model law or regulation but that was later changed to a model bulletin. And I know states are sort of doing different things with the NAIC's bulletin. For the benefit of people in the room, if you turn to page 186 in your binders you can see a copy of the NAIC's Model Bulletin on the Use of Artificial Intelligence Systems by Insurers. Could someone please provide a brief summary of what it does and what the NAIC is trying to accomplish?

Cmsr. Humphreys stated that in December of 2023, after a year of work, we did adopt the Model Bulletin. We did a model bulletin rather than look at new model legislation or model regulation because in this case the states already have authority over market regulation, market conduct rates, and underwriting. And artificial intelligence is a tool that companies are using in these different spaces. So, we thought that rather go down

a new model perspective, we would draft a model bulletin that provides guidance to the industry and we wanted it to be uniform across the States. And so, we really have focused on what our expectations are for companies when they are using artificial intelligence in terms of the governance structure that they have internally to oversee their use of artificial intelligence, the risk management techniques that they're employing within the company and kind of the testing and the review of the outcomes of their use of artificial intelligence. We put that guidance together towards the end of last year. Right now, 13 jurisdictions have approved it and they are Alaska, Connecticut, the District of Columbia, Illinois, Kentucky, Maryland, Nebraska, Nevada, New Hampshire, Pennsylvania, Rhode Island, Vermont and Washington. And many of us here have had a number of conversations with our legislators and legislatures about it and I think NAIC staff came out to Texas last month to kind of walk through the bulletin. So, we're open to having staff come out and kind of overview what it is and go through why we did it and really just go through a section by section so you have confidence in the product that we're putting out there. In Pennsylvania the way that we implemented it is I took the NAIC model, we opened it up for stakeholder comments and we citied to Pennsylvania code where the Model bulletin talks about different regulations related to unfair trade practices and others. So, we did that and we vetted it with the industry. We got a number of comments. Many were supportive. Others suggested some edits that were discussed throughout the NAIC process and obviously we had a very robust process at the NAIC. We did not take all of the edits. We tried to stay as uniform as possible to the model to give the industry that level of uniformity across the state so we weren't each implementing it differently. In addition to the bulletin, I would just let you know I'm the chair of the NAIC's Big Data and Artificial Intelligence working group and one of the activities that we are undertaking is a review of insurance company use of artificial intelligence. On the website we have already surveyed companies in the life space, the auto space and the homeowner space. We are about to start in the health insurance space where this summer we'll probably pilot with a handful of companies what we think the survey looks like to try to get feedback to make sure we're answering the questions that we hope to ask and giving us good appropriate data with the idea of after we get through the pilot stage go out with the full survey of the industry later this year, maybe early next year. I would be glad to continue to provide updates to NCOIL on any of those reports that we've already done or on the health insurance survey once we actually get there.

Cmsr. King stated that the model bulletin has been a very deliberate process. First, we had to agree with the terms of reference because people call one thing another and that is why this is a very deliberate process. First, we have to agree when we call something it means the same for the rest of us and so nobody has rushed through this. Now that we've got the model bulletin, now we're sitting around and putting the Georgia adjustments to it and actually talking to our consumers, to our legislators, and then we will publish that in Georgia. And that's the process of we wanted to make sure it's consistent with the rest of the nation but we have to check the authority to make sure that what we are publishing, we truly have that authority in our code. So, it's a very deliberate process. Nothing is being rushed about this. And one of the concerns that I had very quick is first of all, we have accountability. All the regulators understand what we care deeply about regarding discrimination, red lining and all those things. We are

applying that same process to the use of this machine learning to make sure that the basic protections are there and that our job to take care of our citizens is not being eroded with the use of artificial intelligence. And then we also have to be careful because we don't want to stymie innovation as well because we know that the industry is using this and obviously there's some privacy concerns there and we have to make sure that we can speak to those concerns to our citizens. So, it is a very deliberate process but every state is going I think through a similar process as Pennsylvania and Georgia and others had to go through.

Rep. Oliverson stated that the NAIC staff that did come to our hearing in Texas and that was really very wonderful and I would just say to all the members in the room, if you're an insurance committee chair and you want a good update on what is sort of the state of regulation in artificial intelligence and insurance, you should take Cmsr. Humphreys up on his invitation and invite the NAIC to come and update you because they do a phenomenal job and I think from my perspective as the insurance chair in Texas what I was hoping to achieve, which is actually what we achieved, is to share that message with my committee members and then hopefully the rest of the legislature what the NAIC has already found out about the degree to which this is an evolving issue and probably doesn't lend itself very well to very heavy, top-down legislative and regulatory activity. That may actually be harmful more so than helpful. So, I think that message was well received and we appreciate that the NAIC was willing to be part of that. I did want to ask one quick question and open it up to other members if they have questions too and that is what has been your experience as you've reviewed the use of artificial intelligence with respect to machines handling and processing claims? Is that something that we're seeing? And I have heard comments about we're going to hold them to the same standard that we would hold a human being to so if they're engaged in discriminatory behavior, we don't care if the machine did it or a person did it. They're still at fault. But I'm just curious about what are you hearing in terms of how insurers are using artificial intelligence to help process claims?

Cmsr. Humphreys stated that is part of what we ask in each of the surveys. It's different across the different industries that we've already surveyed. I don't have the data in front of me, but we can follow up afterwards because we do look at whether they use artificial intelligence in marketing, in claims, in pricing, in underwriting. And we report on that and how the companies are actually using it and the number of companies that are using it is part of the complete report. And again the purpose of the bulletin is to make sure the use of artificial intelligence is another insurer tool that complies with our underlying unfair trade practice statutes and other consumer protection statutes.

Cmsr. King stated that we're seeing companies using it initially in our state as fraud detection and so they identified potential fraud schemes and then it's sent over to an investigator who then adds the human and decision maker as to whether to open a case or not. But the amount of claims of being processed it's such that these companies there's no way they could ever hire a sufficient staff just like our offices are limited about how many staff we have. The machines are accelerating or going through the mundane tasks of identifying those outliers and then it rises to a human actually making a determination so those are some of the trends that we're seeing.

Cmsr. Conway stated that in Colorado we passed a law in 2021 to, broadly speaking regulate what we call external consumer data and information systems but really what we were getting at was to go in and regulate and make sure that artificial intelligence was being used appropriately and to ensure that we could go out and tell the public that we know that artificial intelligence is being used correctly and in compliance with laws. I think the short answer to your question is that yes, insurance companies are using artificial intelligence and machine learning to process claims at varying levels but I think it's going to continue to grow. Colorado was not one of the states that adopted the bulletin because we have our own state law in place but I think what we are also going to see is that regulation of artificial intelligence is coming. It's either going to be the case that we as regulators regulate it in the insurance space or somebody else is going to step into our space. I think you'll see Attorneys General start to go into that realm. Obviously, the federal government has had conversations too. So, I really do think it's incredibly important for us to fill that void as regulators because we're going to do it better than anybody else will, candidly. So, directly to your question yes, they are using artificial intelligence to process claims and it's going to continue to grow but as long as we're in that space and we're regulating that space, I think we can do it well.

Rep. Oliverson stated that this may just be my own personal bias as a healthcare provider but as you look at this issue from a healthcare space it occurs to me that utilization review and prior authorization is literally such a hotly debated, contested topic that multiple states, including mine, have had to pass legislation in order to regulate the use of those two items. And so, I would be curious as the insurance chair in Texas to see how companies in the health space are using artificial intelligence to automate those processes. Because I think now we get into a situation where there's demonstrable potential negative impacts on consumers as far as access to healthcare that's a whole other level of magnitude different than paying your roofing claim. So, I'll be curious to see what comes out of that effort and to see how that's being used.

Cmsr. Conway stated that our law requires us to implement it, to put regulations together based on the line of insurance but also on insurance practice. So, we started with life insurance, we moved on to auto and now we're actually engaging in the health space. And the beginning part of the conversation is to ask folks exactly what they think we should be looking at on the insurance practice side of things. And overwhelmingly, what folks have told us is that they want us to look at those utilization management issues and they want us to step in to see how insurance companies are using artificial intelligence or machine learning or whatever it may be to really kind of process the utilization management components that you just touched on and make sure that they're being used appropriately or deal with the problems if they're not being used appropriately.

Rep. Oliverson stated that to amplify what you just said, this is where the issue of extrapolation comes in. When you're talking about reviewing claims, now you're going to let the machine review the claims but then you're going to apply the results broadly across a bunch of claims that you haven't even looked at. Would it would be possible to share the survey results with our membership when you get them.

Cmsr. Humphreys replied, yes. It'll probably be early spring of next year because we haven't started the pilot yet. We're going to pilot it over the next couple months and see what we learn and then go out at the end of this year with the formal survey. It takes maybe two months to get the survey data back and then we have to clean the data, put it in the report form. But we can absolutely do that and in the meantime, if you'd like, we can have NAIC staff share the reports that are already public in the three other lines. But just to build on Cmsr. Conway's point, utilization management and prior authorization is going to be specifically in the health survey. While there's a lot of similarities between each of the industry surveys we did want to tailor it specifically to the industry that we're looking at and obviously with all the attention being paid to prior authorization and utilization review and the articles that we see come out in the claims space we did want to make sure that we focus some of the questions in their use in those areas.

Rep. Oliverson stated that we are running a little bit short on time, but I did want to give us a chance to hear an update regarding the NAIC's Third-party Data Models Task force.

Cmsr. Conway stated that this has been a growing conversation at the NAIC among a lot a of the membership about concerns of third-party models and how they're impacting the insurance space across the board. Obviously, it's kind of front and center in the artificial intelligence conversation but it's much broader than that too. In Colorado, we're having a lot of conversations for example about how third-party models are impacting our homeowner's insurance space and how risk scores are calculated, making sure that mitigation is properly accounted for. But the list of issues can go on and on. So, the NAIC membership and the officers decided at the beginning of this year to start a new task force specifically looking at potentially regulating third-party models and how we would go about regulating third party models. In the first year of that work, I'm the Chair of that task force, we're really going to kind of have conversations about what are the different structures and models out there that we could build upon in order to build out a regulatory structure and then ideally going into next year, we'll start to put pen to paper on drafting some sort of regulatory model that we would use for third-party entities. But there's a lot of questions that we've got to get through before we get there. We have to understand exactly what types of third-party models that we're most concerned about and exactly how we would go about regulating those entities that are obviously not licensed insurance companies. So, we're in the midst of that conversation and I think it's going to be a good, robust conversation and we're looking forward to it.

UPDATE ON WORK OF NAIC'S LONG TERM CARE ACTUARIAL (B) WORKING GROUP

Rep. Oliverson stated that the last item on the agenda is an update on the NAIC's Long Term Care Actuarial Working Group. We understand that the Working Group has continued its work relating to trying to develop a single long term care insurance multi state review approach. Obviously, this is an area of insurance that has been very problematic probably over the last two decades. We're very curious to hear where you all are on that.

Cmsr. Conway stated that was an executive level task force and I was the vice chair for two years and also chair for two years. We are at the point where we've created what we refer to as a multi state actuarial (MSA) group that is reviewing filings, reviewing rate increase filings if long term care insurance companies want to go through that MSA. The whole goal of that is to make sure that we're getting as consistent as we can rate increases across the nation so that we're not supplementing each other's rate increases. One of the issues that we've struggled with along the way is that we had two different kind of structures of rate review that the MSA team would conduct. One was really a regulatory framework that came out of Texas. The other one was out of Minnesota. The MSA team now is at the point where they're trying to combine those two so that we can have one regulatory structure that insurance companies are working with and that we are getting information out to the states so that we can understand exactly what is happening with the MSA team and we have more uniformity. But that work is ongoing and it'll continue through this year. My guess and my hope is that we do get to a single approach by the end of this year going into next year.

Cmsr. Humphreys stated that I just want to stress the importance of the long-term care work and it's something that we've been working on for years now and it's really important that the regulators are finally kind of rallying around a single methodology that we can all use in that it's able to be replicated so we can bring it back to our states. So, whether it's a company filing for initial guidance through the multi state process or coming directly to my state I'm going to be able to look at it the same way and that was important to us throughout that process as we weighed it in the working group. And I think they're really getting to a good place for an industry that has been really challenged to your point of over the last 20 years ,that we're getting to a place where we will uniformly look at long term care rate requests to be fairer across the country and between our states.

Rep. Oliverson stated that on behalf of NCOIL, I thank you all for your participation and it's great to see so many commissioners represented from so many different states. We truly value our partnership with the NAIC and look forward to working with you on these important issues.

ADJOURNMENT

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

FINANCIAL SERVICES & MULTI-LINES ISSUES COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
FINANCIAL SERVICES & MULTI-LINES ISSUES COMMITTEE
2024 NCOIL SUMMER MEETING – COSTA MESA, CALIFORNIA
JULY 18, 2024
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Financial Services & Multi-Lines Issues Committee met at The Westin South Coast Plaza Hotel in Costa Mesa, California on Thursday, July 18, 2024 at 4:00 p.m.

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. Michael Meredith (KY)
Rep. Edmond Jordan (LA)
Rep. Brenda Carter (MI)
Sen. Paul Utke (MN)
Rep. Bob Titus (MO)
Rep. Nelly Nicol (MT)
Sen. Jerry Klein (ND)
Asm. Jarett Gandolfo (NY)
Asw. Pam Hunter (NY)
Sen. Bob Hackett (OH)
Rep. Forrest Bennett (OK)
Rep. Ellyn Hefner (OK)
Del. Walter Hall (WV)

Other legislators present were:

Rep. Joseph Gullet (GA)
Rep. Martin Momtahan (GA)
Rep. Matt Lockett (KY)
Rep. Michael Sarge Pollock (KY)
Rep. Rachel Roberts (KY)
Rep. Cherlynn Stevenson (KY)
Rep. Dennis Bamburg (LA)
Sen. Royce Duplesis (LA)
Rep. Gabe Firment (LA)
Sen. Franklin Foil (LA)
Rep. Kyle Green (LA)
Rep. Brian Glorioso (LA)
Rep. Jason Hughes (LA)
Rep. Shaun Mena (LA)
Sen. Kirk Talbot (LA)
Sen. Bill Wheat (LA)
Sen. Arthur Ellis (MD)
Sen. Lana Theis (MI)
Sen. Michael Webber (MI)
Sen. Jeff Howe (MN)
Sen. Joseph Thomas (MS)
Asm. Alex Bores (NY)
Asw. Catalina Cruz (NY)
Rep. Greg Scott (PA)

Also in attendance were:

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

Pat Gilbert, Director, Administration & Member Services, NCOIL Support Services, LLC

QUORUM

Upon a Motion made by Rep. Matt Lehman (IN), and seconded by Asw. Pam Hunter (NY), NCOIL Vice President, the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Lehman 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 April 13, 2024 and May 31, 2024 meetings.

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

Sen. Felzkowski stated that we're going to start today with a continued discussion on the NCOIL Transparency in Third-Party Litigation Financing Model Act (Model). You can view the latest version of the model in your binders on page 122 and on the website and app. Before we go any further, I'll turn things over to the sponsor of the Model, Rep. Matt Lehman (IN).

Rep. Lehman stated that we have a lot of people scheduled to speak today and I look forward to that. I want to make sure I'm clear on one thing - I want to stay focused on what I have said for years has been my fundamental philosophy at NCOIL which is we are not creating model language that goes back and gets stamped in your states for approval. This is where we build the foundational structure of a bill and you take it back to your states. I know we've had some discussions around rates and other things that in my opinion, really belong more in the states. I do appreciate all the input people have given. I think we have made good progress. We had an interim meeting in May and since that time we made a couple of changes to the Model. Some are just technical, some are for clarity. And then there's two that I would call substantive changes which I'll discuss here. The first substantive changes is around making sure that individuals are added to the definition of a "foreign country of concern." We talked about wanting to keep the entities or foreign governments that are bad players out. We also want to keep individuals who are on the list for the federal government that are bad players out as well. So, they have been added and that's in section 3 of the model on page 124. The other substantive change is to sections 7 and 16 of the model which are on pages 128 and 133. These expand the scope of disclosure. The model now requires that funding agreements be disclosed without waiting for a discovery request. All the parties of litigation that required to get that including insurers who have a duty to defend a party in the litigation.

I want to be clear that I think there are four very core parts of this Model that I think we need to stay focused on. One of those is who can do this? We talked about adding individuals. We want to be clear that we do not want to make our judicial system a

trading floor. We don't want people to look at it and say is this a good investment or a bad investment? So, we've got to make sure we know who is behind these investments. The second thing is to make sure they do not have access to data. There should never be a process where I can file a suit only so I can get a seat at the table so that I can take proprietary information - that's in this Model. Third, I think we need to make sure that their role is very clear - you do not dictate the direction of the suit. As the funder you are providing the money and you step aside. The legal profession will determine the direction that should go. So, you have no say in that direction of the suit. And then the fourth, which is the new one, is the required disclosure versus the discovery process. I know there are some folks that are opposed to that and we're going to hear about that today but I made those changes because I want to hear why that manner of disclosure is bad public policy. I think as lawmakers we're required to pass legislation that's good public policy and transparency in my opinion, is always good public policy. Also, the reason I took this disclosure language too is that it appears in the West Virginia law and the co-sponsor of the Model is Del. Steve Westfall (WV) and I felt like if it's relevant in West Virginia it's relevant here. And my understanding was there was not a lot of opposition to this in West Virginia so again, I want to have that discussion.
I'd also like to stress that the version before you is not going to be the final version. We're really trying to get this in a good place. Like I said, that is foundationally and structurally sound. We'll probably have an interim meeting between now and November and then hopefully we can finalize something in San Antonio in November. I'll stop there and just make a quick note that I know there's a lot of people here to talk about this and it's important to make sure that we are respectful of positions.

Sen. Felzkowski stated that we have several speakers here today and we need to remain on schedule so we are going to set forth some time limits. Professor Klein, please keep your remarks to 10 minutes at most. For everyone else, if you haven't spoken on this Model before, you'll be capped at five minutes. And for everyone else, since you've spoken on this Model before, your remarks will be capped at three minutes and limited to only the changes that have been made to the Model since our last discussion.

Ken Klein, Louis and Hermione Brown Professor of Law at California Western School of Law thanked the Committee for the opportunity to speak and stated that before being a law professor I was a business defense attorney. My entire professional life has been defined, among other things, by defending cases and by insurance, so I'm happy to talk about this stuff. I just wanted to tell you an opening thought and Rep. Lehman I have to tell you with all candor, in many ways, from a defense attorney's perspective all that litigation is, is setting price. It is setting price on a dispute. That's what it is. And it was never lost on me as a defense attorney that I had a built-in advantage because time and resources were on my side. And if I found out that a plaintiff had resources as well, such as a financing agreement, that was bad news because it meant I couldn't squeeze them and I was going to have to win this one on the merits. I had intended to talk about these four vectors that I read in the Model but we'll see where it intersects. First, let's just talk about protecting consumers, the consumer side of this. Next slide please. So, intuitively litigation finance agreements feel wrong, right? They feel like payday lenders or credit card companies that are being over aggressive. They feel predatory. And so we want to

cap rates or amounts of return but they are not the same as these other entities because the plaintiff has an attorney, right? The plaintiff has an attorney who tells them this is what they're offering to lend you. These are the terms of the loan. This is what you can expect out of the litigation. So, they don't need the consumer protection of caps on rate of return or the equivalent of usury laws. Rather, what you're going to do with these things is you're going to not help any consumer but you are going to hurt some who needs the money and for them it's a fair deal informed by their attorney. I will note as a technical matter that the Model has some strangeness in its definition of a consumer in two ways. A consumer is basically defined as a flesh and blood individual who is in your forum state as a resident. That means that you provide no protection to a plaintiff who is from the next state over and you provide no protection to an individual who has organized their business as a small company or a partnership because they are no longer a flesh and blood human.

Regarding deterring foreign bad actors, I will just tell you for me it is a mystery why this is a state level issue as opposed to a federal issue but I will tell you that the notion of foreign owned entities being across from me or people who's motives were other than the merits of litigation is nothing new. For example, many reinsurers are owned by foreign entities that insurers have some foreign ownership interests. And many litigants have bad motives. They're actually seeking to acquire information from their opponent. That's why they're in the process. These are not new problems for the litigation system. We have existing architecture to deal with it. That architecture works. There is nothing special about litigation finance agreements in this regard. And so, if you add a layer of regulation for litigation finance agreements all you're doing is burdening the system, making it more expensive to get to a result without gaining any extra benefit. The "I" in NCOIL is insurance, right? So, we're talking about insurance and the pressure on insurance premiums, except the industry's own data and I'm particular talking about an Insurance Research Council study that was released that shows that litigation costs do not correlate to rising premiums. That's not the driver. Now the second point here is important. On the commercial side of litigation financing, and I believe other panelists work in that space, insurance companies are usually not involved. And so, it's not an insurance issue in commercial litigation financing for the most part. The litigation system already has cradle to grave architecture to weed out frivolous lawsuits and there is a lot of study on that in my space which is legal scholarship. And what it concludes is that it's working. Fundamentally, frivolous lawsuits do not generally proceed through the system. So, at the end of the day anything you do including this Model that makes litigation harder to win, harder to file, makes all litigation harder to win and harder to file. But most litigation is not, in fact frivolous. So primarily you are hurting meritorious cases without weeding out very much frivolous cases. This issue has actually been studied and this reference in the slide is to that study and all I'll say is these economists, and there has not been any contradicting paper that has followed, actually looked at does litigation financing involvement increase frivolous litigation? There is no evidence of that. Does it in fact deter wasteful bullying tactics? There is lots of evidence for that. I will say this, insurance companies do control litigation when their insured is the defendant. So, if control is an issue, you better look at both sides. Now the last thing on this slide is disclosure. Here's the thing, I have as a defense attorney, an inherent advantage. I know that I am likely over-resourced as opposed to my opponent. If I'm a

litigation financier funding the plaintiff it doesn't matter to me whether you know about me or not. But you know who it does harm? It harms the plaintiff who doesn't have a litigation financier because they have now been isolated as the plaintiff the defendant can squeeze.

I have basically three closing thoughts. The first is it's not really clear to me why litigation financing agreements are an insurance issue. They aren't driving premium. The second is this is an unbalanced system, right? It's a system that favors defendants. I loved that as a defendant. But what I'm telling you here is you want to know what was the monetization of my advantage, there's a pretty good measure of it. The net profits of litigation financing are a pretty good measure of what was my advantage as a defendant. Or put another way, a litigation financing agreement is simply a fund that is looking at the landscape of commercial real estate, the stock market, a variety of other investments and saying where can I make the most return on my money? If you as a defendant, an insurance company, for example, are finding that litigation financing is looking at the landscape and saying, "You know the place where I can make the most money, investing in your misbehavior." Well, if you don't want them to invest in you don't be quite so investable. I have lived through decades of litigation reform movements and this is simply another form of them. And the reason they keep coming up is because they don't work. Money always finds a way. If you're a football team that is constantly losing to your biggest rival, you need to play better. You don't need to lobby to outlaw the other team's owner.

Will Weisman, Director of Commercial Litigation at Parabellum Capital, thanked the Committee for the opportunity to speak and stated that Parabellum is a commercial litigation funder. I'm also a licensed attorney. I was a defense lawyer for many years. Before entering litigation funding, I actually worked in the insurance industry. I was at Liberty Mutual so insurance issues are near and dear to me and were a big part of my career professionally. Insurance coverage for funded commercial cases, the type of cases that Parabellum funds, essentially doesn't exist. We don't fund disputes where an insurance company is ultimately going to be responsible for the judgment. We fund business to business disputes for things like breach of contract, patent infringement, intellectual property disputes and business torts, which are not covered by insurance. The other thing I want to mention just to kind of properly set the table is how few cases commercial funders actually fund. Unlike consumer funders, which enter into thousands of transactions per year, commercial funders like Parabellum fund relatively few cases per year. And that's true of our competitors as well. I wouldn't say you could count the number of investments we make per year on two hands but if you said two hands and two feet you might get there. We don't invest in a lot of transactions so it's just not a lot of investment activity. Regulation of commercial litigation funding around the country is very much the exception, not the norm. And that's for good reason. Courts have long had the ability to probe funding if they want to and they typically don't do so. And the reason they don't is because one, it's very well accepted that it's not relevant to the underlying litigation and two, the funding agreement itself, communications with the funder and the like are protected work product. And a number of very serious non-partisan groups have looked into this exact issue and looked into it recently and have concluded that regulation isn't needed here for the commercial space. And I'm talking

about the Federal Rules Advisory Committee which writes the federal rules on civil procedure, the Government Accountability Office (GAO), which is the nonpartisan arm of Congress, the Uniform Law Commission, and the New York City Bar. They all have reached the same conclusion that commercial funding is a rare phenomenon and that the regulation of the type that the Model is proposing is not needed.

So, I think with that in mind we should talk about what makes the Model particularly problematic from where I sit. And I think what everyone needs to appreciate is how prejudicial it is to a funded party to actually be required to turn over the funding agreement. The funding agreement tells defense counsel exactly how much money a plaintiff has to spend on their case. And it also tells them other critical information that bears directly on litigation strategies such as exactly how much a plaintiff will realize from any settlement. No one in this room, and I've never heard anyone suggest this, would say that defendants have to turn over their defense budget or that insures have to turn over information about how much they're reserving for a case or other information that bears directly on defense strategy. And yet, that's exactly what the Model calls for. The other thing which we will see happen here is if you require turning over the funding agreement not only are you prejudicing the plaintiff, you're exasperating the problem of inefficient, wasteful litigation. Defendants don't stop at the funding agreement. They don't say thank you for telling us, now let's move on to the substance. I was a defense lawyer. We all know the name of the game here. It's delay, it's run out the clock. So, what follows from turning over a funding agreement are ancillary discovery fights. People want to see the communications with funders, the analysis that went into the underwriting by a funder. And you have to then adjudicate all of these ancillary disputes which are a sideshow before you can ever get to the substance. I don't think that's what's intended here. I think that the Model is well-intentioned and I think there's a better way to go about it and I just want to take a final minute here to talk about what that might look like. I think the place to start for sound public policy is protection against the prejudice that I'm so worried about and I think that everyone in this room should be worried about. Automatic disclosure of the funding agreement causes substantial harm. The funding agreement itself should be subject to the ordinary rules of discovery. If it's relevant, if it's germane to the dispute, it can be disclosed. If it's not relevant, if it's a sideshow, if it's a defense tactic to get at strategic information it shouldn't be disclosed. The legitimate concerns here are transparency. People want to know who's funding this case to make sure there's no conflict of interest or nefarious activity going on. Commercial funders don't have a problem with being disclosed. So, I think a bill that required a party to disclose that they're a funded party without turning over the funding agreement I think you'd find wide acceptance in my industry to that. The other I think very legitimate concern is passivity. You want to know about a funder not exercising undue control. And there's ways to get at that information without prejudicing the plaintiffs. You can require a statement from the plaintiffs that the funder is not controlling the litigation. Attorneys who have an ethical duty to not allow that can be required to submit that information to the court. And we've seen other courts deal with these issues that way. That's an effective, sound way to regulate in this area which doesn't cause harm to plaintiffs and slant the playing field in favor of the defense bar and I think that should be the focus here.

Brad Nail, of Converge Public Strategies representing Uber, thanked the Committee for the opportunity to speak and stated that we thought it would be helpful for the committee to hear the perspective from one of the businesses who was likely to be a defendant in some of the litigation that's backed by the large litigation funding companies so this is not the seen as just another insurer versus trial lawyer issue. We have serious concerns about the impact that heavily funded securitized litigation is having on our courts. I would ask you to imagine a really bad scenario to explain why both transparency and oversight are needed in this space. Imagine a plaintiff who has accepted financing in the course of conducting its litigation. As is typical today, no one knows the details of that financing or the relationship between the plaintiff and the finance company. Not the defendant, not the courts overseeing the litigation. Imagine that the plaintiff and the defendant negotiate in good faith and reach a settlement that's agreeable to both sides. Then the litigation finance company steps in to prevent that settlement because they believe the settlement is too low, that it doesn't maximize their potential profit from the lawsuit. Imagine that the finance company actually takes action to prevent the plaintiff from settling the case even going so far as to try to substitute the finance company as the plaintiff. This is happening today. I would encourage you to read about the antitrust cases involving Sysco Corporation and their litigation funder Burford Capital and meat producers in Minnesota where a motion to make the litigation funder the plaintiff was denied. And the similar case in Illinois where the motion to make the litigation funding company the plaintiff was granted.

I would ask you to imagine another bad scenario. And in any regulated industry one would suspect that individuals with prior convictions for fraud would be heavily scrutinized if not prevented from operating the same business for which they were convicted of fraud. But in the case of Tribeca Capital, there have been no such limitations because there is no oversight. The company that is, according to their website, the largest litigation funding company in the U.S. is run by someone who pled guilty to fraud in conjunction with prior litigation funding activity. Tribeca Capital just last month announced an injection of $50 million into their litigation funding business from a foreign investment group called Nera Capital. Their own press release describes it as a $50 million funding facility for antitrust claims and law firm portfolios. That $50 million is just a drop in the bucket when you look at the scope of litigation funding in the U.S. Westfleet Advisors, which is a litigation finance advisory firm, in March of this year reported that there was $15.2 billion in combined assets allocated to U.S. commercial litigation investment. That's how they wrote about it in their press release. These are assets. This is an investment. They are turning our civil justice system into another market for speculative investment activity. So, as is nearly always the case for you as legislators you are called upon to balance competing interests. Access to justice is important. We understand that a sizable segment of the industry is dedicated to smaller individual financing arrangements for plaintiffs with meritorious cases and immediate financial needs. But the activity of litigation financiers in the aggregate necessitates action. The Model before you is good and we will support it. We think it could be made better. We've spoken with Rep. Lehman and offered some language to strengthen the transparency and disclosure elements of it even further. I would also direct your attention to the discussion draft of federal legislation released last week by Congressman Issa which contains disclosure requirements to the court that we think are

a good solution. So, I'll conclude by emphasizing to you the need for this Model and the need for real transparency and oversight of the activity of these investment firms.

Mahima Raghav, AVP & Senior Consultant of Claims, Judicial & Legislative Affairs at Zurich, thanked the Committee for the opportunity to speak and stated that I too have practiced as a defense attorney in the past and now work on a social inflation task force within the company. So, I'm going to start with some statistics. These statistics are quoted from a Swiss Re report. They talk about litigation funding being comprised of personal injury cases and mass tort claims and commercial litigation – 75% of litigation funding contracts support commercial litigation and mass torts. Two thirds of settlements involve large companies and not small businesses. About 30$ of patent infringement cases are believed to have involvement of litigation funding. And as Mr. Nail mentioned, the industry is estimated to be about $15.2 billion. Law firms report that they take litigation funding usually because of lack of funds and to hedge risk which sounds awfully like insurance. And lastly, the internal rate of return for some of these litigation funding companies is about 25%. That represents a wealth transfer from the plaintiff back to investors and law firms.

So, this is an investment and all investment classes usually have some kind of regulation or some kind of guardrails around them. They usually contain both a consumer angle, something like mortgage lending where consumers are protected to understand contracts, and a market integrity portion where we can trust, for example, that the stock market isn't subject to rampant insider trading or manipulation. Similarly, we need these two issues addressed and the Model does address both in the form of the disclosure requirement and not just the discovery as Rep. Lehman had indicated. Unfortunately, we're seeing some examples that go contrary to some of the research quoted earlier by Professor Klein. I'm going to go through just some of those examples for you. In the Camp Lejeune cases, multiple fraudulent claims were found. Those were filed from lead generators or advertisers looking for plaintiffs to drum up the appearance of more cases. There were various vaginal mesh cases where unnecessary surgeries were performed again, on the medical funding end. Forty thousand fake claims were discovered in the Deepwater Horizon mass litigation. Individuals found claims on Craigslist soliciting Americans with Disabilities Act (ADA) type claims and a bounty for a #metoo claim also on Craigslist for $100,000. In New York, there's a slip and fall case which conscripted indigent individuals many asking for food from their attorneys to fake accidents in order to file insurance claims. There was, of course, funding involved in that as well. And I'll just spend a moment on the Tom Girardi debacle here in California. Mr. Girardi was a prominent attorney. He was subject to the rules of California, both the ethical and legal rules, and he continued for over a decade almost close to two decades taking funding, not paying his clients and practically using his law firm as a ponzi scheme. That entire scheme was supported by multiple rounds of lending which nobody knew about, of course which is why we need the disclosure. If courts had been privy to some of this information they could have offered some protection to the plaintiffs who later received nothing. The other debacle that I'll mention is McClenny, Moseley and Associates where Texas attorneys descended on Louisiana homeowners. They filed fraudulent claims on their behalf and had taken a hefty loan collateralized by Zantac litigation. So, while it seems like this could just be a benign help to the consumer, unfortunately, just the

amount of money involved does lead to law firms getting themselves into bad situations at best and fraudulent activity at worst. I'll also mention that it was mentioned earlier something about insurance and being foreign and whatnot and it's not lost on me that my company's name is Zurich. However, we are heavily regulated in every state and I would invite the funders to be as heavily regulated if they wish to be in the similar scheme.

Eric Schuller, President of the Alliance for Responsible Consumer Legal Funding (ARC), thanked the Committee for the opportunity to speak and stated that we represent companies that offer the consumer legal funding product. I just want to clarify the average funding we give the consumer is about $3,000 to $5,000. So, we're not giving people tens of thousands of dollars for their cases. We're just making sure they can pay their mortgage, rent, car payments, and keep a roof over their head and food on the table. A couple things that we just want to clarify is on the changes that were made. We agree with Rep. Lehman that this needs to be a foundational bill. And so, with that, we suggest taking the profit restrictions out of it and let each individual state make that determination because we have had states who have put some stuff in and we had other states where they haven't had that. We think that should be up to the individual states. As far as the disclosure requirements, we'd like to recommend that the committee go on the path of what Indiana did where if requested, there's an acknowledgement of the transaction. Then it follows a normal course of discovery and filling and it's inadmissible against the consumer. This way does not slant the process one way or the other. By having an automatic disclosure regardless of the discovery process, you're basically tilting the case in favor of the defense. You're giving them a whole lot of information that they may or may not be able to have during a normal course of discovery. We're not opposed to regulation. In fact, our organization supports regulation. We just want to make sure this product is regulated properly and is available to the consumers but also does protect the legal system.

Jack Kelly, Managing Director of the American Legal Finance Association (ALFA), thanked the Committee for the opportunity to speak and stated that ALFA is America's oldest trade association for the leading of prominent members in the American legal finance business. First, I want to reiterate what was stated by Mr. Schuller. Our fundings are not in the business of providing funds to prosecute litigation. That’s very important to note. Earlier Prof. Klein shared with us his points and as we went down the table until we came to me there was an entire discussion about large multi-million dollar funding of litigation. That's funding the litigation. For any of us who practiced we know what it is to collect fees but that is knowing that somebody is paying you legal fees. That is giving you money to pay for the prosecution litigation. That's paying for your witnesses. That's paying for your discovery. That's paying for the lawsuit. We do not do that. We have nothing to do with that. We provide a small amount of money to somebody who already has litigation filed and initiated in a personal injury case - $3,000 to $5,000 to pay for your rent, to get your car fixed, to maybe get schoolbooks when you have to get them for your kids. And that money is non contingent. It's only paid back if you prevail in the case. We support this Model. Rep. Lehman and I worked on this 10 years ago. That day unfortunately, the Model was not adopted. It was a tie vote. It wasn't defeated, it wasn't passed. It was tied. Rep. Lehman went back to Indiana and

he passed legislation. A dozen states have done the same thing and what we have here today is a lot of that bill. We have included in here much of the bill that was passed in the New York Senate by Senator Jeremey Cooney who is a member of this committee but is not here today. And it's a good bill. Two things that Rep. Lehman brought up is can you dictate the case? No. This legislation says you cannot be involved in the decision process. It precludes it. And that's what we need. We need to protect consumers. But there's only one issue that I have concerns with and I really want to commend the committee and thank them for the technical amendments made to the Model. The amendment concerning disclosure of funding we have concerns with and our goal is to work together and get this Model done. But our concern is this - I spent a lot of years working in in the poultry world. And if you're a poultry grower and you're down in Alabama and you're out on your F-150 and you have an accident you have to get that F-150 repaired and deal with your insurance company about how this is going to be paid. But you've got to get down and be able to get in there and get the chickens fed. And anybody who's ever fed chickens knows if you don't have the feed lines filled at night and the water clean you're not going to do too well getting those chickens fed and they're going to die.

So, you go out and you get $5,000 to help get that truck repaired and you're back out there. But next door to you down the road the guy's a little bit richer than you are and he's got a brother who's a big fancy lawyer and he can go to him and borrow the $5,000 and he just says, you pay that back when you got some money and we'll work it out. Now the guy who had to go get the funding the way this proposal is written he's got to tell the other side that he got funding just because he doesn't have the financial advantage of being able to go to somebody rich or have somebody's that's going to lend him the money. Is that equitable? Anybody here who studied the law or taught the law and lived the law knows one word, equity. Equity is what the law is all about. And is that equitable? How do we deal with the equity of letting that funding be disclosed or not disclosed? And I think that's the issue. I think what Rep. Lehman and others have said is that's what we've got to wrestle with. How do we do that? My position is you should only have to disclose funding if the money is used for the prosecution of the litigation. If the money that you get pays for the lawyer, if the money that you get pays for discovery. If the money that you get pays for witnesses. Then you should have disclosure. But if the money is used to get your truck fixed. Is that really fair? With that, I thank every member of the committee. This committee has done a great job in working with this and I want to thank Rep. Lehman for the work he's done and the fairness that's been done.

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 NAMIC is supportive of the Model as it stands. I think it's a good baseline starting point for regulation for an issue that deserves a lot more scrutiny and that is, as Rep. Lehman said, what are the implications of the fact that litigation is increasingly becoming an investment market? I want to focus specifically on what we like about this. The main thing is what's in the title and that's disclosure. I also want to be clear because from some of the earlier speakers I'm not sure if I'm reading the right Model. This Model doesn't ban third-party litigation funding in any way. The provisions it includes are fairly modest, in fact. The most important one we think is a disclosure provision. We think the

new language is also an improvement in that regard. I do think it needs a little further refinement and the further refinement is not to apply only in cases where the plaintiff is actually being funded because that's the way it's structured right now. We think it needs to broadly cover investment in litigation that is contingent on the outcome of the case. Because on the commercial side that is the more common pattern rather than plaintiff funding, we believe. A couple of responses to arguments you've heard. You've heard some contradictory arguments, and you would think sometimes if they're contradictory maybe one of them is right. But I don't think in this case that any of them hold up under very good scrutiny.

First of all, on the litigation budget argument, let's think about this for a minute. What the Model actually requires is disclosure of the agreement, what's going to be in the agreement between the funder and the person receiving the funding? Well, things that they want to be able to enforce legally against each other. So, this idea that that needs to include everything about their litigation strategy. It doesn't. None of that is going to need to be in the agreement. There's no reason for it to be in there. We're talking about who the parties are, the funded amount, those sorts of issues. Basic information that doesn't go so far as to reveal strategy. I think that's a red herring. Second, I want to make this clear, the same sort of concern would exist on the insurance disclosure side. Almost every one of you comes from a state because I think this is true in almost every state where in litigation the insurance coverage at issue is disclosed. Not the fact that there is insurance, not the name of the insurer. The actual insurance policy. In some states that happens before the litigation is even filed. So, I agree insurance and third party litigation funding are not exactly the same thing. Insurance serves a lot of roles in society that don't have anything in particular to do with litigation fortunately. But in terms of what needs to be disclosed in litigation we think that analogy is pretty good. Again, states are requiring that for insurance, if it's not a concern there it shouldn't be a concern on the other side as well. Finally, we heard an argument that if the funding has to be disclosed that somehow reveals that the plaintiff is in a bad financial position. That never made much sense because they basically would be saying I might have been in a bad one but now I'm not because I got this funding. Earlier we heard the argument of no, it's the opposite. If you don't disclose funding, that proves you're at a disadvantage. That's not a very reasonable inference. You don't know from the fact that someone didn't get funding that they needed it but didn't get it. They may just as well have not needed it. So, I don't think that argument holds up very well either although I do think it makes more sense than the original opposite argument. So, I'll stop there. There's a lot more we could say, but again, we think the Model is a good first step. We think the disclosure provision is the key. We think it needs to stay strong and be about disclosure of the actual agreement.

Rep. Edmond Jordan (LA), NCOIL Secretary, stated that I've heard this for several meetings now and I tend to side with Mr. Kelly on a lot of this regarding disclosure if it's covering the litigation costs. First of all, I don't necessarily agree with disclosure at all but to the extent that we will do it, if it's funding those costs then that's fine. But if it's funding that's necessarily expenses for the plaintiff then maybe that does not need to be disclosed. However, my question is more about the Model itself and maybe I missed it. In Section 7, I think it's saying that the duty is on the plaintiff or his attorney to disclose

and so I'm not sure if we're not overstepping a little bit. At least in Louisiana, with that we might be legislating something that might be better left to the Supreme Court who legislates attorneys and attorney behavior. But more so in Section 8 for the violations, the violation is on the litigation finance company. So, the way it reads right now, me as an attorney if I decide that I'm not going to do that then there's no violation at all. There's nothing that you can do to enforce it against me. I guess the punishment is against the company and I'm not sure maybe I missed it, but I'm trying to see if somebody can reconcile that for me.

Rep. Lehman stated that I think that issue goes back to it's something that you do based on what's best in your state. Because the things Rep. Jordan just described might be different in Indiana than in Louisiana. Rep. Jordan stated that maybe we need to figure out if we can reconcile those items in Section 7 and Section 8 to make it more compatible.

Rep. Michael Meredith (KY) stated to Prof. Klein that I'm not an insurance agent. I'm not a lawyer. I'm a small-town country banker. And when you mentioned the fact that you didn't see a need for anything with regard to caps on these fees or interest in these situations because they're represented by a lawyer, I find that a very curious proposal. Because I kind of feel like I represent clients that have 20 and 30 year relationships with me and I have to disclose all those fees. We have caps on all our fees. And many times if they can get a better deal through Fannie Mae or Freddie Mac or somebody else I'm going to send them there because it's a long term relationship. When in reality, even though you might be represented by an attorney, that attorney's going to be paid based on a contingency of what your case is worth and what they can squeeze out of that case. And so, they have a measure of future ability for their own gain as well. Just like we would. But we're still enforced by the same level of caps on fees and interest. And so, I don't think that argument holds up. I'd like you to respond to that. Prof. Klein stated that no one's a big fan of regulation. Regulation just puts an inefficiency on everything. The reason we have consumer protection regulation is because we view consumers to be in a disadvantageous position. They need the money so they go for a payday lender. They don't have anybody telling them that's a bad deal. They get these flashy credit card companies coming in and saying it's basically free money. They don't have anybody telling them it's a bad deal. That's not a plaintiff who's a consumer. A plaintiff who's a consumer and has filed a lawsuit has an attorney. They are the plaintiff's attorney. If they do their job ethically - some of them don't. Some insurers don't do their job ethically. Some legislators don't do their job ethically. But most people do. If they do their job ethically, they are telling their client here are the pros and cons of this deal. We're giving you the information. You're an adult. Does this deal make sense to you? And so there is no reason in that setting, recognizing that some people get hoodwinked, to have a layer of regulation that says a well-informed consumer, well counseled person who needs the money and the deal makes sense to him can't take it because we're going to cap what the deal can be. Rep. Meredith stated that I would just say I think a highly regulated industry like any kind of financial services that has disclosure requirements already you are providing those same levels of pros and cons that an attorney would provide. And again, in that situation, the attorney's contingencies are still

going to figure into that discussion and so I think that is not something that necessarily holds water. That's just my personal opinion.

Rep. Meredith then stated to Mr. Weisman, you have referred to your work previously with Liberty Mutual and you talked about strategy and some of those kinds of things in that process. I just want to be clear that that does not represent anything about Liberty Mutual's views. Mr. Weisman stated that I'm not here on behalf of Liberty Mutual. I'm with Parabellum Capital.

Mr. Kelly then asked Sen. Felzkowski for leave to be able to submit a statement for the record. Sen. Felzkowski replied, yes.

Rep. Lehman thanked everyone for their comments and stated that I think we had a good robust discussion today. I think some very valid points were brought up on both sides of this. I know that several people reached out about splitting this Model into two Models, commercial versus consumer. I think it needs to leave NCOIL as one. What you do back at your state, you can split these apart but I don't want to run two different Models through NCOIL when they're very similar. So, we will keep this as one Model. Also, as Rep. Jordan brought up some issues on violations, I'd call that a small tweak and if there are other small tweaks that we need to address let us know. But obviously this is going to hinge at the end on disclosure and I think we really need to work on that piece. As we get into the interim meeting of the Committee sometime between now and November, please let me or NCOIL staff know where you're at and where you want to see some changes. Because we do need input from this committee. I think Mr. Kelly makes a valid point on do we talk about disclosure if it's being used to fix my truck versus being used to pay my lawyer? There's some merit in that. I think there's merit in Rep. Meredith's comments. I think one comment was made about insurers don't have to disclose their money but they're a second party to these claims, not a third-party. So, there's a difference there and they're heavily regulated in those states. I think that's what brought our attention to some of this is I think a lot of stuff is going on that you heard about, some nefarious stuff is happening because of the lack of regulation. So, I think we need to stay focused on that. So with that, thank you for the discussion. Please reach out to me and to NCOIL staff. I would like to get some amendments put together for our interim meeting so we can consider this in San Antonio in November[1].

PRESENTATION ON REGULATION OF BAIL BONDS INDUSTRY

John Looney, Executive VP of the National Association of Bail Agents, thanked the Committee for the opportunity to speak and stated that I am also President of the Montana Bail Agents Association and I'm a bondsman. So, why am I sitting in front of NCOIL? Well, it's because I'm an appearance surety bond producer. I write insurance. Bail is an insurance product. It involves risk assessment and premiums. At the core of it it's a surety bond. Bail, it's a contractual agreement between the courts, a defendant

[1] Wes Bissett, Senior Counsel of Gov't Affairs at the Independent Insurance Agents & Brokers of America (IIABA), and Mike Lane, Associate General Counsel at State Farm Insurance Company, each submitted a witness slip in support of the Model.

and the surety producer that the defendant or offenders is going to appear for court. It's a financial agreement. If I write a surety bond and the defendant fails to appear I have to pay the court. With that comes a lot of responsibility and accountability which means I get to define the terms of my surety bail agreement or my contractual agreement with my defendant. If he fails to appear, I can go arrest him and return custody of him back to the court. I think it's important that regulators understand the use of the correct terminology and the insurance surety bail system. There's a significant difference between secured bail and cash bail. We get a lot of questions and it's in the news all the time you hear about the changes in cash bail and we need to do bail reform. Cash bail is a judge setting a cash requirement of whatever amount for a defendant to get out of jail in order to move through their court and get their problems taken care of. Whereas a surety bail or secured bail is a surety writing an insurance product that says we're going to accept the liability. The court then transfers custody of that defendant to the bail bondsman and the bail bondsman promises that that defendant's going to appear for court. The role of the surety bondsman is to ensure court appearance. That's it. My insurance that I write says I promise this guy's going to show up for court. I protect public safety because I put a lot of stringent requirements on my defendants when I remove them from the custody of the jail. They're required to check in with me weekly. They're required to tell me where they're at. They're not allowed to leave the state. They have to have family with them. They have to tell me where they live. Public safety is paramount when a surety bondsman is involved. We advocate for victims. We make sure that our defendants aren't going where they're not supposed to be going. They follow the rules that the court set for them before they were released from court or released from jail. We alleviate jail overcrowding. The pretrial services or anything other than a bondsman don't work 24/7, 365. A bondsman works 24/7, 365. If you get arrested on a Friday night at 5:30, you don't get to see a judge until Monday at 9:00. A bondsman can come in and get you out and start the process anytime.

And that brings me to my next thing which is the difference between secured bail and pretrial services. Secured bail operates at zero cost to the taxpayer unlike your state-run pretrial services which require significant public funding. The key difference is the 24/7, 365 day a year availability. Our doors don't close. Surety bailsman or surety producers are available 24/7. Also, there is an aspect of accountability. Bail agents are accountable financially and contractually with the court that says I took custody of the defendant. I'm going to make sure that he does what you say Judge and I'll make sure he comes back and appears before the court. And also, there is efficiency. I don't know that it needs to be said, but I don't know of another government program that runs more efficient than the bail industry. We have the latest technology, we have the training, we have all the things in place that we put there to secure our financial obligations. The importance of legislative regulation is the number one consumer protection. Regulations prevent the exploitation of defendants, individuals and families during one of the most vulnerable times of their lives. Also, with market stability, standardizing rates of premium bail promotes healthy competition among bail bond businesses and prevents any single company or entity from dominating the market. And also accountability and transparency - regulatory frameworks require bail bond companies to adhere to guidelines and maintain ethical standards and preventing fraudulent practices. One of the big issues with regulatory frameworks is the clarity and interpretation of laws. In my

home state of Montana, there's 207 courts and not a single one of them processes a bail bond the same way because there's no regulatory framework in place that says this is how a bail bond works. It's kind of like the Wild West. Good laws and regulatory frameworks create consistency in application so there isn't a question of if I write a bond on one side of the state versus another side of the state. It also increases judicial efficiency. In other words, we don't have judges or jurisdictions creating their own version of how a bail bond works. And good laws will maintain legislative intent. So, in plain English, we write a law or the legislature passes a law, it should not be able to be interpreted any other way than what it was intended to be interpreted as. In conclusion, the secured bail is a vital component of our criminal justice system. It bridges the gap between public safety, judicial efficiency and the rights of defendants. Effective regulation and clearly defined legislative language are crucial to maintaining the integrity of that system. By fostering a fair and transparent bail bond industry you can ensure that justice is served while protecting the interests of all stakeholders involved.

Jeff Clayton, Executive Director of the American Bail Coalition, thanked the Committee for the opportunity to speak and stated that the Coalition is a trade association of insurance companies who underwrite the liability written by our friends the bail bondsman throughout the U.S. Since the conquest, simple words – “all prisoners shall be bailable by sufficient sureties” has sort of been the fight over bail. And for those of you don't remember when the conquest was it was the year 1066. So, for guys working in bail like me, that means a lot of job security. But what it does mean in the modern era is that you have three branches of government regulating our industry. You have the judicial branch regulating it at an administrative level. Who can write bonds in that particular court and on a case by case level? Whether we can accept this bond, whether we use criminal proceeds to post that bond. And then we have departments of insurance issuing licenses to bail bondsman regulating surety corporations. And then we have regulations of when people don't pay and we shut them off from continuing to write bonds and that is handled. And so when you look at all the jurisdictional lines and try to decide where this jurisdictional lines are, we use a legal term of art to define that which is quite fuzzy. And every state does it differently. And we are here to help you do that. Why are we here? We're here to tell you it's a critical thing to regulate. Why? Because the accused’s access to bail depends on it. The integrity of the system and the answering for the charges depends on it. Criminal deterrence depends on it. And so, it is a very important concept. When I transitioned from law practice to government relations, I was running a bill for then Governor Ritter and I sat down at a table with my dad and his partner who were old time cops, retired cops and lobbyists. And they said, “hey, Jeff, how's your first week going?” And I said, “To be honest with you, I don't think I'm going to be able to get this bill out.” And they said, “well, why not?” And I said, “my sponsor just doesn't know what he's talking about.” My dad's partner looked at me and he said, “Jeff. I'm going to give you a little advice. If you want to pass a bill, you need a sponsor that knows how to run a two car funeral. And your guy didn't know how to run a two car funeral.” This is a personality business. This is a business of knowing what you're talking about and I like to think that we know what we're talking about when it comes to the regulation of bail. So, if you need to know what you're talking about and you need to run that two car funeral and you feel like you can't run it, definitely give us a

call. We're here to help and explain the framework of how all this happens in each of your States and help you make the best public policy you can.

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). You can view the model in your binders on page 134 and on the website and app. Also before you and on the website app as well are some responses to some questions that were distributed before the conference in an effort to try and get some clarification on some issues related to the Model.

Asw. Pam Hunter (NY), NCOIL Vice President and sponsor of the Model stated that we have been speaking about this model for quite some time. We did have an interim meeting and there were some questions that came out of that meeting and my colleagues have some of those questions that were passed around. And we have a couple folks here today to talk about this model and we're not going to be voting on it today. There's been differing opinions and statements relative to this issue and we need some clarifying. So, if each of you who are here today could provide some feedback especially in the form of proposed amendments to the model that would be great. I also think that we're supposed to see a video and if you could touch briefly on the amendments that would be great as I think we all need a better understanding on some of these issues. So we will watch the video and then have a discussion. And after this meeting if you have any amendments, you can send them to me or NCOIL staff and I hope we can work through this to try to get to some conclusion for this model in November.

Ben. LaRocco, Senior Director of Gov't Relations at EarnIn, thanked the Committee for the opportunity to speak and stated that we did a video of what the actual customer experience is for EarnIn users. So, you'll be able to see sort of what it's like from the time you download the app and have your account until you actually use the product and what that looks like. So, that's what's going on here. So, go ahead and hit play and I will narrate as we go through because there's no sound. So, anybody can download the app in the App Store. This is what it will look like when you do. So, you start, you connect your bank account. We use a third-party service called Plaid and many financial services companies use that. It allows us to have read only access into the user's bank account. That's how we verify their employment and we do some risk modeling based on that as well. So, this Platypus Bank is not a real bank but just gives you a representation of what it might look like. This is also where you choose where your money goes into when you access your funds. So that's the other reason that you connect your bank. You are able to add a debit card if you would like. If you add the debit card, you're able to get your earnings in seconds for a fee which you'll see the option of how that presents itself in just a minute. You don't have to have a debit card in order to do that. There's your various terms and conditions and further verifying your employer.

Again, we work direct to consumer. So, virtually anybody that has a regular paycheck and a direct deposit employer can use EarnIn. There's two main ways right now that we

verify earnings. One, we use your work e-mail to verify your employment. And two we track the amount of time that you're at work. And you choose which one to use. So, this is what the user experience will look like once you've gone through the setup and accepting the terms and conditions, that $100 is the amount of earnings that you have. You've earned it. This is you choosing how much of that $100 available you want to use. So again, the standard version is free. That's Automated Clearing House (ACH). That's usually next business day, but could be up to three days. Or you can debit and there are fees for the debit which is immediate and those are disclosed there in the process. So, you choose which one you want. The other way we make money is we ask people for voluntary tips. We've talked about this before, this is the user experience for that. You'll see that we do suggest a tip but it's very easy to change that and make it anything you want, including zero. So this person just chose to tip zero. Here is the amount they're accessing, the total amount they're paying and the amount of the day of their pay date so that way they'll know when we get paid back. So that's the transaction. I don't have any other further prepared remarks. I did submit answers to the questions. We submitted some amendments to the model with the reasoning for those amendments. And then we submitted some comments on the amendments that others submitted.

Andrew Kushner, Senior Policy Counsel at the Center for Responsible Lending (CRL), thanked the Committee for the opportunity to speak and stated that I don't have a ton of prepared remarks today. I really appreciate this continued conversation. I printed out copies of our responses to the committee's questions which are before you. I think the one thing that I do want to mention actually is some late breaking news in the this space. Just today the Consumer Financial protection Bureau (CFPB) issued a notice of proposed interpretive rule under the Truth in Lending Act (TILA) and there are three key aspects to that rule that are likely very relevant to this committee's work and in particular to some of the questions that Asw. Hunter was talking about - are these products loans? What constitutes a finance charge? The CFPB, the nation's federal financial regulator expert in interpreting and applying TILA, is proposing a rule that would say that earned wage advanced products like EarnIn and what we're talking about in the context of this Model are credit products under the TILA. That's a straightforward conclusion that we think is correct by applying the language of the statute and prior judicial decisions and prior guidance from the CFPB and other federal agencies. And the rulemaking also says that those expedited fees that you saw an example of, as well as most tips are finance charges subject to TILA. In our country we have essentially a dual system of credit regulation. At the state level, interest rate caps and some of the more substantive terms of credit transactions are set. At the federal level there's the umbrella TILA that governs disclosure obligations for all different types of credit products, their terms and conditions. And what the CFPB has said is that the baseline definition of a credit product, earned wage access fits within that. And we think that's the right result and we think that should inform this committees work. We submitted amendments to the proposed model. I think the key aspects of our amendments are these products should be regulated as credit. There should be a cost cap because these products, like other credit products, can effectively create their own demand when folks are paying for them and paying high rates for them and getting caught in a cycle of reborrowing and the CFPB's work really backs that up.

Rep. Lehman asked Mr. LaRocco if it's correct that the only fee you charge is the service fee if they choose something other than ACH, and then also a tip? Mr. LaRocco replied yes, there's no late fees. There's no interest. There's no mandatory fees of any sort. Rep. Lehman asked if there is a fee to sign up for the program? Mr. LaRocco replied, no.

Sen. Felzkowski asked what is the role of the employer here then? At some point, somebody's paying this back. Can you walk us through the mechanics? Mr. LaRocco replied, yes, that's a great question and that is one of sort of the differences that we have in our proposed amendments is the terms of how you get paid back and there's three main ways that companies partner with employers. One is they don't partner at all. So, we have two million customers, the vast majority of those customers we don't have a relationship with their employers. We have 100 Congressional staffers that use our product, but we don't have any relationship with the U.S. Congress. But we do have relationships with some employers and there's two ways that companies have relationships with employers. One is sort of like a co-marketing agreement where there's not actually a business relationship it's more of like a referral. We have relationships like that with large employers like Home Depot and Walgreens where they basically say download the EarnIn app and you get a discount on that fee. So, it's less than the $3.99 for other people. The other way is that you are integrated in the employer's payroll system and then you get paid back basically from the employer rather than through the employee's bank account.

Sen. Bob Hackett stated that I understand where the fees come in with tips and then you multiply it annually for the year for the short period of time, it can really increase the Annual Percentage Rate (APR) especially when there's not a lot of money in the tip. If you use an example of $11 on $100 and you multiply that for the whole year, that's a lot. The other two things you mentioned were the debit card and another fee. Do you make any money off of the debit card? Mr. LaRocco stated that if you get your wages on a debit card then the issuing company and that's usually going to be the earned wage access company does get the interchange fee on that and that would be the same interchange fee that anybody else would get. And there's no fee to the user for that it comes from the normal interchange system. Sen. Hackett stated that with EarnIn because you bring in a lot more debit cards potentially can you negotiate directly with that third party company that's saying, "hey, look, you know, you normally charge this. We want a little part of that." Mr. LaRocco replied the interchange fees are set by Visa so even with a big number for us that's still a small number to Visa, so we don't really have that sort of market power unfortunately.

Sen. Paul Utke (MN), NCOIL Treasurer, stated that as I'm listening to this I want to just dig down a little bit further and it looks like all of the ways that you could make money are voluntary. They can pay fees, they can make tips. How do you stay in business? Are they just that generous or what pays the bills? And then the other thing is, if the paycheck can still go to the individual and rely on them to give you payment back, what kind of bad debts do you encounter? Mr. LaRocco stated that those are great questions and very common questions that we get. All of the fees are voluntary. There's a lot of financial services especially that serve the working class that are monetized by

punishment like overdrafts, late fees, and high interest rates. We only monetize if we have a system or a product that the consumers want to opt into. But to your point, we don't necessarily know every transaction that a certain person is going to choose the fee or a certain person is going to pay a tip or not. Most people don't tip. About two thirds of the transactions opt into the expedited fee and so when you're doing hundreds of millions of transactions which is how many transactions we've done over the course of our business, you know on average how many people are going to choose the fee and how many tips are going to be made and that gets built into the business model. As far as not paying us back, every company is a little bit different and it fluctuates throughout the year. A published number is about 3% of transactions don't get paid back. So just putting that into perspective and talking about what Sen. Hackett said, you take 3% and the average transaction is nine days long. So just the non-payment rate of 3% over nine days if you were to annualize that, that's 128% APR. So, 3% may sound like "oh you get paid back 97% of the time." But when you analyze that it's 128%. And so the APR disclosure in that instance when you're dealing with such a short amount of time I think becomes a lot less salient and not actually applicable to the true cost that the user might be paying which is why we've suggested other disclosures which we feel would be more salient to the customer.

Rep. Matt Lockett (KY) asked if there is any data that would suggest that you have repeat customers? In other words, somebody gets in a cycle of having to get a loan one week and owe the next week the same thing? What kind of data do you have that would show that? Mr. LaRocco stated that I think we see a couple use cases and actually with what the CFPB put out today, we disagree violently with what the CFPB said today. It's almost certainly going to be decided in the courts and that's why I think NCOIL has a big opportunity here. There's an existing rule, it's not a good fit for this product. It needs some clarity on the federal level and it seems like the courts are probably going to provide that unless Congress steps in. But I think on the state level NCOIL can do that. The CFPB today showed like a U-shaped curve. So, there's a lot of people that use it just two or three times and then never use it again. There's a lot of people that use it a couple of times and then don't use it again or they use it and then they don't use it for three months and then they come back and they use it for a couple months and or for a little while then they don't use it again for a couple months and they come back. And then there's some people I think a lot of us know these people that they just aren't great managing their money and they do use it a lot. Generally when I get asked questions by lawmakers like you, it's if people are going to use our product a lot. But if you take away our product, they're going to be using some other product a lot too. They're going to be using a credit card. They're going to be using loans, they're going to be using something else. And the downside risks to the customers that really just are not great at managing their money are going to be higher in most of those other products than the downside risks of our product.

Mr. Kushner stated that there are a couple of figures put out by government regulators on that issue. The California Department of Financial Protection and Innovation (DFPI) has a data set of earned wage access transactions provided by companies and they found on average users took out 36 transactions a year. The CFPB today said in their data set the average was 27. And what's interesting about what the CFPB said is

roughly half of those users took out more than one a month but the average was still 27 a year which means you have a small number of really high users, people who use it all the time. And in fact that's a distribution you see with payday loans as well, about 70% of payday loan originations go to users who take out 10 or more of them per year. And there's a relatively small number of users with high frequency but that for us is very concerning because it shows that there are a small number of people who are the source of a lot of the origination in this market. You see similar statistics in sports gambling apps on your phone. There's a small group of users who use the apps all the time and that for us is a reason why cost caps and other protections are necessary to protect folks who really are financially vulnerable.

Asm. Alex Bores (NY) stated that you mentioned that two-thirds of users roughly do the expedited option and the majority don't leave tips. Is there any more precision about how many people leave tips or sort of how that revenue compares to the short term expedited option? Mr. LaRocco stated that it changes. With two million customers about 45% of people leave a tip. About 20% never tip ever. About 10% tip every time. And most people tip sometimes and not other times. Our medium tip is zero. Our average tip is $1.25. So, that's sort of the order of magnitude of what you see.

Asw. Hunter stated that I just mentioned to my colleague, it didn't escape me that it's ironic that the conversation we just had relative to litigation funding was I don't have money, I need to be fronted money and I may have to pay a little bit of money in order to get money. And this is in some ways a similar situation. I worked, I need money and getting money from someone to maybe pay a little bit of money. There's an overall problem in this country that dictates we need these kinds of products and that's not what we're here to solve today. It's interesting with that new information today that was released. Is it a loan? Is it not a loan? I think when we first started this conversation several months ago I started the conversation with “I worked, why can't I get paid today?” And that started this whole kind of conversation relative to why am I having to pay a fee for getting my money today? Employers could essentially pay their employees every single day. They don't. Or can't for a variety of reasons. So, we’re presented with this Model that I hope with amendments and based on all of your considerations that we can present a foundation that you bring back to your state. But this is not going away. This issue is not going to stop just because we don't do something about this. And each state obviously is going to be presented with this issue that they're going to have to address and addressing the underlying problem obviously is probably a greater issue than trying to fix this. But I do appreciate the repeated conversations that we're having relative to this. Obviously with EarnIn you’re fitting a need for consumers who obviously have for whatever reason a myriad of issues that they need money and they need it today. We would be remiss if we didn't take into consideration obviously consumer protections because we want to make sure people are protected when they have these products. So, we're going to have to go back and look at this and if you have any questions and more thoughts about amendments we'd like to come up with some kind of solid foundation for you all to consider. We'll probably have an interim meeting before our November meeting. I would suggest strongly in the states that you represent to bring this back to your legislatures and really kind of dig down because if we don't do

something the companies are going to be out there continuing to do what they're doing and we're talking about actual pay for people working at their job.

ANY OTHER BUSINESS

Sen. Felzkowski stated that I have one more piece of business which is really a reminder that our Workers' Compensation Insurance Committee has jurisdiction over a Model Law dealing with structured settlements. That model crosses different lines of insurance so we've begun providing notice to everyone when the model is being discussed by the work comp committee. It's likely that the work comp committee will have another presentation on structured settlements during its November meeting. So, if you have any questions or comments, please reach out to the Chair, Sen. Lana Theis (MI), or the NCOIL staff.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Utke and seconded by Rep. Lehman, the Committee adjourned at 5:30 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
FINANCIAL SERVICES & MULTI-LINES ISSUES COMMITTEE
INTERIM COMMITTEE MEETING – SEPTEMBER 20, 2024
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Financial Services & Multi-Lines Issues Committee held an interim meeting via Zoom on Friday, September 20, 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. Tammy Nuccio (CT)
Rep. Matt Lehman (IN)
Rep. Mike Meredith (KY)
Rep. Edmond Jordan (LA)
Rep. Brenda Carter (MI)
Sen. Paul Utke (MN)
Rep. Nelly Nicol (MT)
Asm. Jarett Gandolfo (NY)
Asw. Pam Hunter (NY)
Asw. David Weprin (NY)
Sen. Bob Hackett (OH)
Sen. George Lang (OH)
Rep. Forrest Bennett (OK)
Rep. Ellyn Hefner (OK)
Del. David Green (WV)
Del. Walter Hall (WV)
Del. Steve Westfall (WV)

Other legislators present were:

Rep. Jim Gooch (KY)
Sen. Lana Theis (MI)
Sen. Hillman Frazier (MS)

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 Asw. Pam Hunter (NY), NCOIL Vice President, 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 that the purpose of our meeting today is to continue discussion on two model laws, both of which we would like to try and have a vote on during our Annual Meeting in November. Updated

versions of both of those models were distributed and posted on the website in advance of this meeting.

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. We've had some really good discussion on this and will be continuing that discussion today. We've been making progress on the Model and before we go through some of the discussions on it, we'll start off by turning it over to the sponsor of this Model, Rep. Matt Lehman (IN).

Rep. Lehman thanked everybody that's participated in this discussion. There's been a lot of feedback on this and there's still some moving parts of this we want to talk about. As you can see in the latest version of the model, there are two things I'm going to deal with. The first one being disclosure and changes in Sections 7 and 16. Those govern how and when to disclose the litigation funding agreement. I still think they need to have a little more conversation. When we began this discussion, I know one of the most contentious issues was disclosure - the existence of versus the contents of. In Indiana, we passed it out with the existence of it but we have language that has it subject to discovery which is also in this model. The West Virginia language requires the contents be disclosed and at our last meeting I believe we had a long discussion on that. We had added in the West Virginia language in our model because I wanted to start that conversation here in terms of seeing what people had to say in terms of whether that was too broad or not broad enough. The automatic disclosure requirement should or shouldn't be in the model? So, after listening to testimony there, I was having conversations with several attorneys outside of the interested parties or even NCOIL and I do think there's possibly a need for some further discussion. The concern that the legal people had was that we were going maybe too far into the litigation lane into the judicial path. And so, if you had a state that has very strict and very good judicial rules or procedures, then they don't really need this and discovery is the path. If your state does not have that then maybe the West Virginia language should be your path. So, I guess that's why I want to kind of flesh out a little more.

I also heard from many about what's driving this. I was just at a conference yesterday on where the market is today and inflation was discussed. What's driving insurance rates up to where they're 40% higher? A lot of its inflation. But they said one big factor was third-party funding litigation. And the gentleman that's bringing this up had no idea I was even there and doesn't know who I am. And so afterwards I said something to him and he said "I think it really is more in the class action in that space." So, the question was, should this be somewhat limited to those commercial type risks versus the consumer type risk. So again, that's something I want to hear from those that are here today. With that, I'm going to go walk through another couple things here. First, let me step back. From a philosophy standpoint, I've been around NCOIL a long time and my philosophy has been pretty consistent and I think we need to make sure we're building frameworks for states, not to build the final product to get to your states. So, in this discussion, some of that hinges on what's best for your state and maybe we put in drafting notes and put in language that would say your state should do this, this or this.

But I think again the model is to serve as a policy guidance for the space to use in your legislature. So, you'll see a note at the top of the model that I wanted to discuss today a little bit of the definition of “charges” in Section 3. I included that note because I do feel that a lot of discussions so far around this has centered on the disclosure but I want to make sure that we talk about the full dialogue and the charges as well. I know some folks have reached out saying there shouldn't be a specific rate in the model and it should be left up to the states. I’m interested in hearing thoughts on that.

Additionally, I know in our state, we shy away from referencing federal law because we have laws within the state to deal with these types of products. So again, maybe this gets down to more of a drafting note, citing what your state would use. I don't want anything to be construed as “NCOIL didn't care about it, why should you?” So, does not having a rate in the model set the table up for that? We all have a concern on the high interest rates on consumer debt. So I want to hear everybody’s comments on that. Obviously, the goal is to have all this ready so that we can have a final vote in San Antonio. There are other issues as well in terms of tightening up definitions of a not-for-profit and making sure this applies not just maybe to attorneys, but also to law firms and affiliates, and tightening up the environmental exemption. There's a few other small changes as well but if people have comments on any of those provisions, please share those as well. The last thing I'll say is that I think it’s important for us to come to an agreement at some point here by November and not wait as I believe this is continuing to be a bigger problem. It's growing momentum around the country and it's important we provide guidance. People are looking to us for that guidance and I think we need to find a way to go here. And therefore, I'm looking forward to that discussion about the two major issues and other issues you might want to weigh in on.

Del. Steve Westfall (WV), co-sponsor of the Model, thanked Rep. Lehman for all his work and stated that I spoke to Rep. Lehman recently about how I think there needs to be full transparency and the West Virginia language is the way to proceed but if we can get some kind of compromise to say something like if your state allows it, this is the way to go, that might be best. I know during one of the Zoom meetings we had, one person was saying that they don’t do any of this business in West Virginia or Indiana so that it didn’t matter what the laws were in the state. I kind of took offense to that and I think Rep. Lehman did too. But we're growing and I think this is causing rates to go up. Our rates went up about 20% this year. I'm still 100% behind full transparency and we'll see what happens but hopefully we can get to a compromise somewhere that really works in other states.

Brent Walker, Director of Government Relations at The Coalition Against Insurance Fraud, thanked Rep. Lehman, Del. Westfall, and the Committee for all of their work on this. The Coalition is unique in that we have over 300 member organizations from consumer groups, government entities and insurers, and we're dedicated to fighting insurance fraud. I did look at this model from that anti-fraud perspective and I just want to stay in my own lane there around the fraud aspect. And if you've been following recent stories in the New York Post you see some examples of where insurance fraud can creep in and involve litigation financiers. We do support this effort and I think it's an important one. I do want to make some comments on our review of the draft and I did

note how consumer funding companies and commercial funding companies were handled separately or differently in the model. And I just want to remind everyone, fraudsters are creative and if there are loopholes or ways to exploit a statute they will find it. And so, I hope that our comments are helpful in preventing some of those areas where maybe fraudsters can seek to exploit maybe some of the differences. And we suggest maybe a universal approach to some of these suggestions or prohibitions.

Primarily, the model addresses foreign entities of concern, countries and individuals for the commercial side but it doesn't have that same restriction on the consumer side. I think that's a fair suggestion that both types of funding companies should not receive financing from a foreign entity, company, or individual of concern. I also think that would apply to the sharing of information under court order or seal. I did note and I appreciate that both types of funding companies should not have any influence or decision making, that's handled separately in each of the sections and I appreciate that. But I also think that the registration and annual reporting with the state should apply to both if we're really going to achieve full transparency. I think that's something that is important. And I think to that end, sufficiently spelling out how you're going to disclose a corporate financer's corporate identity, their investors, their principals, that seems to go with other existing sections in the draft around the reporting and registration. And then finally, I do think it's fair to ask that investors, funding companies and their principals if they do register and report with the state, they should be prohibited from having crimes of fraud or moral turpitude and there should be some diligence around that. And as Rep. Lehman said, perhaps whether it's language or drafting notes, I would ask you to strongly consider some of these suggestions. I do think this is an important effort. I also understand that litigation financing helps the consumer with access to justice and access to the court system. We just want to make sure that we prevent any loopholes for fraudsters to exploit.

Eric Schuller, President of the Alliance for Responsible Consumer Legal Funding (ARC), thanked the Committee for their work and thanked Rep. Lehman for having some discussions in between the last call and this call. Just a couple of things that we'd like to address, one is on the charges section. Our recommendation has always been to remove the reference to specific charges. I think making sure that the states have the individual right and ability to make that determination on their own is important. And our concern was referencing the Military Lending Act rate itself. I sent this to about a dozen lawyers and I got five or six different responses to what exactly that language means. And so our concern is that it could be interpreted in multiple different ways as to what exactly that rate is. By leaving it up to the individual states it then would be clear like it is in Indiana, like it is in several other states. On the section on disclosure, we like where it has evolved to but I would just like to add one more caveat to that in that it would be upon request rather than automatic. Our concern is that if you have it to where it is an automatic like it is here now, not everybody's going to know about this. Not everybody follows the statutes as close. And you could have people and attorneys and consumers involuntarily or unknowingly violate the statute. If you have it upon request then there is no ifs, ands or buts about it as to whether or not there is some disclosure of the existence of the contract. We're not opposed to that. But I think it should be upon

request. This way there is an affirmative request to make sure that that document was produced and not inadvertently left off.

Jack Kelly of the American Legal Finance Association (ALFA) thanked the Committee for its work and stated that the disclosure language is very good. We might just want to go a little more generic in the reference to civil procedure. That sort of conforms to either West Virginia's term of civil procedures or Indiana's. So, we might just want to say "according to the civil procedures of the state." I think the model uses the word "trial procedures" or something like that but perhaps we just make it generic as I think that's pretty standard.

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 trial lawyer organization. I just wanted to point out a couple of things that have been raised repeatedly throughout the year. By my count, there have been 18 states that have already passed some form of legislation regulating litigation finance. And the vast majority of those states have left the disclosure question to existing rules of civil procedure, meaning that if there is any model regarding the disclosure requirements in this it should be left to existing rules of civil procedures. That's how most states out there have addressed it. This issue has come up repeatedly in those states, and it has gone to that position in those places. And so I just want to flag that as the vast majority of states that have dealt with this. The other thing I wanted to just raise with everyone again is that Professor Ken Klein pointed out during his presentation at the summer meeting that disclosure does not advance justice. It does not benefit anyone except by giving the defendant in litigation a competitive advantage in the way they handle their cases. And so, those are just two major issues that I wanted to remind everybody of.

Mark Behrens, co-chair of the Public Policy Practice Group at Shook, Hardy and Bacon, thanked the Committee for the opportunity to speak and stated that I represent a number of defendants in mass tort cases as well as an insurer. I have a few reactions. One is the disclosure does need to follow the West Virginia approach and needs to be more robust than what's in the draft model right now for a few reasons. One is one of the key issues in these cases goes to the funder's element of control over the case because that can compromise the attorney's ethics. And I know that there's a provision in the model that says the funder's can't control but without production of the agreement, we can't tell whether there is actual control. We can't tell whether the statute would be violated without seeing the agreement itself to see what it says about that. The other thing too is the agreement can say who is providing the funding. So, a key part of this model is no funding by foreign entities of concern. Just having written notice that there's funding doesn't tell you who the funder is. Again, you need the contract, the agreement, to know whether the statute is being violated. The other reasons why you need to know what's in the agreement is the level of funding because that can go to the element of control. Somebody that has only put a penny into a case may not have control. Somebody that's put a pound into the case may exercise significant control over the case. They may be deciding whether the case is brought, how it's litigated, when it settles, and how much it settles. Those are things that go right to the ethics of this practice and the influence on the judiciary.

And the other reason why the level of funding is significant is that it can go to potential cost shifting. Right now in discovery, for example, we have a system in the United States where the producer pays, where the plaintiff can ask the defendant for every document. And in some of these mass tort cases, it could be 20 million pages of documents. Typically, we don't require the individual plaintiff to contribute to the cost of that discovery. We put it all on the defendant. Because we typically view an individual plaintiff as somebody that's unable to pay for that kind of discovery. Well, that changes when there's a funder involved. Now, it's not David versus Goliath. It's Goliath versus Goliath when we're talking about commercial litigation funding. And again, courts need to know when those things are going on. They need to know the terms of the agreement because it can affect those types of decisions. So, I think it's very important to move towards the West Virginia approach. And it's not true that at least when you're dealing with commercial litigation funding that we leave this up to state civil procedure. Indiana did this, but it's not what West Virginia did. It's not what Wisconsin did. I don't believe that it's what Montana did. So, what we're seeing in other states more reflects the West Virginia approach. If there is a concern about how it impacts the courts, I think that the way you could thread that needle is to have the courts decide the admissibility of these agreements. So, it's important for the courts and the litigants to have the agreement. But whether the jury could ever hear it, that I think would be appropriate to leave to the courts according to the rules of evidence.

And then just very briefly, a couple of other things because these can be dealt with later. But I do think some of the definitions need to be tightened up. For example, I highlight two in particular, the definition of “commercial litigation financier” says it's a funder who enters into an agreement with a plaintiff. Well, plaintiffs don't enter into commercial litigation funding agreements. So, the way the model is written now it wouldn't even apply in commercial litigation. I know that's not the intent but that is what the model says. And the same thing with the disclosure language that's in there now dealing with commercial litigation financiers. It's talking about when a plaintiff enters into an agreement. On the commercial side the plaintiffs are not entering into these agreements and I think it's very important that the definitions reflect the actual practice. And the only other one I'd mention is on “foreign entity of concern” where there's a reference here to an individual but when you look at what the definition is it's, an individual can't meet any of those criteria. So, I think you either need to change the definition to include something like a Russian Oligarch as an individual of concern, but it doesn't fit under the definition right now.

Jon Schnautz, Vice President at the National Association of Mutual Insurance Companies (NAMIC), thanked the Committee for the opportunity to speak in strong support of the concept of disclosure and transparency in this model. And we think the language that was circulated last week needs some work to get back to what it needs to be on that concept. I'll just briefly say we support the goal of transparency that's in the title of the model. It's been the goal from the beginning. We think the best way to achieve that is to do something analogous to what's been done in every state here as to insurance policies and that is make the actual agreement disclosed to the other party automatically. I think Mr. Behrens covered that point pretty well so I want to focus on

something a little bit different which is, listening to conversations so far, it seems like the discussion at this point is a little less about whether disclosure is appropriate and a little more about who should be requiring it. So, I want to focus on that because from our perspective we think it is entirely within the province of the legislature to act on this issue if it so chooses and I just think there's a lot of points there but I want to highlight a few.

First, there's about 15 states that already require pre suit disclosure of insurance policies by statute. Now, I want to be very clear, we don't support those bills but they do exist. There are statutes out there on that and to my knowledge we have never argued when we argue against them that the legislature lacks authority to pass those statutes. Instead, we argue they're bad policy. So, I think that's one bit of evidence to say that the legislature can act here if it chooses and that the model can go there. In addition, state statutes, both past and proposed, specifically on the topic of third-party litigation funding have included language that is substantively identical to what was in the model back in July. The most obvious example is West Virginia. That's what the language is based on. But looking around the country there are bills proposed, some still under consideration, in Ohio, North Carolina, Minnesota, Florida, Georgia, Iowa, and Arizona. This is not a comprehensive list but again, each of these bills include a disclosure requirement that is substantively identical to what was in the July version. We think that proves that a state legislature can go there if it so chooses. Finally, and I think most critically, NCOIL itself has a precedent here. There is an Asbestos Bankruptcy Trust Claims Model Act NCOIL adopted in 2017 and re-adopted two years ago. It was sponsored by Sen. Jerry Klein (ND) and Sen. Bob Hackett (OH). I think both are on this committee. That model includes very specific disclosure requirements for plaintiffs in asbestos suits and includes the content of the disclosure, the timing of the disclosure, the requirements to supplement the disclosure, and speaks to the relevance and admissibility. In other words, it is much more prescriptive than what this model included back in July. And so we think the precedent is there for NCOIL speaking to a very similar issue regarding disclosure in another context.

So, in conclusion, NAMIC supports the July disclosure language. We look forward to further discussion on the model. I will briefly touch on just a couple of points that have been raised so far. The first one is on the charges definition issue. I think if I'm hearing right that there is some room for compromise here. Speaking for us, we would be willing to support the removal of a specific cap in the model. What we would like to see though, is an appropriate drafting note that clearly leaves that issue up to the states. In other words, we would not support removal of the cap. We think that would be used to carry the implication that NCOIL considered the issue and decided a cap was inappropriate. Leaving it to the states is contextually very different than that. And then I guess the final point is we do think the model should continue to apply to all types of funding. We think that's important. There have been some comments here that could have been taken otherwise and so I wanted to make that point clear.

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 to begin, I'll say that addressing this issue and addressing the abuse of the legal system in general is our most significant public policy priority today. There's nothing that

outweighs it. And so, we'll be working on this issue as we have in the last couple of years. We'll be working on this in many states in 2025 and beyond and we think it's critical to have a meaningful starting point for state legislators to look to. So, we strongly appreciate and thank NCOIL and Rep. Lehman and Del. Westfall for their leadership on this. Some of the speakers have stole my thunder a little bit in their remarks so I would say we urge you not to water this proposal down and agree that with the disclosure language, to the extent that you can keep it as is and not water it down. That that would be ideal. I especially wanted to comment on the rate provision and we really agree with NAMIC's suggestion on that. We think the removal of a reference to a rate cap would be troubling because of the implication that some might take from that and try to suggest to policymakers. So, even if there were a reference to a rate cap provision with almost a fill in the blank element to that we think that would be helpful. There could even be a drafting note associated with that that outlines the caps that are in place in places like Tennessee and Arkansas and Montana. So, we urge you to continue your good work on this and not to water it down. It's not just the insurance industry that's focused on this. There are many policyholder organizations that we're engaging with at a state level that strongly support this effort and we urge you to adopt it in November. It's critically important to have a meaningful guide for state policymakers in place going into 2025.

Mike Lane, Associate General Counsel at State Farm Insurance, thanked the Committee for its work and stated that I want to echo some of the comments that were just made. We obviously do have concerns with the slide back with regard to the disclosure language from the July version. We think this is going to be a bigger problem. It's not just an insurance issue problem. And NCOIL will be a standard. And so, if we end up with just disclosure of the existence of the contract that will be viewed in the other states as a standard. And so, we really do think that the actual contract, in order to address any abuses that could come from this, has to be disclosed. So we would support changing the language to what it was in July.

Hilary Segura, Vice President of State Government Relations with the American Property Casualty Insurance Association (APCIA) thanked the Committee for the opportunity to speak and stated that APCIA very much appreciates the efforts of Rep. Lehman and Del. Westfall and the entire committee tackling this very important issue. I would echo a lot of the comments that have been made earlier so I will be very brief in my comments. I would just say that there are core parts of the litigation financing legislation that are crucial to our insurance membership, that being the disclosure requirements and the model already is including language regarding the foreign entities of concern. And also language to make the non-party funder's role clear. For that, we are appreciative of it but we do believe that the model itself needs to have language regarding the disclosure of the agreement itself. As has been noted previously, legislation in West Virginia and Wisconsin and Montana have already included the disclosure of the contents of the agreement and we think that is a very important component. As NCOIL is a national standard bearing across the country, we think that is important to be included in the final model.

Eric DeCampos, Senior Director of Strategy, Policy & Government Affairs with the National Insurance Crime Bureau (NICB), thanked the Committee for the opportunity to

speak and stated that I just wanted to echo some of the other comments regarding concerns around any rollbacks and any sliding on the disclosure piece. We certainly want to avoid taking away that transparency which can certainly help illuminate bad actors, fraudulent activities or criminal enterprises that may seek to use this type of legal avenue to carry out their unscrupulous activities. So I just wanted to make that mention as well and we certainly hope to see this model move forward with disclosure language that can address our concerns.

Asw. Pam Hunter (NY), NCOIL Vice President, stated that I want to commend Rep. Lehman on this model. It is a strong model that does protect consumers by making sure the contracts are easy to read, that no kickbacks are paid, that allows funding transparency to all parties and that has a cap on charges. From the beginning you had the language addressing maximum charges, which is critical to protecting our constituents. And I do Chair the Banking Committee in New York and you know how important it is to make sure consumers aren't abused and overcharged. And I think we should keep the rate cap language in to show that this legislation protects consumers from abusive charges.

Rep. Edmond Jordan (LA), NCOIL Secretary, thanked Rep. Lehman and everyone who's worked on this model. I want to echo some of the sentiments of Asw. Hunter in that I do think we do need to keep the rate cap in. However, I struggle a little bit with the disclosure because really, I think as it relates to the commercial side I tend to agree with some of the comments that were made and saying that we maybe need to have some regulations on them and deal with those issues. Because I think class actions are a totally different animal and I've been involved in some of those so I understand some of that. But as it relates to the consumer section of it, I really don't know if this is needed at all and I do believe that it gives the defense a strategic advantage. It puts the plaintiffs at a disadvantage by having it disclosed but certainly, I would vehemently disagree with those that say that the contents of the contract should be disclosed. I think one of the distinctions that we're missing is as it relates to an insurance contract, the insurance company is a party to the lawsuit. In these cases, these third-party litigation finances are not a party to the lawsuit, especially on the consumer side. And so I think it puts the plaintiffs, especially those that lack funding and lots of people that are involved in some of this litigation are not high wage earners, at a distinct disadvantage by not only disclosing the contract but also disclosing the contents of the contract. So I would suggest that neither one of those things be disclosed as it relates to the consumer side. But if we're going to do something on the consumer side maybe go as far as disclosing the existence, although again I'm against that, but certainly not releasing the contents of it. I don't see the benefit of that even to the defense, other than to give them an advantage of knowing that the plaintiff may be in some financial troubles. And again that leads to them maybe lowballing an offer and doing some other things that are just not in the interest of justice.

Sen. Paul Utke (MN), NCOIL Treasurer, stated that we've been hearing a lot about some potential changes to the model as we've been leading up to this meeting and one of them centers on the rate cap language and my only question is about whether there is a clearer way to word the rate, if it's going to have a ceiling, then referencing the federal

law currently cited. And I think it was mentioned earlier that there is some confusion to it. And I don't know what's right or what's wrong but if there's a way to clarify that, if there's going to be a rate in the system, that could work. And I've had people both ways talk about let the states just do it but then again the state still can modify it down the road if they so desire but having it in there is to kind of keep some control or at least set a bar. We all know when you set a bar that's where everybody targets, whether it's a high bar or low bar, that's where they're going to end up. And so I understand the reason people say leave it out and just let the free market run with it but in some of these things with consumers involved and in some cases they are into things that they're not very familiar with when they get to the legal system, then some direction is probably good. So as we move forward with this I guess my questions would be, is there more clarity to how that rate is worded? Or is this the best way? I don't know. And I will look at it some more too as we go forward because in the end we want protections and we want clarity to make sure that this is something that is a useful tool for the states as take this up and run it through their legislature and debate it. So we still have more work and more educating to do at least in my case as I want to get some additional information.

Asm. Jarett Gandolfo (NY) stated that I first want to commend Rep. Lehman on crafting a very solid model. I think it really will do a great job to promote transparency and fair contracts and prevent fraud and protect consumers. But I do think keeping a maximum rate for charges is a crucial piece of this for preventing abuse and protecting consumers. It gives it a little more teeth. I would like to see the maximum rate language stay in as others have mentioned. NCOIL is just setting a framework in other state legislatures that can be negotiated up or down or eliminated entirely. But by keeping the rate in, it's going to show that NCOIL has considered this and that we are recommending a certain rate and don't want it to appear like an afterthought. So I think leaving it in is the best course of action.

Sen. Felzkowski stated that I do like the previous disclosure language and it was based a little bit on Wisconsin's strong disclosure language. I think Mr. Behrens made some real good comments which I agree with and I would just say we have strong disclosure language in Wisconsin and I think if you look at settlements that have happened since that strong disclosure language has been there, they don't think in any way, shape or form it has hurt our plaintiffs. Nor has it hurt their settlements at all. So, as we talked about, NCOIL is a model and I think when we go lighter on some of these disclosures or lighter on language, other states will look at it and say, "well, if it wasn't important to NCOIL to put it in, why should we even take a look at doing something stronger? Or maybe if disclosure wasn't important to NCOIL why should we look at it that way?" So I think that's something that when we're looking at model legislation we have to be very cognizant of.

Rep. Lehman thanked everyone for their comments. I think what I'm hearing is we want to make sure that we have maybe some more clarity around strong consumer protections on that rate language. But I think I heard overwhelmingly we want to make sure we are making the statement that we're very strong on consumer protections. As far as the disclosure goes, I'm sensing a lot prefer the way it was previously. I think what I'm hearing is that the problem seems to be more around the commercial side of things

so maybe we need to have a broader discussion of do we squeeze tighter on the commercial side? But I do appreciate everybody's comments and we'll continue to work on some language so when we get to San Antonio, we'll hopefully have a good product.

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. Similar to the model we just discussed, we've been discussing this issue since last November and now we've been making progress on the Model before you which has also gone through several discussions and markups. I'll turn things over to the sponsor of the model, Asw. Hunter.

Asw. Hunter thanked everyone that has participated in the discussions on this issue since we first introduced it in November last year. As you can see, I have made some changes to the model and that version has been distributed and is on the website. Those changes are based on the proposed amendments submitted by both consumer advocates and industry representatives so I've tried to maintain a balanced approach here. I think it's worth repeating that is this is a great opportunity for NCOIL to provide guidance to states on this issue. Some states have taken action on this but they have taken different approaches and recently at the federal level, the Consumer Financial Protection Bureau (CFPB) has announced its intent to issue a rule declaring that these types of products are credit and subject to federal Truth in Lending law. And that proposed rule really just muddies the waters further on this issue as both consumer advocates and industry representatives have widely different opinions on the rule and it's almost certain that this rule is going to be subject to years of litigation. So, it's clear that state legislators and by extension us, NCOIL, are going to have to provide guidance here. I look forward to the discussion today and I'm confident that we can reach a consensus by our meeting in November to vote on something.

John Barnes, Vice President of Government Relations at Catalis, thanked the Committee for the opportunity to speak and for its work to develop a model that regulates this emerging industry and in doing so provides important safeguards for both consumers and for providers. Our company does business in many states that are represented here today and by helping our state regulators our goal is to protect consumers and promote healthy marketplaces. Concerns we've heard from legislators directly when talking about this model is that there's a clear gap that is missing from consumer protections and specifically putting a limit on the number of advances that a consumer can take out at once. Without such a limit there's significant risk that consumers can overextend themselves financially. The most effective way to regulate this product is in real time and the only way to do that in real time is through a centralized database which would track these advances and prevent consumers from taking out multiple advances simultaneously. This is the same approach that's already in place for small dollar non-bank consumer credit products in 14 states around the country from Washington on the West Coast to Oklahoma, North Dakota, Illinois, Florida, Alabama, Wisconsin, Michigan and many other states. There's a reason that legislators have come together and said this is an important consumer protection and we believe it's important that it applies here since these products are not underwritten and there's

no credit check involved so without this centralized system providers just have no way of knowing in real time who is lending to who and how much has been lent. The risk is clear. Without safeguards, consumers can easily take out multiple advances across different apps, across different providers, and it's a clear way to get into a cycle of debt in an unhealthy reliance over time. I know all of you know this, but research from Harvard and the California Department of Finance Protection Innovation has shown that on average, consumers take out 26 earned wage advances per year and that most consumers have more than two of these apps downloaded on their phones. So, without proper safeguards, we can quickly get into an overextension and financial strain.

Finally, if the committee agrees it wants to do something to ensure this consumer protection it's critical to include the database in the model because without it being written into statute, regulators simply don't believe they have the authority to implement the database. As said earlier, it's critical to include language like this because many legislators will say “if it wasn’t important to NCOIL why should we consider that?” So that's what we're asking the committee to do today is to take a closer look and ensure there are consumer protections that keep consumers safe from getting overextended. By doing so, we can ensure that when this goes out to the states there'll be no question that consumers are protected and the industry will benefit from the transparency as well.

Ben LaRocco, Senior Director of Government Relations at EarnIn, thanked the Committee for the opportunity to speak and stated that I want to address a few issues that are in the model. First, I want to address the comments just made. I've been working on this issue for many years in every state and never once have I heard a legislator say that the government should have a full database of every earned wage access user and every transaction. It seems like a lot of very sensitive data that need not be in the government's hands. So we can talk more about that if there's interest but I do want to discuss some issues in the model. I think a lot of work has gone into this and I definitely appreciate a lot of the work that Asw. Hunter and others have done. I do want to flag a couple of issues that I think probably need a little bit more work. First, I think the first one is disclosure. We’ve been talking a lot about disclosures in the states. This will be the third model bill that will be passed by various organizations on this issue. We've been spending years debating disclosures on the federal level even beyond the CFPB rule which was mentioned. And getting disclosures right is very important. And there's various points when you want disclosure. You want disclosures when the person first downloads the app. You want disclosures when they're at the point of sale. And then you want disclosures as follow-ups too. So, I think we need to do a little bit more work on that in this model and the specifics of that. Section 8(b)(9) specifically I think needs some more work.

Also section 8(b)(8) regarding the receipt of funds. We don't control when people receive funds, we control when we send funds and I think there's one provision where they have to receive the funds the day before they're paid. And that’s a problem because what happens if they get paid at night and they need $50 in the morning and then want to go get the app? Should we say “no, you're prohibited from taking out this money because it's your payday?” I think that was an addition that I think needs to be reworked a little bit. And then section 8(c) where there is an exemption from the usury

laws, we had suggested an exemption from lending and money transmission laws. We think there needs to be some clarification that if you get an earned wage access license you would not also need any other license to do earned wage access. If you also lend or if you also transit money you would need those, but by the fact that you get the earned wage access license you don't need to also get those things because that could be very burdensome if we would have to comply with all of the lending laws and all of the money transmission laws and the earned wage access laws. So we think there needs to be some language that says if you do this you do not also need to comply with the other products. I think it was great that there was clarification that tips be treated differently than other fees and other things. One thing I would clarify in the language is it says a tip is a fee. Typically, a fee is something that you trade for a service. A tip is a voluntary gift or gratuity. So, not to say that it shouldn't be regulated but it should be treated differently than a fee.

In section 8(a)(3) there's some language on account debiting. It gives a lot of control to the regulator. Basically, it says the regulator can make up whatever rules they want on account debiting. It's not that there can't be any rules around account debiting but we're always concerned when something just says the regulator gets to decide whatever they want and they get to go and run with it. There is already a very robust set of laws and regulations on how accounts can be debited so we think that needs to be looked at. And then lastly, Section 11. We suggested that be struck and it was left in. That basically gives control of the company to a regulator saying essentially you can't sell the company or transfer something unless the regulator approves it. It would be very burdensome if anybody that had an earned wage access license had to get 50 different state regulators to approve the sale, especially small players that might want to get bought by somebody else if they have to get that sort of regulatory approval. So we suggest we take a look at that.

Andrew Kushner, Senior Policy Counsel at the Center for Responsible Lending, thanked the Committee for the opportunity to speak and stated that I'm here on behalf of my organization, a nonprofit, nonpartisan research and advocacy organization that fights predatory lending, as well as the National Consumer Law Center which has also given comments on the model. And I just wanted to express our disappointment with two changes in particular to this version of the model. Number one is the change related to the fee cap. I thought the last version of the model certainly wasn't everything that consumer entities wanted but it certainly represented more of a compromise and a balanced approach than what we've seen, especially in other state legislatures when industry has introduced their version of the bill. It had an exemption from state usury laws, which we're opposed to but an all in holistic fee cap that included both fees and tips and that has been weakened in this version to only include mandatory fees. Number one, I think there's a clarity issue with that provision. It's not entirely clear to me what a mandatory fee is. There's no dispute I think that none of the companies in this industry charge mandatory fees in the sense of that fee that you absolutely have to pay. What they charge are expedite fees to receive earlier access to funds and the language that defines a fee that, it isn't clear whether it includes a $3.99 fee that you have to pay to get access to your money the next day which is in most cases how consumers use these products. So if the intent is not to include it, it feels like that then the fee cap does

nothing because the industry really doesn't charge mandatory fees. At a minimum the model needs to be clarified to include that. And then beyond that, we don't believe in any distinction between fees and tips. These companies use a whole host of techniques to push users to tip. We've detailed this in some of our publications and we think an absolute fee cap that takes into account all monies paid to the to the provider is essential. Separately, there's some weakening around the rules governing tips. I thought that one way that this organization was really doing a great job in breaking ground in the last version of the model is the language around not allowing companies to preset a tip and any tip amount had to be affirmatively selected by the user. That's no longer in the model and that seemed like a pretty common-sense consumer protection especially if tips are going to be excluded from the rate cap. So I think while we weren't fully in favor of the model as it appeared a couple of months ago, it certainly represented a better balance for consumers than this version and we'd like to urge the committee to reconsider the changes I've talked about.

Andy Morrison, Associate Director at the New Economy Project thanked the Committee for the opportunity to speak and stated that we're based in New York City and we work with community and labor partners across the state. We again strenuously oppose any model legislation and we would oppose any legislation being enacted in New York that would exempt earned wage access from the usury laws. The reason being is that we don't have payday lending in New York and that's what earned wage access is. It's just payday lending on a phone and they've used a lot of clever legal fictions and distorted what their product really is to try to evade state laws and now they want to entrench it in in state law that they deserve an exemption. The reason we don't have high-cost payday lending in New York like about 18 other states is that we have a usury law. So it would be a travesty and it would undermine decades of work that's gone on in New York to preserve our strong usury cap and we on behalf of labor groups in New York and community groups really implore you all to not exempt earned wage access from usury laws.

Mr. Barnes stated that in 14 states which includes states like Kentucky, South Carolina, Wisconsin, Illinois, Michigan, and Delaware, they have these real time databases. It is only a red light green light function. It doesn't stop anyone from offering a loan product. It only goes off of what the consumer has taken out. So in 25 plus years, we've never had any sort of hack. It's all just for the state regulator to have that data. It doesn't go into other states. It's just in that central state. So it's something that some of the legislators in this meeting have actually voted for in your states. And so I just wanted to clarify that there's a little bit of misunderstanding on that.

Rep. Brenda Carter (MI) stated that I really appreciate all the work that's went into this Model and we just recently passed legislation similar to this in Michigan and it was bipartisan because we recognized that we had to have some type of transparency and controls on rates and other things. But one of the things that I'm still concerned with in Michigan is the fact that how many times a borrower can take out funds and what the availability is. In a city like mine, if they can borrow from one lender and then go the next day and borrow for another and then another, then there's no way of finding out whether or not this person has actually maximized their income or put themselves in some type

of situation where they cannot get out of this hole. So even though I'm not really familiar with this centralized database I would like to learn just a little bit more about it and for us to just consider it, especially in our communities that use payday lending as a source of income control.

Asw. Hunter thanked everyone for their comments and stated that I just want to say as we've been having this conversation over the last several months this industry has really blown up, and especially since COVID. And it's interesting because as we're having conversations in New York about buy now pay later and now we're talking about earned wage access and we've been working on these bills all year long, consumers are using these products at an exponentially high rate. The buy now pay later people are using these for groceries. It's not like they're trying to buy a mattress and split it up in four payments. Yes, maybe some people are doing that, but people are using these products for every day things. Just like with the earned wage access, it's I need my money today. Is it a fee? Is it a tip? Those are questions but there's obviously a broader problem why all of these products are so popular and necessary and I'll reiterate the importance of us being standard bearers to make sure that we are at the forefront of policy that is impacting our constituents on an everyday basis. And as said earlier, with these models you can take them back to your state and work on it but we need to have a foundation and make sure that it's not always pro industry and it's not always pro consumer and that makes it very difficult to get to a consensus but we can't shy away from tackling these hard issues just because they could potentially be contentious. That this is really important. And it literally is people's livelihoods at stake. So we need to get this right and I believe that we have taken all sides into consideration and there's not a group or entity that we have not had conversations with. And now it's time to send in everything that you have before the meeting in November and I do hope that we'll have our final document ready to be able to review and pass in November.

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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PRESIDENT: Rep. Tom Oliverson, TX
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National Council of Insurance Legislators (NCOIL)

Transparency in Third Party Litigation Financing Model Act

Sponsored by Rep. Matt Lehman (IN) and co-sponsored by Del. Steve Westfall (WV)

Draft as of November 12~~September 13July 1March 13~~, 2024. To be discussed and considered by the NCOIL Financial Services & Multi-Lines Issues Committee on November 23~~September 20July 18April 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. The Act also requires the disclosure of commercial litigation financing agreements and sets forth certain prohibitions regarding commercial litigation funding.

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 36%~~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 Department of Consumer Affairs ~~[official identified in Section 18]~~. Any contract which exceeds such rate shall be considered usurious as defined by [insert citation to state usury law].

Drafting Note: States may wish to replace Department of Consumer Affairs to a different state agency in this and other sections depending on their state regulatory structure.

3. "Commercial litigation financier" means a person that enters into, or offers to enter into, a commercial litigation financing agreement with a plaintiff or with lawyers or law firms asserting legal claims on behalf of the plaintiff in a civil proceeding. The term does not include a nonprofit organization exempt from federal income tax under section 501(c)(3) of the United States Internal Revenue Code.

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 seeking remediation of, or to recover the cost of remediating, a site that is or has been on the U.S. Environmental Protection Agency's Superfund National Priorities List.

8~~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].

9~~6~~. "Foreign entity of concern" means a~~n 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.

(e) “Foreign entity of concern” shall also include any individual that owns, has a controlling interest in, or is a director or senior officer of any entity that falls within subsections 9(a) through (d).

6~~7~~. "Consumer litigation funding" means a non-recourse transaction in which a consumer litigation funding company purchases, with funds paid directly to the consumer, 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.

7~~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.

5~~9~~. "Consumer" means a natural person ~~or estate for a decedent related to wrongful death claims who has a pending legal claim and~~ who resides or is domiciled in [State] or is a plaintiff in a civil action in [State]. The term includes estate for a decedent related to wrongful death claims.

10. "Funded amount" means the amount of monies provided to, or on behalf of, the consumer in the consumer litigation funding contract. "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~~healthcare 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~~healthcare 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~~healthcare 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.

5. A consumer litigation funding company may not provide funding to a consumer litigation funding transaction that is directly or indirectly financed by anyone included within Section 3.(8~~5~~) or (9~~6~~).

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.~~

~~(a)~~ In a civil proceeding in which a plaintiff enters into a consumer litigation financing agreement, and thus the contracted funds are not provided for the prosecution of the litigation, 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.

~~(b) In a civil proceeding in which a plaintiff enters into a consumer litigation financing agreement, and the contracted funds are provided for the prosecution of the litigation, 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, a copy of any such contract.~~

2. 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 Civil~~Trial~~ Procedure and Evidence, subject to this legislative

finding that said contents are relevant to the civil proceeding, by a party other than the plaintiff, or an insurer that has a duty to defend another party in the civil proceeding.

~~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.

Drafting Note: States may wish to replace "a reasonable time" with a numeric entry for specificity.

4. The written notice provided under subsection 1(a). is not admissible as evidence in a court proceeding.

5~~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 six month~~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 to a consumer litigation funding company.

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 c~~Communications between ~~the~~ a consumer's attorney ~~in the legal claim~~ and ~~the~~ a consumer ~~legal~~ litigation funding company to allow the consumer litigation funding company to ascertain that status of a legal claim or a legal claim's expected value ~~as it pertains to the consumer legal funding~~ shall not be discoverable by a person against whom the legal claim is asserted or filed~~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 or commercial litigation financier has first registered with the [State] pursuant to this Act, the company or financier may not engage in the business of consumer or commercial 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 consumer affairs~~state~~ to make an evaluation of the character and fitness of the applicant company or financier, including but not limited to any beneficial ownership exceeding 20%. 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 consumer affairs~~state~~, upon investigation, finds that the character and fitness of the applicant company or financier, 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 consumer affairs~~state~~, if the department of consumer affairs~~state~~ so requires, a bond satisfactory to the department of consumer affairs~~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 consumer affairs~~state~~ has notified the applicant in writing that the application has been denied, or

(b) the department of consumer affairs~~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 consumer affairs~~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 or commercial litigation financier that registered with the department of consumer affairs~~state~~ between the effective date of this article or when the department of consumer affairs~~state~~ has made applications available to the public, whichever is later, and one hundred eighty days thereafter may engage in consumer or commercial litigation funding while the ~~company's~~ registration is pending approval with the department of consumer affairs~~state~~. All funding and financing 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 or commercial litigation financier may use any form of consumer litigation funding or commercial litigation funding contract in this state unless it has been filed with the department of consumer affairs~~state~~ in accordance with the filing procedures set forth by the secretary of state. Such procedures shall designate a reasonable timeframe for the state to raise objections to any filed form.

9. The director of the department of consumer affairs~~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 and commercial litigation financier that engages in business in the state shall submit a report to the department of consumer affairs~~state~~ no later than the thirty-first of January of each year specifying:

(a) number of ~~consumer~~ litigation fundings by the company or financier;

(b) summation of funded amounts in dollar figure; and

(c) annual percentage charged to each consumer or commercial funding recipient where repayment was made.

2. The department of consumer affairs~~state~~ shall make such information available to the public, in a manner which maintains the confidentiality of the name of each company, financier, customer, 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~~ enter into a commercial litigation financing agreement ~~that is~~ directly or indirectly ~~financed by~~ with a foreign entity of concern, or a foreign country or person of concern.

Section 14. Commercial Litigation Disclosure Prohibitions

A party or an attorney or law firm for a party shall~~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. 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 financier, 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 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.~~

~~2. 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. ~~The~~ admissibility of commercial litigation financing agreements at trial shall be governed by the [State] Rules of Civil Procedure and Evidence. ~~Such agreements are relevant and shall be admissible at trial based solely on their disclosure pursuant to this Section.~~ Commercial litigation financing agreements shall be admissible at trial.

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.

Drafting Note: States may wish to replace "a reasonable time" with a numeric entry for specificity.

~~4. The written notice provided under subsection 1. is not admissible as evidence in a court proceeding.~~

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 department of consumer affairs 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.

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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)

Earned Wage Access Model Act

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

Draft as of October 23~~May 15~~, 2024. To be ~~introduced and~~ discussed and considered during ~~the interim~~ meeting of the Financial Services & Multi-Lines Issues Committee on November~~September~~ 23~~May 31~~, 2024.

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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 salary, 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 to or received from a consumer, over which the consumer has no option, 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 salary, 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:

(1) A~~a~~ny 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.

(2) A service provider, such as a payroll service provider, whose role may include

verifying available earnings, but who is not contractually obligated to pay earned but unpaid income as part of an earned income access transaction; or

(3) An obligor that offers a portion of salary, wages, or compensation directly to its
employees or independent contractors prior to the normally scheduled pay date.

(hk) “Fees" means any amount charged or received by a provider to a consumer for an earned income access transaction, including amounts ~~to be~~ paid voluntarily as described in paragraph (i9) of subdivision ~~two~~(b) of section 8 of this Act.

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

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

(kj) “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.

(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. <u>For purposes of this subsection, the location specified in an application may be "online."</u>

(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, is convicted under any ~~the a~~Act of Congress governing crimes involving moral turpitude ~~entitled "Truth in Lending Act"~~ and the regulations thereunder, as such A~~a~~ct 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, including electronic, 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 earned income access business, and any business with which the earned income access business is operationally or financially consolidated, 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 complies with all applicable local, state, and federal privacy and information security laws and regulations ~~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 all rules that ~~established by~~ [insert appropriate regulatory department] may promulgate; 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 mandatory 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 or receives a fee for the earned income access transaction that does not exceed the earned income access rate cap or charges or receives 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 provider offers the consumer at least one reasonable option to obtain proceeds at no-cost to the consumer and clearly explains how to elect such no-cost
option;

(8~~7~~) the provider initiates all payments of proceeds no later than the next business day following a consumer's request for funds ~~the consumer receives the proceeds no less than three business days after a consumer's request for no-fee procession, no less than one business day after a consumer's request for processing subject to a fee, and 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~~;

(9~~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 full potential cost of the transaction, including any expediting fees, any suggested tips, any other potential charges a

provider might impose directly on a customer and the cost expressed as an annual percentage rate;

(10~~9~~) if the provider offers consumers the opportunity to pay an additional amount for an earned income access transaction voluntarily, such as a tip or donation

(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 offers $0 among any amounts suggested ~~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;~~

(11~~0~~) the provider does not charge a late fee or prepayment penalty on the earned income access transaction;

(12~~1~~) 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;

(13~~2~~) the provider does not report on the earned income access transaction to a consumer reporting agency prior to, during, or after the transaction;

(14~~3~~) the provider does not require a consumer to waive the right to class action to engage in an earned income access transaction;

(15~~4~~) 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~~

(16) if the provider charges a subscription or membership fee it shall be optional and shall be for a bona fide group of services that include earned income access

transactions.

(17~~5~~) the consumer is eighteen years of age or older.

(c) Transactions made in accordance with this section shall not be subject to usury laws, or the licensing laws governing lending or money transmission laws of [State], to the laws of [State] governing deductions from wages or payroll or the purchase, sale or assignment of, or an order for, earned but unpaid income.

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

(e) Notwithstanding the provisions of this article or any other law to the contrary, a provider may avail itself of any lawful remedies available to such provider by contract or at law to seek and collect payment of outstanding proceeds, charges, fees, or any other amounts available by contract or law if a consumer provides materially false information in the course of procuring an earned income access transaction, or received such amounts or proceeds through fraud or other unlawful means. For the purposes of this article, "fraud" shall mean a knowing or reckless misrepresentation of the truth to a provider or a third party, or concealment of a material fact either by statement or conduct, by a consumer to induce such provider to enter into an earned income access transaction.

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] may~~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. The [insert appropriate regulatory department] shall approve the change of control, unless it makes a determination that doing so would be counter to the public interest.

(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, could shut down the effective operations of the company by their voting activities or authorities that lie within the company's established corporate governance structure or if any person, directly or indirectly, owns, controls or holds with power to vote twenty~~en~~

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 earned income access business, and any business with which the earned income access

business is operationally or financially consolidated, 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].

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CHIEF EXECUTIVE OFFICER: Thomas B. Considine

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NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

INSURANCE FRAUD MODEL ACT

Adopted by the NCOIL Executive Committee on July 28, 1995; amended on February 26, 1998; and readopted on November 16, 2001; November 19, 2004; and November 22, 2009. Re-adopted by the Financial Services & Multi-Lines Issues Committee on July 12th, 2019 and by the Executive Committee on July 13th, 2019 with amendments sponsored by Sen. Jason Rapert (AR)

To be discussed and considered for re-adoption during the Financial Services & Multi-Lines Issues Committee on November 23, 2024.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF _____

The legislature finds that insurance fraud is pervasive and expensive, costing consumers and the business community of this state millions of dollars each year. Each family incurs in excess of several hundreds of dollars annually in direct and indirect costs attributable to insurance fraud. Insurance fraud takes innocent lives through stated accidents, arsons and unnecessary medical procedures. Insurance fraud increases premiums, leaves consumers with fewer insurance options, and places businesses at risk. Some forms of insurance fraud can also lead to the financial collapse of smaller insurance companies, and negatively impacts all insurers regardless of size. Insurance fraud reduces consumers' ability to raise their standard of living and decreases the economic vitality of our state.

Therefore, the legislature believes that the state of _____ must aggressively confront the problem of insurance fraud by facilitating the detection, reducing the occurrence through stricter enforcement and deterrence, requiring restitution and increasing the partnership among consumers, the insurance industry and the state in coordinating efforts to combat insurance fraud by enacting the following Act.

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Section 1. Definitions

As used in this act, unless the context requires otherwise, the following terms have the meaning ascribed to them in this section.

Actual Malice. "Actual Malice" means knowledge that information is false, or "reckless" disregard of whether it is false.

Conceal. "Conceal" or "Concealment" means to take affirmative action to prevent others from discovering information. Mere inadvertent or unintentional failure to disclose information, by itself, does not constitute concealment. Action by the holder of a legal privilege, or one who has a reasonable belief such a privilege exists, to prevent discovery of privileged information does not constitute concealment.

Insurance Policy. "Insurance Policy" means the written instrument in which are set forth the terms of any certificate of insurance, binder of coverage or contract of insurance (including a certificate, binder or contract issued by a state-assigned risk plan); benefit plan; nonprofit hospital service plan; motor club service plan; or surety bond, cash bond or any other alternative to insurance authorized by this state's financial responsibility act. Insurance Policy also is any other instruments authorized or regulated by the department of insurance.

Insurance Professional. "Insurance Professional" means sales agents, managing general agents, brokers, producers, adjusters, investigators, examiners, consultants, and thirdparty administrators. An "Insurance Professional" may be a direct employee, independent contractor or in any other similar status of providing service to the insurance company.

Insurance Transaction. "Insurance Transaction" means a transaction by, between or among: (1) an Insurer or a Person who acts on behalf of an Insurer; and (2) an insured, claimant, applicant for insurance, public adjuster, Insurance Professional, Practitioner, or any Person who acts on behalf of any of the foregoing, for the purpose of obtaining

insurance or reinsurance, calculating insurance Premiums, submitting a claim, negotiating or adjusting a claim, or otherwise obtaining insurance, self-insurance, or reinsurance or obtaining the benefits thereof or therefrom.

Insurer. "Insurer" means any Person purporting to engage in the business of insurance or authorized to do business in the state or subject to regulation by the state, who undertakes to indemnify another against loss, damage or liability arising from a contingent or unknown event. "Insurer" includes, but is not limited to, an insurance company; self-insurer; reinsurer; reciprocal exchange; interinsurer; risk retention group; Lloyd's insurer; fraternal benefit society; surety; medical service, dental, optometric or any other similar health service plan; and any other legal entity engaged or purportedly engaged in the business of insurance, including any Person or entity which falls within the definition of "Insurer" found within the _____ Insurance Code §_____.

Pattern or practice. "Pattern or practice" means repeated, routine or generalized in nature, and not merely isolated or sporadic. Evidence of pattern or practice may include acts in this state or any other jurisdiction.

Person. "Person" means a natural person, company, corporation, unincorporated association, partnership, limited liability company, limited liability partnership, professional corporation, agency of government or any other entity.

Practitioner. "Practitioner" means a licensee of this state authorized to practice medicine, osteopathy, surgery, psychology, chiropractic, pharmacology, or other healing or treatment professions or arts as may be authorized or licensed by this state or the licensed practitioner of any non-medical treatment rendered in accordance with any other recognized method of healing; any other licensee of the state or Person required to be licensed in the state whose services are compensated either in whole or in part, directly or indirectly, by insurance proceeds, including but not limited to automotive repair shops, building contractors and insurance adjusters, or a licensee similarly licensed in other states or nations.

Premium. "Premium" means consideration paid or payable for coverage, or benefits, under an Insurance Policy. "Premium" includes any payments, whether due within the Insurance Policy term or otherwise, and deductible payments whether advanced by the Insurer or Insurance Professional and subject to reimbursement by the insured or otherwise, any self insured retention or payments, whether advanced by the Insurer or Insurance Professional and subject to reimbursement by the insured or otherwise, and any collateral or security to be provided to collateralize obligations to pay any of the above.

Premium Finance Company. "Premium Finance Company" means a Person engaged or purporting to engage in the business of advancing money, directly or indirectly, to an Insurer or producer at the request of an insured pursuant to the terms of a premium

finance agreement, including but not limited to loan contracts, notes, agreements or obligations, wherein the insured has assigned the unearned Premiums, accrued dividends, or loss payments as security for such advancement in payment of Premiums on Insurance Policies only, and does not include the financing of insurance Premiums purchased in connection with the financing of goods and services.

Premium Finance Transaction. "Premium Finance Transaction" means a transaction by, between or among an insured, a producer or other party claiming to act on behalf of an insured and/or a third-party Premium Finance Company, for the purposes of purportedly or actually advancing money directly or indirectly to an Insurer or producer at the request of an insured pursuant to the terms of a premium finance agreement, wherein the insured has assigned the unearned Premiums, accrued dividends or loan payments as security for such advancement in payment of Premiums on Insurance Policies only, and does not include the financing of insurance Premiums purchased in connection with the financing of goods and services.

Reckless. "Reckless" means without reasonable belief of the truth, or, for the purposes of Section 3(c), with a high degree of awareness of probable insolvency.

Withhold. "Withhold" means to fail to disclose facts or information which any law, or regulation, (other than this act) requires to be disclosed. Mere failure to disclose information does not constitute "withholding" if the one failing to disclose reasonably believes that there is no duty to disclose.

Section 2. Fraudulent Insurance Act

Any Person who, knowingly and with intent to defraud or for the purpose of falsely depriving another of property or for pecuniary gain, commits, or attempts to commits, participates in or aids, abets, or conspires to commit or solicits another Person to commit, or permits its employees or its agents to commit any of the following acts, has committed a Fraudulent Insurance Act:

(a) Presents, causes to be presented, or prepares with knowledge or belief that it will be presented, by or on behalf of an insured, claimant or applicant to an Insurer, Insurance Professional or Premium Finance Company in connection with an Insurance Transaction or Premium Finance Transaction, any information which contains false representations as to any material fact, or which Withholds or Conceals a material fact concerning any of the following:

(1) The application for, rating of, or renewal of, any Insurance Policy;

(2) Any claim, whether in whole or in part, for payment or benefit pursuant to any Insurance Policy;

(3) Payments made in accordance with the terms of any Insurance Policy;

(4) Any application used in any Premium Finance Transaction;

(b) Presents, causes to be presented, or prepares with knowledge or belief that it will be presented, to or by an Insurer, Insurance Professional or a Premium Finance Company in connection with an Insurance Transaction or Premium Finance Transaction, any information which contains false representations as to any material fact, or which Withholds or Conceals a material fact, concerning any of the following:

(1) Any solicitation for sale of any Insurance Policy or purported Insurance Policy;

(2) An application for certificate of authority;

(3) The financial condition of any Insurer;

(4) The acquisition, formation, merger, affiliation or dissolution of any Insurer;

(c) Solicits or accepts new or renewal insurance risks by or for an insolvent Insurer;

(d) Removes the assets or records of assets, transactions and affairs or such material part thereof, from the home office or other place of business of the Insurer, or from the place of safekeeping of the Insurer, or destroys or withholds the same from the Department of Insurance;

(e) Diverts, misappropriates, converts or embezzles funds of an Insurer, an insured, claimant or applicant for insurance in connection with:

(1) Any Insurance Transaction;

(2) Any claim for payment or benefit pursuant to any Insurance Policy.

(3) The conduct of business activities by an Insurer or Insurance Professional;

(4) The acquisition, formation, merger, affiliation or dissolution of any Insurer. It shall be unlawful for any Person to commit, or to attempt to commit, or to aid assist, abet or solicit another to commit, or to conspire to commit any Fraudulent Insurance Act.

Section 3. Unlawful Insurance Act

Any Person who commits, or participates in, or aids, abets, or conspires to commit, or solicits another Person to commit, or permits its employees, contractors or its agents to commit any of the following acts with an intent to induce reliance, has committed an Unlawful Insurance Act:

(a) Presents, causes to be presented, or prepares with knowledge or belief that it will be presented, by or on behalf of an insured, claimant or applicant to an Insurer, Insurance Professional or a Premium Finance Company in connection with an Insurance Transaction or Premium Finance Transaction, any information which the Person knows to contain false representations, or representations the falsity of which the Person has Recklessly disregarded, as to any material fact, or which Withholds or Conceals a material fact, concerning any of the following:

(1) Any application for securing, rating of, or renewal of, any Insurance Policy;

(2) Any claim, in whole or in part, for payment or benefit pursuant to any Insurance Policy;

(3) Payments made in accordance with the terms of any Insurance Policy;

(4) Any application for the financing of any insurance Premium;

(b) Presents, causes to be presented, or prepares with knowledge or belief that it will be presented, to or by an Insurer, Insurance Professional or a Premium Finance Company in connection with an Insurance Transaction or Premium Finance Transaction, any information which the Person knows to contain false representations, or representations the falsity of which the Person has Recklessly disregarded, as to any material fact, or which Withholds or Conceals a material fact, concerning any of the following:

(1) Any solicitation for sale of any Insurance Policy or purported Insurance Policy;

(2) Any application for certificate of authority;

(3) The financial condition of any Insurer;

(4) The acquisition, formation, merger, affiliation or dissolution of any Insurer;

(c) Solicits or accepts new or renewal insurance risks by or for an Insurer which the Person knows was insolvent or the insolvency of which the Person Recklessly disregards. It shall be unlawful for any Person to commit, or to attempt to commit, or to aid assist, abet or solicit another to commit, or to conspire to commit an Unlawful Insurance Act.

Section 4. Criminal Penalties

Any Person who violates Section 2 of this Act is guilty of:

(a) A Class A misdemeanor if the greater of (i) the value of property, services or other benefit he wrongfully obtained, or attempted to obtain, or (ii) the segregate or aggregate economic loss suffered by any Person or Persons as a result of his violation of Section 2, is less than _____;

(b) A Class B misdemeanor if:

> (1) the greater of (i) the value of property, services or other benefit he wrongfully obtained, or attempted to obtain, or (ii) the segregate or aggregate economic loss suffered by any Person or Persons as a result of his violation of Section 2, is _____ or more but less than _____; or
> (2) the greater of (i) the value of property, services or other benefit he wrongfully obtained, or attempted to obtain, or (ii) the segregate or aggregate economic loss suffered by any Person or Persons as a result of his violation of Section 2, is less than _____, and the defendant has been previously convicted of any class or degree of insurance fraud in any jurisdiction;

(c) A Class C misdemeanor if the greater of (i) the value of property, services or other benefit he wrongfully obtained, or attempted to obtain, or (ii) the segregate or aggregate economic loss suffered by any Person or Persons as a result of his violation of Section 2, is _____ or more but less than _____;

(d) A felony in the third degree if:

> (1) the greater of (i) the value of property, services or other benefit he wrongfully obtained, or attempted to obtain, or (ii) the segregate or aggregate economic loss suffered by any Person or Persons as a result of his violation of Section 2, is _____ or more but less than _____; or
>
> (2) the greater of (i) the value of property, services or other benefit he wrongfully obtained, or attempted to obtain, or (ii) the segregate or aggregate economic loss suffered by any Person or Persons as a result of his violation of Section 2, is less than _____, and the defendant has been previously convicted two or more times of any class or degree of insurance fraud in any jurisdiction;

(e) A felony in the second degree if the greater of (i) the value of property, services or other benefit he wrongfully obtained, or attempted to obtain, or (ii) the segregate or aggregate economic loss suffered by any Person or Persons as a result of his violation of Section 2, is _____ or more but less than _____

(f) A felony in the first degree if:

(1) the greater of (i) the value of property, services or other benefit he wrongfully obtained, or attempted to obtain, or (ii) the segregate or aggregate economic loss suffered by any Person or Persons as a result of his violation of Section 2, is _____ or more but less than _____; or

(2) the greater of (i) the value of property, services or other benefit he wrongfully obtained, or attempted to obtain, or (ii) the segregate or aggregate economic loss suffered by any Person or Persons as a result of his violation of Section 2, is less than _____ and the defendant has been previously convicted two or more times of any degree of felony insurance fraud in any jurisdiction; or

(3) the greater of (i) the value of property, services or other benefit he wrongfully obtained, or attempted to obtain, or (ii) the segregate or aggregate economic loss suffered by any Person or Persons as a result of his violation of Section 2, is less than _____ and his violation of Section 2 of this Act placed any Person at risk of, or caused, death or serious bodily injury.

Drafting Note*: It is the intent of the coalition that the criminal penalties for fraudulent insurance acts should track the existing criminal penalties for similar crimes or fraudulent acts.*

Section 5. Restitution

Any person convicted of a violation of Section 2 of this Act shall be ordered to make monetary restitution for any financial loss or damages sustained by any Person as a result of any violation. Financial loss or damage shall include, but is not necessarily limited to, loss of earnings, out-of-pocket and other expenses, paid deductible amounts under an Insurance Policy, Insurer claim payments, all costs reasonably attributable to investigations, legal actions, and recovery efforts, including reasonable attorneys fees, by owners, Insurers, Insurance Professionals, law enforcement and other public authorities, and all costs of prosecution.

When restitution is ordered, the court shall determine its extent and methods. Restitution may be imposed in addition to a fine and, if ordered, any other penalty, but not in lieu thereof. The court shall determine whether restitution, if ordered, shall be paid in a single payment or installments and shall fix a period of time, not in excess of _____, within which payment of restitution is to be made in full.

To the extent permissible, it is the intention such Restitution shall not be dischargeable in any bankruptcy or similar proceeding.

Section 6. Administrative Penalties

(a) (1) Any Practitioner determined by the Court to have violated Section 2 shall be deemed to have committed an act involving moral turpitude that is inimical to the public well being. The court or prosecutor shall notify the appropriate licensing authority in this state of the judgment for appropriate disciplinary action, including revocation of any such professional license(s), and may notify appropriate licensing authorities in any other jurisdictions where the Practitioner is licensed. Any victim may notify the appropriate licensing authorities in this State and any other jurisdiction where the Practitioner is licensed, of the conviction.

(2) Upon notification of a conviction of any crimes enumerated in Section 2 of this Act or a substantially similar crime under the laws of another state or the United States, this State's appropriate licensing authority shall hold an administrative hearing, or take other appropriate administrative action authorized by state law, to consider the imposition of the administrative sanctions, up to and including license revocation, as provided by law against the Practitioner. Where the Practitioner has been convicted of a felony violation of Section 2 of this Act or a substantially similar crime under the laws of another state or of the United States, this state's appropriate licensing authority shall hold an administrative hearing, or take other appropriate administrative action authorized by state law, and shall summarily and permanently revoke the license. It is hereby recommended by the legislature that the [highest court in the state, bar association or other disciplinary agency or responsible organization] shall summarily and permanently disbar any attorney found guilty of such felony.

(3) All such referrals to the appropriate licensing or other agencies, and all dispositive actions thereof, shall be a matter of public record.

(b) (1) A Person convicted of a felony involving dishonesty or breach of trust shall not participate in the business of insurance and may not be eligible for any state licensure relative in any capacity to the business of insurance.

(2) A Person in the business of insurance shall not knowingly or intentionally permit a Person convicted of a felony involving dishonesty or breach of trust to participate in the business of insurance.

Section 7. Civil Remedies

(a) Any Person injured in his or her person, business or property by reason of a violation of Section 3 may recover therefor from the Person[s] violating Section 3, in any appropriate court of this state the following:

(1) Return of any profit, benefit, compensation or payment received by the Person violating Section 3 directly resulting from said violation;

(2) Reasonable attorneys fees, related legal expenses, including internal legal expenses and court costs;

An action maintained under this subparagraph may neither be certified as a class action nor be made part of a class action.

(b) Any Person injured in his or her person, business or property by reason of a violation of Section 2 may recover therefor from the Person[s] violating Section 2, in any appropriate court of this state the following:

(1) Return of any profit, benefit, compensation or payment received by the Person violating Section 2 directly resulting from said violation;

(2) Reasonable attorneys fees, related legal expenses, including internal legal expenses and court costs;

(3) All other economic damages directly resulting from the violation of Section 2;

(4) Reasonable investigative fees based on a reasonable estimate of the time and expense incurred in the investigation of the violation(s) of Section 2 proved at trial:

(5) A penalty of no less than $_____ and no greater than $_____.

An action maintained under this subparagraph may neither be certified as a class action nor be made part of a class action.

(c) Any Person injured in his or her person, business or property by a Person violating Section 2, upon a showing of clear and convincing evidence that such violation was part of a Pattern or Practice of such violations, shall be entitled to recover threefold the injured Person's economic damages together with all reasonable attorneys fees and costs. An action for treble damages must be brought within _____ year(s) of such violation. One third of the treble damages awarded shall be payable to the state to be used solely for the purpose of investigation and prosecution of violations of this Act or other fraudulent behavior relating to Insurance Transactions, and/or for public education relating to insurance fraud. An action maintained under this subparagraph may neither be certified

as class action nor be made part of a class action, unless the violations of Section 2 giving rise to the action resulted in criminal conviction of the violator[s] under Section 4.

(d) The State Attorney General, District Attorney or other authorized prosecutorial agency shall have authority to maintain Civil proceedings on behalf of the State Insurance Department and any victims of violations of Section 2. In any such action, the court shall proceed as soon as practicable to the hearing and determination thereof. Pending final determination thereof, the court may at any time enter such restraining orders or prohibitions, or take such other actions, including the acceptance of satisfactory performance bonds, as it shall deem proper.

(1) The Courts of the state shall have jurisdiction to prevent and restrain violations of Section 2 of this Chapter by issuing appropriate orders.

(2) In any action commenced under this subparagraph (d), the Court, upon finding that any Person has violated Section 2, shall levy a fine of up to $25,000 for each violation. Any court in which a prosecution for violation of Section 2 is pending shall have authority to stay or limit proceedings in any civil action regarding the same or related conduct.

Any court in which is pending a civil action brought pursuant to subparagraph (d) of this Section 7 may stay or limit proceedings in actions brought pursuant to subparagraphs (a)-(c) regarding the same or related conduct or may transfer such actions or consolidate them before itself or allow the plaintiffs in such actions to participate in the action brought pursuant to subparagraph (d), as it shall prescribe.
Any cause of action under this section for violation of Section 2 or Section 3 must be brought within three (3) years of the commission of the acts constituting such violation, or within three (3) years of the time the plaintiff discovered (or with reasonable diligence could have discovered) such acts, whichever is later.

An insurer shall not pay damages awarded under this Section 7, or provide a defense or money for a defense, on behalf of an insured under a contract of insurance or indemnification. A third party who asserts a claim against an insured shall have no cause of action under this Section against the Insurer of the insured arising out of the Insurer's processing or settlement of the third party's claim. An oblige under a surety bond shall not have a cause of action under this section against the surety arising out of the surety's processing or settlement of the obligee's claim against the bond.

Any Person injured in his business or property by reason of a violation of Section 2 or Section 3 of this Chapter may recover under only one of the subparagraphs in this Section.

Section 8. Exclusivity of Remedies

The remedies expressly provided in Section 7 shall be the only private remedies for violations of this Act and no additional remedies shall be implied. The remedies available under Section 7 shall not be used in conjunction with or in addition to any other remedies available at law or in equity to duplicate recovery for the same element of economic damage. Further, in any civil action pleading both exemplary damages and the treble damages available in Section 7(c), plaintiff shall elect one or the other remedy, but not both, at the conclusion of the evidentiary phase of the trial.

However, nothing in this Act shall limit or abrogate any right of action which may exist in the absence of this Act, but no action based on such a right shall rely on this Act to establish a standard of conduct or for any other purpose.

Section 9. Cooperation

(a) Any Insurer or Insurance Professional that has reasonable belief that an act violating Sections 2 or 3 will be, is being, or has been committed shall furnish and disclose upon request any information in its possession concerning such act to the appropriate law enforcement official or authority, insurance department, state division of insurance fraud, or state or federal regulatory or licensing authority, subject to any legal privilege protecting such information.

(b) Any Person that has a reasonable belief that an act violating Sections 2 or 3 will be, is being, or has been committed, may furnish and disclose any information in its possession concerning such act to representative of an Insurer that requests the information for the purpose of detecting, investigating, prosecuting or preventing insurance fraud subject to any legal privilege protecting such information.
(c) When any law enforcement official, authority, state or federal regulatory or licensing authority requests information related to an investigation or prosecution of allegations of potential insurance fraud, an Insurer or Insurance Professional shall take all reasonable actions to provide any such information in its possession, subject to any legal privilege protecting such information.

(d) Any Insurer or Insurance Professional failing or refusing to cooperate with a request for information from an appropriate local, state or federal governmental authority may, subject to the court's discretion, forfeit any eligibility for restitution from any proceeds resulting from such governmental investigation and prosecution.

Section 10. Immunity

(a) In the absence of Actual Malice, no Person shall be subject to civil liability and no civil cause of action shall arise for any of the following:

(1) The disclosure of information related to Persons or conduct suspected of violating Sections 2 or 3 of this Act to federal, state or local agencies, officials, their agents, employees and/or designees.

(2) The receipt or possession of information related to Persons or conduct suspected of violating Sections 2 or 3 of this Act when the information was received pursuant to and for the purpose of complying with the provisions of this Act.

(3) The disclosure of information to any organization, whether governmental or private, established to detect and prevent fraudulent insurance acts, their agents, employees or designees; and/or a recognized comprehensive database system approved by the Insurance Department.

(4) The receipt or possession of information received from any organization established to detect and prevent fraudulent insurance acts, their agents, employees or designees; and/or a recognized comprehensive database system approved by the Insurance Department.

(b) The immunity granted in subsection (a) shall also apply to employees, contractors and agents of Insurers or insurance licensees whose responsibilities include the investigation and/or disposition of claims involving suspected violations of Sections 2 or 3 of this Act when sharing information on such acts or persons suspected of engaging in such acts with other entities or organizations employees of the same or other Insurers or insurance licensees, or other appropriate individuals or organizations, whose responsibilities include the investigation and/or disposition of claims involving suspected violations of Sections 2 or 3 of this Act.

(c) State agencies and their employees and/or designees shall not be subject to civil liability for disclosing information identified in subsection (b). No civil cause of action shall arise against any of them by virtue of the publication of a report or bulletin related to the official activities of the State agency.

(d) Any Person against whom any civil action is brought who is found to be immune from liability under this section shall be entitled to recover reasonable attorney's fees and costs from the party who brought the action.

(e) Nothing in this is intended to abrogate or modify a common law or statutory immunity heretofore enjoyed by any Person.

Section 11. Regulatory Requirements

(a) Anti-Fraud Plans - Within six months of the effective date of this legislation, every Insurer with total annual direct written premiums in excess of five-hundred thousand dollars ($500,000) shall prepare, implement, maintain and submit to the department of insurance an insurance anti-fraud plan.

Each Insurer's anti-fraud plan shall outline specific procedures, appropriate to the type of insurance the Insurer writes in this state, to:

(1) prevent, detect and investigate all forms of insurance fraud for which the carrier is authorized to issue policies or bonds, including fraud involving the Insurer's employees or agents; fraud resulting from misrepresentations in the application, renewal or rating of insurance policies; claims fraud; and security of the Insurer's data processing systems.

(2) educate appropriate employees on fraud detection and the Insurer's anti-fraud plan.

(3) inform policyholders about insurance fraud and how to protect against and prevent fraud.

(4) provide for the hiring of or contracting for fraud investigators.

(5) report insurance fraud to appropriate law enforcement and regulatory authorities in the investigation and prosecution of insurance fraud.

(6) pursue restitution for financial loss caused by insurance fraud, where appropriate.

(7) designate the person responsible for oversight and implementation of the insurer's anti-fraud plan, and provide full contact information.

The Commissioner may review, and in their discretion accept or reject, each Insurer's anti-fraud plan to determine if it complies with the requirements of this subparagraph.

It shall be the responsibility of the Commissioner to assure Insurer compliance with antifraud plans submitted to the Commissioner.

The Commissioner may require reasonable modification of the Insurer's anti-fraud plan, or may require other reasonable remedial action if the review or examination reveals substantial non-compliance with the terms of the Insurer's own anti-fraud plan. The Commissioner may require each Insurer to file a summary of the Insurer's anti-fraud activities and results. The anti-fraud plans and the summary of the Insurer's anti-fraud activities and results are not public records and are exempt from any privacy or public

records act, and shall be proprietary and not subject to public examination, and shall not be discoverable or admissible in any civil action, whether arising under this Act or any other proceeding involving civil litigation.

This section confers no private rights of action.

(b) Fraud Warnings

(1) (A) No later than six months after the effective date of this Act, all applications for insurance, and all claim forms regardless of the form of transmission provided and required by an Insurer or required by law as a condition of payment of a claim, shall contain a statement, permanently affixed to the application or claim form, that clearly states in substance the following:

"It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits."

(B) The lack of a statement required in this subparagraph does not constitute a defense in any criminal prosecution under Section 2 nor in any civil action under Sections 2 or 3.

(2) The warning required by this subsection shall not be required on forms relating to reinsurance.

(c) Enforcement - Notwithstanding any other provision of the Insurance Code, the following are the exclusive monetary penalties for violation of this Section. Insurers that fail to prepare, implement, maintain and submit to the department of insurance an insurance anti-fraud plan are subject to a penalty of $500 per day, not to exceed $25,000 together with license suspension or revocation.

Proposed by the Coalition Against Insurance Fraud, 1012 14th Street NW, Suite 200, Washington, D.C. 20005, 202-393-7330. The Coalition is an independent, nonprofit organization of consumers, government agencies and insurers dedicated to combating all forms of insurance fraud through public information and advocacy.

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BUDGET COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
BUDGET COMMITTEE
2024 NCOIL SUMMER MEETING – COSTA MESA, CA
JULY 17, 2024
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Budget Committee met at the Westin South Coast Plaza in Costa Mesa, CA on Wednesday July 17, 2024 at 4:00 PM.

NCOIL Treasurer, Senator Paul Utke (MN), presided.

Other members of the Committee present were:

Rep. Deborah Ferguson, DDS (AR)
Rep. Rachel Roberts (KY)
Rep. Brenda Carter (MI)
Sen. Jerry Klein (ND)
Asw. Pam Hunter (NY)
Rep. Ellyn Hefner (OK)

Other legislators present were:

Rep. Matt Lehman (IN)
Sen. Bob Hackett (OH)
Rep. Tom Oliverson, M.D. (TX)

Also in attendance were:

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

MINUTES

Upon a Motion made by Rep. Brenda Carter (MI), and seconded by Sen. Jerry Klein (ND), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's November 17, 2023 meeting in Columbus, OH.

2025 BUDGET PLANNING DISCUSSION

Sen. Paul Utke (MN), NCOIL Treasurer and Chair of the Committee, stated that the Committee is here today to discuss and plan for NCOIL's 2025 budget. Before going through the proposed budget, Sen. Utke noted some procedural matters: today's meeting is only for the Committee to discuss the document distributed and determine if any changes should be made – no votes will be taken. The Committee will then meet at the NCOIL Annual Meeting in San Antonio in November to formally adopt the 2025 budget and send it to the Executive Committee for final consideration at the conclusion of the Annual Meeting.

Sen. Utke noted that in addition to a copy of the proposed budget, a document showing the organization's 2024 financials as of June 30, and a document showing the organization's year- end financials for 2023 and 2022 have been distributed. Sen. Utke stated that NCOIL is in the midst of having another strong year and the numbers in the proposed 2025 budget represent an expectation that things will remain positive for the organization. Sen. Utke then turned things over to Cmsr. Tom Considine, NCOIL CEO, to go through the proposed budget and entertain any questions.

Cmsr. Considine stated that starting with dues - 29 states paid in 2022 and 32 states paid dues in 2023. Based on current commitments we have received this year, 34 states are projected to pay dues in 2025. The reason why the total amount anticipated does not read $680,000 ($20,000 times 34) is because some states split dues payments between Chambers and there are a few states that, for the past several years, have only had one Chamber pay. As of today, 11 states have paid their 2024 dues, and most states operate on a July 1 fiscal year, so the majority of dues payments typically arrive after this meeting.

Cmsr. Considine then moved to Corporate & Institutional Partners (CIP) revenue: the proposed amount is $500,000. That is an increase in last year's budgeted amount which we think is justified given the reality of a thriving CIP program. As of June 30, we have received approximately $380,000 in CIP dues, but that doesn't include some dues that were reclassified as Spring Meeting revenue. As a reminder, that is a practice that we started a couple of years ago – reclassifying revenue allotted for conference registration discounts to realize it where it occurred. Also, in an effort to build up the Insurance Legislators Foundation (ILF) scholarship fund, we have asked certain CIP members to make their CIP dues payment to the ILF scholarship fund with those members still retaining all CIP benefits. So, the $380,000 number before you doesn't include that either. As long as nothing changes in terms of the way the CIP program has been operating and does not become the primary source of revenue for NCOIL, then I think we're in a great place to see the CIP program continue to grow, subject to periodic closures like the one we had in 2022 to achieve the necessary financial balance.

Cmsr. Considine then moved to meeting support & revenue. The 2025 numbers are similar to those from 2024 but with some adjustments based on things such as the location of the conferences and anticipated conference sponsorship levels.

Moving to interim calls, the number of $5,000 mirrors what we budgeted for last year and is almost exactly what we are tracking to receive for 2024. We will be having a couple of interim calls following the Summer Meeting which should get us to the $5,000 mark for this year.

Rep. Carter asked why there is a budgeted decrease in Spring Meeting revenue in 2025 from 2024. Cmsr. Considine stated that when we budgeted for 2024, we knew Nashville would be a popular meeting location and therefore we budgeted for an anticipated boost in attendance and thus revenue.

Cmsr. Considine stated that overall, the total support & revenue number comes in at $1,830,000 which reflects consistency as well as continued growth.

Moving to the expense side – CIP expenses are expected to be similar to this year. As a reminder, we have seen an increase in CIP expenses over the past few years since we began holding the CIP Planning Meeting in locations outside the typical NCOIL conference cycle locations. We just held the Planning Meeting in Jekyll Island, GA last month and are already contracted to hold next year's in Newport, RI and expect a similar cost.

Moving to the stipend program – as note 2 in the proposed budget states, the budgeted amount for the legislator stipend program assumes a complete consumption of $9,000 for all fully contributing states. We have noted a steady upward trend in stipend usage year to year.

Moving to the retainer and incentive payment. For the retainer, as note 3 in your document shows, the number continues to reflect 100% of the retainer being paid from NCOIL, not the ILF. Additionally, it contains the annual contractual increase of 3%. For the incentive payment, that number is based on a contractual formula involving a change in NCOIL net assets over a contractual base amount. As the overall NCOIL performance results increase, so does the incentive payment to staff.

Moving to conference expenses, the numbers are similar to years past and generally correspond with which locations we expect to have more attendance which means more expenses.

Moving to future location deposits – that number is based on how future contracts read, and they all largely mirror past contracts.

Moving to travel, we retitled that line "Travel/Legislator Recruitment" to also account for expenses incurred during travel that are for the purpose of legislator recruitment such as our annual legislator recruitment dinner at the National Association of Insurance Commissioners (NAIC) Fall Meeting as well as trips taken to state legislatures and state departments of insurance.

Moving to Professional Fees. As a reminder, prior budgets had two lines, one labeled "Audit Fees" and the other labeled "Accounting Fees." In 2022, it was agreed that the lines should be merged and titled as "Professional Fees." The amount of $37,000 reflects: NCOIL bearing a greater portion of the audit expenses and the ILF a lesser share; standard accounting fees; and a researcher position focusing on Model Law passage.

Moving to Miscellaneous – that number remains the same. Lastly, the D&O insurance amount remains the same, with NCOIL Support Services, LLC paying half of the total.

Overall, the proposed budget has support and revenue at $1,830,000 and expenses at $1,721,679.08 for an excess of $108,320.92 which reflects consistency and continued

growth as well as the pattern of budgeting conservatively as agreed upon my arrival here as CEO in 2016. Cmsr. Considine then asked if there were any questions before turning it back to the Chair.

Sen. Utke reminded the Committee that there would be no vote on this budget today, but this meeting serves to discuss any changes that should be made prior to the Annual Meeting in November where the Committee will vote to adopt the final version of the budget.

Rep. Carter stated that she has a lot of experience with organizational budgeting and she thinks this is a very good budget.

Cmsr. Considine stated that given NCOIL's growing financial strength, it may be time to think of novel ideas for growing legislator attendance and the overall advancement of the organization, for example, removing the National Meeting registration fee for legislators.

Rep. Tom Oliverson, M.D. (TX), NCOIL President, asked what the true fiscal impact would be of removing the legislator registration fee and stated he would be open to discussing it, but it would be important to know what the financial outlay of having a legislator attend a Meeting is. Cmsr. Considine responded saying that that the true fiscal impact of removing the legislator registration fee is about $50,000 per year once you take into account early bird versus normal registration and the outlay per legislator is about $300.

Rep. Rachel Roberts (KY) stated that if you remove the legislator registration fee completely, it could encourage a large number of legislators from the Meeting's host state to register and attend but not fully participate which could increase conference expenses. Accordingly, having a fee, even a reduced fee such as $100 may help prevent that.

Cmsr. Considine mentioned that as legislator participation increases, industry attendance increases as well which accordingly increases revenue.

Rep. Deborah Ferguson, DDS (AR), NCOIL Immediate Past President, stated that it's important to look at whether it's the registration fee that's a big barrier to attending or if it's other costs associated with attending Meetings such as airfare and hotel stays. She asked how many stipends were offered per state per year and if it was a cumulative number of stipends or a certain allotment per Meeting.

Cmsr. Considine responded that there are two stipends offered to fully Contributing States for each Meeting and they are not cumulative. It could be worth discussing making them cumulative, but there would be a concern that six legislators from one state attend the Spring Meeting and utilize all the stipends and then there would be a drop off in participation from that state throughout the rest of the year since all stipends were utilized during the Spring Meeting.

Rep. Matt Lehman (IN) stated that he is open to having discussions to lower the registration fee, but would like some more information before making any decisions. He acknowledged that the travel costs associated with attending National Meetings has increased over recent years and having the stipend program has been a great way to help legislators cover travel expenses. It is important to see if the original goal of the program which was increasing the number of states involved at NCOIL Meetings has been met and he would like to see the data over the past four or five years to see how many new states are coming and how many stipends are utilized per state.

Sen. Bob Hackett (OH) stated he believes the stipend program has been effective and Ohio stipends have been fully utilized over the past few years.

Rep. Ellyn Hefner (OK) stated that if the goal is to increase legislator participation, then lowering the registration fee makes sense. A lower registration fee would make it more affordable for new legislators and would also help attract legislators from states that do not currently have strong participation in NCOIL. It would be beneficial to see how states have utilized their stipends as well as the states that are NCOIL Contributing States but do not send many legislators.

Sen. Utke stated these will be good points for discussion at the upcoming Annual Meeting in November and he appreciates everyone sharing the goal of increasing legislator participation.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Roberts and seconded by Sen. Hackett, the Committee adjourned at 4:30 PM

JOINT STATE-FEDERAL RELATIONS & INTERNATIONAL INSURANCE ISSUES COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
JOINT STATE-FEDERAL RELATIONS & INTERNATIONAL INSURANCE ISSUES COMMITTEE
2024 NCOIL SUMMER MEETING – COSTA MESA, CALIFORNIA
JULY 18, 2024
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Joint State-Federal Relations & International Insurance Issues Committee met at The Westin South Coast Plaza Hotel in Costa Mesa, California on Thursday, July 18, 2024 at 10:00 a.m.

Representative Rachel Roberts (KY), Chair of the Committee, presided.

Other members of the Committee present were:

AR Rep. Deborah Ferguson, DDS
IN Rep. Matt Lehman
KY Rep. Michael "Sarge" Pollock
LA Rep. Kyle Green
LA Sen. Kirk Talbot
MO Rep. Bob Titus
MN Sen. Paul Utke
MI Rep. Brenda Carter
MI Sen. Lana Theis
MT Rep. Nelly Nicol
ND Sen. Jerry Klein
NY Asm. Jarett Gandolfo
OH Sen. Bob Hackett
OK Rep. Ellyn Hefner
RI Sen. Roger Picard

Other legislators present were:

CO Sen. Dafna Michaelson Jenet
FL Rep. David Silvers
GA Rep. Joseph Gullett
GA Rep. Martin Momtahan
LA Sen. J Adam Bass
GA Sen. Larry Walker
ID Rep. Rod Furniss
KY Rep. Cherlynn Stevenson
KY Rep. Michael Meredith
LA Rep. Gabe Firment
LA Rep. Jason Hughes
LA Rep. Edmond Jordon
LA Rep. Chance Henry
LA Sen. Bill Wheat
LA Rep. Brian Glorioso
LA Rep. Shaun Mena
LA Rep. Dennis Bamburg
LA Sen. Royce Duplessis
LA Sen. Franklin Foil
MD Sen. Arthur Ellis
MN Sen. Jeff Howe
MS Sen. Brian Rhodes
MS Sen. Joseph Thomas
MS Sen. Walter Michel
NY Asm. Alex Bores
NY Asw. Catalina Cruz
NY Asw. Pam Hunter
OK Rep. Mark Tedford
OK Rep. Forrest Bennett
RI Sen. Hanna Gallo
WI Sen. Mary Felzkowski

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 Rep. Ellyn Hefner (OK) the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Bob Titus (MO) and seconded by Rep. Brenda Carter (MI), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's April 12, 2024 meeting.

UPDATE ON NCOIL MENTAL HEALTH PARITY MODEL ACT

Rep. Roberts stated this is a Model that I am very passionate about and the overall issue of mental health is something that I have been a champion for during my whole time in office. I appreciate everyone that has participated in the robust discussions around this issue. As many of you know, there are currently some very comprehensive and significant federal mental health care regulations that are in the process of being finalized. In fact, earlier this month, the rules were submitted to the Office of Management and Budget and the White House for final review. It's not certain as to when the rules will be released. We keep hearing that they are imminent. But based on what we've seen from the introduction of the rules until now, they will significantly affect mental health parity. Accordingly, I think it's best for us to put the Model on hold until we see the final rules and determine how they will impact the Model. Assuming the rules will be released in advance of our November meeting, I'll plan to have an updated version of the Model ready for discussion at that time. I will note that there is one change to the Model since the last time we discussed it and that is to the last section on page 47 governing coverage of mental health wellness examinations. After several conversations with stakeholders, I have removed the 45-minute timing requirement just to make that section more workable and easier to implement if states should enact it.

Sen. Dafna Michaelson Jenet (CO) stated I want to thank you so much for your continued efforts on this. I'm really excited to see how it's coming along and very excited to hear what the federal government comes up with. Thank you for your continued efforts. I look forward to watching it continue to succeed.

DISCUSSION ON RESOLUTION IN SUPPORT OF ESTABLISHING CATASTROPHE SAVINGS ACCOUNTS

Sen. Walter Michel (MS) stated I'm proud to sponsor this Resolution as I think the concept of catastrophe savings accounts is one that can really help people with planning

and recovering from a natural disaster. My home state of Mississippi is one of several states that has enacted legislation setting up a statutory framework for this product and it's been very beneficial for our consumers. As set forth in the Resolution, a catastrophe savings account operates very similarly to a health savings account in that it's a tax advantaged regular savings account or money market account used to assist with post catastrophe losses, or to self-insure all or a portion of one's home.

Kirsten Trusko, Co-founder of Payments as a Lifeline thanked the Committee for the opportunity to speak as well as Kevin McKechnie and the American Bankers Association team for the invitation to join you all today. He asked me to share about what we're calling disaster savings accounts and the fintech, financial technology, that makes this type of account much easier to have, use, and manage for people than ever before for every American who may want one. This is a speed tour through a topic, but I am happy to go into greater detail later on the technology and the deployment in the field. Mr. McKechnie asked I introduce myself and Payments as a Lifeline. If you want to look it up it's PAALPAY.org. It shows a background in fintech and insurance and payments and passion for serving the underbanked. In the U.S. we have 50 to 80 million people without access to traditional bank accounts. It's a challenge and it's especially a challenge in disaster response. What is PAAL and who belongs to it? PAAL is a 501(c)(3) non-profit. It's a coalition of financial and insurance technology firms, or fintech. PAAL was conceived in Hurricane Katrina and born in COVID. In Katrina I was at KPMG leading the only practice of the big four consultants that focused on serving the underbanked. Red Cross called, KPMG did a pro bono project just under $1 million dollars to help convert Red Cross over to these prepaid cards to be able to get money more quickly to people. But flash forward, of the 1.8 million charities in the U.S., only Red Cross uses this and they use a really old form of the technology. By COVID, little had changed in the U.S. in disaster funds delivery. So, we stood up PAAL as a non-profit coalition to proactively reach across public and private sectors with a goal to educate and enable disaster and aide funds to be delivered fast, safe, with automatic accounting and fraud control. The American Bankers Association (ABA) Office of Insurance Advocacy is part of this leadership team of PAAL. PAAL also has a broad advisory counsel comprised of innovative leaders in this space to advise, inform and introduce PAAL to their networks. These advisors span across government, the largest non-government organizations, corporate foundations. And even some of the smallest, most agile non-profits.

What problem is PAAL trying to solve? PAAL's mission is to fill a huge gap in disaster resilience delivering money to the right person at the right time, for the right purpose. PAAL delivers funds, money, from non-profits or from government into the hands of survivors quickly while minimizing fraud. We explain to the funders that money is delivered fast, safe, and with dignity. How can PAAL do all of that? It's using fintech and payment technology that can credential the survivors, track the payments anonymously, anonymized aggregated data, and block unauthorized use. PAAL partners with Visa and other top fintech's in doing this. Has PAAL been deployed to disasters? Yes. PAAL has

been on the ground since 2021. Across the U.S. and into Europe. We've spanned from delivering initial funds in minutes for people to get safe. All the way to the long haul 5-to-6-year plans for recovery and rebuild. We've helped in hurricanes, tornadoes, building collapses, fire, COVID, and medical disasters including Maui. Now, we're part of a proof of concept in a low-income county in North Carolina to build disaster financial resilience in advance. We're partnered with the county, with the government, with non-profits and with FEMA. And a key goal here is to build a template. So, this can be repeated again and again across counties and cities and states to build in advance disaster financial resilience. PAAL and its members are part of the FEMA and SBA disaster financial resilience collaborative. As is the ABA.

Let's talk a bit about preparing versus responding to disasters. Let's build the arc before the flood comes. The PAAL technology can do three things to build resilience before disaster. Help recipients to harden their homes to lessen the disaster impact and reduce insurance claim costs. It helps people to escape to safety faster. And number three it speeds survivors on their journey back to a normal life. Knowing PAAL is there and ready to deploy is one element of resilient strategy. A larger effort, the one that takes time to become effective would be to have every American who wants one to open and fund a disaster savings account. This enables Americans to save now for future disruptions instead of waiting for financial disaster and rescue later. Here's a bit about the disaster savings account. After government, the financial systems that know your customer regulatory process is the most powerful credentialing system that we know of. In the successful health savings account (HSA) model, accounts are opened in banks using social security numbers, address and the full universe of government issued IDs to establish that the beneficial owner of the account is who they or their employer say they are. Today tens of millions of Americans, more than a third of all employees have HSA funds in almost 40 million health savings accounts. Which, by definition, is money sitting there waiting to be used for expenses associated with medical care. Contrast this to every other health benefit or insurance scenario where people start the calendar year with zero dollars. But HSA owners have this money in savings set aside in advance.

This is the world we should all want for the property & casualty market. Via disaster savings accounts, Americans would be able to save for future disaster expenses on the same tax advantage basis that HSA owners now have for health care expenses. So, disaster savings accounts as resiliency, a conclusion. Just like preventive care is a qualified HSA expense, making your home more resilient to disasters should be a DSA expense. The proposal ABA has drafted based upon a prior 2014 federal bill specifically embraces pre-event remediation as qualified expenses. The remediation via disaster savings accounts could deliver three key benefits. It could lower claims costs in disasters. It could potentially lower premium costs over time and maybe even attract more insurers into specific states. The sponsor of the bill had said, "I'd never seen a disaster made worse by affected individuals having more money." Adoption of the disaster savings accounts over time means that Americans will be empowered to meet the costs of being prepared before. And to recover from a disaster before it strikes. I

urge you to support the Resolution and to support the disaster savings account coalition that the ABA is assembling.

Jason Lane, Senior Vice President and Director of Government Relations for the California Bankers Association thanked the Committee for their time and stated the Association represents the majority of banks doing business in California. We are all aware of the acute regulatory and environmental challenges that issuers have identified as stressors especially in the California market. Before advent of health savings accounts, health insurance struggled in a similar way. There wasn't an insurance product available to people that incentivized savings through tax advantages. Property & casualty markets face the same problem today. If Americans could save tax free for disaster preparation, we might expect to see a number of beneficial market adjustments. For example, to address rising premiums, homeowners could take advantage of the savings offered by higher deductibles. Higher deductibles likely benefit insurers as well. Attracting capital is already hard to find but could be easier if exposures were reduced across personal lines. We would expect savings in reinsurance for that market as well over time. We would also expect to see Americans saving sufficiently to at least pay their deductible through their disaster savings account. Consumers with increasing funds specifically set aside for disaster mitigation pose a very different risk than consumers without such a savings vehicle. Americans should be able to save for their future disaster expenses on the same tax advantage basis that HSA owners have for future medical expenses. Owning and protecting where you live, even if you rent, is as vital as food security. Since disaster savings accounts would be serviced and maintained by banks, those accounts will enjoy all the fraud mitigation and safety and soundness regulation governing existing depository accounts. Just as HSA's are frequently restricted to qualified expenses through merchant and product codes, DSA funds would be subject to similar restrictions in the law and similar technology in the marketplace. The proposal that the ABA has drafted really embraces the concept of pre-event remediation. Adoption of DSA's over time means that Americans will be better prepared to meet the cost of recovering from disaster before it strikes. I urge you to support the resolution and to support the DSA coalition ABA is assembling.

Mr. McKechnie thanked the Committee for introducing and considering the resolution. To wrap up from our side, you heard about pre-funding and becoming more resilient before the storm. You've heard about the good things that happen in the health savings account example where people prepare by definition for medical emergencies they don't know about yet. I was unaware until Ms. Trusko invited me to her group that our predominant methodology for managing disasters in this country is to identify the survivors and wait for non-profit companies to give them money. And that's well and good and stands I suppose in those organizations good favor. But that's not a strategy. This is a strategy. This is something everyone can have access to. This is something the government can put money into if they choose to. It's something people can put money into so that they can help themselves and it's something that your employer could put money into. And that's how health savings accounts work. And that's why we

think that harnessing the engine financial services offers Americans to make them more resilient before the disaster will ultimately benefit of all of the states, I think is everybody at this point that's experiencing some kind of deflection in the natural course of convective storms, terrible hurricanes, earthquakes. If you're shaking, on fire, or drowning you're going to need help. And you're going to need help quickly. But if you wanted to get out of the way or make your home or apartment more resilient before any of those things happen, you're going to need a disaster savings account which is why we're very grateful that you support them and we would encourage the states to adopt them as our friends in Alabama, Mississippi, and South Carolina have done.

Rep. Roberts stated as a legislator from Kentucky, and I know this true of all of the legislators here, we've all had our states face natural disasters. And as these continue to happen, I'm very excited about this prospect to help our constituents and the people of our states. Several of us were just in D.C. for the NCOIL Fly-in and we had some really great robust forward conversations around this on the hill as well.

Sen. Larry Walker (GA) stated you compare this to Health Saving Accounts. Health Saving Accounts require that you have a qualified high deductible health insurance plan. Does your legislation propose requiring property insurance with a certain mean level of deductible? Mr. McKechnie said it doesn't require an insurance mandate at all and within the ranks of the HSA industry, I'm Executive Director of the ABA's Health Savings Account Council, there is an industry wide request of Congress to retreat from that mandate because we don't think requiring insurers to alter how they do business is the right way to move forward here. What we think is that people should be saving money for themselves. The insurance industry may start offering products that are more advantageous for both them and for their policyholders. I'll give you an example, if you have the tolerance for it, should you be able to buy a policy that has a $5,000, $10,000, $20,000 deductible. Sure. But I think the market can sort that out. It shouldn't be part of the legislation.

Sen. Walker said I don't want to incentivize people going uninsured and then we have the public having to bail them out just if they have $10,000 in an account. So, the way health savings accounts work is you don't really have to pre-fund it. You can run your money through after you incur the medical expenses. Would this work the same way? And if that's so that seems to kind of defeat the point to me. Mr. McKechnie said there could be flexibility. It could work the way you describe. It could also be because it's contemplated as an employee benefit, your employer could fund it and 14% of all of the contributions to HSAs in 2023 were employer contributions. Would you fund it ahead of time? That wouldn't be prohibited. And so, one idea that emerged is during the underwriting process for a new mortgage, would you want to include full funding for your catastrophe savings account? That would be an option that's open to you. But if you don't have any money to do that, or if you have yet to accumulate the dollars to do that, would you fund recovery or preparation without putting that money first in your DSA? We have the technology in place already so that any contributions can be made HSA

qualified. We would contemplate having that technology copy and pasted to the DSA side.

Rep. Michael Meredith (KY) said it would take statutory change at both the federal and state level for the tax advantages of an account like this to work. There's no way under federal mechanisms now to allow for this. It would both have to change at the federal and state level. Mr. McKechnie stated yes, it would have to be a bill in everyone's Legislature and Congress to create the vehicle in the first place.

Sen. Hackett stated I totally support the bill. The only problem that I see with the bill is it has to be a catastrophe. And one of the problems that a lot of insureds are facing is a huge increase in premium rates. And so, if you're in an area where you don't have a catastrophe, you can't really use this type of savings account to help you pay the premium on that. And I realize that we don't want to create a product that high income people can use as a tax break. But on the same token, was there any thought about if you face such an increase in premium over a period of time, and I know there is a way if the companies are pulling out of a state because of catastrophe, there's ways that you can do that. But what about premium, helping consumers, because insurance companies a lot of the times will increase even though they'll have a problem in Florida you'll see problems increased premiums increase across the county, some of the national companies. So, was there ever any thought that maybe these accounts can be used to pay premiums or not without a catastrophe?

Mr. McKechnie stated yes, there is. In the proposal there's things you can use the money on before any kind of disaster strikes and those things do include certain features of being able to manage your insurance costs. So, the cost of the product you're purchasing. And the other way they manage insurance costs is were you to experience or be in a flood, you could purchase something like a new base flood elevation certificate with those dollars and that's specifically written in the proposal. And the way that the IRS code works for HSA's is there is a list of how an HSA works and there's an entirely separate list of what you can spend your money on. And in this proposal that model would be the same with one exception. There would be a list of things pre-event that you could spend your dollars on. Resilient roofs, hardening of more storm-resistant windows and limited insurance products. In HSA's you can for example use those funds to pay for COBRA expenses. And so, we would contemplate if you're like oh wait there's going to be huge spike in Ohio, but there's nothing happening in Ohio. Well, maybe that's something that ought to be qualified. And in your Legislature, you might contemplate that, and we would respect that of the federal level as well.

Rep. Forrest Bennett (OK) said you mentioned about federal and state changes being needed. The way that I think about this is sort of like the 529 education savings plans that we have in Oklahoma that don't necessarily as far as I'm concerned require any federal approval. What's the issue of the federal piece there? Is it portability of the savings account? I see a future where we're able to kind of establish this at the state level without necessarily the federal government. Mr. McKechnie stated you're

absolutely right. As a matter of fact, the Resolution starts in that spot which is it would be appropriate and encouraged for all of your states to do what South Carolina, Mississippi, and Alabama have already done. There are however a couple of states that do not have income tax. And so, one of the pressures not to establish one of these things if you're a consumer is what really is the benefit to you? The emphasis on having Congress do it just like in HSA's is federal income taxes are a much larger bite of everybody's income and without a tax discussion and going into that space, all we're suggesting is that governments start incentivizing people to take care of themselves before there's an event. And the best tool you have to do that is to forgive collecting taxes on whatever you can put into the account. And that number just to head off that question, you have to pick a place to start, or they can't score the bill. And I'm sure you're familiar with this in all your legislatures. So, that number is $5,000. You can put $5,000 into your account and that would come off your adjusted gross income. Just like it would in a health savings account environment. And that number is arbitrary. You can engineer it to your hearts content. Whatever the system can bare is whatever the system can bare.

Rep. Roberts stated I think given some of the questions we had today we will bring this back up for further conversation at our Annual Meeting in November.

DISCUSSION ON RECENT FEDERAL RULES ENCROACHING ON THE STATE-BASED SYSTEM OF INSURANCE

Rep. Roberts stated next up on our agenda is a discussion on the recent federal rules encroaching on the state-based system of insurance. We'll start with the tri agency rule which deals with several items including short term limited duration insurance and fixed indemnity insurance. I note that NCOIL did submit a comment letter opposing the rule which you can view on the website and the app. The nature of the opposition from NCOIL is jurisdictional in nature focusing on the fact that regardless of one's views on these types of products they are best regulated at the state level under the state-based system of insurance. With us here today is JP Wieske of the Health Benefits Institute. Mr. Wieske was scheduled to deliver a joint presentation with Lucy Culp of the Leukemia and Lymphoma Society that would serve as somewhat of point, counterpoint but unfortunately, she came down with an illness and could not join us today.

Mr. Wieske stated to start with some background, short term limited duration insurance is something that's existed for quite some time. It was used to fill gaps obviously. For the longest time it was set to be 12 months. States allowed extensions; individual state laws had rules. The short-term limited duration market really functions very similar to what was the individual market pre-Affordable Care Act and pre-HIPAA. There was broad underwriting. In fact, usually a 5 year or a 2 year look back as a piece of that and pre-acts that was applied pretty broadly. There were always some concerns around the way some of the policies were underwritten as a piece of it. But it was really functioning to provide coverage for consumers who were facing a gap, right? I had short-term insurance decades ago when I left college in between looking for a job. Others had it

during that time as well when they're looking for those or in between jobs when you had waiting periods, those sorts of things. And so that continued to be sort of the product. We move forward and short term became a little bit different of a market. We're going to talk about fixed indemnity and there's a number of policies that are considered what are called accepted benefits. These are policies that are accepted from federal regulation. Short-term is not that. It's a separate sort of carve out through the ACA as a piece of it and increasingly as the market deteriorated during the later Obama years, there was concern that there was a cannibalization of the individual market into the short-term market. The Obama administration at the very end took action and moved that down to, and just an FYI this is Ms. Culp's slide, they moved that down to a 3-month timeframe. Now, it was never functionally implemented. It came through, it didn't end up being implemented. The Trump administration rescinded the rules and then as you know, moved to the interesting definition of short-term being one year and limited duration being defined as 3 years. So, you essential had a three-year policy. Which again, made these short-term policies very similar to what the individual market looked like pre-ACA with the underwriting, typically no pregnancy coverage, typically no mental health coverage attached to it.

Now, moving onto hospital and fixed indemnity, just to explain what it is. These offer fixed payments based on various benefit triggers. $100, if you go into the hospital. These are not intended to provide full coverage for your medical and will not in fact. I probably shouldn't do this, my Aflac folks will probably come after me later, but it's the Aflac style policies, right? Where you get paid if you have something that happens. Under HIPAA it is an accepted benefit, it's exclusively regulated by the states. It is required to be non-coordinated as a benefit. Initially, the Obama administration during its time had created rules that required you to in fact prove that you had major medical coverage to be allowed to purchase fixed indemnity coverage. The subject of the lawsuit Central United v. Burwell. They lost that case. The case was interesting from the standpoint that it means there was pretty significant limits placed on that and the Biden administration sort of jumped through and just ignored it. States again, are the primary regulator. We are continuing to have calls. NAIC model 170 was adopted when I was still a regulator. So, that gives you an idea of how long ago it was, how long we've been working on Model 171, which is the regulation version of that. So, we've been working on that since then. That's a long time. It's important to note that states have rate informed filing on this. They have licensure of the underlying insurer. They have requirements on the agents. And they actually deal with consumer complaints. So, they have the entire nexus of hospital indemnity from a regulatory standpoint. And again, the concern from the consumer groups is that there have been policies that have moved towards looking a lot like replacing major medical. There was a company offering what you would call RBRVS rates, Medicare rates, a percentage of Medicare rates as reimbursement. That was their quote unquote "fee schedule" and offered policies up to I believe $1 million in coverage. That looks awfully like a major medical policy. So, there were some concerns. In fact, that company has now shifted away from that market and is trying to sell major medical and actually tried to do ACA polices under that restriction.

And again, to voice the consumer concern, not all states have taken action. There's a feeling that there are certain states that have not aggressively pursued problematic areas and have not aggressively pursued companies that are in fact marketing and developing these products as ACA replacements. And in a number of cases, there are file and use policies so they're never actually looked at.

I would note the idea of the number of people, will get an idea of the number people subscribed. The NAIC has what's called a market conduct annual statement and they are now doing their first iteration of the other health. And we really have no idea how many people are actually enrolled in these policies on a state-by-state basis. All the accepted benefits. So, for the final rule on short-term limited duration. Now, we're going to the present and we were in the past. Now, we're here. The federal government, this is where the primary regulatory efforts have been inside this rule. They have now again limited the short-term limited duration to 3 months. They've redefined what limited means to allow a 1-month extension, so a 4-month maximum. There are new requirements on the issuer. The issuer in fact is not allowed to issue multiple policies. But that also applies to the quote unquote group and this is where we expect a lawsuit to come eventually. So, if you are XYZ insurance company, XYZ holding company, and you have 12 insurers under your arm, in normal insurance parlance each one of those 12 can issue policies, right? So, they're all separately regulated. Under this rule it says if any one of those 12 sells a short-term limited duration policy to a consumer, in fact XYZ insurance company is barred from selling any more policies. It's important to note they also did not, and I found this interesting, that they did not create a new special enrollment into the individual market once your short-term ends. So, you have a 3-month policy, once that ends, you don't have a special enrollment period (SEP), I don't know what you do, you have to buy another short-term policy if you're in the middle of the year, if you don't have a Special Enrollment Period. Now, that does not apply to the group market. If an individual is in a short-term policy and they move into a group, the SEP applies. SEP, that means that they get access to the employer coverage. The other interesting piece here is the effective date. If the effective is 9/1 which functionally means for you as state legislators, pretty soon you may start hearing that short-term policies may not be available depending on the filing issues inside your state. It is virtually going to be very difficult for insurers to file new versions of these policies to be available 9/1 and given that this butts against the ACA filing deadlines for major medical, it's almost impossible for most states to actually go through this process. So, that's going to be concern from availability at least probably from 9/1 to 1/1 of 2025.

The fixed indemnity rule had a number of big changes proposed. They backed off on almost all of those and actually have merely a new consumer notice. There is a bit of a problem, and again, another filing issue that's effective January 1, 2025. The federal government has decided that you need to in fact send a new notice to every single consumer who has ever purchased a policy and has it in effect. So, if you purchased your policy in 1998, you'll get a new notice indicating that you have a fixed indemnity policy and what it is, and you're required in most cases to file those with the states. So,

there is some concern again, from an availability standpoint and a filing standpoint that that's going to be a problem. There is also some concern, and there's actually a lawsuit. The company that was Central United v. Burwell is now Manhattan Life, they changed their name. They're suing over the notice arguing that this notice in fact did not meet the standards. And if you read the notice, it's in fact, at least from our perspective inaccurate. It says, it is not medical insurance. Fixed indemnity is medical insurance. It's just not major medical insurance. So, we agree with the sense it's not ACA qualifying. But it is medical. So, we have concerns with that. And they also proposed a number of changes, and they pontificated a lot inside the rule about what their going to potentially next year. They were looking at a stricter per period basis to basically require you instead of saying you can do $100 for a doctor visit, you can now only do $100 a day. That's it. And you could not have any other sort of variations in it. They also had a broad concern about the IRS tax treatment, they want to treat these as taxable policies. That is if you receive a benefit. So, if your car gets destroyed and you get money for a new car, you don't necessarily have to pay taxes because they're reimbursing you. Same thing here except their proposing that this in fact becomes taxable.

They've also talked about specified disease. Now, specified disease polices are policies like cancer that, you know, provide cash in the case you're diagnosed with some horrific disease. They highlighted a concern that if they implement the fixed indemnity rules as they proposed that insurance companies will respond by creating more robust specified disease policies and so, that is their concern. They highlighted that. Last, they had a long discussion in and around level funded plans. Level funded plans are self-funded ERISA plans sold to small employers. Those plans typically have what you would call low attachment points. The risk to the employer is low. There's substantial reinsurance. But they're concerned that again, in the small group market especially that it is cannibalizing the small group market and making the ACA small group market much riskier. It's not something that HBI agrees with, but that is certainly what the administration and some of the consumers are concerned with.

We talked briefly about this on short-term limited duration, and I'd be looking to have some discussions with some folks. I'm not aware of lawsuits but of course I wouldn't not necessarily be. But I'm expecting that there will be some lawsuit related to both the timing, the 9/1, looking for a delay because it's impossible. And more importantly the control group. I talked to one lawyer for an insurance department who believed, he gave it an 80% shot that it would be knocked down. That's that a problematic sort of proposal. That there's really almost nothing that applies on a group basis rather than an individual insurer basis. So, that's something. And again, we talked about the fixed indemnity lawsuit potentially on the notice, Manhattan Life. We expect that is coming. I will also note we've heard the administration if you look at their administrative guides, they're expecting to reissue these rules early next year. And as a result, will likely they feel they can go straight to final, so they'll be no opportunity to provide comment. Our concerns, I think in general, we believe at HBI that states are the best place to regulate this. We do think that the way they sort of structured the short-term limited duration is anti-consumer.

We would have preferred if you're going to limit the timeframe that you allow consumers to have a policy through the end of year. And we'll line that up with the ACA open enrollment periods. Because there are people who will miss the open enrollment deadlines and will not be able to buy coverage. We do support the idea that none of these products should be sold or marketed as ACA replacements. And we're also concerned on the fixed indemnity side that this is a product that has worked for years for consumers and provides support for the really high deductibles that we're seeing in the market.

Last, from the patient consumer standpoint. I think there is broad concern from the consumer groups that you see some problems in this market. Ms. Culp highlights the secret shopper studies. If you were looking at somebody who is going to a licensed agent, you see less problems. If they're going to a call center, they have seen some problems in enrollment, aggressive tactics, folks who are not in fact licensed. There are some legitimate concerns I would say that from my perspective states are trying to find that. It's harder to deal with. And there are concerns I think inside the market when you look at whether this going to have a negative impact on the ACA market. That's sort of the focus and the reason the Obama administration's taking action. And then, you know, short-term limited duration again, we've talked about this, that there's a feeling that states have a hard time regulating it. I would note and that's partly because they're sold through associations. So, you buy your coverage from associations, it's from another state and they may be licensed in say Missouri but the product actually is sold out of say Kentucky and so, there is a concern there. Last, on fixed indemnity I think there's some broad concerns about the policies getting a little bit more robust and not being replacements. The so-called mini meds which existed pre-ACA.

Rep. Roberts noted that NCOIL does have an existing short-term limited duration insurance Model Law that is scheduled to be considered for readoption next year. So, it will be interesting to see how these rules will impact the model being readopted. Next, we'll focus on the federal trade commission's noncompete rule. Again, I note that NCOIL did submit a comment letter opposing the rule which you can view on the website and the app. And again, the nature of the opposition from NCOIL is jurisdictional in nature focusing on the fact that the rule is an unlawful encroachment on the state-based system of insurance.

Jonathan Harris, Associate Professor of Law at Loyola Law School thanked the Committee for having him and stated my research and my teaching focus on contract law. And the intersections with the workplace and employment law. And I've written quite a bit about restrictions on worker mobility including non-compete agreements over the last years. I'm going to just cover three things here. The first is what does the Federal Trade Commission's banning non-compete say? The second is why did the FTC decide it was necessary to issue this rule? And third, what are the prospects for this rule going forward, as well as other possible bans on non-compete agreements and other restrictions on worker mobility. First what does the rule say? It's pretty simple. It

bans all contracts or policies that prohibit a worker from or punish a worker for leaving a job to work for another employer or operate a business. It includes not only formal employees but also other types of workers including independent contractors. So, it's quite expansive in that way. And it has no exceptions except for what it calls senior executives who are employees who earn over $150,000. For those workers, existing non-compete agreements are okay, but they can't be bound by new ones. The rule also includes defacto non-compete agreements. Things like training repayment agreement provisions or TRAP's that employers impose to require workers to repay their training costs if they leave within a certain period of time. Also, non-solicitation agreements. And it says that contracts like that function as non-compete agreements by effectively keeping workers from leaving their jobs or punish workers for leaving their jobs or starting businesses.

Second, why did the FTC decide this rule was necessary? There's been some research over the past several years that's focused more on restrictions on worker mobility generally, especially non-compete agreements. The biggest number that stands out now, about 1 in 5 workers in the United States are bound by non-compete agreements. And while these kinds of agreements began with higher skilled, higher paid employees, they have trickled down over the years to more middle and even low wage workers. Many of you might have heard the story of Jimmy John's requiring its sandwich makers to sign non-compete agreements and that kind of thing has gotten a lot more attention by academics and policymakers. I think it also is based on President Biden's whole of government approach that he's been focusing on the last few years. Issuing executive orders to promote competition and protect US workers. Of course, the name non-compete agreement is based on not competing with another company. So, this rule was based on the FTC's unfair methods of competition authority. And it is using powers that it hasn't exercised since the 60s and early 70s. That brings me to my third point which is what are the prospects for this rule going forward and other efforts to end restrictions on work mobility. There was a preliminary injunction issued against the rule earlier this month in the Northern District of Texas. The Judge there determined that the FTC's rule making authority was only for housekeeping or procedural rules not sweeping substantive rules like this one. There's another case in the Eastern District of Pennsylvania that also challenges the rule. We might end up with a circuit split with the 5th circuit ruling one way and the 3rd circuit ruling another. It could arrive at the doorstep of the Supreme Court. And as we've seen lately the Supreme Court has more of general hostility towards administrative agencies and their expertise than we've seen in the past. As well as it's newly created major questions doctrine that it might use both of those to strike this rule down. One interesting thing though about it is there are some people who have advocated for the rule because it prompts a free market according to them. And for those in favor of getting rid of artificial restraints in markets including labor markets, they saw it as a good thing. There were 26,000 comments that the FTC received for this ruling. They said that 25,000 of those were in favor of it.

In the meantime, while this rule works its way through the courts, there are other agencies that are getting involved in non-competes and other restrictions on worker mobility. Remember the whole of government approach those agencies are doing this. The National Labor Relations Board (NLRB) is one of those. The NLRB general council last year issued a memorandum declaring that it believes most non-compete agreements are in violation of Section 7 of the National Labor Relations Act because they have a tendency to chill worker collective organizing. That is if you raise the consequence of being fired for organizing a union by not only the workers loses their income, but also not being able to get another job, that has a tendency to chill their right to organize and act concertedly. An Administrative Law Judge just a few weeks ago agreed with it and ruled that non-compete agreements and non-solicitation agreements that an employer had were unlawful under the NLRA. So, we'll see where that goes. As it relates to looking forward, it sounds like ALJ's with the NLRB might be more protected than other in-house agency judges. So, there's a more worker friendly board in NLRB right now in place. And that would probably last through any new Trump administration even if that comes to be for a little bit. So, that's one. Another is the Department of Labor has been suing employers for using restrictions on worker mobility including those training repayment agreement provisions, the TRAPS, considering them kickbacks of wages that employees are required to pay their employers.

And then last but not least, of course, states and municipalities are getting into this as well. We've seen a huge focus on non-compete agreements from states in the last few years. Of course, here in California for a long time we've had a ban on enforcement of non-compete agreements. That law was strengthened recently to not only refuse enforcement of non-competes but actually ban them outright. There are 3 other states where there fully banned, those are Oklahoma, North Dakota, and Minnesota. And then another 33 states have restrictions on non-compete agreements. Many of those restrictions include income restrictions. Colorado and D.C. are two examples that prohibit non-competes for workers earning below a certain amount. And then there is also focus on other what they call stay or pay contracts that are contracts that make workers pay to leave whether it's for training costs or any other reason. And the potential of those being used more and more as work arounds to non-compete agreements as those non-competes get more scrutiny, employers have already been talking about other ways that they can keep workers from leaving without using non-competes that they think are more enforceable. So, state attorneys general are looking at that as well. And enforcing their own competition and unfair and deceptive acts and practices laws in this arena.

Wes Bissett, Senior Counsel, Government Affairs for the Independent Insurance Agents and Brokers of America "the Big I" stated I'm going talk a little bit about the FTC non-compete rule, the lens through which we looked at it, and then some related issues. I'd say it's not a classic insurance regulatory issue. I think it's a fascinating case study though on policymaking in 2024. And I imagine there are folks in this room who really like the outcome of the rule. There are probably some who disagree with it. And there

are probably some who like the outcome but maybe question the means by which it was implemented. So, we'll talk all about that. To understand where and how independent agents looked at this, I think it's important to understand what an independent insurance agent is. So, unlike other distribution channels in the marketplace, independent agents own their own books of business. They own their own business. That's not always the case obviously with other types of distribution channels. Our members are able to place business with multiple insurance companies. They're not bound to one. And just as background, the independent agent channel based on data last year has placed over 62% of all property & casualty insurance market volume in the US. Significantly high in the commercial lines marketplace, over 87% and our market share is growing in the personal lines market and is over 50% now in the homeowners market. But for an agent, the core asset of their agency, their business, is intangible. So, employment agreements in some cases, non-competes and other cases, other forms of employment agreements are used to oftentimes protect that intangible value. So, the employment agreements are used between the agency itself and the individual agents that work and operate within that agency and they're used to protect the investments, the customer relationships that that agency has, it's goodwill in the community, the confidential knowledge. Just the generally the overall business, or their overall value of that business. One thing I think it's also important to understand too and there's often confusion on this point is people don't always view or define the term non-compete agreement in the way that it's used. Sometimes they think of non-competes as all forms of employment agreements out there. They'll confuse a non-solicitation agreement or non-disclosure agreement with a non-compete. But what we're talking about here is the very narrow non-compete agreement which bars a person from working for a competitor or starting their own business when they leave a job. So, essentially telling someone that they can't work in the profession that they've chosen, in the area that they wish to operate. There are other narrower forms in less obtrusive forms of employment agreements out there including things like non-solicitation agreements and NDA's. So, what we're talking about in this context, or what I sometimes refer to as true non-compete agreements and not these other form of employment agreements that are often more important to insurance agents.

The recent history here, I guess we even go back a little bit further, historically non-compete agreements were regulated exclusively at the state level. But increasingly over time, they've been subject to scrutiny both at the federal and state level. And this is not a particularly partisan issue. Both Democrats and Republicans look at this with scrutiny. Professor Harris talked about how there's been this focus on low wage workers in particular. The Jimmy John's case study. People wondering, have we lost control over non-compete agreements if we're having minimum wage employees who are making sandwiches be compelled and coerced into signing non-compete agreements and not having them be used between people who really have leverage in negotiating power. He talked about the 3 states that since the 1800's had largely banned their use and Minnesota joined those ranks last year. We've seen a flurry though of activity over the last 10 to 12 years as it relates to restrictions on the use of non-competes. There has

been sort of salary thresholds that have been established. And anyone working below that salary level a non-compete cannot be used in connection with person. Those levels are sometimes based on annual income, they're sometimes based on hourly income. But we've seen a flurry of activity. There's a ton of bills that were introduced but you can see there's at least 12 states in recent years that have passed something along those lines. And that will no doubt continue. Then in January of last year we saw the FTC propose it's non-compete ban.

When we looked at this, we testified before the FTC on this and then submitted written comments. Our initial reaction, although we didn't belabor the point with the FTC is that they lack the authority to issue this rule. We sort of figured it was a waste of time to argue to the FTC who had just spent a ton of time issuing and developing this rule that they didn't have the authority to do so. So, assuming they were likely to move forward, we focused on 3 primary issues. We focused on what the rules would be. Could non-competes be used in connection with the sale of a business? All four of the states that banned the use of non-competes generally do allow non-competes to be used in connection with the sale of business. That's incredibly important. We also wanted to ensure that other forms of employment agreements would not be affected by the rule. And then lastly, we recommended the addition of an exception for highly paid workers.

And then when the final rule was adopted in April, and this is where the policy making part of this does get interesting, there were 3 commissioners on a 3 to 2 vote who decided to implement this fairly broad and significant rule and ban the use of most non-competes. Professor Harris talked about the nature of the rule itself. It does have vast and significant impacts. We're talking about 30 million workers, 20% of the workforce who have non-competes today. It applies to all types of workers. It's scheduled to take effect less than 2 months from now, September 4th. And after that date most non-competes that are in place will be invalidated. And a business would be violating a law after that if it attempted to enforce that non-compete. For reasons I'll point out here on the next slide, the likely impact though on agents will be lesser due to the revisions that were made by the FTC between the initial rule and the final one. The biggest change they made, this had been part of the initial proposal, but the inclusion of an exemption for the sale of a business. This is critically important for independent agents and for a lot of businesses and it really benefits sellers and buyers. This is different that the Jimmy John's hypothetical, right? If you're selling a business, this is an arm's length negotiated transaction between sophisticated parties. This isn't someone being coerced to sign a non-compete if they want to work for a job. It benefits sellers because the value of the asset that sellers are transferring has greater value if they can enter into a non-compete. It's good for buyers because buyers have a knowledge that if they buy an insurance agency or another business, the person they just bought it from isn't in a couple weeks going to set up shop like right down the street. So, it really benefits both parties. And thankfully, the FTC has created an exemption that in this limited context they don't apply. The original proposal sort of arbitrarily said that if they had a 25% ownership stake that non-competes could still not be used with anyone that had less than that. I think there

was some compelling arguments that were made and the FTC decided to eliminate that arbitrary limitation.

Two other key issues that I mentioned, the sort of the three earlier, the FTC makes clear that in general terms other forms of employment agreements are not affected or prohibited by this regulation. The one sort of limitation to that is if you have a form of an employment agreement that's so restrictive that really looks like a duck, quacks like a non-compete agreement, you can't use that. And as the Professor said, it doesn't just exclusively ban non-compete agreements, but things where there would be financial consequences for a person after the fact, right? If there were liquidated damages that you would have to pay to take another job, those are prohibited as well. And he talked about the senior executive exemption that was added. There's an earning test and duties test that's associated with that. It has to be someone in a policymaking position as that term is defined in the rule.

So, what's the fate of the rule? I mean this is the big question, right? We spent about 15 minutes talking about this. It may very well be overturned by the courts. The Professor talked about two cases. I think there's a third now that's been filed. You see there in those bullet points that follow. I think these are just things that courts will be thinking about and that just observers will be thinking about. There's no federal law anywhere that expressly bans the use of non-competes. You know, the FTC asserts it has the authority under the 1914 FTC Act to do this. The impact of this rule is vast. We're talking about 20-25% of the American workforce. The FTC's authority to issue legislative substantive rules whatever you think of this particular one has been questioned. There are many that argue that this type of policymaking should be left to federal and or state policymakers. In this case, there was a great argument to be made given the historical background that it should be state legislators. And the recent Supreme Court activity doesn't favor the FTC. The Chevron doctrine has come and gone since the last significant court case looking at the FTC's authority and we now have the major questions doctrine. It doesn't bode well for the FTC. I think interesting questions for policymakers even at the federal level are what's the precedential impact of this rule making if it stands? If three commissioners of the FTC can get together and decide to do something that's this impactful on the American economy, how can it use that, they might use it in some good ways, they might use it in some bad ways. But what are the limits on that power? How else could it be employed if it's allowed to stand? Just for like government nerds like me, it's kind of an interesting question to think about. What I suspect will happen if I had to look in my crystal ball is this will likely be overturned. And so, what we'll probably see is the states taking on their historic role of regulating and overseeing non-compete agreements. We've seen that flurry of activity. I think if the FTC's role goes away that's certainly likely to pick up. And the two things I would leave you with at the end are employment agreements including non-competes and that especially in that limited case where a business is sold are important business management tools for independent agents. Any legislation that you might work in your states where this issue would come up, we would hope it would allow the use of non-

competes at least when a business is being sold and not restrict the reasonable use of other forms of employment agreements like non-solicitation agreements.

Rep. Matt Lehman (IN) stated my question goes to Professor Harris, you said they're looking beyond just these contracts and saying things like incentives that you had to pay back if you leave, etc. I'll use an example of a family member who is a physician, got out of college, was offered a job, urology and surgical, and they paid off $250,000 of his school debt in exchange for a time period that he had to stay at that facility. If he chose to leave, he had to pay that back. He fully agreed to that because they were paying off a quarter million dollars of his school debt. If these get tossed out, now you have the situation if you got people coming out of school, they want that incentive of let me get a job and have somebody else pay off my debt. How is this from an impact of just maybe the economy even in looking at those types of individuals. How would this rule impact that? And would that not create a whole other issue on the fact that many, many, in the medical field are using this as a tool to get out of debt?

Professor Harris stated my first answer would be that this rule from the FTC would not impact the scenario you're describing. That wouldn't be a non-compete agreement. And from what you're describing it doesn't necessarily sound like it would function as one either. Rep. Lehman stated to be clear, he does have a non-compete agreement and that's part of the agreement. Professor Harris said then part of the agreement would not be enforceable unless he's earning more than a $150,000 a year in which case he would be considered a senior executive and the current non-compete would be enforceable. But any new one would not. On the training piece that you mentioned though, there are examples of that from my research more often than not what I've been seeing is that training costs are used to justify contracts to make workers pay in order to leave at amounts that are often unaffordable for them. One example is a PetSmart pet groomer who was earning minimum wage salary and was under a $5,000 training repayment agreement provision that she ended up violating and they sued her for that plus, attorneys fees and court costs. And it ruined her credit score. Research that has been done has shown that most of time employers don't use these training contracts to actually provide useful training skills to the worker. Moreso, they use them as work arounds to traditional non-compete agreements. And I think that's why there is concern about this kind of game of whack-a-mole starting if this rule gets struck down.

Rep. Lehman stated as a law professor do you feel like, to a point Mr. Bissett made, three bureaucratic positions in a regulatory body, can make this decision versus a legislative body. This has a huge impact, should it not be done legislatively? Professor Harris stated that's going to be a decision for the courts to make, I think. I'm not an Administrative Law expert so I'm not going to try to opine on that. What I will say is that it did go through the traditional notice and comment period. They look at the comments for over a year, there were 26,000 comments submitted. So, to the extent that any agency can do things like this, I don't think it's limited to just the FTC in this rule. I think it's a larger question of the role of administrative agency generally.

Sen. Hackett stated I'm a layman, I'm not an attorney. I dealt with this issue many, many times. I was on the board of a hospital. Many times, they had attorneys on retainer. So many times, the big corporations said, in Ohio we really narrowed the definition of what qualified on a non-compete, so, it was really hard. But the attorneys would say for the corporation, "we're on retainer, we know we're going to lose in court. We'll go ahead and lose in court on that." Because the other person, the individual, has to go out and hire an attorney and they basically say to the guy, "you either pay your attorney, or you pay us." You know, "pay us back and don't compete." And so, has that changed? Has the DOL come into the picture? Has that changed where the person who leaves on a non-compete can get their attorney fees paid by the corporation, etc? I know anything can be done in the courts. But that was the issue that we hold over their heads. You could leave us, but you got to go out and hire an attorney. You got to pay the attorney. So, you're going to pay either way. You're either going to not compete against us or you're going to pay your attorney because you'll probably win in court?

Professor Harris stated I think in some ways that was part of the thinking behind this very sweeping blanket ban of non-competes that the FTC ended up enacting because they know that while if many non-competes ended up in court, they might not be enforceable. Most workers aren't going to have the ability or the money, the wherewithal, to hire an attorney and fight it after the fact. And so, they made the decision to do it ahead of time instead to try to get rid of any possible confusion and that kind of deterrent. But I do think that notwithstanding what happens with the FTC rule, there will be continued litigation about this, these kinds of contracts for sure and in state courts more than anywhere. And you're right, many, many state courts end up striking down non-compete agreements in the end. But then again, the question always comes down to that's only if they're challenged in the first place. And even if they are struck down, the rest of that contract might still be enforceable.

Sen. Hackett stated and that's why 25,000 of the 26,000 said that they were for it because they were told ahead of time that you have a non-compete clause, if you try to break it, you'll probably win but it'll cost you money, you're going to lose either way under that scenario. Professor Harris stated I do know the DOL is suing some employers for using what I was talking about before, these training repayment agreement provisions. And, in that case they're obviously suing on behalf of the government. But the workers, they're doing in their interest as well.

Rep. Bennett stated Rep. Lehman said something that I'd love to disagree with about decisions being made by legislators as opposed to bureaucrats and my view is that corporate lobbyists are a lot more effective than those who are advocating for removing non-compete clauses. But if it does fall to legislators to make this decision, I'm fascinated and sad about this Jimmy John's example - in that scenario, if say, you live in the Kansas City Metro area and you leave a Jimmy John's on the Missouri side and go get hired at Subway on the Kansas side, and Jimmy John's tries to sue for non-compete but one of those states doesn't have, non-compete rules and one does. Don't you think

then that the legislative solutions needs to come at the federal level as opposed to a state level. Because this patchwork then wouldn't work. I'm just interested in in a little bit more background about this Jimmy John's non-compete. Professor Harris stated first of all my understanding is Jimmy John's no longer uses these. So, after the public scrutiny they got, they quickly got rid of them. But in terms of your question around the state border issue. That was actually something that our Legislature here in California dealt with it in recent legislation because they were concerned about the effectiveness of the state's ban on non-compete agreements given so much happening now with remote work. And companies being located all over the place.

In addition to making non-compete agreements unlawful and banned per se also included more restrictions that make that ban more applicable to both employers and workers that have a nexus with the State of California. But as it relates to your larger point, I think that's a real argument and a real reason for why a federal approach to this in my opinion makes sense. I don't know if we'll get that, but it does seem like having a unified approach is better for workers and frankly for business too. So, they understand the landscape that they're operating. And then one other thing I'll say, I tease my students about this in my employment law class. You know, non-compete agreements are unenforceable for us attorneys and we made it that way. Because we know they're bad for us in many ways. So, I mean they're bad for our clients too. And so, so I think there's some real logic to that.

Mr. Bissett said if I recall correctly, just going back to the Jimmy John's, I don't want to go too deep in the well. But I think that there were maybe in Illinois and some other states, it was deemed unenforceable by courts. I even think in some cases that there was administrative action was taken up against that, so I think there was the right result there. I said that my expectation is that where you'll see most actively will be at the state level. But I do think there's another scenario that can play out. Let's assume for a second this rule is tossed out by the courts. That could create a greater incentive for Congress to act. There has been bipartisan bills that have been introduced but not moved very far in the past. I'm just very sinical about the ability of Congress to pass legislation which is why I thought that most of the activity going forward would be at the state level. But I think for the substantive reasons you outlined, if the FTC rule is thrown out there would perhaps be some momentum on the federal level in a way that we just haven't seen in the past. Remains to be seen.

Rep. Mark Tedford (OK) stated I'm an insurance agency owner as well. Oklahoma is one of the states where non-competes are banned. What we see a lot of agencies use are like these non-solicitation and non-piracy agreements. If you can maybe respond to how the FTC rules would affect either one of those types of agreements. Mr. Bissett responded it would not. Except that there would be an agreement that called itself non-solicitation, but the words were so over the top the text that it actually got to the point where it started to look like a non-compete. But in general terms with a broad brush, the

FTC rule only applies to true non-compete agreements and not to other forms of employment agreements. Which was significant in a good way.

Rep. Meredith stated this may be an issue that is more of an issue in the jurisdiction of Kentucky where we're at. But with relation to the TRAP agreement issue that you've talked about extensively, one of the places that I have seen those used tremendously in our state is with law enforcement. Because in Kentucky you have to go through 20 week, 22 week training process and a lot of the larger municipalities and counties use that, because you obviously have to pass that to become a certified officer. And so, they use that for folks who might be on the margins, and they don't think maybe it'll pass those. They get hired by smaller local government unit. They go through that process. And then that larger city or county goes out and poaches those from them. Now, what we have seen effectively most of the time is that larger agency is who is end up reimbursing the smaller agency. But they do usually have a requirement for a 2 to 3 year or payback. Would those be affected in those situations in the same way?

Professor Harris stated I've seen many of these both for law enforcement, fire departments, EMTs, with like you said, oftentimes they can kind of pit municipalities against each other. And I think in a way that's not good. So, in terms of the FTC rule and its effect, first of all these are public employers. But what you're describing I think would be probably not affected for a couple reasons. First of all, if, tell me if I'm wrong, but I've been seeing more states pass laws that require if a municipality is poaching a police officer or someone like that from another municipality, that municipality that poaching municipality has to reimburse or repay those training costs to that. Rep. Meredith stated most of ours that I have seen at the level in Kentucky are done as an agreement between the employee and the city or county that they work for. However, generally the poaching agency is who is doing the reimbursement to the other agency. But the agreement is generally between officer and their agency. Professor Harris stated yes, so I've seen those too. So, the answer would be if that training repayment agreement provision functions as a non-compete in the sense that it keeps the worker from leaving to seek other employment or operate a new business. Then under the rule it could be considered an unlawful non-compete as well.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Carter and seconded by Rep. Lehman, the Committee adjourned at 11:30 a.m.

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National Council of Insurance Legislators (NCOIL)

Model Act in Support of Mental Health Wellness Exams

Sponsored by Rep. Rachel Roberts (KY)

Draft as of November 12, 2024. To be discussed and considered during the Joint State-Federal Relations & International Insurance Issues Committee on November 24, 2024.

Table of Contents

Section 1. Title

This Act shall be known as the [State] Act in Support of Mental Health Wellness Exams.

Section 2. Purpose

The purpose of this Act is to require health insurance coverage for mental health wellness exams in an effort to promote greater utilization of such exams and strengthen the mental health of the citizens of [State].

Section 3. Definitions

(a) The following definitions apply for purposes of this Act:

(1) "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 [*insert citation to general medical licensing statutes*];

(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, primary care, 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 [*insert citation to general medical licensing statutes*];or

Drafting Note: It is not the intent of this Model to include clinical or other support staff not expressly listed here in the definition of "Mental health professional."

(2) “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) age-appropriate screenings or observations to understand a person’s mental health history, personal history and mental or cognitive state and, when appropriate, relevant adult input through screenings, interviews and questions.

Drafting Note: It is not the intent of this Model to require that a “mental health wellness examination” include a discussion of potential options for medication.

(3) “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.

Section 4 – Coverage of Mental Health Wellness Examinations

(a) To the extent permitted by federal law, all health plans shall provide coverage for an annual standalone mental health wellness examination 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 <u>preventive services or primary care</u> ~~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, provided, however, that cost-sharing shall be required if the applicable plan is governed by the Federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on cost-sharing for this service.

Section 5. Rules

The [xxxxxxx] shall adopt rules to effectuate the provisions of this Act, including appropriate penalties for violations.

Section 6. Effective Date

This Act shall take effect [xxxxxx].

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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)

Resolution in Support of Establishing Catastrophe Savings Accounts

Draft as of June 18, 2024.

To be discussed and considered by the NCOIL Joint State-Federal Relations & International Insurance Issues Committee on November 24, 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).

PROPERTY & CASUALTY INSURANCE COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
PROPERTY & CASUALTY INSURANCE COMMITTEE
2024 NCOIL SUMMER MEETING – COSTA MESA, CALIFORNIA
JULY 20, 2024
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Property & Casualty Insurance Committee met at The Westin South Coast Plaza Hotel in Costa Mesa, California on Saturday, July 20, 2024 at 10:45 a.m.

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

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Sen. Larry Walker (GA)
Sen. Dan McConchie (IL)
Rep. Michael Meredith (KY)
Rep. Michael Sarge Pollock (KY)
Rep. Rachel Roberts (KY)
Rep. Edmond Jordan (LA)
Sen. Lana Theis (MI)
Sen. Michael Webber (MI)
Sen. Paul Utke (MN)
Sen. Walter Michel (MS)
Sen. Jerry Klein (ND)
Asm. Jarett Gandolfo (NY)
Asw. Pam Hunter (NY)
Sen. Bob Hackett (OH)
Rep. Tom Oliverson, M.D. (TX)
Rep. Jim Dunnigan (UT)

Other legislators present were:

Rep. Deborah Ferguson, DDS (AR)
Rep. David Silvers (FL)
Rep. Joseph Gullet (GA)
Rep. Martin Momtahan (GA)
Rep. Rod Furniss (ID)
Rep. Matt Lockett (KY)
Rep. Gabe Firment (LA)
Rep. Brian Glorioso (LA)
Rep. Kyle Green (LA)
Rep. Shaun Mena (LA)
Sen. Jeff Howe (MN)
Rep. Bob Titus (MO)
Sen. Brian Rhodes (MS)
Asm. Alex Bores (NY)
Rep. Ellyn Hefner (OK)
Rep. Mark Tedford (OK)
Rep. Greg Scott (PA)

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. Walter Michel (MS), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Sen. Michel and seconded by Sen. Jerry Klein (ND), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's November 13, 2024 and June 14, 2024 meetings.

CONTINUED DISCUSSION ON NCOIL STRENGHTEN HOMES PROGRAM MODEL ACT

Rep. Bennett stated that we'll start today with a continued discussion on the NCOIL Strengthened Homes Program Act which you can see in your binders on page 326 and on the website and app. Before we go any further, I'll turn things over to the sponsor of that Model, Rep. Jim Dunnigan (UT).

Rep. Dunnigan stated that we had a good discussion on this Model at our spring meeting in April as well as during our interim meeting last month. And just to do a quick recap of where we are and where I'd like to see us end up, the current version follows what's becoming a very popular concept across the country which is establishing a strengthen homes program within the Department of Insurance to provide grants to people to retrofit their dwellings and their roofs to certain standards. And then on the back end, we need to resolve the question of should insurers be required to issue some type of a premium discount to those who have strengthened their homes and met certain building requirements. So, today we're going to look at the Oklahoma law that recently passed and see what we can gather from them because as I said during our interim meeting, I like what they're doing and they provide more detail and guidance that we can use in our model. And I also like the provisions in there that limit the program to single family primary residences and they give priority to lower income applicants. So, today I'm looking forward to hearing from Oklahoma Insurance Commissioner Glen Mulready and he can provide us with his background and experience in the state law. And this is also a great opportunity for NCOIL to kind of determine where we want to land so we can take action on this at our November meeting.

Cmsr. Mulready thanked the Committee for the opportunity to speak and state that we modeled our bill based on the Alabama law that has been in place for a number of years now and we have learned a lot from them and Alabama has been super helpful with that. And I might also add that Brian Powell is the individual who was at the Alabama Insurance Department who has walked that through for years with Alabama and he has now moved and is on staff at the National Association of Insurance Commissioners (NAIC) and is assisting all the different states around with this issue. So, he's become quite an expert in that space and with the Insurance Institute for Business and Home Safety (IBHS). We've been on the phone with them a number of times and in fact I will throw out there too that we and other states are organizing a trip down to IBHS facilities to learn in more detail about their program. As noted, our law is limited to homes that

are owner occupied, single family primary residences. We will require a homestead exemption and that is the easy way of determining that it's an owner occupied home. We are using the IBHS system so we'll have an evaluator that the homeowner will pay for and it's going to cost them $200 or $300 to have an evaluator come out and determine exactly what that roof is like or what the understructure of that is to make sure that that's meeting requirements. They then will solicit three proposals from certified IBHS certified roofers. Now we have some in Oklahoma already there prior to this program but we're getting word out there too to try to get another constituency for us to communicate with to make sure that that we've got IBHS certified roofers who can then do the actual work. Property owners then basically agree to retrofit their property or build new to the roofing silver or gold standards that IBHS has. Ours really for the most part will be focused on the roof part. Oklahoma is a big wind and hail state and so our main focus is on roofs. We get our more than our fair share of convective storms and 80% of that damage when that comes through Oklahoma is roofs. So, we have a deadline of six months to have that work completed. We then will be issuing the grants directly to the roofer so money is not going to the homeowner, it's going to the roofer. We're currently just putting this all in place and the plan is to divide our state into five zones as we don't want to be accused of only taking care of Oklahoma City or Tulsa or ignoring the rural areas and so we want to have sort of a fair shot at that for all the different areas of our state.

But that's what we're crafting right now. And from a funding standpoint, we are non-appropriated agency but we do have leftover funds. And with the legislature, every time I brought this program up to a legislator in the hallway their very first question was "how much money do you want?" And I would say "I don't want any money. All we want is permission." And so, we set some limits on there to make that a little bit more palatable to folks or just lower any concerns with the funding side of that. So, we're allowed to use up to 50% of our leftover funds, up to $10 million. And we will have that $10 million this year to issue grants which at the moment we are going planning to cap at $10,000 each. I learned from Alabama that they had a much lower threshold and then realized that that full IBHS standard was quite a bit more than that and so that's how our number has been changed. So, our intent is to issue out $10,000 grants to homeowners as they are redoing that roof to fortify their home. We did have a little bit of a curveball thrown at us late in the session when it went over to the Senate and they did add a sunset clause on that. So, this program will come up again. It goes into effect November 1st of this year. It will come up again for a review and a sunset in three years. So, that's what's happening with our law. It's received a lot of attention. We are receiving a number of calls and we've received a lot of media generated attention as well.

Matt Overturf, Regional Vice President at the National Association of Mutual Insurance Companies (NAMIC) thanked the Committee for the opportunity to speak and stated that I just want to express our appreciation for the committee's work and Rep. Dunnigan's work on this issue. As you recall, it started last year as just a mandatory discount which we obviously expressed some concerns about. NCOIL has since expanded that discussion significantly to a broader package of items and I'll include in that the catastrophe savings account conversation that we had on Thursday. The Committee also readopted the Model State Uniform Building Code which we find very important and

now we've expanded into grants and discounts. The one suggestion that I would make with respect to the mandatory discount language is to pull some language from Rep. Michael Sarge Pollock's (KY) (Vice Chair of this Committee) bill that requires the discount be actuarially justified and also leaving the amount or the percentage of that discount up to each insurance company where they are able to do it for what works for their risk profile, their book of business in each state. We find that to be a very important inclusion and Rep. Pollock was kind enough to include that in the Kentucky bill so we appreciate that very much.

Rep. Dunnigan asked Cmsr. Mulready how the person shows that the roof has been done by the proper person? How do they certify that? How do you track it? Cmsr. Mulready stated that the certified evaluator who goes out at the beginning of that process that I mentioned, they are an IBHS certified evaluator. They will circle back at the end as well when they go out and inspect that it's done to standards. They then report back to us and that's when the check gets released. But that's that same evaluator that will be doing be it at the beginning and at the end of that process. Rep. Dunnigan asked what if the person improved their roof on their own dime. Can they then come back to you for a retro grant or does it have to be done prospectively? Cmsr. Mulready stated that it has to be done prospectively. We need that evaluator out prior to. With IBHS standards, anyone today could go and get class 4 shingles and receive a discount on their insurance. But the idea with this program is a lot more robust than that. It involves the underlayment and the thickness of the underlayment, the water, the vapor barrier, the drip edges of a certain size - so there's just a lot more to it. Rep. Dunnigan asked if the law mandates discounts from the insurance or does it allow it to naturally flow if they put it on and they qualify for whatever discounts the insurer may have? Cmsr. Mulready stated that our law does not mandate the discount but our research shows, and we actually sent a publication up to the legislature as we were trying to push this through, already filed with us are discounts that range from 10% to 43% on that wind and hail portion of the premium. That’s already on the books today.

Rep. Dunnigan asked how Kentucky does their insurance discounts or adjustments with their similar program. Mr. Overturf stated that the language in the bill was “actually justified” which I think we talked about here but then that actuarily justification is left up to each individual company. They submit that to the Department of Insurance. Early on, we saw some states where that language wasn't included and the department said the discount is going to be a certain percentage so then it was the same for everyone whether or not it worked for that individual insurer or not. That's the concern we're trying to avoid with the language that we were able to get in the Kentucky bill.

Rep. Pollock stated that I wanted to share a few comments about our Kentucky bill and we did follow Alabama as well somewhat. I want to thank everyone that worked on it and I want to specifically thank Kentucky Insurance Commissioner Sharon Clark and our insurance department. This is important because in Kentucky we have tornadoes and 70 mile per hour winds and a lot of things are really devastating our state and so this was a good piece of legislation and we're all coming together to make this happen. As far as funding goes, what we found out was a fortified roof was about $1,500 to $2,500 more than a typical roof and so the restricted funds that we generated which was $5

million on this particular bill come from our fines and fees from our insurance companies who make that up. There's an application process and Cmsr. Clark oversees that and if everything's approved, that $1,500 to $2,500 goes to that part of it. The other part of the funding was to get our contractors certified. That was a big piece to it. The other big piece was, as Mr. Overturf shared with you, about the discounts for insurance premiums and what that looks like and it was important that we provided that. I compared it to a security system type of discount that insurance companies provide when you go through the certain channels. And so that is left up to each of the insurance companies as to what that looks like. So there is a discount out there that we wanted to make sure was available but the final language I think really made sense. And so that's what we did and I hope that helps and contributes towards the model that we're looking for here out of NCOIL.

Cmsr. Mulready state that I want to echo the comments about Cmsr. Clark. As the legislative process went along this year, she and I talked quite a bit as we were both on that same path. And then since passage, we have spoken a number of times. We've scheduled some joint calls with Brian Powell to just ask a lot of questions through that. We worked at the beginning together quite a bit but we're in different time schedules now. Kentucky's takes effect in 2026 and ours takes effect November 1st of this year. So, we're a little bit different timeline but we've been working closely together with her.

Rep. Bennett asked if Cmsr. Mulready if he could talk a little bit about how you're ensuring that the $10,000 grants aren't going to homes that have just had roofs replaced - how are we making sure that the money and the effort is getting to the places that need it the most over and above sort of separating the state into five sections? Cmsr. Mulready stated that going back to Rep. Dunnigan's question, it really is centered around that evaluator. They are the sort of the eyes and ears and the checks and balances there for us and they're certified by IBHS. They're going out at the beginning to determine whether things are in place and whether that fits their standards. Because they may come back and say, "Listen you've got a quarter inch plywood on your roof and that that doesn't work. We need a higher level of that in order to be a truly fortified roof." So, they are the eyes and ears on the ground and they're at the beginning of that process and they're going out and inspecting afterwards and just making sure that that contractor has done that to those standards. And nothing happens until that evaluator comes back to us and certifies that that roof has been done to those standards.

Rep. Dunnigan stated to Cmsr. Mulready that your grant is $10,000 which may motivate somebody that's kind of borderline about whether to do something. Cmsr. Mulready stated that to clarify, it's not set at $10,000. We are paying that cost difference for the standard roof to then upgrade to the fortified roof. That cost differential is what we will be paying for up to $10,000. Rep. Dunnigan stated that so then you're similar to Kentucky where the $1,500 to $2,500 enhanced roof is what you're covering. Cmsr. Mulready replied yes. Rep. Dunnigan asked have you found that's working? Is that motivating people? Are we just capturing those people that I guess need to do their roof anyway and now they're getting the grant to upgrade or motivating people to redo their roof? Cmsr. Mulready stated that we're still early. We are not receiving applications at this point. Our intent is to start receiving applications in the fall and issue our first grants

January 1st of 2025 so it's really just too early to answer that question. I think my response to that from a gut level would just be we really don't care. If there are more homes that are fortified roofs that's just a good plus for us in Oklahoma. We don't really care whether they were going to do it anyways or they're choosing to do that because of the grant. I don't know that we have a preference with that.

Rep. Pollock stated that I echo Cmsr. Mulready's comments in that we're early as well but I want to note that contractors are seeking out Cmsr. Clark. There's a lot of buzz about it overall, but the bottom line is for us to help offset claims. Is this fortified roof going to keep your shingles on? Probably not, but it will hopefully in time provide us some extra coverage to keep the inside part of our homes protected. And so obviously again we are early in the process, but our contractors are super eager to get certified.

Rep. Dunnigan asked Rep. Pollock if he is comfortable that the insurance companies who are giving discounts, that those discounts are available for people and that they get the discounts. Rep. Pollock stated that we changed our initial language to get our insurance industry involved. So, the language we have in our bill of making it optional more or less of providing those discounts instead of just mandating a specific discount, it changed everything as far as the wording in our bill for the insurance industry. It was a big deal. Mr. Overturf can share on that process but I think once we changed the language in that discount part that was a big thing for all those involved. Mr. Overturf stated that I agree with that and I believe the Kentucky law, it's still a mandatory discount, it's just what that discount is is left up to the insurer. So, there's still the mandate to offer something by each insurer. And obviously as has been said, it's too early to have the process set up but there will be an expectation that discounts are offered.

Sen. Jeff Howe (MN) stated that I'm a building code official and this is my first time in this committee so the question I have is why go down this road and not the building code road and just enhance the building code and make that a requirement? Rather now it seems like we're going to have certain houses built to a certain level and I come from a state that has a mini-maxi building code so the building officials can only require what's in the code and I'm interested to find who are your experts are going out and watching this construction if that's not a code official who we normally have do that process. Where are these folks coming from to do that? And so I guess that's my question is why not just enhance the building code in your state to require this and make it happen so the entire state when it's done to that level would get that insurance discount? Cmsr. Mulready stated that my response to that would be the state legislature certainly could choose to do that too, to change the building code statewide. That would have an enormous impact on cost to everybody and I think that would be the negative aspect that you would hear at the legislature. There's one city in Oklahoma who has changed their building codes. For a number of years there they had a little target on their back with tornadoes and had a number of deaths even at an elementary school there and so that generated that city to change their building codes. But as far as I know, I don't know that any other city has strengthened those building codes like the city of Moore has.

Sen. Howe stated that in order to make that happen in our state, the state would have to adopt an optional appendix that a city could do. Otherwise in our state, it's a statewide code that if you're a licensed contractor, you have to build to that standard. So, cities have the option to adopt the building code, but they don't have the option to change that billing code. So we're in a little different situation and so when we adopt the code in our state, the International Building Code we're able to modify that throughout the state but we are not allowing cities to pick and choose to increase an area. In your state I take it that they have the option to adopt the code or not or increase the requirements as they see fit. Cmsr. Mulready replied yes, things are different in our state from what you described. Building codes are established by each community, each city. In fact, it was a little bit ironic one day I was out visiting with another city with the city leaders, with the city manager, the Fire Chief, and talking some things through and the city manager mentioned to me that he wished that I would do something about the building codes. And I had to nicely say to him that you are in control of that. We don't control that. And I mentioned as I did just a minute ago the city of Moore, who did indeed step in and do that for their community. But we do not do that statewide. It's each community that is establishing those building codes in Oklahoma.

Mr. Overturf stated that this whole conversation came about at the beginning of the readoption of an NCOIL Model State Uniform Building Code Model and NAMIC believes that it's important to have a statewide enforced building code. But as we just discussed, states do it vastly different. Some states have a statewide enforced building code. Some states have just a statewide building code that's not enforced. Some leave it up to local governments. It's kind of all over the map. But from our perspective, a statewide enforced building code is a foundation to mitigation against disasters. This model is just in addition to that.

Rep. Dunnigan stated that I really appreciate the work that's been done by Alabama and everybody else following it. It's nice to hear everyone's experience and we'll incorporate that into the model. And just to the building code comment, as was mentioned within the last year we readopted the NCOIL Model State Uniform Building Code and so we have that model which is a separate piece. And I agree it needs to be in the building code and we have that model in place.

Rep. Bennett thanked everyone and stated that the building code conversation is important but for me, the point of this legislation is making fortified residences attainable for the average consumer and that's the piece of it that I appreciate. But I think it's going to take a multi-pronged effort to make sure that consumers are protected and our infrastructure is being resilient.

UPDATE ON NAIC'S PROPERTY & CASUALTY MARKET INTELLIGENCE DATA CALL

Rep. Bennett stated that we're going to talk about the NAIC's Property and Casualty Insurance Market Intelligence data call. As many of you know, this country is facing an arguably unprecedented hard market in terms of affordability and availability within the homeowners and auto market. So, the information gathered from this data call will

hopefully be able to help policymakers determine how we can help consumers and improve the market.
Cmsr. Mulready stated that we embarked on this data call at the NAIC on March 8th. The target was to collect data from 80% of the national property market based on premium volume. We also then allowed individual states that were going to engage in that if they wish to as part of that data call, solicit data from maybe smaller carriers that would not be included in that, those that are domiciled in their states that might have a decent amount of market share within that state but certainly not going to show up on the radar on the national picture. And so, there's a number of those included in there as well. The Federal Insurance Office (FIO) had wanted to do a data call. They solicited each state and mine included and they wanted all this data down to zip code level and they wanted it in 30 days. Maybe it wasn't 30 days, but it was a very unreasonable time frame. And I responded that the answer wasn't no, but the answer was we cannot meet these time frames. And so, from that, the NAIC leadership worked with FIO and felt like this really is our role and we can capture this and we are the ones rightfully doing this.

So, we reached agreement with FIO to capture this data and to pull it all together into something readable and helpful and then we'll be passing that along to FIO. There was a concern with the data especially during an election year where we didn't want that weaponized if you will, that's my term, not the NAIC's term. So we have some control of this data call so that we can anonymize it and aggregate data and get that out there so that it would be helpful so it hopefully will give us some deeper insights into market concentrations, competitiveness, coverage gaps, that sort of thing. There's an information gap certainly out there. We are collecting amount of premiums, policies, claims, losses, limits, deductibles, non renewals and coverage type. So that went out, as I said on March 8th. There was a deadline of June 6th to have things back. The vast majority of that was sent back to us, but the NAIC has been then chasing some of that additional data. I know, speaking for myself in Oklahoma, one of our domestics was one of those that I have included, they had just gone through a CEO change and it kind of fell through the cracks. And so, we've helped follow up with that to capture that data. So, there's sort of this chasing of some of those that may have fell through the cracks at this point. So, we would expect that we will be passing along data to FIO shortly as they're sort of cleaning up that data. Different companies collect that in different ways. Of course, it's coming into the NAIC not all in the same format and that's part of the process of what's happening right now. I don't have an exact date, but we'll be providing those subsets out to FIO as we have received those at the NAIC.

Rep. Bennett asked Cmsr. Mulready if he knows how many states participated in the data call. Cmsr. Mulready stated that I do not have that number. We were not concerned about the states as much as we were concerned about 80% of the market share and trying to get to that number.

CONTINUED DISCUSSION ON NCOIL ONLINE MARKETPLACE GUARANTEES MODEL ACT

Rep. Bennett stated that next on our agenda is a continued discussion on the NCOIL Online Marketplace Guarantees Model Act. We had an introductory conversation about

this at our meeting in April and since that time, Rep. Brian Lampton (OH) has signed on as sponsor and I have signed on as a co-sponsor. I think the model serves as an important piece of policy to sort of clarify certain things and I do look forward to this conversation. We won't be voting on this today. There's still plenty of time to have conversations with potentially a vote in November or even in the spring meeting of 2025.

Byron Wobeter, Associate General Counsel of Insurance at Airbnb, thanked the Committee for the opportunity to speak and stated that I'm joined by Brad Nail and we're pleased to express our support for the Model. I also want to thank Rep. Lampton and Rep. Bennett for sponsoring this Model. As Rep. Bennett mentioned, at your last meeting in April we provided an introduction to Airbnb and the online marketplace guarantee that forms part of our terms of service with our hosts and our guests and Airbnb. This is known as our host damage protection, or HDP. The HDP program has been part of Airbnb's terms of service for over a decade. To recap, Airbnb is an online marketplace facilitating the rental of property between a property owner, a host and the renter, the guest. We currently have over five million hosts making over eight million properties available throughout the world. We are in many cities, towns, rural areas all over the world. As you may know one area of concern for our hosts is any damage caused by the guests to their property when they stay in an Airbnb listing. And just to recap, under our terms of service, the guest is contractually liable to the host for any damage that they caused during the Airbnb stay. And HDP just guarantees this contractual obligation when the guest doesn't pay the host back for any damages that they cause HDP backstops that obligation. Airbnb, then, has obviously recourse against the guests for any nonpayment and we do and can pursue them contractually. HDP is a limited incidental guarantee offered to Airbnb hosts as part of our terms of service. It's consistent with many other online platforms that offer similar guarantees, online platforms that connect to users. It's not insurance as guarantees are legally distinct from insurance when they're incidental to a company's other primary business. Of course, our primary business being a platform to facilitate the renting of properties. There's no additional charge or fee to the host for the guarantee and it's simply just an ancillary part of our service. And with that, I'll be happy to answer any questions the committee may have regarding guarantees or our HDP guarantee contained in our terms of service and I'm going to turn it over to my colleague Mr. Nail to discuss the implications of the Model.

Mr. Nail stated that the threshold question we usually ask ourselves when we're entertaining a new model law is why is this necessary? I think we and the sponsors have identified a need to codify the practice of offering marketplace guarantees to provide consistency across the States and to provide guidance to your regulators who have questions about how these guarantees work. Today, there are some states that have existing statutes permitting this type of guarantee but most states rely on a web of case law to affirm the appropriateness. We believe that both the marketplace and the regulators will benefit from the clarity in the statute that this Model would provide. We've attempted to identify other potential stakeholders and work with them on this language and I know the sponsors have had conversations with other stakeholders trying to make sure that everyone's thoughts are heard and relevant concerns are addressed. This includes the insurance trade groups who've provided feedback. Some of that feedback has been incorporated from the discussion draft that was circulated previously to this

model that is before you now. Several of the parties we've spoken to have identified the similarity to the service contract model which some of you may be familiar with. And obviously we'll continue to work toward resolution of any additional relevant concerns that are brought forward by the committee or other stakeholders.

The proposed model does the following. It sets out definitions specific to this type of guarantee. It requires registration, so the state is aware of businesses offering guarantees under this law. That again is similar to the service contract model that you're familiar with. It sets out minimum financial strength for businesses to engage in this practice to ensure that the guarantees will be satisfied. It's consistent with the statutory scheme in many states and codifies the case law position in others by clarifying that these non vocational incidental guarantees do not constitute the transaction of insurance. This is something that's ancillary to the primary business that is being conducted. This clarification will be helpful to your insurance regulators if there's a question around lawfulness. It requires disclosures for consumer protection and prohibits any activity that could be misleading to consumers. And finally, it authorizes enforcement of these requirements by the appropriate agency in your state whether it's the Department of Insurance or Attorney General, or perhaps another agency in your specific state. The practice of offering performance guarantees that are ancillary to a company's primary business has been around for years. As more of our commerce has moved online and as we witnessed the proliferation of three party transactions within the sharing economy, guarantees like the one that Airbnb offers become even more important. So, like many of the model laws that are introduced for your consideration, the goal of this one is primarily to provide clarity and uniformity in the statutes. So, we support this effort. We believe that the model accomplishes that goal and we hope that you'll give it your favorable consideration.

Jon Schnautz, Vice President of State Affairs at NAMIC thanked the Committee for the opportunity to speak and stated that my colleague Mr. Overturf at the April meeting alluded to some of the concerns we have with this model generally. I want to be a little more specific about those today because we do have some concerns. I think some of them are fairly easy to resolve. Some of them may not be. But the first set of issues I want to talk about are more general. This model puts before NCOIL an issue that's foundational but doesn't actually come up here all that often which is exactly what is insurance? If you look through the literature on the topic, it's actually not as easy to define as you might think. There is not an agreed definition of it. I believe at one point the NAIC spent about a decade trying to come to consensus on exactly what the term should include and didn't reach one. However, I will say that a three party transaction in which one party is assuming the liability of another to a third-party is really similar to how a lot of things that everybody regards as insurance work. Auto liability insurance is essentially that sort of setup. The liability portion of homeowners insurance is very much that kind of three party transaction. A lot of commercial policies are exactly the same way. So, I guess I would paraphrase Potter Stewart, the former Supreme Court Justice, “I may not know exactly what insurance is, but this looks a lot like it.” And so that's our main foundational concern and it's a difficult one to address without not pursuing the model at all. But I do want to put that out there because what Airbnb is asking to do here, and it's not just for them, they may be perfectly responsible about this program, we

have no reason to think they wouldn't be - but for any online marketplace, this is allowing them to assume that assumption of risk transfer sort of role that again looks like insurance. And that when it is called insurance in all of your states is subject to volumes and volumes of well justified regulation as opposed to what's in this model which is pretty bare bones, frankly. It's nothing like that. So that's the first concern.

To go a little bit to the specific concerns, I guess the first one I would say is I think there's a lack of evidence at least to date by the proponents of this model that there is something about what the regular insurance market is doing that makes this necessary. In other words, is there a deficiency out there on what coverage is available? There is commercial coverage for short-term rentals for people who do it all the time. Many homeowners insurers for rentals that aren't always rentals, for example ones that the owner occupies, offer that coverage through an endorsement. It's not part of the standard coverage, I want to be clear but it from our perspective to some extent is available. So, I think the proponents of this model ought to have to carry the burden of showing why does the regular insurance market not already cover this sufficiently? That's the first concern. The second specific concern is this bill is a lot more expansive than the issues that the proponents have identified to try to address. They've talked about in the past at the last meeting about sort of smaller items, lamps and towels and those kinds of things. The coverage today was referred to as limited and incidental. If it's intended to be limited and incidental, then revise this model so that it is only covering limited and incidental items because there's nothing in the model that actually requires that right now. It's much broader. And so if you're going to go down this road, I think you should make it what the proponents have suggested they wanted which is a more limited sort of coverage. The last specific point is there are a couple of sections in the model that really haven't been talked about at all but from our perspective are particularly off the point to what proponents are trying to do. Sections five and six are all about the relationship between the provider of these guarantees and an actual insurance policy. And if there's a reason that needs to be in this model, we're willing to hear it. But I don't think we've heard it yet. We've heard about why they want to have a program that's different than insurance. That's fine. Why do we also need language in this model that goes to the insurance point? To conclude, I want to be clear, on our general concerns, I'm not sure how easy those are to address. Those are big picture philosophical concerns with the whole model. So, I don't want to suggest that if the specific issues are addressed that we would just be fine with the model. I'm not sure that's true. But I do think those specific concerns at a minimum should be addressed.

Rep. Bennett asked if Mr. Wobeter to outline what insurance coverage Airbnb requires of the people on his platform? And does Airbnb offer any of those products? Mr. Wobeter stated that we don't require insurance coverage. We ask the host to get with their broker and obtain the appropriate insurance coverage. However, we do have and maintain liability insurance programs and these are just typical liability insurance programs for the hosts throughout the world and those are for slip and falls and things like that.

Rep. Bennett asked if Mr. Wobeter could respond to the assertion of what's the need for the Model? Can you talk about what kind of spurred the need to establish this? Mr. Wobeter stated that as we kind of talked a little bit earlier, we've been offering this

program for over a decade. We went to the NAIC in 2016 and a white paper was drafted and published on this program and we didn't have any questions regarding the program because the way we set it up was lawful. We've had recent questions from regulators on the philosophical point, what is insurance and what is not insurance? And so, given those questions the need is clarity. As we kind of mentioned earlier, some of it's codified in statute. Some of it you have to go to the case law and to codify all of that we think it's necessary to make it clear and also to provide the consumer protections that we think are important given the proliferation of these guarantees online.
Mr. Nail stated that Mr. Schnautz is asking all the right questions. He's asking the same questions that some regulators are asking and the answers are best provided by the legislature. If you look at the service contracts, if you look at extended warranty programs, these are things that can look a lot like insurance but they're not because we've vetted them through the legislatures and determined that those programs make sense to exist outside of the sphere of insurance and this really falls in line with that.

Sen. Larry Walker (GA) stated that earlier a question was asked as to whether insurance is required by the host and the answer was "no, but we have a liability insurance program available." Are you telling me that the hosts are not required to have liability insurance? Mr. Wobeter replied no, not to join our platform. Sen. Walker stated that's a little concerning to me. Sen. Walker stated there was testimony given that other stakeholders have been involved in the conversation of the crafting of this proposed model. Were Vrbo or HomeAway a party to this? Mr. Wobeter replied no, from our last review, they don't have something like this. But various others out there that connect users were consulted and we discussed it with them. Sen. Walker stated that makes me wonder are you just trying to get a competitive advantage.

Mr. Nail stated that it's not an issue of a competitive advantage as right now, Vrbo just has a different set up to where they operate. They might end up adopting something like this as there's nothing stopping them from doing it. Sen. Walker asked if Airbnb has a physical presence in Georgia? Mr. Wobeter stated that I'd have to check on that and get back to you. Sen. Walker stated that for Georgia citizens that allegedly damaged property and it's basically turned over to Airbnb to then sue my Georgia residents, I'm just concerned about their due process if you don't have a presence in Georgia. I don't think you do but you may. If one of my citizens rents an Airbnb and they were alleged to have damaged the property, instead of working it out with the host or filing it on their insurance, they have Airbnb coming and that to me poses some concern.

Mr. Nail stated that if I can clarify a little bit, Mr. Wobeter didn't go into much detail on this because we didn't want to repeat all the stuff from the last meeting but the first step is always for the host and the guest to work it out on their own. The guarantee that Airbnb offers, and it's only to the host, they're not providing anything to the guest, they're just guaranteeing to the host that the issue is going to get resolved. But the first step is always for the host and the guest to try to work it out.

Sen. Walker stated that the question was asked, what need are we trying to fill? I think when you rent a property through Airbnb there's an option for the guests to pay a damage waiver or buy insurance. There's certainly insurance available in the private

market already to cover this kind of thing. There's insurance for the host and the guest for this type of thing. So that's my last comment, what are we trying to solve that's not already available? Mr. Nail stated I would look at it as a supply side issue. In order for people to feel comfortable putting their property available for this they need some guarantee that if something happens to it it's going to be resolved favorably. Sen. Walker stated they can buy insurance in the private marketing. Mr. Nail stated that some homeowners' insurance might offer coverage, some homeowners insurance is going to exclude coverage. There might be riders or endorsements that are available. It's complex, but it's through this guarantee program, and they're certainly welcome to and should consult with their insurance brokers and agents before doing this, where we can provide consistency and peace of mind to the property owners and this guarantee program works well for them.

Mr. Wobeter stated that to address your comment on Airbnb going after your citizens, we do have various appeals processes in place where we will work with them and make sure that we have the story right before we would do something like that.

Rep. Bennett asked what is the most common scenario where Airbnb has to step in and sort of act as an arbitrator in this scenario between a property owner and a renter? Mr. Wobeter stated it's actually quite rare. I think we looked at it recently and it's one out of over 500 nights involved Airbnb. So it's rare to begin with. The most common situations are towels, sheets and various small items that don't amount to a lot of money. And so how it kind of works generally is the guest may damage a towel and the host goes directly to the guest and says you damaged this towel, here's a photo, I'd like X amount of money. A lot of times those guests will either pay or they'll work it out some other way before it even comes to us. But we're really talking about low level items for the most part.

Rep. Bennett stated from a customer satisfaction standpoint and I guess the speed of resolving the issue, can you talk about what that timetable is now and what it might look like. I know that there have been scenarios where certain government subdivisions have required you to provide some kind of product in this way. What is the timeline difference and what is the customer satisfaction experience difference between those two things? Mr. Wobeter asked what is meant by timeline. Rep. Bennett stated the moment of realizing that the towel had been damaged or stolen to being made whole. Mr. Wobeter stated many of these requests for reimbursement that come to Airbnb are handled well within 14 days. It's only the larger ones that are actually even more rare that could take a little bit longer. So, they can be handled very quickly. And then your second question was? Rep. Bennett stated what would be that timeline if there was an insurance product required for this? Mr. Wobeter stated that it would make it certainly more cumbersome because you would have to go to a third-party. Then they would go through and determine what happened. Whether the host and guest tried to work it out and that timeline would probably be expanded and it would make the process a lot more complicated.

Rep. Tom Oliverson, M.D. (TX), NCOIL President, stated following on what Rep. Bennett was asking, I had a vacation property for a while and we didn't use Airbnb but the

company that managed the property for us just collected a deposit in advance from everyone that rented that property and then if there was a towel or something simple like that damaged the cost would come out of that deposit. Why not do that? Mr. Wobeter stated I think one thing is we don't want to have consumers put that money up front and as I said earlier it's quite rare that they damage anything. Rep. Oliverson stated but don't you think that if they were charged a deposit that also influences consumer behavior on some of this stuff? Mr. Wobeter replied I guess it could.

Mr. Nail stated that I think you're thinking of the kind of trip that I tend to take where we take a golf trip once a year with 12 guys and we rent a big house and we pay a deposit for that kind of thing. But when you check into a hotel here you're not necessarily paying a deposit. They have your credit card on file and they can deal with you on damages and I think it's a different market at least in some respects.

Rep. Oliverson stated that having been on the landlord side of this thing what you're describing to me gives me a certain amount of discomfort with your business model from the standpoint of I don't like the idea of as the landlord having to work this out with the renter. I think most people that do Vrbo or things like that like the idea of not having to be physically present there being the landlord and just know that it's being taken care of while they're not there but maybe that's just me. Mr. Nail stated that I think the concern that you just expressed is reasonable and it's similar to the same concerns that we heard on the transportation network companies (TNCs) about using your car to provide people rides but over time and with volume, you see that it works and Airbnb has been around a long time and over time with the kind of volume of business that they do, it does work. But this guarantee is also one of those things that gives that owner some piece of mind that there will be an appropriate resolution when something does come about.

Rep. David Silvers (FL) stated that I do want to note that I've used Airbnb before and you do see the host. They're rated and you're rated as well so I think that would actually impact consumer behavior as well. If you have a really low rating, you probably aren't going to get that that rental.

Rep. Bennett stated I know of folks who use sort of a property management company as sort of an intermediary area where they own several properties and they rent them out to Airbnb. Is some of this stuff being handled in that way? If I own a property in Florida but I never see it but I know I have a property management company that comes in and cleans those towels, it would be on them to determine whether or not the towels have been stolen or damaged. From these conversations so far, I haven't heard that a lot of these issues are coming up. Is there widespread theft and damage that’s just not being reported or is it just a relatively low occurrence? Mr. Wobeter stated that it's definitely rare. Also, we do allow co-hosts as well on our platform and they can actually manage this process as well to go through the guarantee.

Rep. Bennett stated that this is an interesting conversation and we'll continue this conversation likely during an interim meeting and it will be brought up again in November and maybe we'll have something to vote on by then. I appreciate everyone's willingness to engage on this and we will continue these conversations.

INTRODUCTION AND DISCUSSION ON NCOIL MOTOR VEHICLE GLASS MODEL ACT

Rep. Bennett stated next on the agenda is an introduction and discussion on the NCOIL Motor Vehicle Glass Model Act. Before going any further, I will turn this over to Rep. Pollock, sponsor of the Model.

Rep. Pollock stated that I'll be brief and just note that I'm proud to sponsor this model as it's based on a law we recently passed in Kentucky in response to rising concerns about auto glass repair fraud. We took action to protect consumers from deceptive practices in the auto glass repair industry. The law aims to curb fraudulent activities and ensure transparency and fairness in the auto glass repair process. It actually follows what Florida enacted last year so I think we're starting to see a trend of states taking action on this which is why I think it's good timing that NCOIL is taking this on. I look forward to the discussion today and certainly welcome input on the model throughout the process.

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 our member insurance companies to detect, prevent and deter insurance crimes and that includes motor vehicle glass fraud. So, today I'll provide a short overview on vehicle glass fraud as well as hitting on some of the key notes of the Model. And so to begin, when we're talking about vehicle glass fraud we're talking about a scheme that's largely perpetuated by unscrupulous glass shops. And let me be clear, I'm talking about a small number of bad apples in an otherwise good bunch. But nevertheless, they approach consumers in public spaces, usually parking lots or other locations similar to that where they were able to lay eyes on a consumer's vehicle, see the little divots on their windshield. See a tiny little crack on their windshield. And they're able to solicit these consumers to sign contracts with them to repair or replace these windshields. And they tend to operate in states or favor states where there are no deductibles for windshield replacements or repairs. And the reason being is that it's part of the scheme. It's part of the solicitation. And they come up to you and they say, "Hey, I can get your windshield replaced or repaired and you don't have to pay a penny because your insurer will pay for everything." And if that doesn't work, then they'll utilize financial inducements like gift cards or cash. In some cases, we've even seen Omaha Steaks offered. And in addition to that, they tend to exploit contractual mechanisms like assignment of benefits that allow them to assume control of the consumers rights or benefits to an insurance claim. And they use this as a vehicle to file inflated claims with insurers. And in recent years, we've seen some new elements arising out of these inflated claims and that surrounds the advanced driver assistance systems within your windshields. As your car becomes more advanced, basically a computer on wheels nowadays, so too are your windshields. Now they're embedded with these tiny little sensors called Advanced Driver Assistance Systems (ADAS) that are very costly to repair or recalibrate and we're seeing inflated claims coming in for recalibrations that were either not warranted or work was charged but never performed at all. And the end result is inflated claims are being filed. Insurers are flagging these claims as being questionable or for suspected fraud but

these bad actors are quickly turning around and filing frivolous lawsuits against insurers for lack of payment. And there's perhaps no greater example of that than in Florida where prior to 2023 Florida was a sue to settle system. Where the legal and regulatory environment incentivized inflated claims and incentivized frivolous lawsuits around these claims. Over a ten year period, we saw a 4,000% increase in glass lawsuits, from 2011 to 2021. And in 2023 as the legislature was looking into closing some of these loopholes that were being exploited by these bad actors we saw another 46,000 lawsuits filed over an eight month period.

Now, what do we do about it? Well, NICB joined the industry and some other consumer protection or consumer advocacy organizations, in order to successfully advocate for three key provisions. One was the elimination of Florida's assignment of benefits statutes. Taking away that key vehicle that's been serving as the pillar behind these schemes. Prohibiting financial inducements, taking away that key marketing tool that's being used to convince people to sign on the dotted line with these bad actors. And then creating some transparency around recalibrations again, those tiny little sensors in your windshield. The end result of that was very positive, by Q1 2024 glass related lawsuits decreased to just under 3,000. So again, 46,000 during that eight month period in 2023 and then by Q1 2024 less than 3,000. That's a big success and a testament to how effective these reforms were. But there was an unintended consequence to our success. And that consequence was these bad actors, now that the environment was no longer conducive for them to carry out these schemes, they packed up and they moved to other states. And at the top of the list were other no deductible states like Kentucky and South Carolina. Or states with no deductible options like Massachusetts. The reason being is it's another safe haven for them to commit these very same schemes offering the promise of a free windshield replacement because your insurer will pay for everything. But while I made the point about the no deductible states, I want to be clear that just because a state may have a deductible for windshield replacements doesn't mean that they're not being targeted by bad actors as well. I want to direct your attention to this slide here and here you'll see the top ten states for questionable claims involving vehicle glass reported to NICB over the last four years. It's not surprising to see Florida and Arizona at the top of that list where auto glass fraud is a significant issue in these states.

But I want to call your attention to states on this list like Texas, Colorado, and Michigan where there are deductibles for windshield repairs and replacements. And what this is a testament of is bad actors will move to states or they'll operate in states where they believe that they can make a profit off of their schemes. They will move to states where regardless if there's a deductible or not, if they can exploit the regulatory environment, if they can exploit something like assignments of benefits ,then they will do so. And this is why I'm encouraging not just everyone here today on this committee but all states to review their laws, to review their regulatory environment and identify these loopholes that could be exploited. And I need to commend Kentucky for passing comprehensive legislation in the form of Senate Bill 29 which did exactly that. Kentucky was proactive. They didn't want to become the next Florida. And I encourage all states to have that same line of thinking and to be proactive to stop themselves from being the next safe haven for these bad actors. And so, I wish to thank Rep. Pollock for introducing this

Model which is based off of Senate Bill 29 and this is important and I really need to mention this because Senate Bill 29 was the product of negotiations and consensus amongst the myriad of stakeholders. As noted on the screen here from your vehicle manufacturers to the glass industry and even the trial attorneys came to the table to come up with language that can be passed. And so this is why Senate Bill 29 is serving as the framework for this model. And to highlight some key provisions around the model, first and foremost, at the top of the list, it prohibits assignment of benefits for property and casualty policies. Let's take away the vehicle that has served as the pillar for these schemes. Let's do what Florida did, what Kentucky did. Let's take away the ability for these bad actors to take control of a consumer's rights, of a consumer's benefits to an insurance claim. Let's take away the ability for these bad actors to exploit these contractual mechanisms to file inflated and potentially fraudulent insurance claims and frivolous lawsuits against insurers.

Next, guardrails for ADAS. This is as much of a consumer protection issue as an insurance fraud issue. This model will require that when a consumer leaves that glass repair shop parking lot that their ADAS is operating to manufacture specifications. So that way when they're ten miles down the road the ADAS doesn't fail on them and then they end up in an accident. And if that glass shop cannot meet those manufacturer specifications then this model will require that glass shop to direct the consumer to a repair shop or some other entity that can. Again, this is a critical consumer protection. The model also provides guardrails around claims practices. For example, it requires an insurance claim to be filed before any form of repair, replacement, recalibration to a windshield can be performed which will help tackle some of the inflated claims that we're seeing around not just the system, but just in general. The model also provides a list of prohibited unfair and deceptive trade practices. Just going back to the financial inducements, no more cash, no more gift cards, no more Omaha steaks that these bad actors can offer to consumers to get them to sign on the dotted line. And then the final point is there are some anti steering provisions within the model as well and this is designed to ensure that consumers have options when they're seeking out replacements, repairs, recalibrations to their windshields or vehicle glass needed for their motor vehicles.

Sen. Howe stated that from my understanding what you've proposed here is - my insurance company I've got no deductible and if I submit a claim for my windshield they will tell me that there's a list of pre-approved glass replacement installers. And if I go to one of them, I don't need to go get a number of the estimates, the invoice, all the rest of that stuff. If I just go to them, they'll just replace it. It's all taken care of. If I choose to go to someone that's not on their preapproved list, I've got to go through the hoops to have someone else do that. And it's not only for glass, it's that way for any of my body shop repairs. So, is this going to prohibit that type of what you call steering that they can't guide me to some shop that's already pre-approved that they know they're not going to get any of these deceptive practices? Mr. DeCampos stated that the model is designed to just provide a little bit more flexibility to the consumers so that way you're not steered to a very specific provider. It just increases your options a little in order to seek out the repairs or the replacements that you need. So, it's more geared towards prohibiting that one being steered to one particular shop in general. Sen. Howe stated that so in other

words, the answer is yes. Mr. DeCampos stated that the answer is essentially yes. If I remember your question correctly, it's designed to not limit you to just one specific option.

Sen. Howe stated that my concern is I don't have that option to go to those three or four. I'm going to be required to go get a number of estimates to send them in. And to me, that puts more hassle on the consumer instead of just being able to go to two, three different shops and get my glass replaced and I'm done and it's all taken care of because these shops are already pre-approved. I kind of like that option. Rep. Edmond Jordan (LA), NCOIL Secretary, stated that to address your concerns and I'm not sure if Mr. DeCampos understood the question exactly, if you look at section seven, anti steering, it doesn't prohibit what you're talking about. It doesn't prohibit an insurer for maintaining a network of motor vehicle glass repair shops and it doesn't stop them from giving you that list. So, you can still have that list and they can still have the network of dealers that you can rely on if I read that correctly. I think that addresses the issue that you're bringing up. And that's on page 324. Sen. Howe stated that I understand that but in the other sections it still requires me to get an estimate prior to all this and it still seems to require me to go through the hoops even if I do go to those preferred repairs and that's my concern, it requires me to jump through hoops that I really don't want to go through. Mr. DeCampos stated that the way I interpret that is that's actually a critical consumer protection so you're not being faced with these inflated bills after the repairs have been done. And so having that written estimate ensures that you're seeing what is exactly being done from a repair standpoint to your vehicle glass or to whatever body work that’s being performed and ensures that when that claim is submitted to the insurer that it has all of the information necessary for that claim to be processed.

Rep. Pollock stated that the key words I think I heard were “when you contact your insurance company.” And I think in a nutshell is pretty much what this model is and ensuring it’s not somebody else contacting your insurance company. And so this particular model dictates that. This is a consumer protection model and that's what it's specifically meant to be. I look forward to continuing the discussion on the model.

UPDATE ON FEDERAL INITIATIVES IMPACTING THE TITLE INSURANCE MARKETPLACE

Rep. Bennett stated that next on our agenda is an update on the federal initiatives impacting the title insurance market. On page 347 in the binders you'll find a letter that was sent by Rep. Oliverson to the Director of the Federal Housing Finance Agency (FHFA) expressing our concerns about the agency's proposed title acceptance pilot which would permit title insurance obtainment requirements to be waived in certain circumstances. At the NCOIL DC fly in this summer we also spoke with our Congressional counterparts about this. Since then, we've come to learn that the Consumer Financial Protection Bureau (CFPB) has issued a request for information (RFI) which could lead to some more federal involvement in the title insurance marketplace which is troubling from a federal encroachment standpoint.

Elizabeth Blosser, Vice President of Gov't Affairs at the American Land Title Association (ALTA), thanked the Committee for the opportunity to speak and stated that we are the trade association that represents title agents and underwriters. I do greatly appreciate the opportunity to talk on these two topics. We appreciate NCOIL's interest in the topics and Rep. Oliverson's leadership. As this committee has discussed in the past there've been several federal initiatives and activities by the government sponsored enterprises (GSE's), Fannie Mae and Freddie Mac that run contrary to the state based system of title insurance regulation. We also believe these initiatives pose risks to consumers and to the greater real estate market. Given this is the first time I've had an opportunity to address this committee, I do want to do a quick level set on title insurance because we're a little bit different from other property & casualty lines. Whereas most property & casualty insurance covers risks that are going to happen in the future, title insurance primarily covers risks that have happened in the past. So, unpaid liens or fraud or forgery that might be associated with your title. Because of the unique nature of the insurance our claims rates are relatively low which we think is great news for consumers. When you go and buy a home today and you get the keys you aren't thinking in the back of your head do I really own this property? And that's the value that title insurance brings to consumers and in providing certainty within the real estate market. Because of that, about 80% of your one-time title insurance premium goes to risk mitigation efforts. The industry estimates that they find upwards of $600 billion of title risk exposure every year through their title examinations processes related to real estate transactions. Those are then addressed in the curative process, mitigating potential risks for homebuyers.

For reference, only eight cents on every dollar goes to industry profit and when it comes to claims over 50% of claims appear four years after an insurance policy has been issued. So, with that background, let me shift to talking a little bit about the FHFA's title acceptance pilot. By way of background, this is not the first time the GSE's have promoted unregulated title insurance. Back in 2022, we learned that Fannie Mae and Freddie Mac had approved the use of unregulated title insurance alternatives on certain types of loans. While these are marketed as equivalent products they don't necessarily carry the same coverages and most importantly they bypass state insurance laws and regulations. We've also come to realize as we see more of these in the marketplace that they are not necessarily cheaper and in a number of instances more expensive than regulated title insurance. The promotion of unregulated products was escalated in March through the approval of this title acceptance program. It came the same day as the State of the Union when President Biden announced that the administration was going to be eliminating title insurance fees for federally backed mortgages. Obviously, that's a broad statement. And what we know from FHFA's FAQ's that were released that same day is that there's a pilot program that's going to allow Fannie Mae to operate as an unlicensed title insurer on certain refinance loans. As we understand it, the process includes an automated title review and then lenders pay to Fannie Mae a fee to cover any risks that there are as a result of an unexpected title defect. So, certainly that falls within the definition of title insurance under most state laws. There has been significant bipartisan concern about the pilot program including on the Hill and so let me quickly talk about what those concerns are. First, there's been a lack of transparency around the pilot program. If processes that were in place were followed there would have been

ample opportunity for state legislators, regulators, industry, Members of Congress, consumer groups and others to bring up questions and concerns during a public notice and comment period.

Second, we're very concerned about consumer risks and the fact that consumers are going to be put into really an experimental claims process. So, unfortunately, fraud is very much rampant right now in the real estate market, another topic that I'm happy to talk to anyone about, but if you are a victim of impersonation fraud, somebody takes a cash out refinance in in your name, what is your recourses as a victim? Are you going to have to call Fannie Mae and convince them that there was fraud and then negotiate some sort of settlement? It is concerning that all of this would happen outside of a regulated claims process and certainly if the process is lengthy or difficult it could result in loss of home equity or even loss of one's home. Finally, as mentioned earlier, this pilot does run contrary to the well-established state based system of title insurance regulations. With the approval of FHFA, Fannie Mae is acting as an unregulated insurer, certainly you could look at this pilot and say that it is conducting the business of insurance without a license which of course violates the NAIC model and beyond that creates a very concerning precedent. At this point, the pilot program is moving forward despite bipartisan concerns that have been raised by Members of Congress, regulators and legislators. Fannie Mae has put out a request for proposal (RFP) to gather proposals for different products to be used as part of this pilot program.

Next, I can touch quickly on the CFPB's RFI and then I'm happy to take any questions on both of these topics. The CFPB has recently issued am RFI and it raises questions about the bureau's intentions regarding federal oversight of title insurance pricing. The RFI specifically relates to fees imposed in a mortgage transaction and of course that includes title insurance. There's also been some insinuation in this process that title insurance might be considered a junk fee although that was walked back to some extent in a recent congressional hearing. The title insurance industry will be providing some comments and feedback on the RFI and it will center primarily on the fact that we want to come together as government entities and private industry to address affordability. That's an important topic and it's one we want to talk about. It's a discussion we want to be part of. We in the title industry believe in the dream of home ownership and all of the benefits that brings to people. And we want to see more people in homes. The letter is also going to provide some data on the cost of title insurance, showing that costs have nominally decreased 5% over the last five years. If you look at that on a constant dollar basis accounting for inflation, that number actually goes up to 36%. This is primarily due to innovation in the industry, things like digitizing past land records, using digital closings, things of that nature. However, despite the use of this innovation, on average title agents spend about 22 hours on each real estate transaction. Finally, the letter is going to outline the very local nature of real estate and the differences in state property laws and these factors reinforce the value of a state based system that can address these types of nuances. And certainly, states have a strong vested interest in being able to regulate the title risks in their state as well as the authorized insurers. Before I wrap up and take questions, I do want to make everyone aware that FIO did hold a roundtable just last week on title insurance and reforms to the industry. Because the meeting was subject to certain rules, I'm very limited in what I can say about what happened in that

meeting. However, the Department of Treasury did put out a readout on the meeting. I think it's pertinent to these discussions so I'm just going to share that quick readout so you get a sense of the meeting.

This was put out just last Wednesday. Today, FIO at the U.S. Department of Treasury hosted a roundtable discussion with representatives from the financial services sector and consumer groups to discuss the title insurance industry and analyze potential reforms. This was part of the Biden administration's efforts to lower costs for home buyers. Title insurance is a product offered by commercial insurance to mitigate title defects and address disputes concerning property ownership and priority of the mortgage lenders interests arising after closing. Lenders generally require that such insurance be obtained and paid for in connection with the closing of a residential mortgage transaction. Senior Treasury officials led discussions that address the structure of the title insurance industry, the costs and benefits of title insurance, consumer awareness and protection, and various proposals for reforms to lower cost for home buyers. Participants in the round table included representatives from groups that advocate for consumer housing access as well as title insurers and agents, lenders, state insurance regulators, academics and other stakeholders. FIO was tasked with convening the round table in connection with President Biden's call for federal agencies to take all available actions to lower home cost, closing costs and help more Americans access home ownership. Among its other statutory duties, FIO monitors the extent to which traditional underserved communities and consumers, minorities and low and moderate income persons have access to affordable insurance products, advises the Secretary of the Treasury on major domestic insurance matters and consults with state insurance regulators regarding insurance matters of national importance. Today's roundtable will assist FIO and its work as it continues to consider policy options with regard to title insurance.

Sen. Lana Theis (MI) stated that it sounds like this could likely bump up against the *Chevron* changes that were recently made. Who would have standing in that scenario to bring suit? Ms. Blosser stated that I will admit to not being an attorney but I think there's a lot of questions around the *Chevron* case that are going to come up in a lot of different scenarios and think everybody is still sorting that out.

Rep. Oliverson stated that I appreciate all of this information bringing this to us and for those that may not know, we were completely unaware of this issue until the spring meeting in April when Ms. Blosser brought it to our attention. And I would just always encourage anyone to use that as an example of we only know what we're educated about so don't assume that legislators know everything that's going on in the industry. If there's an issue that's affecting your business, we'd like to know about it. The other thing I would say is that when we did go to DC, my reception was generally warm from Members on both sides of the aisle that they thought this was a really bad idea on the part of the federal government to reach into the title insurance industry like this. And I guess we'll see. I'd be curious, has anyone talked about the implications of *Chevron*? I'm not sure that the FHFA has the authority to even do this statutorily. I know they think they do. But I'd be curious if there's been any conversation about potentially suing them over this. Ms. Blosser stated that as I said, there's a lot of questions still on what

Chevron means, whether it relates to this or other ongoing regulatory matters. So, still trying to sort all of that out.

Rep. Bennett stated that I want to note in light of the *Chevron* decision, we'll probably be talking about the impact of that decision on the industry potentially at the fall meeting.

CONSIDERATION OF RE-ADOPTION OF MODEL LAWS

Last on our agenda is the consideration of readoption of model laws. As a reminder, per NCOIL laws, all NCOIL model laws are scheduled for consideration for readoption every five years and if it's not readopted then it's sunsets. You can view the models in your binders starting on page 350. Those models are: model act regarding use of claims history information; model act concerning interpretation of state insurance laws; and state flood disaster mitigation and relief model act.

As a reminder, during our interim meeting last month, we offered an opportunity for comment on these models and so today we won't be taking any testimony but if there are any questions or comments on the models by legislators, we can entertain those now. Does anybody have any comments or questions?

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

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Oliverson and seconded by Rep. Pollock, the Committee adjourned at 12:30 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
PROPERTY & CASUALTY INSURANCE COMMITTEE
INTERIM COMMITTEE MEETING – OCTOBER 7, 2024
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Property & Casualty Insurance Committee held an interim meeting via Zoom on Monday, October 7, 2024 at 2:00 P.M. (EST)

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

Other members of the Committee present were:

Rep. Cara Pavalock-D'Amato (CT)
Rep. Brian Lohse (IA)
Rep. Matt Lehman (IN)
Rep. Michael Sarge Pollock (KY)
Rep. Rachel Roberts (KY)
Rep. David LeBoeuf (MA)
Rep. Nelly Nicol (MT)
Asm. Ken Blankenbush (NY)
Asw. Pam Hunter (NY)
Sen. Bob Hackett (OH)
Rep. Brian Lampton (OH)
Rep. Jim Dunnigan (UT)

Other legislators present were:

Rep. Karilyn Brown (AR)
Rep. Laurin Hendrix (AZ)
Rep. Rod Furniss (ID)
Rep. Jim Gooch (KY)
Rep. James Roberson (NC)
Asw. Catalina Cruz (NY)
Asw. David Weprin (NY)

Also in attendance were:

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

QUORUM

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

INTRODUCTORY REMARKS: CHAIR BENNETT

Rep. Bennett thanked everyone for joining the meeting and stated that we're going to be conducting some business in advance of the November meeting in San Antonio so the committee is able to handle all the issues on that agenda in a timely manner. We have three model laws that we're going to be discussing today. For the first two, The Strengthen Homes Program Model and the Online Marketplace Guarantees Model, we will be taking comments today in an effort to get those models voted on in November. And then the last model which is the Model Act Regarding Insurers' Use of Aerial

Images, we will only be introducing the model today and taking brief comments so that we can have a longer conversation in November.

CONTINUED DISCUSSION ON NCOIL STRENGTHEN HOMES PROGRAM MODEL ACT

Rep. Bennett stated that we'll start with the continued discussion on the NCOIL Strengthen Homes Program Model Act. We had a great discussion about this at the last meeting in July where we heard from Oklahoma Insurance Commissioner, Glen Mulready, on the development of Oklahoma's law and now it's looking like we're getting closer to this model being ready for consideration as some changes have recently been made to incorporate some suggestions that have come about as a part of these conversations by interested parties and legislators. Before we go any further, I want to turn it over to the sponsor of the model, Rep. Jim Dunnigan (UT).

Rep. Dunnigan thanked everyone for their input on this issue. I've made some modifications to the model and I want to highlight what we've changed. The requirement that the grant applications be prioritized to certain applicants, such as lower income applicants and applicants who live in locations that have a higher susceptibility to catastrophic weather events. So we're just trying to have a more targeted approach who's available to these benefits. Requiring the Commissioner to use their best efforts to obtain grants or funds from the federal government or other funding sources to supplement any appropriations made by the legislature. And it makes clear that the legislature appropriation is discretionary and noting that implementation of the program is subject to the receipt of grants or other funds. It adds a drafting note to make clear that states have funded these types of programs in different ways. We've looked at what some states have done and there are different pathways that people have taken so we reflected that in the drafting note. We also set forth in more detail the terms of when premium discounts are and are not required, and limiting the program to single family primary residences. We want to focus on primary residences rather than a secondary cabin in the mountains. So I think the latest version of the model is very fair and it incorporates the feedback that we've heard throughout this last year and it borrows from several other states that have already implemented these programs. And as I said, I appreciate those various states reaching out and offering some assistance. I'm still open to changes and I invite any feedback that you have so we can make this better and we want to have a good work product so we can consider this in San Antonio. This is a great opportunity to provide guidance on something that is becoming popular across the country. And you see almost every day more severe weather events so if we can incentivize and encourage people to strengthen and harden their homes and their structures and have less damage that will benefit all of us.

Matt Overturf, Regional Vice President at the National Association of Mutual Insurance Companies (NAMIC) thanked the Committee for the opportunity to speak and stated that I want to thank Rep. Dunnigan and the Committee for working with us on this issue over the past year. While we have general concerns with mandatory discounts and their application in some states, we believe that this model has struck a good balance. While there's more work to be done to encourage and incentivize mitigation efforts across the

country in addition to this piece of legislation, we do look forward to having those discussions in the future.

Wes Bissett, Senior Counsel at the Independent Insurance Agents and Brokers of America (IIABA) thanked the Committee for the opportunity to speak and thanked Rep. Dunnigan who's work on this has been greatly appreciated. We are very strong supporters of this proposal. As has been mentioned at recent meetings, there is great interest in this topic among a wide array of stakeholders. We've seen an increasingly diverse universe of states taking action on this issue. We've got Atlantic states, we've got Gulf states, but it's not just limited to states that are along the coastlines. We've got Oklahoma and Kentucky that have adopted statutes and Minnesota as well. There's great interest in the need for a vetted and thoughtfully crafted model law so we thank you for the work that's been done here. And like Rep. Dunnigan said we hope that you will act in November so that states that are looking to take action on this issue will have the benefit of your work. We appreciate the work that's gone into the latest draft. I think there are some very helpful revisions that have been made. As you begin and think about bringing this in for a landing in San Antonio, we would mention a couple of other things we think might be helpful.

One thing that's not addressed in the model at the moment is eligibility requirements for both contractors and evaluators. Those are two universes of entities that play key roles here and under the fortified framework that the Insurance Institute for Business & Home Safety (IBHS) has adopted. There's one passing reference to evaluators in the draft and we think it might be helpful to build in some specific requirements for contractors and evaluators and consumer protections. Things that would require them to avoid conflicts so you wouldn't be able to be a contractor and an evaluator with regard to the same particular grant, things like that. We've shared some proposed text along these lines with NCOIL staff that we'd urge you to consider. We took that from Minnesota's law and it's a slimmed down version of what Minnesota enacted a couple of years ago and we think that would be a helpful addition to the model. And then with regard to Section 4 which is where the proposal gets into the potential premium discounts or other reductions we would urge you to eliminate paragraph (c)(4) which imposes a series of really unnecessary paperwork obligations on consumers. And then similarly, we'd urge you to delete paragraph (c)(5) because it's also sort of an inflexible approach that's really unnecessary here. The key is going to be work being done by IBHS certified contractors and then evaluated or inspected by IBHS certified evaluators. That's going to be the key and once that's done, whether the consumer has receipts of the materials that were used on the project is really largely irrelevant. So we would urge you to eliminate those two paragraphs and then any other accompanying provisions that wouldn't be necessary going forward. I do want to mention there's two other very minor issues. We're greatly appreciative of the definition of insurable property that Rep. Dunnigan described in his opening comments. That's in Section 4. One technical issue though is we would urge you to say that insurable property means those things - single family owner occupied housing. The way it's crafted now is that it includes those homes which means that it could mean any form of property but it just must include those kinds of single family homes. So we would urge you to be explicit to say that the properties we're talking about here are only the single family owner occupied homes. And finally, there is a

sunset provision built into the actual text of the model here and while we don't have any philosophical objection to that, one thing you might consider is making that an optional provision. What we've seen is in some of the more recent laws that type of sunset has not been included. I think it was included originally in the Alabama law a decade or so ago because it was really a trial case and it made sense for them to have that type of sunset. Now we have a growing universe of states that we can look to and that may not be something that's essentially a built-in mandatory provision of the model itself and you can maybe make that optional if you decided that you needed it at all.

Hilary Segura, Vice President and Counsel, State Government Relations at the American Property Casualty Insurance Association (APCIA) thanked the Committee for the opportunity to speak and stated that APCIA strongly encourages states to provide various financial incentives to help property owners mitigate their homes. We appreciate the work that you've been doing on this. Many insurers are already voluntarily providing incentives or adjustments in premiums in response to improvements to property resilience including the IBHS fortified standards. Mandatory discounts or other mechanisms that adjust premiums before the degree of risk mitigation can be problematic because they put the cart before the horse in terms of ensuring premiums collected are sufficient to cover losses. But we do appreciate that the model now does anchor such requirements to the actuarial supported determinations. In terms of the grant program we are very glad to see the IBHS fortified roof standard being adopted. We're also very supportive of the means testing and supportive of the data-driven determinations of risk in providing grant funds. The one thing I did want to mention under the grant program is it seems that the definition is still very broad and would include commercial property. And I know it's been narrowed in the discount section so perhaps you may want to take a look at that. Obviously, commercial properties need help too but they tend to be more expensive and can deplete the funds more quickly so if the model is the Strengthen Homes Model perhaps it should also mirror the residential owned property term in the discount section.

Amy Bach, Executive Director of United Policyholders, thanked the Committee for the opportunity to speak and stated that United Policyholders is a national 501(c)(3) insurance consumer education advocacy group. We've been around for over three decades. My one caution about putting all your eggs in the IBHS inspection certification basket is that while it's a wonderful organization and growing fast, they're being asked to do a lot of things and we want to make sure that there's a little flexibility in the model for example, a state like California that has an alternative set of standards, the Safer from Wildfires framework. Understandably, it's nice when there's just one, but giving a little bit of flexibility for other programs might work well. Mr. Bissett made a very important point about figuring out how to ensure some of the integrity of the inspectors. The certain, whoever it is that's going to go out and say, "This looks good. The work looks solid." Let's not have people approving and certifying their own work, that's important.

I do think it's something for lawmakers to really be getting their heads around - are you going to have a registry? I know a lot of areas already have very robust programs. But here in California, we're just building and we're building those channels to get the inspection information to the insurers. And I think that on this front, I think a lot of

insurers are trying to get there. I get that they are nervous about arbitrary mandated premium discounts. But I think let's not make the perfect be the enemy of the good. We don't want rates being excessive. We do need people to be able to get rewarded. We need the rates to reflect reduced risk. Maybe if we can't measure it precisely, we start with a smaller mandated discount at least to address that property owner concern that why should I undertake these expenses if I'm not going to get a break? This is so important. You all know this. Looking at what's going on right now with the recent hurricanes, everything we can do to facilitate risk reduction at the individual and community level obviously we have to be doing. So thank you for this work stream. My organization is available as a resource. We have a whole wildfire risk reduction resource center going in California so that in each county people can click on their county and find out who's giving away money and how. We're also supporting the Thompson-LaMalfa bipartisan effort at the federal level. Hopefully we can all work together.

Rep. Dunnigan thanked everyone for their comments and stated that I will take a look at everything and see what we can incorporate and see what makes sense. I think there have been some very good suggestions offered.

CONTINUED DISCUSSION ON NCOIL ONLINE MARKETPLACE GUARANTEES MODEL ACT

Rep. Bennett stated that next, we are going to have a continued discussion on the NCOIL Online Marketplace Guarantees Model Act. We've been having a good dialogue about this model throughout the year and I think we're getting closer to where we could be voting on this in November. I have signed on as co-sponsor on this model because I think it does a good job of clarifying certain liability related issues within the sharing economy. And before we go any further, I will turn things over to the sponsor of the model Rep. Brian Lampton (OH).

Rep. Lampton stated that I'm proud to sponsor the model and agree with Rep. Bennett about clarifying liability related issues. I apologize that I was unable to attend the meeting in Costa Mesa but I have had several meetings on this with staff and interested parties since then. I understand there's certain concerns being raised and I'm happy to listen to those and incorporate those suggested changes but I haven't seen anything specific yet in terms of removing or changing language. So if you're out there and you want to do that, please let me or staff know. I would like to see this considered for a vote in November, if possible. Again, if we hear concerns only in a theoretical sense without any specific language changes I think we can go ahead and move forward but if we do have some language changes let's get those out on the table as soon as possible.

Brad Nail of Converge Public Strategies, on behalf of Airbnb, thanked the Committee for the opportunity to speak and stated that I want to echo what Rep. Lampton said about the process to date. I just want to stress three things. There are about 23 states that have statutory language permitting guarantees to be included in contracts. Almost none of them have requirements to give states and regulators insight into who's doing what in the market. So this model will help inform those states that already have some laws

about this activity without being overly restrictive or overly prescriptive about it. In the other states that don't already have statutory language, there is typically some case law dating back that either directly or indirectly addresses these types of guarantees but that case law or their common law interpretations sometimes leave some regulators with questions. We're seeing this play out in a couple of states right now where insurance regulators want to look at this practice so this model will bring clarity for regulators as to when and how these guarantees may operate. So I think this model will be the appropriate exercise of legislative authority to set the parameters under which those regulators will operate. And then lastly, the intent of this model has been to limit it to true guarantees. These are situations where a company that is not in the business of insurance that is in the business of providing some other product or service to consumers offers to back that product or service with a guarantee. It's similar to service contracts. It's similar to warranties, both of which are often addressed in your statutes. We do not want companies to use this law to get around insurance laws by selling something that should rightly be regulated as insurance. The changes that were made to this model in the summer were intended to tighten it up and narrow that scope. We think the current language accomplishes that and in soliciting input from other stakeholders, we haven't had any more specific changes requested at this time. So to conclude, on behalf of Airbnb, we support the model and we hope that the committee will be in a position to take it up and give it a final consideration in San Antonio.

Ms. Segura stated that overall, we don't have an issue with the concept of the model but we do still have concerns that it directly conflicts with the definition of travel insurance that's in the NCOIL and NAIC Travel Insurance Model Acts which defines, amongst other things, travel insurance as including damages to accommodations for rental vehicles. And because of this conflict, we're concerned that this could lead to unfair competition as travel insurance companies offering vacation rental damage insurance and other products through the travel insurance model or otherwise that have to go through the full grouping of insurance regulations could be undermined by this new act. It could create confusion by legislators and regulators as to the difference between the established legislative and regulatory structure for travel insurance which was a process of seven years to get the model enacted and it's now in 37 states versus this new model. I don't have any specific language changes for you today but if we have some suggested specific language I'm happy to get it to you as soon as possible.

Cmsr. Tom Considine, NCOIL CEO, stated that this is the first we're hearing about that conflict in language so we really would appreciate some corrective language on that. Ms. Segura replied, certainly.

Jon Schnautz, Vice President of State Affairs at NAMIC, thanked the Committee for the opportunity to speak and stated that this is the same language that we talked about back in July and so much of what I'm going to say is going to reiterate the comments we've made at that meeting. My main message is that in our view we don't think this language is ready for a vote in November in the current form for the reasons I'll elaborate on in a moment. I think the more appropriate response would be for the proponents for Airbnb to more specifically delineate what the issue is that requires a model here in the first place. For example, is there a hole or a gap in the current market for coverage that

makes this kind of requirement justified? Ms. Segura referred to travel insurance. I will also say talking to our members on the homeowner's insurance side, there are endorsements and there are opportunities for coverage that would at least duplicate what this model could cover. We think that starting point would lead to a more productive conversation rather than us trying to rewrite the model with suggested changes.

To try to briefly reiterate our concerns, I guess the first is the most basic in that this model takes a transaction that has all the indicia of being an insurance agreement and calls it something else and then subjects it to a much more limited standard of statutory scrutiny. Insurance regulation, we don't always agree to it, but in general it exists for very good reasons - protection and solvency, ensuring that things are disclosed to consumers, fair claims handling. That's volumes and volumes of statutes in all of your States and this replaces it with a few paragraphs. And we think that's a pretty serious issue. The second point is that if the goal of the model, and we've heard this at times during the conversation, is to fill relatively small gaps in existing coverage, for example, things that would fall under current deductibles, that may be a perfectly acceptable goal. The model in its current form is much broader than that. It has no limits on the amount of coverage or really the type of coverage that can be offered as long as it meets the standard of an indemnity agreement which is very broad. I would also note that this coverage itself allows for deductibles. If you look at section 4(e) of the model in front of you that concept is there. So if the goal is to avoid deductibles, this model maybe shouldn't also include them. The third point, and this hasn't really been discussed at all, in sections five and six of the model, some provisions go not to these guarantee agreements but to any underlying insurance coverage that would be on the back of these guarantees. If there's a justification for that, great, but it really hasn't been discussed in this and we think some conversation is needed talked to occur there or those provisions should simply be taken out of the model. Because again, they've not been part of anything the proponents have talked about. I think that captures our concerns as they stand. I guess as a final point, if this were something that the committee were willing to consider we think this might be a good item for the NCOIL-NAIC Dialogue discussion at the next meeting as it might be a benefit to hear from regulators on this issue. We also heard at the last meeting that this is something the NAIC considered at some point in the past so the benefit of that experience might help out here as well.

Byron Wobeter, Associate General Counsel of Insurance at Airbnb thanked the Committee for the opportunity to speak and stated that we support this model and we're open to further dialogue with NAMIC on any additional language over the next few weeks before the meeting.

Rep. Lampton stated that I would like to have some more discussion with NAMIC on their concerns. I think some good discussion can shed some more light on this for me and I would appreciate that.

INTRODUCTION OF NCOIL MODEL ACT REGARDING INSURERS' USE OF AERIAL IMAGES

Rep. Bennett stated that the last thing that we have on our agenda is the Model Act Regarding Insurers' Use of Aerial Images. We are going to have a conversation today about this and we're going to have a much more robust conversation about it in November. As Chair of this committee I can tell you that under no circumstances am I planning to have any kind of vote on this model at the November meeting. We just want to have the conversation and I think that we've had some interesting presentations on this so far and I think it's worth a lot more exploration. So I just wanted to say that on the front end that we'll talk about it today but we'll talk about it quite a bit in San Antonio and there's no vote planned for that meeting and there won't be one. So with that, I want to open up the conversation. The model stems from a general session that we had in July in Costa Mesa and as the title of the model suggests it deals with insurers use of aerial images in making coverage determinations. I'll now recognize the sponsors of the Model, Rep. David LeBoeuf (MA) and Rep. Lampton.

Rep. LeBoeuf stated that regarding the genesis of this Model, I'm sure many of you have been receiving increased calls about this. I had gotten a barrage of calls from a reporter who was doing a story on a situation where an aerial photograph had done a review of a roof and denied coverage and had misidentified what was assumed to be damage on that property which was actually solar panels. And from that a couple of constituents have reached out because they had similar situations where the photograph used by the insurance company was inaccurate and they were really looking for some type of way to cure that and to be able to have their say. It's essentially a consumer protection issue. It's not looking to prohibit the practice at all. There's a lot of value to using emerging technology, especially around natural disasters. But it's important just to give the policyholder the ability to make corrections if for some reason that methodology did not get the complete story. I think we do need to have a further discussion on some of the definitions in the model in terms of what is a an aerial photograph defined as and different things like that. I'm looking forward to this continued discussion in November.

Rep. Bennett stated that we had an informative session on this in July and one of the things that was really striking to me was the difference in the quality of photos and what that can do for what the rate ends up being calculated as or whether insurance is accepted or denied. I found that to be extremely compelling. And the solar panel example is another great example of that. I think this is really an important conversation to have. We also talked about how we're not trying to do away with aerial imaging. We're just trying to make sure that we're integrating it in a way that is fair to policyholders and that we're not just over reliant on it for the calculation of rates.

Rep. LeBoeuf stated that similar to what Rep. LeBoeuf said, I have talked with policyholders as well. One of my carriers uses fixed wing aircraft imaging to identify specifically if there's a swimming pool on the property because they have an additional charge. And that's an easy fix and not a horrible thing. All we have to do is go in and add the swimming pool and charge the appropriate premium for the risk. That's fine. I think for the insurance companies, we definitely aren't saying we want to stop or limit the practice of this. We introduced a bill in our state having to do with the privacy aspect and specifically for the use of drones. Drones are typically flown below a 500 foot

threshold. We all can hear them. You've heard them over football, basketball or baseball games or other concert events where you literally see them and hear them. And so for me it's a bit of a privacy issue. So I would just like to somehow incorporate that the customer knows or is aware of a possible low altitude drone flying over their home for the purposes of capturing images for any kind of risk related things. Because I think if you're hanging out on your back patio and a drone flies over and you are not expecting it, it can be a bit surprising, and perhaps quite alarming. So I'm looking forward to more discussion on this model.

Ms. Segura stated that I think it's very important to our members that we make certain that any model doesn't prohibit, restrict or limit insurers use of aerial imagery in underwriting, rating and claims handling. A couple of comments regarding the substance of the model. I think ensuring images of being not older than 12 months could be very problematic. There are many service providers of aerial images supply photos that are older than 12 months and that are still very accurate. The section regarding the carrier's processes and point of contact, that should already be established as underwriting evaluations take place with or without using aerial imagery. Usually, the initial contact is the policyholder's agent. Disclosing the risk score may be problematic, as many insurers use third parties and their scoring systems may be protected intellectual property or by contract between the insurers and the service providers. Additionally, providing a score without context could likely confuse the issues that have already been identified as being problematic. If carriers use risk scores they likely vary from carrier to carrier. And then finally, there shouldn't be a separate window of a cure period that's different than existing state law. Carriers underwriting processes are set up to comply with states in which they operate and they should be allowed to make the decisions that comply with existing laws and regulations. Also, a carrier may not want to remain on risk that cures some if not all of the issues that were identified. So they should still be allowed to make appropriate business decisions within their underwriting guidelines.

Rep. Bennett thanked Ms. Segura and stated that I know that finding the line between consumer protection and not inhibiting the industry is going to be a fine line but I'm sure because everyone is so thoughtful and considerate at NCOIL that we will figure out a way forward.

Ms. Bach stated that I'm very grateful to NCOIL for taking up this issue. I think that we have to all recognize that the use of aerial imagery combined with artificial intelligence and risk scoring and models has had a dramatic national impact on availability and affordability of property insurance that's impacting every one of your jurisdictions. And I think recognizing that is what we're trying to do here. What I believe that all of you will want to do is to find that right balance so that we're getting where we want to go which is if people know what characteristics of the property run afoul of their insurers underwriting guidelines that they know what they are and they have a chance to address them. And that's one of the most important parts of this proposal. The harder piece is okay, then what? Once they've remedied, that's a trickier part but I think that just trying to fine tune the tech here is what we have to do because it just kind of exploded on us it feels like. And we went from insurers being willing to insure properties that had lots of flaws to

them being much more selective. We are hearing from so many consumers who say “I got non-renewed I don't really understand why, nothing's changed from my perspective.” I have to respectfully disagree with Ms. Segura that I think we do need people to know what the risk scores are, and I know that there are different risk scoring systems, but we do require people to be able to access their credit score because your credit score impacts the cost of credit for you. And so here because your insurance score impacts the cost and availability of insurance for you we do need to give consumers that information so they can do the right thing to the extent they can and improve the conditions and be able to keep their homes protected. I appreciate the introduction of this model. My organization stands ready and willing to help in any way we can.

Mr. Overturf stated that we've sent this model out to our members and we're still collecting feedback. I will say that initially we have several concerns. Ms. Segura outlined several of those so I won't be overly repetitive but as I said in July as I participated on the general session panel, on one hand we believe that there are existing laws and regulations already on the books in the states that are sufficient to address how insurers cancel or non-renew policies. And in addition, aerial images are a valuable part of assessing risk and we believe that they should not just be permitted but encouraged by policymakers. Unfortunately, as drafted, this model lays a lot of burdens towards that that could discourage the use of aerial images. And for those reasons we want to flag those concerns and we look forward to the continued discussion in November.

Mr. Bissett stated that we really appreciate the introduction of this proposal and look at it very positively. We thank both of the sponsors for their leadership and putting this out. Like NAMIC, we have just begun to circulate this and get feedback but unlike NAMIC, the initial feedback that we've received is very positive. So we look forward to working with the sponsors, the committee and others on this as things move forward. One concern we heard from APCIA is there may be some issues because this proposal contemplates a different timeline than perhaps some of the state non-renewal statutes. And to the extent that's a real concern, states could always extend their non-renewal statutes if they're shorter than 60 days to 60 days. And I know that's something that a variety of jurisdictions are looking at now. There's a strong argument to be made that a 30 day non-renewal period in this type of market is way too short. So perhaps that's another way of bringing about consistency if that's truly a concern for APCIA and its members. We look very much forward to being part of the discussion going forward.

Rep. Lehman stated that some very good points have been raised about this both today and in Costa Mesa but in a nutshell, this is really a time now where carriers are going deeper into technology. And the more they use, the more we have to be able to explain it to our clients, your constituents, my constituents. So I think we need to make sure we're very clear on where we're going with all this because I don't want to cut off the use of technology. We went through this with credit scoring, we went through this with telematics. We went through it with all the other matrixes and everything else we had in the insurance underwriting transparency model I sponsored. We have things, we just have to make sure we're protecting consumers and at the same time not cutting off what

could be a useful tool for the industry. So I look forward to this discussion as it is very timely and I hope we can move something quickly.

ADJOURNMENT

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

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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 discussed and potentially considered during the Property & Casualty Insurance Committee on November 24, 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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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 November 12~~March 13~~, 2024. To be ~~introduced and~~ discussed and considered by the NCOIL Property & Casualty Insurance Committee on November 24~~October 7~~~~April 13~~, 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(B~~C~~)(6~~89~~)

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.

(B) The commissioner shall promulgate rules governing eligibility requirements for grants and the administration of the program, which shall include application forms and procedures for seeking a grant. The rules shall set forth that applications will be accepted on a first-come, first-served basis within each income tier established by the Commissioner, with priority given to lower-income applicants, applicants who live in locations that, based on historical data, have a higher susceptibility to catastrophic weather events, and applicants meeting any other criteria the Commissioner determines is appropriate to meet the purpose of the program.

(C~~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(B~~C~~)(2~~3~~) of this Act.

(3) Comply with applicable building codes.

(4) Maintain records as required by Section 4(B~~C~~)(3~~4~~) and (4~~5~~) of this Act and the terms of the grant.

(D~~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.

(E~~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".

(1) The following shall be deposited into the fund:

(a) All grants and funds received or raised by the Commissioner under paragraph (6) of this subsection.

(b) Any discretionary appropriations made to the fund by the Legislature.

(2) 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].

(3) 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.

(4) All unexpended and unencumbered monies in the fund at the end of the fiscal year shall remain in the fund.

(5) Monies in the fund shall be used to provide grants pursuant to this Section.

(6) The Commissioner shall use his or her best efforts to obtain grants or funds from the federal government or other funding sources for deposit into the fund to supplement any appropriations to the fund made by the Legislature.

(F~~E~~) Implementation of the Program is subject to the receipt of federal grants or funds or from other sources of grants or funds.

Drafting Note: States that implemented these types of "Strengthen Home Programs" have funded them in different ways. The above language primarily comes from Kentucky and Louisiana, but other funding methods have been used such as in Oklahoma where the legislature authorized the Insurance Commissioner to transfer funds from the State Insurance Commissioner Revolving Fund to the Strengthen Homes Program Fund.

(G) To be eligible to work as a contractor on a project funded by a grant under this Section, the contractor must meet all of the following program requirements and must maintain a current copy of all certificates, licenses, and proof of insurance coverage with the Program office. An eligible contractor must:

(1) hold a valid residential building contractor and residential remodeler license issued by the [insert reference to the appropriate state licensing/accrediting body];

(2) not be subject to disciplinary action by the [insert reference to the appropriate state licensing/accrediting body];

(3) hold any other state or jurisdictional business license, registration, or work permits required by law;

(4) possess an in-force general liability policy with $1,000,000 in liability coverage;

(5) possess an in-force workers compensation policy;

(6) maintain certification as a Trained Service Provider with the Insurance Institute for Business and Home Safety;

(7) maintain Internet access and keep a valid email address on file with the Program; and

(8) agree to follow Program procedures and rules established under this section and satisfy any additional requirements established by the Commissioner.

Drafting Note: States with vendor registration requirements may wish to require satisfaction of those obligations as an additional condition of eligibility.

(H) An eligible contractor must not have a financial interest, other than payment on behalf of the homeowner, in any project for which the eligible contractor performs work toward a fortified roof designation under the Program. An eligible contractor is prohibited from acting as the evaluator for a fortified designation on any project funded by the Program. An eligible contractor must report to the Commissioner regarding any potential conflict of interest before work commences on any job funded by the Program.

(I) To be eligible to act as an evaluator on a project funded by a grant under this Section, the evaluator must:

(1) meet all program eligibility requirements established by the Commissioner;

(2) maintain an active certification as a fortified home evaluator for high wind and hail or a successor certification with the Insurance Institute for Business and Home Safety;

(3) not have a financial interest in any project that the evaluator inspects for designation purposes for the Program;

(4) not be an eligible contractor or supplier of any material, product, or system installed in any home that the evaluator inspects for designation purposes for the Program;

(5) not be a sales agent for any home being designated for the Program; and

(6) inform the Commissioner of any potential conflict of interest impacting the evaluator's participation in the Program.

(JE) 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.

(KF) 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) All insurance companies writing property insurance for any property located in [State] that has been certified as complying with the most recent version of the "fortified roof" standard of the Insurance Institute for Business and Home Safety:

(1) shall provide a premium discount or rate reduction on the coverage if the discount or reduction is actuarially justified and there is sufficient and credible evidence of cost savings that can be attributed to the construction standards; and

(2) may provide a premium discount or rate reduction on the coverage in accordance with any standard discount amounts, targets, or benchmarks established under Section 4(C)(1) of this section, and any other adjustment on the coverage. Any insurer required to submit rates and rating plans to the commissioner shall provide an actuarially justified discount, credit, rate differential, adjustment in stadeductible, 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.

(B~~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.~~

(1~~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 roof~~home or fortified commercial~~ standards provided by the Insurance Institute for Business and Home Safety.

(2~~3~~) An insurable property shall be certified as in conformance with the fortified roof~~home or fortified commercial~~ standards only after inspection and certification by an Insurance Institute for Business and Home Safety certified inspector.

~~(3) 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.~~

(3~~4~~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. Upon request, t~~T~~he 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~~.

(4~~5~~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.

~~(6~~7~~) The records required by this Subsection shall be subject to audit by the commissioner.~~

(5~~78~~) 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.

(6~~89~~) For the purposes of this Act~~Subsection~~, insurable property means~~includes~~ residential property that is an owner-occupied, single-family, primary residence, ~~commercial property, modular homes, and manufactured homes~~ that may be retrofitted.

C~~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, targets, benchmarks, 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. Any standard discount amounts, targets, or benchmarks promulgated shall be optional and primarily for the benefit of insurers that are unable to obtain actuarially valid data to provide a premium discount or rate reduction under Section 4(A)(1) due to inadequate resources or experience.

(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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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 and considered by the NCOIL Property & Casualty Insurance Committee on November 24, 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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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)

Model Act Regarding Insurers' Use of Aerial Images

Sponsored by Rep. David LeBoeuf (MA) and Rep. Brian Lampton (OH).

Draft as of October 2, 2024. To be discussed during the meeting of the Property & Casualty Insurance Committee on November 24, 2024.

Table of Contents

Section 1. Title

This Act shall be known as the [State] Act Regarding Insurers' Use of Aerial Images.

Section 2. Purpose

The purpose of this Act is to honor consumer's traditional rights with regard to property insurance in the face of advancing aerial technologies.

Section 3. Definitions

Definitions of certain key terms will be included in later versions of the Model. Comments are welcome and encouraged as to which key terms should be defined.

Section 4. Insurers' Use of Aerial Images

When utilizing aerial images as part of its coverage determinations, an insurer shall:

(a) Ensure that a non-renewal notice include copies of date-stamped images of the property that show the specific conditions that are out of compliance with the insurer's underwriting guidelines and what steps the property owner can take to reverse the insurer's decision. Photos must have been taken within the past 12 months.

(b) Establish a point of contact and a process for currently insured property owners to use to provide documentation of completion of the required work that the insurer communicates to the insured in subsection (a).

(c) Disclose the risk scoring system criteria used and establish an appeal process so the consumer can correct any errors, misunderstandings related to their risk score and modify the risk score where warranted.

(d) Provide the currently insured property owner a minimum of 60 days to cure the defects/conditions underlying a non-renewal from the date the insurer identifies the specific conditions, even if that exceeds the non-renewal notice period as set forth in [insert citation to state non-renewal requirements].

(e) Require an insurer to offer a renewal policy to a consumer who submits proof that they've cured the defects/conditions identified in subsection (a).

Section 5. Rules

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

Section 6. Effective Date

This Act shall take effect xxxxxx.

EXECUTIVE COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
EXECUTIVE COMMITTEE
2024 NCOIL SUMMER MEETING – COSTA MESA, CALIFORNIA
JULY 20, 2024
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Executive Committee met at The Westin South Coast Plaza Hotel in Costa Mesa, California on Saturday, July 20, 2024 at 12:30 p.m.

NCOIL President, Representative Tom Oliverson, M.D. (TX), Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Deborah Ferguson, DDS (AR)
Sen. Justin Boyd (AR)
Rep. Michael Sarge Pollock (KY)
Rep. Edmond Jordan (LA)
Sen. Lana Theis (MI)
Sen. Michael Webber (MI)
Sen. Paul Utke (MN)
Sen. Walter Michel (MS)
Sen. Jerry Klein (ND)
Asw. Pam Hunter (NY)
Asm. Jarett Gandolfo (NY)
Sen. Bob Hackett (OH)
Rep. Forrest Bennett (OK)
Rep. Jim Dunnigan (UT)

Other legislators present were:

Sen. Larry Walker (GA)
Rep. Gabe Firment (LA)
Rep. Shaun Mena (LA)
Rep. Bob Titus (MO)
Rep. Ellyn Hefner (OK)
Rep. Mark Tedford (OK)
Rep. Greg Scott (PA)

Also in attendance were:

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

QUORUM

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

MINUTES

Upon a Motion made by Sen. Paul Utke (MN), NCOIL Treasurer, and seconded by Asm. Jarett Gandolfo (NY), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's April 14, 2024 meeting.

FUTURE MEETING LOCATIONS

Rep. Oliverson stated that the 2024 Annual Meeting will be in his home state in San Antonio, TX from November 21st – 24th. The Meeting will kick off with the 3rd Annual NCOIL Open ILF Scholarship Golf Outing on the afternoon of the 21st and registration for the Outing is open on the NCOIL website. 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 thanks to Sen. Daniel McConchie (IL) working to secure Illinois' NCOIL Contributing State status, and the Annual Meeting will be in Atlanta, GA from November 12th – 15th. Now that Florida has rejoined as an NCOIL Contributing State, we'll look forward to going there in 2026.

ADMINISTRATION

Will Melofchik, NCOIL General Counsel, stated that there were 344 total registrants for the Summer Meeting including 66 legislators from 30 states and of that number there were 22 first time legislators from 10 states. Additionally, 9 insurance commissioners participated and in all, 14 total insurance departments were represented.

Mr. Melofchik then moved into the financials stating that the unaudited financials through June 30th of this year show revenue of $812,490.41 and expenses of $605,613.26 leading to a surplus of $206,877.15.

Rep. Oliverson stated the Audit Committee met on Wednesday afternoon and received the audits for both NCOIL and the ILF from Dianne Batistoni of EisnerAmper. She reported that in reviewing NCOIL and ILF's financials she rendered an unmodified opinion meaning that the financials looked proper and up to industry standard practices. There was a positive change in net assets for NCOIL of $435,784.

Hearing no questions or comments, upon a Motion made by Rep. Forrest Bennett (OK) and seconded by Sen. Lana Theis (MI), the Committee voted without objection by way of a voice vote to accept the 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 Workers' Compensation Insurance Committee readopted the NCOIL Workers' Compensation Drug Formulary Model Law

- The Property & Casualty Insurance Committee readopted: Model Act Regarding Use of Claims History Information; Model Act Concerning State Interpretation of State Insurance Laws; State Flood Disaster Mitigation and Relief Model Act

- The Articles of Organization & Bylaws Revision Committee adopted amendments to NCOIL Articles of Organization & Bylaws

- Ratification of decisions made and actions taken by the NCOIL Officers and staff in the time between Executive Committee Meetings.

Rep. Oliverson asked if there were any questions or if any Committee member wanted anything removed from the consent calendar. Hearing no such requests, upon a motion made by Sen. Walter Michel (MS) and seconded by Rep. Michael Sarge Pollock (KY) 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, Sen. Larry Walker (GA), Chair of the GA House Insurance Committee, Rep. Gabe Firment (LA), Chair of the Louisiana House Insurance Committee, and Sen. Kirk Talbot (LA), Chair of the Louisiana Senate 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.

Sen. Utke stated he would like to nominate Rep. Bob Titus (MO). Rep. Bennett stated he would like to nominate Rep. Ellyn Hefner (OK) and Rep. Mark Tedford (OK).

Upon a motion made by Rep. Brenda Carter (MI) and seconded by Rep. Jim Dunnigan (UT), the Committee voted without objection by way of a voice vote to add Sen. Walker, Rep. Firment, Sen. Talbot, Rep. Titus, Rep. Hefner, and Rep. Tedford to the Executive Committee.

OTHER SESSIONS

Rep. Oliverson stated that the Institutes Griffith Foundation held a legislator workshop on the first day of the conference focusing on the development of the state-based insurance regulatory system as well as timely insurance issues. The Griffith Foundation also held a legislator luncheon during which Professor Weili Lu, Director of the Center for Insurance Studies at Cal State Fullerton delivered a presentation titled “Guaranty with a “y”: A Primer for Public Policymakers”, as well as a legislator breakfast during which

Christopher McDaniel, President of the Institutes Catastrophe Resiliency Council gave a presentation titled “An Examination of the Role of Catastrophe Modeling in Risk Management: Is it More than Throwing Darts?”

There were also three timely and interesting general sessions including:

- Eye in the Sky: How Insurers’ Use of Aerial Images is Impacting Coverage.
- NCOIL Special Series on Preventive Medicine Part 1: Early Expenses Prevent Significant Later Costs.
- Financial Literacy: Providing Students With More Life Skills But At What Cost?

Additionally, Nicholas Whyte of APCO gave a fantastic presentation on the recent European elections. Rep. Oliverson stated he heard from several people that they were impressed that so many legislators knew what was going on in European countries and their elections.

Rep. Oliverson then asked if anyone had any comments or feedback on the sessions and speakers.

Rep. Dunnigan stated that the Institutes Griffith Foundation presenters are typically very good, and he felt the luncheon speaker had a wonderful knowledge base, but it is important going forward to make sure that such knowledge leads to an effective presentation.

Rep. Oliverson stated that Rep. Dunnigan’s comments were well taken and he encourages everyone to fill out the post meeting survey as the feedback helps inform future selections of speakers and sessions.

ANY OTHER BUSINESS

Rep. Oliverson stated that during the NCOIL – NAIC Dialogue he announced the creation of an ad hoc subcommittee to participate in the NAIC Privacy Protections (H) Working Group calls. Rep. Oliverson thanked Rep. Greg Scott (PA) and Rep. Matt Lehman (IN), Past NCOIL President, for volunteering to be a part of that. If anyone else is interested in participating, they should reach out to him or Mr. Melofchik to be added. The National Association of Insurance Commissioners (NAIC) said it would be helpful to have feedback from lawmakers on data privacy issues as they work on their Model Law, so we are looking for some NCOIL legislators to participate.

Cmsr. Considine stated he can’t say enough how humbling everyone’s kindness has been throughout the Meeting regarding his retirement announcement. Comments made during the Welcome Breakfast by Rep. Oliverson, Mr. Melofchik, Asm. Mike Gipson

(CA), Commissioner Ricardo Lara (CA), and from all of the folks that stopped him in the halls were so nice and he became emotional more than once. Cmsr. Considine thanked everyone for their moving words.

Rep. Oliverson thanked Cmsr. Considine and said he hopes that he will continue to be involved in NCOIL beyond his tenure as CEO because so much of what NCOIL has become is because of his leadership and the organization is tremendously grateful to him.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Utke and seconded by Rep. Lehman, the Committee adjourned at 1:00 p.m.