30 DAY MATERIALS AND GENERAL SCHEDULE
NCOIL SPRING MEETING
APRIL 24 - 27, 2025

As of March 26, 2025, and Subject to Change

The Francis Marion Hotel
Charleston, South Carolina

NCOIL SPRING MEETING
Charleston, South Carolina
April 24 - 27, 2025
SCHEDULE

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

THURSDAY, APRIL 24TH

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

FRIDAY, APRIL 25TH

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

Health Insurance & Long Term Care Issues Committee	11:15 a.m.	-	1:00 p.m.
The Institutes Griffith Foundation Legislator Luncheon 80 Years of the McCarran Ferguson Act: Exploring Its History, Role, and Relevance ***Open to Public Policymakers and Staff Only***	1:00 p.m.	-	2:00 p.m.
NCOIL – NAIC Dialogue	2:00 p.m.	-	3:15 p.m.
Networking Break	3:15 p.m.	-	3:30 p.m.
General Session Prescription Drug Affordability Boards (PDABs) Part 1: An Introduction to PDABs	3:15 p.m.	-	4:15 p.m.
Networking Break	4:15 p.m.	-	4:30 p.m.
Life Insurance & Financial Planning Committee	4:30 p.m.	-	5:45 p.m.
Adjournment	5:45 p.m.		
CIP Member & Sponsor Reception ***Open to Public Policymakers, CIP Members, and Spring Meeting Sponsors***	6:15 p.m.	-	7:15 p.m.

SATURDAY, APRIL 26th

Registration *Exhibits Open: 8:00 a.m. – 5:00 p.m.*	8:00 a.m.	-	5:00 p.m.
NCOIL Strengths, Weaknesses, Opportunities & Threats (SWOT) Exercise	9:00 a.m.	-	10:30 a.m.
Property & Casualty Insurance Committee	10:30 a.m.	-	12:00 p.m.
Luncheon with Keynote Address	12:00 p.m.	-	1:30 p.m.
General Session AI in Insurance – What is the Impact of Losing the Human Element?	1:30 p.m.	-	3:00 p.m.

Networking Break	3:00 p.m.	-	3:15 p.m.
Joint State-Federal Relations & International Insurance Issues Committee	3:15 p.m.	-	4:45 p.m.
Adjournment	4:45 p.m.		
Women's Caucus Reception ***Open to all Women Attendees*** ***Please reach out to Pat Gilbert at pgilbert@ncoil.org if interested in attending.***	5:00 p.m.	-	6:00 p.m.

SUNDAY, APRIL 27TH

Registration *Exhibits Open: 8:00 a.m. – 11:00 a.m.*	8:00 a.m.	-	10:00 a.m.
The Institutes Griffith Foundation Legislator Breakfast Developments in Resilience Initiatives and their Role in the Insurance Marketplace ***Open to Public Policymakers and Staff Only***	8:00 a.m.	-	9:00 a.m.
Financial Services & Multi-Lines Issues Committee	9:00 a.m.	-	10:45 a.m.
Executive Committee	10:45 a.m.	-	11:15 a.m.

Please note all speakers listed are scheduled to speak as of March 26, 2025. There will be modifications between now and the start of the Meeting.

Note: There will be a room (Rutledge on the Mezzanine 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, April 24, 2025

NCOIL CIP President's Policy Roundtable
Thursday, April 24, 2025
2:00 p.m. – 5:00 p.m.
*****Open to President's Roundtable and Speaker's Roundtable Corporate & Institutional Partners (CIP) Members Only*****

Welcome Reception
Thursday, April 24, 2025
6:00 p.m. – 7:00 p.m.

Welcoming Remarks:
The Hon. Pamela Evette
South Carolina Lieutenant Governor

Friday, April 25, 2025

Welcome Breakfast
Friday, April 25, 2025
8:00 a.m. – 9:30 a.m.

1.) **Welcome to Charleston**
2.) **Will Melofchik**
    -Comments from NCOIL CEO
3.) **Asw. Pam Hunter (NY)**
    a.) President's Welcome
    b.) New Member Welcome and Introduction
4.) Any Other Business
5.) Adjournment

First Time Attendee Legislator & Staff Meeting
Friday, April 25, 2025
9:30 a.m. – 9:45 a.m.

First Time Attendee Interested Party Meeting
Friday, April 25, 2025
9:30 a.m. – 9:45 a.m.

Networking Break
Friday, April 25, 2025
9:30 a.m. – 9:45 a.m.

Workers' Compensation Insurance Committee
Friday, April 25, 2025
9:45 a.m. – 11:15 a.m.

Chair: Rep. Carl Anderson (SC)
Vice Chair: Rep. Brian Lampton (OH)

1.) Call to Order/Roll Call/Approval of November 22, 2024 Committee Meeting Minutes

2.) Discussion on the Use of Artificial Intelligence in the Work Comp Marketplace
John Alchemy, M.D., Founder & CEO – RateFast
3.) Presentation on Impact of Vertical Integration on Prices, Medical Utilization, and Outcomes
Sebastian Negrusa, Ph.D., VP of Research - Workers' Compensation Research Institute (WCRI)
4.) Introduction and Discussion of NCOIL Experience Rating Modification Model Act
Rep. Matt Lehman (IN) – Sponsor
Tim Tucker, Executive Director, Legislative and Government Affairs - National Council on Compensation Insurance (NCCI)
5.) Presentation on Trends and Developments in South Carolina Work Comp Marketplace
Scott Beck, Chairman – South Carolina Work Comp Commission
6.) Any Other Business
7.) Adjournment

Health Insurance & Long Term Care Issues Committee
Friday, April 25, 2025
11:15 a.m. – 1:00 p.m.

Chair: Rep. Michael Sarge Pollock (KY)
Vice Chair: Sen. Justin Boyd (AR)

1.) Call to Order/Roll Call/Approval of November 22, 2024 and March 14, 2025 Committee Meeting Minutes
2.) Introduction and Discussion of NCOIL Prior Authorization Reform Model Law
Sen. Walter Michel (MS) – Sponsor
Melissa Horn, Director of State Legislative Affairs – The Arthritis Foundation
Terrance Cunningham, Director, Administrative Simplification Policy - American Hospital Association (AHA)
Emily Carroll, Senior Legislative Attorney - American Medical Association (AMA)
3.) Discussion on Resolution Regarding Audiology Services, Hearing Instrument Specialists Services, and Classification of Non-Over The Counter Hearing Aids as Prescription Devices
Rep. Deanna Frazier Gordon (KY); Rep. Michael Sarge Pollock – Sponsors
Julian Roberts, President & CEO – American Association of Payers, Administrators, and Networks (AAPAN)

4.) Continued Discussion and Potential Consideration of NCOIL Improving Affordability for Patients Model Act

Rep. Tom Oliverson, M.D. (TX), NCOIL Immediate Past President – Sponsor

5.) Consideration of Re-adoption of Model Laws

a.) Transparency in Dental Benefits Contracting Model Act – Originally Adopted 12/12/20

Sen. Justin Boyd (AR) – Sponsor of Proposed Amendments; Asm. Jarett Gandolfo (NY) – Co-sponsor of Proposed Amendments

b.) Short Term Limited Duration Insurance Model Act – Originally Adopted 9/26/20

6.) Any Other Business

7.) Adjournment

The Institutes Griffith Foundation Legislator Luncheon
Friday, April 25, 2025
80 Years of the McCarran Ferguson Act: Exploring Its History, Role, and Relevance
1:00 p.m. – 2:00 p.m.
*****Open to Public Policymakers and Staff Only*****

Hal Weston
Clinical Assoc. Professor & WSIA Distinguished Chair in Risk Mgmt. and Insurance
Georgia State University

NCOIL – NAIC Dialogue
Friday, April 25, 2025
2:00 p.m. – 3:15 p.m.

Co-Chair: Asw. Pam Hunter (NY) – NCOIL President
Co-Chair: Sen. Paul Utke (MN) – NCOIL Vice President

1.) Call to Order/Roll Call/Approval of November 23, 2024 Committee Meeting Minutes

2.) Recap of NAIC Spring Meeting and Discussion on NAIC 2025 Priorities

3.) Update on NAIC's "Framework for Regulation of Insurer Investments," Including Request for Proposal for Credit Rating Provider Due Diligence

4.) Artificial Intelligence
    a.) Preview of NCOIL General Session
    b.) Update on NAIC's AI-Related Activities
5.) Update on Work of NAIC's Long-Term Care Actuarial (B) Working Group
6.) Discussion on Insurance Affordability and Availability Issues
7.) Any Other Business
8.) Adjournment

General Session
Friday, April 25, 2025
Prescription Drug Affordability Boards (PDABs)-Part 1: An Introduction to PDABs
3:15 p.m. – 4:15 p.m.

Moderator: Sen. Mary Felzkowski (WI)

Laura Jenkins, Ph.D.
Senior Associate
Chares River Associates

Andrew York, J.D., Pharm.D.,
Executive Director
Maryland PDAB

Networking Break
Friday, April 25, 2025
4:15 p.m. – 4:30 p.m.

Life Insurance & Financial Planning Committee
Friday, April 25, 2025
4:30 p.m. – 5:45 p.m.

Chair: Rep. Brenda Carter (MI)
Vice Chair: Sen. Pam Helming (NY)

1.) Call to Order/Roll Call/Approval of November 22, 2024 Committee Meeting Minutes
2.) Discussion on the Use of Genetic Testing Information in Life Insurance Underwriting
    Lisa Schlager, VP of Public Policy - Facing Our Risk of Cancer Empowered (FORCE)
    American Council of Life Insurers (ACLI) Representative

3.) Consideration of Resolution in Favor of Encouraging a Redesign and the Use of Lifetime Income Investment Solutions in Defined Contribution Plans
Sen. George Lang (OH) – Sponsor
TIAA Representative
4.) Life Insurance 101 Presentation
Leah Walters, Senior VP, State Relations - ACLI
5.) Update on Developments in the Long Term Care Insurance Marketplace
Melissa Bova, SVP of State Affairs & Policy - Finseca
6.) Any Other Business
7.) Adjournment

CIP Member & Sponsor Reception
Friday, April 25, 2025
6:15 p.m. – 7:15 p.m.
*****Open to Public Policymakers, CIP Members, and Spring Meeting Sponsors*****

Saturday, April 26, 2025

NCOIL Strengths, Weaknesses, Opportunities & Threats (SWOT) Exercise
Saturday, April 26, 2025
9:00 a.m. – 10:30 a.m.
*****Open to All Attendees*****

Please click here to complete a brief survey about NCOIL. The responses to that survey will be compiled and used to facilitate the exercise in Charleston.

1.) Introductory Remarks
2.) Strengths
3.) Weaknesses
4.) Opportunities
5.) Threats
6.) General Comments
7.) Closing Remarks

Property & Casualty Insurance Committee
Saturday, April 26, 2025
10:30 a.m. – 12:00 p.m.

Chair: Rep. Forrest Bennett (OK)
Vice Chair: Sen. Larry Walker (GA)

1.) Call to Order/Roll Call/Approval of November 24, 2024 and February 14, 2025 Committee Meeting Minutes
2.) Presentation on Florida's Property Insurance Market Reforms
    The Hon. Mike Yaworsky – Florida Insurance Commissioner
3.) Presentation on Legislative Developments in the Title Insurance Marketplace
    Elizabeth Blosser, VP of Gov't Affairs – American Land Title Ass'n (ALTA)
4.) Continued Discussion on NCOIL Model Act Regarding Insurers' Use of Aerial Images
    Rep. David LeBouef (MA); Rep. Brian Lampton (OH) – Sponsors
    Amy Bach, Executive Director – United Policyholders
    David Buono, Deputy Insurance Cmsr. – Pennsylvania Dep't of Insurance
    Nathan Rand, Global General Counsel - Nearmap
5.) Continued Discussion and Potential Consideration of NCOIL Online Marketplace Guarantees Model Act
    Rep. Brian Lampton (OH) – Sponsor; Rep. Forrest Bennett (OK) – Co-sponsor
6.) Any Other Business
7.) Adjournment

Luncheon with Keynote Address
Saturday, April 26, 2025
12:00 p.m. – 1:30 p.m.

The Hon. Alan Wilson
South Carolina Attorney General

General Session
Saturday, April 26, 2025
AI in Insurance – What is the Impact of Losing the Human Element?
1:30 p.m. – 3:00 p.m.

Moderator: Asm. Erik Dilan (NY)

Wayne Turner
Senior Attorney
National Health Law Program

Kartik Sakthivel, Ph.D.
VP, CIO, Sr. Managing Director
LIMRA

Lindsey Klarkowski
Policy VP, Data Science, AI/ML & cybersecurity
Nat'l Ass'n of Mutual Ins. Companies (NAMIC)

Peter Kochenburger
Visiting Professor of Law
Southern University Law Center

Networking Break
Saturday, April 26, 2025
3:00 p.m. – 3:15 p.m.

Joint State-Federal Relations & International Insurance Issues Committee
Saturday, April 26, 2025
3:15 p.m. – 4:45 p.m.

Chair: Sen. Lana Theis (MI)
Vice Chair: Rep. Ellyn Hefner (OK)

1.) Call to Order/Roll Call/Approval of November 24, 2024 Committee Meeting Minutes
2.) Presentation on Developments in Flood Insurance and State Resiliency Initiatives
    Dana Sutton, AVP, Atlantic Region Flood Practice Lead - NFP
    South Carolina Office of Resilience Representative
3.) Discussion on Potential Federal Tax Initiatives Impacting Insurance Markets
    Doug Lathrop, VP, Tax Advocacy – American Council of Life Insurers (ACLI)
4.) Discussion on Federal Healthcare Proposals and Impact on State System
    Bailey Reavis, Gov't Relations Manager – Families USA
5.) Introduction and Discussion on NCOIL Health Savings Account State-Federal Regulatory Coordination Model Act
    Rep. Jim Dunnigan (UT), NCOIL Secretary – Sponsor; Sen. Jerry Klein (ND); Rep. Ellyn Hefner (OK) – Co-sponsors
    Kevin McKechnie, Executive Director, Health Savings Account Council – American Bankers Association (ABA)
6.) Any Other Business
7.) Adjournment

Women's Caucus Reception
Saturday, April 26, 2025
5:00 p.m. – 6:00 p.m.
*****Open to all Women Attendees*****
*****Please reach out to Pat Gilbert at pgilbert@ncoil.org if interested in attending.*****

Sunday, April 27, 2025

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

The Institutes Griffith Foundation Legislator Breakfast
Developments in Resilience Initiatives and their Role in the Insurance Marketplace
Sunday, April 27, 2025
8:00 a.m. – 9:00 a.m.

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

Lars Powell, Ph.D., Director & Senior Research Professional
Center for Risk and Insurance Research
The University of Alabama

Financial Services & Multi-Lines Issues Committee
Sunday, April 27, 2025
9:00 a.m. – 10:45 a.m.

Chair: Asm. Jarett Gandolfo (NY)
Vice Chair: Sen. Tim Grayson (CA)

1.) Call to Order/Roll Call/Approval of November 23, 2024 Committee Meeting Minutes
2.) Aligning Data Sharing with Existing Privacy Laws
Ronald I. Raether, Jr., CIPP/US, Partner - Troutman Pepper Locke
3.) Presentation on the National Insurance Producer Registry (NIPR)
Karen Hornig, CEO - NIPR
4.) Presentation on Developments in the Cannabis and Insurance Markets

Kevin McKechnie, Executive Director, Health Savings Account Council – American Bankers Association (ABA)
Chuck DeWeese, Traffic Safety Consultant - Responsibility.org.

5.) Discussion on State Initiatives Regulating the Bail Bond Industry
Jeff Clayton, Executive Director - American Bail Coalition
6.) Any Other Business
7.) Adjournment

Executive Committee
Sunday, April 27, 2025
10:45 a.m. – 11:15 a.m.

Chair: Asw. Pam Hunter (NY) – NCOIL President
Vice Chair: Sen. Paul Utke (MN) – NCOIL Vice President

1.) Call to Order/Roll Call/Approval of November 24, 2024 Committee Meeting Minutes
2.) Future Meeting Locations
3.) Administration
    a.) Meeting Report
    b.) Receipt of Financials
4.) Consent Calendar – Committee Reports Including Resolutions and Model Laws Adopted/Re-adopted Therein
5.) Other Sessions
    a.) The Institutes Griffith Foundation Legislator Sessions
    b.) General Sessions
    c.) Featured Speakers
6.) Any Other Business
7.) Adjournment

WORKERS' COMPENSATION INSURANCE COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
WORKERS' COMPENSATION INSURANCE COMMITTEE
2024 NCOIL ANNUAL MEETING – SAN ANTONIO, TEXAS
NOVEMBER 22, 2024
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Workers' Compensation Insurance Committee met at The Westin Riverwalk Hotel in San Antonio, Texas on Friday, November 22, 2024 at 2:15 p.m.

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

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Rep. Toby Overdorf (FL)
Rep. Brian Lohse (IA)
Rep. Matt Lehman (IN)
Rep. Rachel Roberts (KY)
Rep. David LeBeouf (MA)
Rep. Brenda Carter (MI)
Rep. Nelly Nicol (MT)
Sen. Jerry Klein (ND)
Sen. George Lang (OH)
Rep. Mark Tedford (OK)
Rep. Dennis Powers (TN)
Rep. Lacey Hull (TX)
Del. Walter Hall (WV)
Del. Steve Westfall (WV)

Other legislators present were:

Sen. Josh Carnley (AL)
Sen. Clint Penzo (AR)
Rep. Rod Furniss (ID)
Rep. Peggy Mayfield (IN)
Rep. Deanna Frazier Gordon (KY)
Del. Mike Rogers (MD)
Sen. Roger Hauck (MI)
Sen. Mark Huizenga (MI)
Sen. Michael Webber (MI)
Sen. Jeff Howe (MN)
Rep. Bob Titus (MO)
Sen. Dennis DeBar (MS)
Sen. Hillman Frazier (MS)
Sen. Walter Michel (MS)
Sen. Joseph Thomas (MS)
Rep. Greg Oblander (MT)
Sen. Bill Gannon (NH)
Rep. Ellyn Hefner (OK)
Sen. Roger Picard (RI)
Rep. Joe Solomon (RI)
Sen. Mary Felzkowski (WI)
Sen. Eric Nelson (WV)

Also in attendance were:

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

QUORUM

Upon a Motion made by Rep. Brenda Carter (MI) and seconded by Sen. George Lang (OH) the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Sen. Lang and seconded by Del. Steve Westfall (WV), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 19, 2024 meeting.

PERSPECTIVES FROM THE BENCH ON STRUCTURED SETTLEMENTS

Sen. Theis stated that we'll start today with a continued discussion on structured settlements. Before we begin, there's a little bit of background here. NCOIL has an existing Model State Structured Settlement Protection Act (Model) which you can view in your binders on page 107 and on the website and app as well. The model was amended during the summer of 2022, and since that time, there were some requests to have the topic back on the agenda to further educate the committee on structured settlements. We did discuss this topic at our spring meeting in April, and now we're going to have some new perspectives on the topic as we're going to hear from some presiding judges. We'll start by hearing from David Rose, VP of State Gov't Relations at Aflac, speaking on behalf of the National Structured Settlement Trade Association (NSSTA), alongside The Honorable Victor Lopez, a New Mexico District Court judge.

Mr. Rose thanked the Committee for the opportunity to speak and stated that MetLife and other members of the NSSTA are grateful for the continued discussion of the Model. And we especially thank Sen. Paul Utke (MN), NCOIL Treasurer, as this is something that's near and dear to his heart as he's worked on it closely in Minnesota and here at NCOIL. We look forward to continuing the discussion at NCOIL. Today, we're going to hear the perspective of the judiciary. I am pleased to introduce Judge Victor Lopez, a district court judge in New Mexico. Incidentally, the original sponsor of the Model was former New Mexico Senator Carrol Leavell. Judge Lopez's biography is before you so I won't go into that in detail but I will just point out that as a part of his judicial work over the years, on a monthly basis he considers at least two to three petitions to approve structured settlement transfers.

Judge Lopez thanked the Committee for the opportunity to speak and stated that as a district court judge, I regularly hold hearings to try to determine whether a structured settlement payee, which we can also call a transferor because they're the ones that are going to eventually or possibly transfer their settlement to a factoring company, should be allowed to receive from the factoring company a deeply discounted payment in exchange for the transfer of these benefits to the company. I'm here to provide the committee with an understanding of the information that judges should be provided so they might make an independent determination as to whether it is in the payee's best interest. That's the fundamental concept that we consider is what is in their best interest.

It's a sort of paternalistic role. We don't have a lot of information given in this process. But let me put it in this way. I was having breakfast this morning and a person sitting next to me was talking about an auto accident she had recently that required her to purchase a new vehicle. She was fortunately not injured in the accident but if she had been injured and if she had sustained damages of say $1 million dollars to compensate her for her injuries, her settlement might have been placed into a structured settlement which would include a future stream of fixed periodic payments. Those are the kinds of situations that we deal with and that this statute deals with. Because after you receive such a settlement, factoring companies might learn about the accident or they might solicit her generally in the media with regards to selling her settlement rights. Normally, you receive a long stream of payment over many years. The idea there under federal law and under state law is to make sure that those funds are not dissipated over time. And so there are some built-in protections but possibly one of those protections is having the judge review the situation. But a factoring company might learn about this and offer to purchase the rights to meet immediate needs.

I've had many people come before me where they need to repair a transmission or pay credit card debt or pay down a home or pay for a down payment on a home. The reasons are quite varied. At this point, after the original tort case, the victim has probably discharged her personal injury attorney and just hears from the factoring company, either by telephone calls, internet, or television commercials. I have seen requests where factoring companies might offer to buy a $1 million dollar structured settlement for pennies on the dollar, some as low as 50% or 30% of the future payout if received over time. And these tort victims can only see dollar signs and are happy to get a fractional payment to meet immediate needs rather than having the patience to wait for the stream of payments to be paid out. This is an unfortunate situation in many cases because it's hard for the judge to have enough information to know whether this makes sense or not. The primary problem with structured settlement transfers in this area is the disparity of bargaining power between the injured tort victim and the factoring company that seeks to purchase the victim's structured settlement. The factoring company has an attorney while the victim has neither an attorney at that point and also doesn't have an advisor or even a guardian ad litem to speak up in my court about the advisability of the transfer. The judge serves in the paternalistic role of deciding whether the proposed purchase is in the tort victim’s, and I'm going to call them the tort victims, but we can also call them the transferor, best interest for that money to be paid out and for them to take such a big hit on the value of that. Essentially, the judge is there to make a best interest decision with his or her hands tied behind their back. The factoring company’s attorney only presents the bare minimal facts about the terms of the transfer but says nothing about the tort victim also known as the transferor. We sure could use an option within the statute and I think NCOIL is talking about this, to appoint an advisor or a guardian ad litem to review the case before the hearing and provide the judge with a report so that we can prepare for the case and be prepared for that and ask questions.

In New Mexico, we do have the authority to appoint guardian ad litem’s prior to holding a hearing on approving settlements involving minor children or incompetent adults. Usually, the guardian ad litem will recommend approval of the settlement, but other times they may say no because of lack of information, medical care issues, or it's just

inadequate to fairly compensate the minor child. Certainly, judges tasked with deciding structured settlement transfers can use such a procedure to appoint guardian ad litem's and review their reports in advance of the hearing to make sure that we consider necessary facts in advance of having to decide the petition. But we need the statute to be amended to allow the judge the discretion to make such a guardian ad litem appointment paid for presumably by the transferring company. Under federal law, a fundamental goal of structured settlements is to set up a stream of future payments to protect against the victim becoming a burden on the social benefit and medical programs that we have. The problem is that judges only hear from the factoring company's attorney at our hearings, without input from a professional to present toward victims' interests. For example, how did the original accident occur? How was the victim injured? Was there a head injury involved that might affect the victim's capacity or decision making? Does the victim have dependents, children, a spouse, a mother, for example, who would be affected by a transfer of the negotiated future payment stream? The payee's current and future living medical and other needs, and those of the dependents need to be considered. Did the payee attempt to do prior transfers of structured settlements? Because we do see a lot of repeat business in this area, and some of these initially are turned down. And so they try another judge by refiling. And these victims normally do avoid these discussions when that does happen. Judges just don't know why prior petitions were denied. But it would be helpful to have that information so that we can figure that in and put that into our overall decision making with regard to maybe the other judge had a real good reason for denying it at that point. We'd like to know that.

And so the judge just does not have the facts at this point. During the hearing, we hear from the injured victim only vague recollections of the past incident. But they will explain how they need the money today to fix a car, to start a business, or to pay credit card debts. Judges need sufficient information in the petition process and the guardian ad litem report testimony including the victim's sworn testimony in affidavit and other essential factors if we're going to be able to engage in the meaningful best interest review which is hard to do at this point. We're just not receiving the information and some inexperienced judges might decide to accept what little they get while other judges may just deny the petitions. And this process, in my view at least, makes no sense. So I'm here today to ask you to bring some reason to the process and to consider amending the model to help improve the fair administration of justice by getting judges more information so that we might make the best interest decision guided by necessary facts at hand.

Sen. Bill Gannon (NH) stated I don't like the best interest standard in this case. I would think as long as I'm a competent person then it's ok. If I was incompetent or you had some reason to think that I was under duress or something, I could understand you're getting involved but if it's my decision why shouldn't it be my money to take and do as I please? Judge Lopez stated that's true and that's one of the views that is being presented, especially in the advertisements on television. I hear it all the time. But what you have to realize is that there's a strong lobby there that really promotes this process because this is a billion-dollar industry and so the person that we receive information from, well we receive very little information and we hear them at the hearing. These

hearings are by telephone or by video generally and so you don't see the whites of their eyes essentially and it's hard to judge their credibility as there's no adversarial process involved where you have an attorney on one side or the other developing the facts. You just have one attorney and they're the attorney representing the factoring company. So it's hard for the judge to assess that. But the federal intent originally was to make sure that the stream of payments were going to be sufficient to carry this person into the future and that is totally defeated by allowing these payments to be terminated before the time and at a hugely discounted rate. That is the problem. It becomes a social problem. Sen. Theis stated that we're going to wait on other questions until the rest of the speakers are finished.

Brian Dear, Executive Director of the National Association of Settlement Purchasers (NASP), thanked the Committee for the opportunity to speak and stated that NASP, as many of you are well aware, has been working with NCOIL and others during the recent legislative cycles in Minnesota, South Carolina, and other states on this issue. And I certainly understand some of Judge Lopez's perspectives. Before going further, I did want to touch on the best interest standard and the comments made by Sen. Gannon as it is important. And one of the things I think is very important that we never forget on these types of cases is that every single one of these cases involving one of these structed settlement transfers is someone's story. Every person comes from a different walk of life. You have some people involved in these transactions who are injured in an accident, some minorly, some severely. You have some people who are receiving these structured settlements as a result of a wrongful death case. And we have people in these transactions that come from all walks of life. In this last week, I had a person here in Harris County on a case that one of my clients brought to court and the payee in that case was an attorney. She had her own consulting business. She entered into a transaction to sell a portion of a structured settlement that she received as a result, unfortunately, from the wrongful death of her mother in a plane accident. And after essentially exploring her options, she discovered she could get a far better deal selling her structured settlement at an 8% rate than she could from hard money lenders to expand her business.

There's a lot of talk about people taking advantage of folks in this industry but I do want to make sure that we focus on each individual because every person's story is different. We have people who absolutely fall on hard times that are trying to lift themselves out of a difficult situation. We have very sophisticated people involved in some of these transactions who are lawyers, who are doctors, who are accountants. Those are people who do not necessarily need to have a guardian ad litem review everything about their lives and tell them what's best for them. Now, in certain circumstances, when the court finds it appropriate, we absolutely support an ad litem appointment and that's something that judges have the existing ability to do. And if a judge wants to have an ad litem, they can absolutely appoint it. Our clients are the people who are paying those fees. I do want to make sure that everyone is very aware that's an existing power judges have right now. I don't think it's something that we need to necessarily force into a statute. There's a lot of people who focus on pennies on a dollar. This is a very hyper-competitive industry. There are many companies in this space. And we supported an amendment to the NCOIL model suggesting that all payees get multiple offers before they enter into an

agreement. We have tried to do as many of those safeguards we can to make sure people are educated that they have a lot of options here. Similarly, with the comments about prior transactions, in the existing NCOIL model right now, there are disclosure requirements for prior transactions. There are disclosure requirements to make sure that people are aware of all the people's dependents and all of that information. So the NCOIL model has a lot of protections right now that address some of those very concerns. I'd now like to introduce The Honorable Omar Maldonado, a County Court judge in Hidalgo County here in Texas.

Judge Maldonado thanked the Committee for the opportunity to speak and stated that in 2014, I became the first elected judge to serve in County Court No. 8 in Hidalgo County, Texas and it is still where I preside today. I have overseen and currently oversee criminal, civil, and family matters and I have directly overseen countless proceedings involving the transfer of structured payments. As such, I have become familiar with reviewing the sale of such payments and fully understand all aspects, positive and negative, associated with selling a portion or all of the individual structured settlement payments. I've seen the benefits of selling these payments and how it affects individuals. Often, this is one of the largest assets that people may have and it is my duty as a judge to oversee and determine after reviewing the facts that any of the sale is in the individual's best interest. That is always how it has been and the Model adopted by NCOIL in 2022 provides all the resources and tools for any member of the judiciary to be able to fully and effectively review the facts to determine whether the sale is in the best interest of the person seeking to sell their structured settlement payments. Our law here in Texas was adopted based on previous versions of the NCOIL model and in compliance with the federal law requiring a court to make a best interest determination. In my opinion, there is no need at this time to adopt additional changes to the 2022 NCOIL model. When Congress authorized these sales, they placed the responsibility on the court to gather the facts and information and to decide the best interest and I believe that is how it should remain.

Every member of the judiciary who reviews these matters has the ability to personally inquire about the facts surrounding the individual circumstances to determine if it is in their best interest. As a judge, I am free to appoint a guardian ad litem or another advisor to represent the individual seeking the transfer if I, through questioning and reviewing the court's filing, determine that there is a lack of capacity to adequately determine if the sale is in their best interest. In the case of a minor, the appointment is wholly of course warranted. However, not all individuals warrant such an appointment. When Congress enacted the federal law requiring such sales, they placed the burden to make these findings solely on the court. And it is the judiciary's duty to make the finding and to avail itself to any civil procedures necessary to make that finding. Therefore, at this time, I would urge you to not adopt any changes and to review such needs when scheduled for review in 2027. And by doing so, it allows the members of NCOIL the opportunity to consult with members of the judiciary to see if any additional changes are of course warranted. I was having this conversation with Judge Lopez earlier and we were talking about how many cases I specifically handle. I am a court of general jurisdiction. On an average day, we handle about 50 criminal cases and another 20 civil cases. So about 70 cases a day. And we handle that in a matter of about three hours.

Every day I make decisions that I have to use my gut instinct. And it is our job to do that. And with the experience that I have over the last ten years, I feel like I have been very proficient in doing so. Whether a person's mental competency is an issue is something that I can determine within seconds sometimes in particular cases, especially in criminal cases. This is no different. I think that if we take that ability away from judges, I think that we're basically stripping them and us of what we train ourselves to do every day. And so I just wanted to make sure that you all understood that as judges, we handle cases every day. I am a court of general jurisdiction. We hear hundreds of cases on a weekly basis and decisions are made that often involve these type of decisions about what's in the best interest of the litigants and the parties that are in front of us.

Rep. Brenda Carter (MI) asked what kind of protections are in place to ensure that the structured payment settlements are in the best interest of the payee and their dependents? Mr. Dear stated that in each of these cases, and I represent a lot of these companies, what we generally do and when we're making our presentation to the court is I solicit questions directly from the person involved in the case. I will typically give the court a very brief overview of the transaction, but it's not my story to tell. It's the person who's involved in that story to tell. And we will go over everything from their age, if they're married, if they have any children, if they're working, if they're in school. I've spent quite a bit of time letting the judge know this stuff because this is typically the judge's first introduction to a person. As Judge Maldonado mentioned, they're kind of used to seeing a lot of people over time but I always want to make sure that the court has a background of who they are, what they're doing, if they're working, if they're recently out of work, if there's someone who was injured in an accident and can no longer work - we always elicit that just because that brings in a little bit more of a need for a judge to pay attention in those cases. As opposed to others like when I have an attorney who owns their own business. Pretty early on, you get to figure out where do the courts need to be focused at to make sure they're getting that information. We will tell them through questions to that person. We want to make sure that the judge has the answers about that person. We want to give the judge information of who that person is, what's going on in their lives. That will then turn into what was the underlying reason that they're receiving this money because there are certain cases that's a wrongful death case or a case where I was bit by a dog and I've completely recovered from those injuries. There are some people who still have issues and we elicit that so that the court knows. Because again, that brings an extra little cue to the judge to put a little bit of more kid gloves on it.

We'll go over the terms of the transaction. We'll spend quite a bit of time on what they're paying and using the money for. It’s not necessarily required, but a question I always try to ask is, what alternatives have you looked at outside of this transaction before you've gotten to this point? Under the NCOIL model, our clients are required to advise people that they have the right to go speak to a lawyer or a financial advisor if they want to choose to do so. In some states it is required that they do so before they move on. I'll ask if they've done that. And then if they haven't done that, I'll then make sure they understand. I'll always go to the fact they understand I'm not their attorney. I obviously can't give them any kind of legal or financial advice and that they absolutely have the right to go talk to a lawyer or financial advisor if they want to do so. And I will always

cover that even at this very moment in this hearing. If you want to take more time and you want to take a pause to go do that, you absolutely have that right. So we cover all of those things. If someone's done prior transactions, I will bring those up because I want the judge to know because we do have repeat sellers. Some people sell once and they're done. Some people will occasionally come back. I had a very sweet lady who had completed a number of transactions. Unfortunately, her daughter had some criminal issues. She ended up having to take care of her grandchildren, and that brought a lot of other necessary things that she never expected to have to deal with. Her last transaction, she said she'd taken care of her grandchild and she never expected to and had never been 20 miles outside of Dallas County and she said she wanted to go on a vacation as she always wanted to see Las Vegas and wanted to do it while she still could. And I walked up to the judge, whom I know and anytime she has a concern she routinely appoints an ad litem, and I said before we get started I'm going to let you know that this lady wants to do this transaction because she wants to go on a cruise and she wants to go to Las Vegas. I'm going to tell her story now, and then you're going to probably say yes to it. And she did. So we have people from all walks of life and when I say every person's story is different, it is and we have to be cognizant of that.

Sen. George Lang (OH) stated to Judge Lopez, you talked about some states that have put guardians in place. Who pays for that? Is that the taxpayer? Judge Lopez replied no. It's usually the defendant who is offering the settlement and that's in the context of minor settlements. So, it's whether it's the insurance company or the attorneys for the defendant who caused the injury.

Sen. Theis thanked everyone and stated that if anyone has any further questions on this topic, please reach out to me or Sen. Utke.

PRESENTATION ON THE STATE OF WORK COMP COVERAGE FOR MENTAL INJURIES

Michael Duff, Professor at the St. Louis University School of Law, thanked the Committee for the opportunity to speak and stated that what I want to do is summarize and update how mental injuries, of which post traumatic stress disorder (PTSD) is one, are covered throughout the country but I think more importantly is to give you my sense of why mental injuries are being covered at all. That is really the hardest thing to be thinking about. A lot of things happen in the law because there are legal movements that develop and there's not a better explanation than that. So if anyone in this room were to say to me workers' comp doesn't cover a series of injuries because that's just the way it is, that's not going to be very effective with my students who are the up and coming lawyers. The question is, why is it the way it is? Why is it that for time immemorial almost, it seemed like workers' comp didn't cover mental injuries? And I'm going to explain what I mean by that in a minute. And the long and short of it is because tort didn't cover mental injuries. That's really the bottom line because everything that is done in workers' compensation presumes a kind of quid pro quo, a grand bargain, one set of rights for the other set of rights.

Well, what I'm going to tell you is that there was no such thing as something called negligent infliction of emotional distress. It did not exist in 1910 when the quid pro quo originally originated at least in the U.S. So there was nothing to exchange. The problem is that as that theory expanded, tort liability expanded. And so all of a sudden you have situations where emotional injury is arguably tied to work and if you don't cover it with workers' comp, what you're going to get is a tort case. That's not speculative. Why injuries are covered is another part of this. There's obviously a political dimension too. We see more and more PTSD discussion as a matter of public policy. And I cited in the slides here a typical article from the Journal of Public Health Policy basically talking about the extent to which PTSD is increasing particularly with respect to first responders who see horrible things and do horrible jobs and how there was this upswell of support for the idea that I see something horrible at work and frankly I am psychologically impacted for some period of time thereafter. That's a very simple fact pattern. And now I attribute a lot of what's going on to the pandemic and the reason I do is because during the pandemic we had things like workers' comp causation presumptions that you probably all know about and the question is why did we have those? And the reason is because we didn't have anything else and there's not a better reason than that. You could say that probably work played some role in the development of COVID-19 but I'm not going to go through all that but I think what that did was loosen up people's minds and think about workers' comp coverage differently. I'm not going to read the statistics to you, but there is this sense that there are more instances of people developing psychological disability as a result of work-related traumas of one type or another.

And as a matter of public policy, we know that there are high-stress jobs. And we also know that people that have high-stress jobs are, the rates of depression are going up and suicide is going up. All of these things are happening. So there is this upswell of psychological injury. Now the question is, as you well know, how much of it is related to work and why should workers' compensation cover this? Historically, we have three kinds of compensation of mental injury that we talk about in workers comp law. One is called physical mental, another is called mental physical, a third is called mental mental. Physical mental, most of us are aware of this type of situation. Somebody suffers a really serious back injury and they're at level seven pain for a year. And they get depressed. And it's been uncontroversial for many years for that, even though it's a psychological disability that results to depression, to be compensable. And PTSD falls into the third category - purely psychological or mental stimulation causing mental or psychological disability. Thirty-four states cover mental mental injuries which means obviously that 16 do not. What I'm going to explain is that of that 34, nine states cover mental mental injuries only for first responders. Now, they don't just cover it. It has to arise out of and in the course of employment, the standard formula that we all know. However, you'll notice there's something I left out of that arising out of and in the course of employment, and it is accident. There is not an accident qualifier there. So what states do is even though theoretically they cover PTSD, they have conditions that have to be satisfied by the claimant before they can be eligible. So, for example, the situation that freaks everybody out is the idea that there is a personnel action, somebody's disciplined, they're fired, something like that happens. They develop some kind of psychological trauma and file a workers' comp claim. There are many states that say, no, that is not the qualifying event or accident that will allow you to file a successful

workers' comp claim. Disciplinary actions, job transfers, demotions, layoffs, you get the idea. The idea is we don't want to open up Pandora's box and cover everything that just seems like the normal way that a business is operated. Some states, like Maine, have enhanced proof standards. So whatever the event is at work, it has to be the predominant cause of the psychological disability that results. Not a cause, not a significant cause, not a substantial cause, the predominant cause. Well, that's another way you can say it's covering mental-mental injuries but not in a sweeping way because you have to get over that standard.

Twenty-five of the 24 states that cover mental-mental generally cover them for any employee. So any employee that can meet the standard that's developed, it's covered. Having said that, there are still criteria that the event that caused the injury usually has to be unexpected, unusual, extraordinary, and not just something that upset me. Something really unusual. Some states are even narrower and they say that the mental injury must have been caused by a specific type of event like a violent crime, witnessing someone's death, those are really traumatic things. And notice what's happening. Mental-mental is covered, but it's narrowed significantly so it's going to be very hard to cover. First responders, this is where most of us have heard about this. There is a political drive on the part of labor organizations, emergency medical services and firefighters, and so forth, to cover these types of disabilities. Some mental-mental states use separate criteria altogether for first responder claims. And 11 states have a rebuttable presumption and this is the part that really becomes stick. So if you have a rebuttable presumption of PTSD, what does that mean? It means somebody accurately diagnoses a person with PTSD, and you just have a diagnosis and once that happens and it's tied to some work-related event, what happens is that the burden shifts to the employer to prove that it didn't happen because of work. Now try thinking about proving a negative and how difficult it can be to prove a negative as it is to prove a positive.

So when you shift the burden of proof like that, very often that can result in coverage. So that group of 11 states, the rebuttable presumption criteria is really the one that's going to lead to enhanced coverage. Nine states generally prohibit mental-mental claims, but they make an exception for first responders. A lot of states aren't doing that and I would tell you that I think there's sort of constitutional problems lurking in that division. That's all I can say about it. People are alarmed by Connecticut. I don't know if you've been hearing about Connecticut – they have an act expanding workers compensation coverage for post-traumatic stress injuries for all employees and that sounds dramatic until you get into the small font here and you have a series of really dramatic events that would have to happen. And I'm not going to go through them all, but they have to be serious events that occur. And if that happens, then yes, theoretically that is an employee that qualifies. But look at the next slide. It's not a presumption. It's very different from those other standards that have a presumption. The PTSD must directly result from the event. So you have really a difficult causation standard there. It's not anywhere near as dramatic as it looks in the news because I wouldn't want to be the claimant's attorney trying to prove the case under that standard. New York is really the more serious one where a worker files a claim for mental injury premised upon extraordinary work-related stress incurred at work. Now, what I want you to notice about this is that you could theoretically have someone who had a cumulative

psychological injury over time. And that originally applied to first responders. It was expanded, it's passed both Chambers. I don't know if the Governor has signed it. That is the one that is dramatic. That's the one that suggests well suppose I'm at work and over the period of five years I'm just getting more and more stressed because you're a bad boss and then one day that's it, that is extremely problematic to defend and potentially very expensive because when does it end?

Rep. Matt Lehman (IN) stated that everything you talked about is all about the presumption of the injury and when, where, how, and why. My question is how do you calculate the compensatory damage? When I break a leg, I go have surgery, I get so many days off work, and all of that is statutory, either you get a certain amount of dollars or you get the medical bill paid. How do you calculate the compensatory damage on a mental claim? Prof. Druff stated that it's not a problem with temporary total, it's not a problem with permanent total, because that's all a function of the average weekly wage so that's just math. The problem is permanent partial disability and when that permanent partial disability is scheduled and you have some combination of scheduled injury and unscheduled injury. That is a great question because if you have partial disability that's not scheduled, that could go out into time. How do we even know when the disability ends? You have problems with intervening causation that are really significant.

Rep. Lehman stated that would be my concern is there's other factors that go in potentially to mental illness. We had a gentleman who was going through a traumatic time in his life and then witnessed a death at work. I'm a broker in the insurance business. And the mental stress was caused by which? Which had a greater impact on his mental stress? The life issues or the incident at work? And then how do you say what category that's in? Is it permanent, partial? And that really shed the light on we can begin to statutorily say what is the cause but I think we really need to be working also on the end of what bucket do you put that in when it comes to the compensatory side? Prof. Duff stated that I think you're going to have rules like that that deal with the extent of time that a particular kind of claim would be paid and those kinds of things.

Rep. Mark Tedford (OK) asked if you could talk a little bit about the New York law and the cumulative trauma kind of approach they're taking and how it would be dealt with in a workers' comp policy setting where the coverage trigger is by an occurrence and how they deal with that. You could have trauma that goes over multiple policy periods, multiple carriers, how are they dealing with that? Prof. Duff stated that how they're dealing with that of course isn't clear because it's new and the whole concept really is new. But there is a big difference between a serious one-time event that causes somebody psychological disability and something that's more like over a period of time the person is just experiencing high anxiety in a workplace and at a certain point the there is the straw that broke the camel's back. And you have what we call in torts the eggshell skull plaintiff. You can have the eggshell skull person with respect to psychological injury so somebody is just experiencing more cumulative anxiety than somebody else and how do you deal with it? These laws are going to have to be tailored. And by the way this is all a factor of non-coverage. That's basically what's driving this. People woke up one day in the pandemic and said, "Oh this isn't covered

and this isn't covered and this is isn't covered." So now we're rethinking and the same thing has happened in tort law for over 100 years.

PRESENTATION ON THE TEXAS WORK COMP INSURANCE SYSTEM

The Hon. Jeff Nelson, Commissioner of the Texas Dep't of Insurance Division of Workers' Compensation, thanked the Committee for the opportunity to speak and stated that I was asked to talk a little bit about what has made the Texas workers' compensation system successful and what has made us unique and I think those two things go hand in hand. I think a lot of the successes we have in Texas have been thanks to some of the political fortitude over the years and some of the major changes that the legislature has undertaken to put us in such a good position today. Before I get into all that, I wanted to just give a brief sort of snapshot of who we are as an agency and then sort of what the workers' comp market is like in Texas. So, for starters, we are the Texas Division of Workers' Comp. We are the regulator of the system. We're neutral. We do not advocate on behalf of injured employees. There is a separate state agency called the Office of Injured Employee Council who does that. We have over 400 full time employees in our agency. They're spread out across our 20 field offices across the state. although most of them are in our Austin field office just across the street from the Capitol. We are funded by a self-leveling maintenance tax on workers' comp carriers that is capped at 2%. We have five main legislative directives given to us and those are dispute resolution, healthcare management, claims to customer services, workplace safety, and then of course compliance and investigations since we are the regulator. Now, what's the market like in Texas? Texas has a very healthy workers' comp insurance market. We have over 300 insurance carriers that write comp and they write about $2.6 billion in direct written premium every year.

Now, even though we do have those 300 carriers, the top ten carriers make up about 75% of the market and Texas Mutual is by far our largest carrier. They make up about 41% of our whole market. Since some of the reforms that I'm going to get into in a little bit, in 2003, workers' comp rates are down 81% and that's something we're very proud of while we're seeing better outcomes for injured employees. One of the signs of a healthy workers' comp market is how big or small the residual market is and we are very fortunate in Texas that our residual market is below 0.3% of the overall system. And it's been good for insurance carriers, too. Workers' comp has been the only consistent, profitable line of insurance for carriers in the state for at least the past decade. So, what makes Texas different, what makes us unique? And like I said, it's really about the legislative reforms that have gone on since workers' comp started in 1913 but really since 1989. So, that's what I was going to dig into a little bit today. So, I'm going to tell you, there's always legislation going on with workers' comp just like any other system but what I wanted to focus on today are these three changes. First, when workers' comp started in 1930, some major reforms in 1989 and 2005. And then it wasn't really until 2010, 2011 that all of those 2005 reforms got implemented. So, those are going to kind of go hand in hand together. So, for starters, in 1913, that was the first workers' comp law that was passed in Texas. And since 1913, we've been unique. Workers' comp has been optional for Texas employers since then. I think we're one of only two states where it's optional for employers and it's really worked out well for us, I think. Employers that

do not have coverage, we call them non-subscribers, and we do track those numbers. Now, even though employers have a choice to get coverage or not, 76% of all private sector employees do carry workers' comp and they cover 87% of all private sector employees in the state.

So, it means that these employers think workers' comp is the best route to go for them and for their employees. And I know this makes us very unique. And when I talk to other states about this, they think it's kind of weird. But it works out well for us. And I think it's been a driver for some of the changes that we've had. One of my old bosses, Governor Rick Perry, used to talk often about how competition among states drove innovation. He would call them the laboratories of innovation and I think that's sort of what's happened in Texas. We don't have a captive workers' comp market. Employers don't just have to get comp coverage. They can choose to go another direction and because of that, the legislature has put in programs and policies years ahead of sort of what the standard has become now. So I really want to give an appreciation to the work that the legislature has done and the foresight that they've had to put us in such a good position today. So, the first major reform was in 1989 and these were significant changes to the point that anything prior to 1989 we call old law and anything after 1989 we call new law. They wrote an entirely new code. Of course, there were a ton of changes there. I really want to focus on three and I'll be quick in it. First, they eliminated pretty much all lump sum medical settlements. They created a new dispute resolution process. And they limited attorneys fees to 25% of the employees recovery. And that first one eliminating settlements has had a huge impact that's been lasting today. The Workers' Compensation Research Institute (WCRI), a national organization who does workers' comp studies, recently published a study comparing 17 states and their overall claims costs. What they found is that Texas has the second overall lowest claims cost of all these workers comp systems. We were 32% below the average and they directly attributed our low claims cost to the fact that we do not allow lump-sum settlements in our system.

The other thing it did is it created our modern dispute process. This was another effort to sort of bring attorneys out of the system and to reduce litigation cost to really simplify that process. This is very similar to how it is now in most states - informal mediation, we call a benefit review conference, a formal contested case here and in front of an administrative law judge. And then go into our three-judge appeals panel. From there, you can of course go to district courts, but these changes have really had lasting impacts on our system, especially the changes with settlements. At that time in 1989, costs were out of control, businesses were fleeing the state and 70% of claims were going to litigation and ending in settlements. Injured employees weren't getting back to work. They didn't want to get back to work. So, that one change has really had a lasting impact on our system. Things kind of cruised along for a while, then in 2005 we had another set of major changes that really drove some of those significant cost savings that I was talking about. Again, there are multiple changes to this bill, but the major changes I want to touch on is it created the Office of Interim Employee Counsel and required us to develop treatment and fee guidelines. And it had us adopt a pharmacy formulary. So, the Office of Injured Employee Counsel is a separate state agency that's very unique to Texas. This is an agency that is funded by the workers' compensation

maintenance tax and it is made up of a team of ombudsman across the state whose job it is to assist injured employees through the dispute resolution process. It's an alternative to them having to hire attorneys to navigate the system. These ombudsman are not attorneys but they are specialized in the dispute process. They know the ins and outs to the point where 50% of all injured employees in Texas choose to use an ombudsman rather than a higher representation to take them through a case.

The Office also offers various educational opportunities and just helps with the claim, helps with how to file paperwork and reminders that they have doctor's appointments coming up. And it's been really beneficial to the injured employees in Texas. And it's been a cost saver as well. And that was a difficult thing to do creating a new agency to essentially advocate against insurance carriers funded by an insurance maintenance tax. But it's actually been a cost saver for all parties in the state and it's been very beneficial. But I think the biggest change during those reforms was instituting treatment and fee guidelines. The treatment guidelines created a standard way to handle the medical portion of claims. It said what treatments would be pre-approved and what required pre-authorization and it really just brought in a standardization of care. It also introduced fee guidelines. And by statute we were required to make those Medicare based. And I thought that was very smart for two reasons. First, health care providers understand Medicare billing. Their front offices are familiar with it. It wasn't much of a change. The second thing is, we tied it to an inflation factor, the Medicare Economic Index. So, every year our fees are automatically adjusted. And this has helped tremendously. We don't have to go to the legislature every five, ten years to have a big fight about what the fees are. We don't have to undertake a three-year rule project to discuss what fee changes need to be made. They're automatically changed every year. And workers' comp systems around the country are struggling with health care providers in the system. And I'm not saying we don't have those challenges but doctors in our system know they're going to be paid. They know the fees are going to consistently be updated, most likely increased. It’s been very helpful in that regard and I thought that was a very kind of prescient decision that was made. So even with all the health care inflation going on, there has been a 30% reduction in overall health care costs, a 20% reduction in total claims, a 26% reduction in professional services, a 20% reduction in hospital, and a 71% reduction in pharmacy fees. I think we can be held up as an example for how to have a successful system and it's thanks to the legislature for working to get it done.

ANY OTHER BUSINESS

Rep. Nelly Nicol (MT) stated that I wanted to mention that this week is National Kids Chance Awareness Week. I'm on the board of the Montana Kids Chance and it's a great organization. I just want to make sure everybody knows what it is. We give money to kids that have had parents injured or killed in a workplace accident. It's a great program and I wanted to let you know about it. Please look it up and if you would like to donate any money go ahead and contact me.

ADJOURNMENT

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

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CHIEF EXECUTIVE OFFICER: Will Melofchik

NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

Experience Rating Modification Model Act

Sponsored by Rep. Matt Lehman (IN)

Draft as of March 26, 2025. To be introduced and discussed during the Workers' Compensation Insurance Committee on April 25, 2025.

Table of Contents

Section 1. Title

This Act shall be known as the [State] Experience Rating Modification Act.

Section 2. Definitions

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

(A) "Employer" means a sole proprietor, a corporation, a partnership, a limited liability company, or another entity with one (1) or more employees.

(B) "Experience rating" means a rating procedure utilizing past insurance experience of the individual policyholder to forecast future losses by measuring the policyholder's loss experience against the loss experience of policyholders in the same classification to produce a prospective premium credit, debit, or unity modification.

(C) "Subrogation claim" means a claim or an action that is filed or otherwise initiated by a company against a third party that caused a loss to an insured party to recover from the third party the amount of a claim paid by the company either to the insured party or on behalf of the insured party for the loss to the insured party.

(D) "Successful subrogation claim" means a subrogation claim that results in payment of money by a third party to a company, even if the amount of money paid to the company by the third party is less than the amount of the claim paid by the company either to the insured party or on behalf of the insured party for the loss to the insured party.

Section 3. Experience Rating and Employer Contract Bidding

(A) After [insert date following enactment], a party may not prohibit an employer from bidding on a contract solely on the basis of the employer's experience rating.

(B) This Section does not preclude a party from considering an employer's experience rating when awarding a contract.

Section 4. Experience Rating in Subrogation Claims

(A) Except as provided in subsection (D) of this Section, when a company makes a successful subrogation claim, the governing rating bureau shall revise the experience rating of the insured party in the manner set forth in this section.

(B) After a company makes a successful subrogation claim, the governing rating bureau shall revise all of the insured party's prior experience ratings that were modified as a result of the insured party's claim for which the company made the successful subrogation claim.

(C) The governing rating bureau shall revise the prior experience ratings described under subsection (B) in a manner that accounts for the entire amount the company received as a result of the successful subrogation claim, and ensures that the insured party receives, by way of the revised experience ratings, a monetary benefit equivalent to the amount the company received as a result of the successful subrogation claim.

(D) The governing rating bureau is not required to comply with this section if, at the time of the successful subrogation claim, the insured party who submitted the claim for which the company made the subrogation claim is not the owner of the policy under which the claim was submitted, or compliance with this section would require violation of a contract that was entered into, amended, or renewed before xxxxxxx.

Section 5. Rules

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

Section 6. Effective Date

This Act shall take effect xxxxx.

HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
2024 NCOIL ANNUAL MEETING – SAN ANTONIO, TEXAS
NOVEMBER 22, 2024
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee met at The Westin Riverwalk Hotel in San Antonio, Texas on Friday, November 22, 2024 at 10:00 a.m.

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

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Rep. Deborah Ferguson, DDS (AR)
Rep. Stephen Meskers (CT)
Rep. Matthew Gambill (GA)
Sen. Larry Walker (GA)
Rep. Rod Furniss (ID)
Rep. Matt Lehman (IN)
Rep. Deanna Frazier (KY)
Rep. David LeBoeuf (MA)
Rep. Brenda Carter (MI)
Sen. Mark Huizenga (MI)
Rep. Mike McFall (MI)
Sen. Lana Theis (MI)
Sen. Michael Webber (MI)
Sen. Paul Utke (MN)
Sen. Michael McLendon (MS)
Sen. Charles Younger (MS)
Rep. Nelly Nicol (MT)
Sen. Jerry Klein (ND)
Asm. Erik Dilan (NY)
Asm. Jarett Gandolfo (NY)
Sen. Pam Helming (NY)
Asw. Pam Hunter (NY)
Sen. George Lang (OH)
Rep. Ellyn Hefner (OK)
Rep. Carl Anderson (SC)
Rep. Tom Oliverson, M.D. (TX)
Rep. Dennis Paul (TX)
Del. David Green (WV)
Sen. Eric Nelson (WV)
Del. Steve Westfall (WV)

Other legislators present were:

Sen. Josh Carnley (AL)
Sen. Clint Penzo (AR)
Rep. Mark Hashem (HI)
Rep. Brian Lohse (IA)
Rep. Peggy Mayfield (IN)
Sen. Jason Howell (KY)
Del. Mike Rogers (MD)
Sen. Jeff Howe (MN)
Rep. Bob Titus (MO)
Sen. Dennis DeBar (MS)
Sen. Hillman Frazier (MS)
Sen. Walter Michel (MS)
Sen. Joseph Thomas (MS)
Rep. Greg Oblander (MT)
Sen. Bill Gannon (NH)
Rep. Forrest Bennett (OK)
Rep. Mark Tedford (OK)
Sen. Roger Picard (RI)
Rep. Joe Solomon (RI)
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. Lana Theis (MI) and seconded by Sen. Jerry Klein (ND) the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. David LeBeouf (MA) and seconded by Rep. Dennis Paul (TX), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 18, 2024 meeting.

PRESENTATION ON THE PRIOR AUTHORIZATION LANDSCAPE

Sen. Walter Michel (MS) stated that Mississippi passed a prior authorization reform law a couple of years ago and we thought it was very significant legislation. I'm thankful to see that the Committee is addressing this and I think that maybe the Mississippi law would be a starting point for the Committee to develop a prior authorization reform model law next year.

Emily Carroll, Senior Legislative Attorney at the American Medical Association (AMA), thanked the Committee for the opportunity to speak and stated that prior authorization is certainly a priority topic for us. We've been working to address this issue for many years, largely in the states up until recently. Every year we put together an annual survey of physicians to sort of assess the impact of prior authorization on them and their patients and as in previous years, the survey results continue to show both patient harm and physician harm as well as impact on the healthcare system and employers and employees. We always kind of initially focus first and foremost on the patient harm because we believe it's significant and this year, we continue to see that – 94% of physicians report care delays because of prior authorization and 78% report that prior authorization has led to treatment abandonment by patients. Maybe most concerning is that nearly one in four physicians report that prior authorization has led to a serious adverse event for their patients and this can include hospitalization, long term or permanent impairment or even death. We also look at the impact of prior authorization on physicians. It's draining and exhausting our physicians and their practices. Physicians spend nearly two business days each week completing prior authorizations and they're reporting that the number of prior authorizations continues to increase. And nearly all physicians report prior authorization is leading to burnout. And I really want to stress that this is all happening against the backdrop of a severe physician shortage in the States and nationally and the growing corporatization of healthcare and prior

authorization is certainly impacting and leading to this environment that we're seeing these issues with. Also, prior authorization is impacting employers and employees. Almost half of physicians report that their patient's job performance has been impacted by prior authorization. So that's a result of absenteeism or decrease in function due to care delays and prior authorization impact. And then finally, we find that prior authorization is increasing costs for the whole healthcare system, and the impact of it is really causing greater utilization of services, repeat office visits, ineffective initial treatments, and more hospitalization and emergency room (ER) visits.

So, what are we proposing to do about it? The AMA is offering a number of solutions. We have model legislation that we've seen introduced in some of the states but really I've kind of bucketed our solutions into a couple categories. First, faster response times. We really need to address these care delays. The AMA would say 24 hours as a turnaround time for urgent care and 48 hours for non-urgent. And we really focused on those hours rather than business days and we're really strong proponents of the use of application programming interfaces (APIs) and other standard transactions to help automate the process but we really stress that automation has to be done in the context of other reform efforts, because we're not just trying to get more prior authorization done faster. We also are really looking at reducing the volume of prior authorization. So, as I mentioned, physicians feel that prior authorization just keeps growing and we're really looking at solutions that would reduce that volume and sort of bring prior authorization back to kind of its targeted or initial goal and kind of targeted utilization management. So, some of our options here are those that have been passed in Texas and other states which is gold carding and that's the idea that if you have high approval rates on certain services or episodes of care maybe you wouldn't have to do prior authorization for those services. And we see a lot of states and others looking at sort of eliminating prior authorization generally for some services that may just not make sense like preventive care or other types of services. We would also look to ensure the clinical integrity of prior authorization. So, on the plan side, the reviewer being a physician who has experience treating that type of patient or doing that type of care. We'd also like them to specifically be a licensed physician because really when you're making a medical necessity determination you're really participating in the practice of medicine. And then also we want to make sure that the clinical standards that are being used to do these prior authorizations are not proprietary and really based on national medically recognized standards of care which most national medical specialty societies have developed.

And then we really like the concept that a lot of states are pursuing around data collection, kind of seeing what's behind the black box of prior authorization. What are the rates of approvals? What are the rates of denials? What are the response times? How often are things approved on appeals? We think first of all, that makes it easier for patients to make informed decisions about their plans but also for policymakers to make more targeted reforms in the future. Continuity of care is a big issue. We've seen many proposals that look at ensuring when patients switch plans, they're able to continue on the medication or continue on the service as they switch for a period. And then we want to prevent repeat prior authorization. So, sometimes you'll see kind of stoppage in care while a patient has to go back and get a prior authorization on something they've been

stable on for a long time. And then just general transparency. What are the criteria ensuring that once you have a prior authorization, the plan's not going to go back and not cover that service? Real clarity and the reasons for an adverse determination when it comes to the patient and physician. And then just more clarity around the appeals process which we hear is often a difficult journey for many patients. So, we've talked about this before many years ago - the AMA, Blue Cross Blue Shield, America's Health Insurance Plans (AHIP), the Medical Group Management Association (MGMA), and the pharmacists came together and created a consensus document which kind of looked at maybe some of the low hanging fruit around prior authorization and what we thought we could accomplish together voluntarily. Unfortunately, we haven't seen a lot of progress in that space and we're still helping to ensure that the promises of that consensus statement are realized. But really, I think the states have led the way on prior authorization reform. This is just a map of some of the states that passed legislation this year. Some of these states like Wyoming, Illinois, Colorado, New Jersey, and Maine - they enacted some pretty comprehensive reforms this year that look at a lot of those solutions I talked about just a few minutes ago.

And then we're seeing some progress on new ideas. Minnesota took some steps this year after having really strong legislation on the books. They went a step further this year and decided to start looking at how to pull certain services and just prevent prior authorization on them. So, some cancer care, mental health services, those sorts of things. Vermont did something similar where they will prevent prior authorization on primary care services going forward. So, we're seeing some innovation there. And I'll mention California also passed a bill that's really looking at the use of artificial intelligence (AI) in prior authorization and they will ensure that if a prior authorization is denied a physician is making that determination rather than the algorithm. I also mentioned that there has been some progress at the federal level which we are excited to see and I think it really builds on the work that a lot of the states have done over the last several years. There is a new Medicare Advantage rule that is in effect as of January 1st this year that makes some significant progress around clinical validity and continuity of care in the prior authorization space. And then there's one more rule that some aspects of it will be adopted in 2026 and 2027 but this one is much broader, and it applies to Medicare Advantage, Medicaid, Medicaid managed care organizations, and qualified health plans on federally facilitated exchanges. And these reduce the response times that plans are allowed to respond on prior authorization and it really takes automation for medical services a step forward which I think some states are really looking at adopting. And then there's a lot of transparency requirements too. So, I think states have a real opportunity with these new federal rules to kind of bring their requirements at a minimum up to these federal standards and then of course, there is legislation that is pending at the federal level as well that looks at a lot of the state efforts and attempts to apply some of those to the Medicare Advantage space.

Miranda Motter, Senior Vice President of State Affairs and Policy at AHIP, thanked the Committee for the opportunity to speak and stated that it's probably not going to surprise you that on all thing's prior authorization, AMA and AHIP don't necessarily see eye to eye as it relates to the value of prior authorization. Which is why we're both here to sort of share those perspectives. I will say though that I do think that there is probably a bright

spot. I do think that there is probably some agreement as it relates to what quite honestly both of our organizations view as a major barrier to making sure that the administrative burden for providers is reduced as it relates to prior authorization. So, I'll spend some time talking about that but I really wanted to speak about five quick areas this morning. First and foremost, the value of prior authorization. Secondly, and Ms. Carroll spoke to it a little bit, but I do think it's incredibly important to spend a few minutes on that consensus statement that she talked about. Third is where I want to spend some time about where I think there may be some alignment and some real opportunity to again reduce administrative burden for providers but at the same time doing so in a way that doesn't jeopardize patient safety, patient care, patient affordability. And then I'll share really some places where states are leading the way as it relates to reducing this barrier. And then I'll close with just a couple of insights as you all may be looking at proposals moving forward, just a couple of recommendations and suggestions as it relates to that. So, with that, why do health plans use prior authorizations? Health plans advocate for the people that they serve by ensuring that the right care is delivered at the right time, in the right setting and covered at a cost that patients can afford. That's essentially why prior authorization exists. And at the outset I think it's really important for me today to say that doctors provide important care and life saving treatment. But we're all impacted by low value care. Low value care is care that has little or no clinical benefit or where the risk of harm for the care outweighs the benefit. Low value care has a significant impact on our country's healthcare system. But more importantly, it impacts patients. And we can't lose sight of that.

So, we've all seen the studies on the financial impacts of low value care. Here is one, a Journal of the American Medical Association (JAMA) study that estimated 25% of all healthcare expenditures is due to waste in the U.S. system and of that total it's estimated that $75 billion to a $101 billion is related to overtreatment or low value care. Other studies show that 30% of healthcare spent in the U.S. may be unnecessary and it may be harmful to patients. So, low value care doesn't just have this financial impact. It impacts patients. It may expose them to harm. It may expose them to additional out of pocket costs. It may expose them to lower quality of life. And really important here is low value care impacts help other doctors have to provide as 87% of doctors have reported negative impacts of low value care. They have also reported that at least 15% to 30% of medical care is unnecessary. So in other words, doctors have to fix care of other doctors and that impacts patients. Medical knowledge doubles every 73 days. Primary care doctors would have to practice 27 hours to keep up on all of those changes and so that's really why it's important that health plans, doctors, hospitals all work together to make sure to reduce that low value care and protect patients from unnecessary harmful care and cost. So, what do plans do? Plans are doing this through a variety of strategies. They enter into value-based arrangements with providers where those providers are actually holding themselves financially accountable for the quality of care that they're providing their patients. Plan share real time provider feedback so that it helps those providers understand if they are operating as an outlier, if they're not following clinical evidence-based standards. And then last, plans use targeted evidence based prior authorization that focus on those clinical areas that are prone to extreme variation and cost or misuse that harms patients or saddles them with unexpected costs. The prior authorization process, I have to say we all agree, can be

burdensome for all of us. For providers, for patients, for plans. And again, that is why it is incredibly important that we all work together.

This is a slide that you just saw from Ms. Carroll and this is exactly as she indicated what we did. In 2018, we all came together - all six of these national associations came together. And in a really public way, committed to improving prior authorization. One of the things that I do want to point out in this consensus statement, because it was significant, is that it recognized not only that the prior authorization process is burdensome but it also recognized that prior authorization was important. And you can see, as it says in this consensus statement, it's important because there's wide variation in medical practice. So as trades, all of us agreed to five areas of opportunity: selective application, program review and volume adjustment, transparency and communication, continuity of patient care, and automation ti improve transparency and efficiency. That was real low hanging fruit, as Ms. Carroll said. So, what have health plans been doing since 2018 to take action? They have been taking action and again, I think it's really important to recognize this because I think that you have probably heard about this consensus statement in your states. You have heard that plans may not have been taking action, but they have. Plans have been leveraging prior authorization by using electronic systems. A survey of our plans on the use of prior authorization in 2019 and 2022 showed that more insurers are streamlining their prior authorization electronic process more than ever before. Plans are also providing support to providers. They're helping them understand why using outdated manual systems is really hard on them. It's an administrative burden but it also doesn't achieve the best in terms of patient care. In 2020, and I think I've spoken to this before, AHIP and our partners launched what is called the Fast Path Initiative and it actually took technology into physicians' offices and helped them understand if they used electronic prior authorization what it meant. It meant faster time to decisions. Faster time for patient care and better understanding in terms of when prior authorization was needed. And the more the providers used it, the better they said the system worked for them.

It also meant that there was less burden from phone calls and faxes and so it was really important. You'll see here just a really quick case study of Elevance, where it actually showed that using electronic prior authorizations really is quicker. The other thing I will say just real quick is plans are also waiving and reducing prior authorization requirements as providers take on financial risk. I mentioned that more plans are using gold carding programs based on ongoing provider performance and consistent adherence to evidence based standards. These gold carding programs are most effective when they're targeted and when provider performance is closely monitored and partnered with risk-based accountability and they're used for certain services where the clinical guidelines are clear. So, let's talk about where there may be some real synergy and where we may align. I think Ms. Carroll and I can both agree where automation is a real opportunity, which is the major barrier today. So, while health plans are building and offering electronic prior authorization, a significant percentage of providers are still using fax and mail. And I think the AMA's own survey showed that it was reported that the most common way they're submitting prior authorizations is by phone. So, despite the fact that if they used electronic prior authorizations, it could be quicker, as I said, quicker decisions, quicker patient care, better understanding of when it's needed - we're still

using outdated manual systems. We have to change that. We have to improve this two way process by providers and I really think that this is a bright spot as we think about next steps. States here, as I said, are already leading the way. They're already understanding that not using a two-way electronic system is a real barrier to moving forward. You can see here over the past few years, at least nine states and D.C. have passed this two-way legislation. It not only requires the health plan to build and make available the system, but it requires the provider to use the system so that we're not building a bridge to nowhere.

I won't spend much time on this because Ms. Carroll talked about it, but not only are states leading the way, but there's certainly a lot of activity at the federal level to make sure that this electronic prior authorization and this technology is being used to build bridges to advancement. The federal rules, as Ms. Carroll talked about, will require and health plans to create API's but they will also importantly require providers to build this workflow into their electronic health record so that they can use this real time information. I think we all believe that this is really encouraging. So in closing, just a couple of thoughts. I can't stress enough that prior authorization is an important tool. It helps make sure that patients' access to coverage for safe effective care is supported by the most updated clinical guidelines. Some important considerations I think for policymakers as they are objectively evaluating proposals are, are the providers in your state actually using electronic prior authorizations? Or are they using phones to submit their prior authorizations? So, does that proposal actually build a bridge to somewhere? Will the providers be held accountable for high quality care? Are they in value-based relationships? How does the reform actually impact patient care? And essentially in those proposals, are we tolerating a certain level of low value care for patients? And then ultimately how does the reform impact patient affordability? Again, there's some studies here that you can look to in terms of what the real financial impact is, not only here but I know as states have considered these proposals and you all have looked at what the financial impact is going to be, whether it's applicable to your state employee program, whether it's applicable to your Medicaid programs, and you've seen the financial impacts. In lots of instances the application of those proposals gets pulled from those state plans because there's a recognition that it will be expensive and that shift then is ultimately given to the small employers that will pay for that. So again, thank you for the opportunity to spend some time with you on this really important issue. We look forward to additional conversations. I mentioned the study and the survey that we did of our plans in 2019 and 2022. We are actually in the process of updating that right now and it should be ready early next year. I look forward to the opportunity to come back and show how plans continue to advance and where there may be some other gaps and opportunities for alignment.

Rep. Deborah Ferguson, DDS (AR), NCOIL Immediate Past President, stated that I appreciate the work of everyone trying to work together and coordinate. Is there any effort to harmonize what prior authorizations are required? Because in a practice when you have 300 or 400 different health plans and then all of a sudden, particularly Medicare Advantage plans, they tend to drop a prior authorization that you didn't know about and then the claim gets denied. Is there an effort to harmonize what's required for a prior authorization? Ms. Motter stated that a couple of things come to mind. First and

foremost, prior authorization focuses on those areas and services that are prone to misuse, overuse, where clinical guidelines are really important to follow, and where there may be cost implications. The other thing I would say is prior authorization largely follows what your coverage looks like. So, as a purchaser of health care, whether it's Medicare, whether it's the state and Medicaid, whether it's the employee or the employer in terms of employer coverage, how the purchaser of that healthcare wants to make sure that there's high quality care and there's affordable care, it really aligns with that. So I would say there continues to be this focus on evaluating the services that are prior authorization but in terms of industry coordination around a particular kind of service for a variety of reasons, I'm not aware of any of that happening right now.

Ms. Carroll stated that I would say some of the disconnects sometimes in an office may come from different clinical criteria so you may have one plan that uses a set of clinical criteria that they have purchased and manipulated whereas another plan will use a different set of clinical criteria. So, one patient service or drug could be medically necessary under that plan's criteria and if they were on another plan, it would be different. So, I think that certainly leads to some hardship on the practices and certainly the patients as well. Rep. Ferguson stated that you can understand as a practitioner how difficult it is when you have hundreds of insurance plans to keep up with who requires what prior authorization. I just think the industry should get together and sort of agree on some standards.

Sen. George Lang (OH) stated that a few things confused me from the presentations since there was some contradictory things. Ms. Carroll, you said it can take up to 72 hours for urgent prior authorization. Ms. Motter, you said 70% are instant, 95% are in 24 hours. I know last week I had an urgent medical need that I had to get a test for which I'm scheduled for next week and it took 15 minutes. So, the 72 hours, is that an outlier? Ms. Carroll stated that our policy actually is that urgent care should be turned around in 24 hours. There are lots of places where there are no requirements around that. Certainly, automation has helped improve the turnaround time but a lot of state laws attempt to really push that into 24 hours and that's what we would suggest. Fifteen minutes is fantastic but that's certainly not the case for most patients. Ms. Motter stated that as Ms. Carroll said, some states have taken action in terms of requiring certain time frames. That 72 hour reference is sort of the outlier and the outer limit. The other thing that I would say is that many health plans, because there may be a Medicaid plan, it may be a state requirement there that they are an accredited plan based upon a national accreditation. And even if you don't have a state specific requirement, plans are held to turn around times based upon keeping that accreditation. Now the 70% that you mentioned, that's when both the health plan and the provider are accessing and using that electronic prior authorization process and that's really I think the sort of light at the end of the tunnel. That's the goal. If there's two-sided utilization of that process, it's much faster and if there are questions or real time further information that is needed, it can be done through that electronic system to get the answer quicker.

Sen. Lang stated that in my private business, I remember how amazing it was when the fax machine came out. I saved money and things were a lot quicker and I thought nothing could ever replace it that technology. Today, nobody uses a fax machine. When

I saw the statistics about the phone being a primary way of doing this, isn't that part of the problem that we are relying on archaic systems when there's new technology there? Ms. Carroll stated that it's certainly part of the problem. And the investment for physicians, many of which are independent practices or small physician practices, in the technology that is needed is a huge hurdle. So, we are working on solutions related to that but I will say that's part of the problem. I really want to stress how much we support automation but the volume of prior authorization is also part of the problem. So if we can both move forward on automation but also address the volume and the other barriers that are part of this, I think we can have a solution – it's not automation alone.

Rep. Tom Oliverson, M.D. (TX), NCOIL President, stated that I have two quick observations and one of Ms. Motter's slides was interesting to me. While you were talking, I did a quick medical literature scan on hyaluronic acid in the knee, and did you know that there was a British Medical Journal article that concluded it was not very much a benefit and literally that same year there was a systematic review that came out that said that it was. And so, when we talk about low value care versus high value care, are we really sure of the literature when we make these statements? Or is it just sort of we're picking and choosing the data that supports our conclusion because of cost factors. I don't really want you to comment on it, I just want to point that out that it literally took me 60 seconds to figure out that the medical community is not universally agreed upon whether or not hyaluronic acid in the knee is actually beneficial or not. The second thing I was going to say is, could we all agree that using the word "prior" means something that should happen before the medication is prescribed? Because what I see and what I have personally experienced as a patient is that my doctor continues to get hit with prior authorizations for medications I'm already on. I'm on a very expensive medication for cholesterol. It's this new one that you have to inject and it's expensive. But we failed everything else and I've had side effects with other medications. We've already gone through the prior authorization process and I haven't changed insurance. And yet every three to six months, my doctor gets slammed with another prior authorization for a medication that I'm on. Now that just disrupts continuity of care and harms a patient's ability to manage chronic disease. So, can we agree that maybe that's not a good application for these kind of tools? That if you go through the process once and you've passed, you don't get to keep dragging people back through the prior authorization process every six months?

CONSIDERATION OF NCOIL VALUE BASED PURCHASING MODEL ACT

Rep. Dunnigan stated that we'll now consider the NCOIL Value Based Purchasing Model Act. The sponsor of the Model, Sen. Mary Felzkowski (WI), is at our conference but had something come up and couldn't be at this committee meeting. It is our intent to vote on the Model as we've been working on this for a year and we haven't heard of any opposition.

JP Wieske, VP of State Affairs for the Campaign for Transformative Therapies, thanked the Committee for the opportunity to speak and for consideration of this model which is very simple. The model allows but does not require Medicaid and drug companies to negotiate what's called a value-based arrangement which allows supplemental rebates

to pay for effectiveness of the medical care. So, for example, one of my clients has the hemophilia gene therapy, which costs $3 million. They're willing to warranty the effectiveness of that with Medicaid and if it does not work within the first year, we fund most of that money back. So that's what this model does. It allows but does not require anybody to enter into these arrangements.

Hearing no questions or comments, upon a motion made by Rep. Carl Anderson (SC) and seconded by Sen. Justin Boyd (AR), the Committee voted without objection via a voice vote to adopt the model. Rep. Dunnigan thanked everyone and stated that the Model will now be placed on the Executive Committee's agenda for final ratification.

CONTINUED DISCUSSION ON NCOIL IMPROVING AFFORDABILITY FOR PATIENTS MODEL ACT

Rep. Dunnigan stated that we'll now continue our discussion on the NCOIL Improving Affordability for Patients Model Act (model). At our Spring Meeting in April, we had a good introductory discussion on this topic and then we continued it in July with some model language that was floated for consideration. Since that time, Rep. Ferguson and Rep. Oliverson have agreed to sponsor the model. You can see it in your binders on page 38 and on the website and on the app. We won't be taking any action on this today, just continuing our discussion.

Rep. Ferguson stated that I really support this model and I'm grateful to Rep. Oliverson for agreeing to sponsor it since I'm leaving the legislature in January. We'll hear more from our speakers today, but ultimately the model prohibits healthcare facilities, including hospitals, from inaccurately imposing hospital facility fees on outpatient services. It makes it difficult for private practice physicians to compete with the hospital rates and it ultimately saves patients a lot of money if they're not billing hospital facility fee rates for truly outpatient procedures.

Rep. Oliverson stated that I appreciate Rep. Ferguson's leadership on this and I'm honored to be able to sponsor this. I can just tell you as a physician that the real problem here is that we have a loophole that's allowing facilities to charge facility fees for things that are done in the office by doctors or other providers that ten years ago, you would have just gotten one bill. Now you're getting two bills for exactly the same thing. We're not talking about MRI's. We're not talking about labs or physical therapy. We're talking about going to the doctor and seeing the doctor. You get a bill from the doctor, and now you're getting a bill from the hospital because it turns out the hospital actually owns your doctor and that's something that I think is problematic on two levels. Number one, there's no added value being provided for that service but there is a duplication of charge now being provided. And the argument is being made that that's in order to make sure the doctors are getting a fair reimbursement. But by my calculations, in no circumstance does 100% of the fee collected on the facility side make its way into the hands of the physician. If there was a reimbursement issue that needed to be addressed, then the way to address that is to address the reimbursement issue, not to

create an avenue to allow a facility to suddenly leverage a healthcare provider's business.

And secondly, to Rep. Ferguson's comments, it deeply disturbs me to see the rise in consolidation in health care and how corporate the practice of medicine has become. I don't think that's good for consumers. You have to ask yourself when the doctor's practice is owned by the hospital or the health plan, who's the patient advocate there? There are secondary gains and entanglements that cloud that medical practitioner's decision making and we need to be doing whatever we can to not incentivize more physician practices to become owned by large consolidated, typically tax exempt or not-for-profit entities that may have a very different set of financial goals and drivers than your traditional doctor. Finally, I think there's a middle ground here and I hope that my hospital friends can see that what we're not talking about here is limiting the ability to charge a facility fee in the setting where facilities are being used or there's ancillary services that are being performed or it would lend itself to a fee. What we're specifically talking about here is charging a facility fee for the privilege of being in the doctor's office and there's no evidence whatsoever to suggest that there's any improvement in the level of service or care or additional services that are provided or quality that's provided by going to see a doctor who happens to be owned or who's practice is owned by a large system versus a private practitioner. So, I really strongly believe in this model. I do think there's a middle ground here and I would urge everybody to come to the table and let's work this out. But let's get rid of the duplicate billing. I had a mother of a patient reach out to my legislative office on Friday, complaining that the large Children's Hospital in my district had just recently sent her a big bill because her daughter went to go see a sports medicine doctor and had a 15 minute consultation in the office and got a charge from the doctor. Two weeks later, she got a $200 bill from the hospital. The patient never set foot in the hospital. There were no additional services provided. It was just a simple consultation and exam. So, we have to do something about this.

Karen Davenport, Senior Research Fellow, Center on Health Insurance Reforms, McCourt School of Public Policy, Georgetown University, thanked the Committee for the opportunity to speak and stated that I think we've already had a very helpful discussion of what facility fees are and what some of the issues are around them. I'll just say, facility fees aren't new. It's normal and accepted practice for in-patient hospital care, for example, for patients to see separate bills from the surgeon and the anesthesiologist and other treating physicians as well as charges for the hospital. And we see that as well as more care moves to the outpatient setting for procedures that patients receive. But as hospitals buy outpatient practices, consumers are seeing more facility fees attached to routine ambulatory care and office visits that don't require hospital admission or a hospital level of care. And I think that's where the consternation largely lies certainly on the side of consumers, and payers as well because the quality, and safety, and intensity of the care you get may often be totally unchanged just because your physician's practice has been purchased by a hospital and is now operating as a hospital outpatient department. So, why should policymakers be concerned about the wider application of facility fees including in settings that before a merger were a plain vanilla doctor's office and still look like a plain vanilla doctor's office to patients who continue to see the same healthcare professionals that they've always seen? In our research, we

talked with consumer advocates, insurance plans, and other academics, and several reasons came up.

First, consumers are facing higher out of pocket costs for outpatient care. That's partly because they're carrying larger deductibles so they really feel any extra bill. But also with two bills, even patients who have met their deductibles or have low deductible plans can face significant cost sharing. That's because two bills can generate two cost sharing payments. Perhaps a copayment for the physician visit. But also, coinsurance for the hospital's bill. Consumers, and for that matter, their employers, also face higher premiums thanks to higher spending on outpatient care with that spending driven in large part by the growth of facility fees and the application of those fees to regular office visits. Consumers who can't afford to pay cost sharing related to facility fees may also decide that they need to find a new provider who practices independently and therefore doesn't charge facility fees. That is if they can find them given the higher level of vertical consolidation that we have in so many health care markets. And between the higher costs that consumers experience and often the frustration of not even knowing if they would be hit with higher out of pocket costs, consumers experience a lot of confusion and anger. Payers are also incurring increased costs for ambulatory care as is the healthcare system at large. And to the degree that facility fees create an incentive for hospitals to acquire more ambulatory practices, insurance plans have less leverage as they negotiate rates for outpatient care, since they must negotiate with larger, sometimes must have systems for their networks, and end up paying more for these services.

Some states have enacted legislation or pursued regulatory reforms related to facility fees. We did what felt like an exhaustive look at all 50 states, plus the District of Columbia on the reforms that some of these states have taken and we see reforms that typically seek to address one or more of three issues. That is the problem of increased consumer out of pocket cost exposure, rising health care system costs, and limited information on facility fee billing and outpatient practice ownership. We've categorized the responses that states have taken into five buckets: banning facility fees for some or all outpatient care; new billing and ownership transparency requirements; public reporting requirements related to facility fee revenue; limits on consumer cost sharing for facility fees; and consumer notification requirements. You can see that effectiveness meter down there on the lower left. We have a cheat sheet for policymakers that I think is in your materials and is also available on our website that goes through all of these solutions and makes some assessment of how effective they are. We also have on our dedicated webpage things that highlight our facility fee research such as a series of active maps that quickly illustrate which states have pursued which reforms and gives a little bit of a snapshot of what those reforms are. I'm going to go through a few of those, but probably not all of them in the interest of time. So, the most assertive policy response states have taken to the growth of outpatient facility fees is to simply prohibit facilities from billing commercial payers for these fees for some or all outpatient services. State laws typically define these prohibitions by types of service or by setting or both. A number of states have banned facility fees for telehealth services while others have banned them for preventive services. Indiana prohibits nonprofit hospitals from charging facility fees for off campus services and Connecticut prohibits facility fees for outpatient services provided both on and off the hospital campus that are billed to evaluation and

management or assessment and management codes so, for a basic office visit, essentially. And then Maine prohibits facility fees for services provided in on and off campus office settings. That ends up having a fair degree of interpretation but that is the language of the Maine statute. And I've noted on the slide that these prohibitions help consumers with costs related to facility fees. Arguably, these bans may also reduce system wide costs but that really depends on the subsequent rate negotiation between the providers and the payers where they may be able to negotiate higher rates for other services, for example to compensate for reduced facility fee billing.

Another strategy that is generating attention, including in federal legislation although I don't think that bill is going to go anywhere in the next six weeks or so, relates to billing transparency. Right now, payers often cannot tell where care is delivered because the facility can bill at the sort of umbrella or enterprise level and use the main campus address or sometimes even the billing address which can be out of state. And three states now require off campus hospital outpatient departments to acquire and use location specific unique national provider identifiers (NPI) when they bill for facility fees. This requirement gives payers and potentially researchers and policymakers more information about when and where hospitals are billing outpatient facility fees and for which services. In particular, it allows payers and researchers to link healthcare professional bills and hospital bills to understand how much is really being billed and paid for giving services delivered in a hospital outpatient department. You can see that these have so far passed in Colorado, Nevada and Nebraska. I'll also say it's not reflected on this map, but Colorado and Massachusetts also require hospitals to provide updated information on their affiliated outpatient practices so those unique NPI's can also be mapped to the larger systems that own those practices. I'm going to skip over public reporting and oversight other than to say that a number of states do require hospitals to report on their revenue, often by service and also by volume related to facility fees. And then three states have had recent studies on facility fees. Maine and Colorado have wrapped up those studies and then Maryland has just kicked one off that was required by legislation in 2024. I'm also going to skip over coverage and cost sharing protections because we only have those in Colorado and Connecticut but those are other strategies for limiting consumers' out of pocket liability related to facility fees. And then finally, I'll touch on consumer notification requirements because those are by far the most popular approach that states have taken so far. States have required facilities to notify consumers about the facility fees that they charge at the time that the patient makes an appointment or via signage at the point of service, or both. Some states also require facilities to notify practice's patients when they acquire an outpatient practice and alert them to the fact that they will now be charged a facility fee when they receive care at the practice. I think that certainly improves transparency for patients to know that they will incur a facility fee and I suppose there's a glimmer of a chance that this can also reduce system costs but I think that's ultimately unlikely particularly if you learn about a facility fee from signage when you're in the office, which was my first experience with facility fee billing. Patients often grit their teeth and go ahead with their visit and deal with the bills when it comes through. Patients can also try to choose to change providers and thus avoid the fee but that can be a very difficult thing to do in markets where there's a high level of vertical integration so it could be more theoretical than a real option.

John Hawkins, President & CEO of the Texas Hospital Association, thanked the Committee for the opportunity to speak and stated that I very much appreciate Rep. Oliverson's intro into this as what we're really looking at is trying to deal with the bad actors out there but not do it in a way where we limit access to care or actually shift costs on to other areas of the system. And I appreciate the hearing you had earlier this year where we teed this up. We're concerned about a broad prohibition on facility fees because we believe there are cases where those fees are legitimate. I will point out that a lot of what we're dealing with in the healthcare system unfortunately is cost shifting from other areas that have to be recovered in those fees and I would argue that's appropriate. But we ought to be looking at strategies to manage those costs down ultimately and I'll touch on a few of those. I'll just remind you, hospitals are the only sector of the healthcare system where we're required by federal law to take all comers regardless of ability to pay, and that's a key part of the commitment to communities that come with a hospital license. Hospitals and health systems are not monolithic. They all have different payer issues related to the communities that they serve. Hospitals provide standby capability and disaster response. There is no explicit funding for those safety net services. And then we're continuing to deal with inflationary challenges and certainly coming out of the pandemic, nursing shortages, physician shortages, other allied health professions, that cost is being borne by the healthcare system as well. That's why we asked last session for our legislature to invest in the workforce pipeline and they stepped up and did that. Again, those aren't immediate, but those are long term things that could help us going forward. Hospitals typically care for a higher proportion of Medicare and Medicaid patients and I'll remind you that Medicare typically pays about 82 on the dollar. So, that's about $100 billion annually in care that is not reimbursed, it's getting shifted elsewhere. Medicaid typically pays about 87 cents on the dollar. That's another $31 billion dollar shortfall. Add to that care for the underinsured, uninsured, and uncompensated care in a state like Texas that leads the nation in the number of uninsured, that equals $3.1 billion in uncompensated care, just in Texas. And that's at cost and it's not just the government payers. We are dealing with insurer underpayment in other areas, particularly in behavioral health. We have data that shows there's about a negative 35% margin across all payers for behavioral health services because those are not paid for equitably under private coverage. And then we had a discussion earlier about all of the red tape from insurer requirements and that's a cost that has to be dealt with.

I do want to just talk a little bit about the commentary about consolidation and I think that is an issue that needs to be dealt with. We know that most of the consolidation actually has been in the payer health insurer and in the private equity space and that is certainly not helpful. I would argue that in most cases, particularly in more rural areas of the state, our hospitals are stepping in because the physicians who are reporting their inability to continue to practice because of their inability to negotiate with payers and the red tape from dealing with those payers, they are looking to exit the market. And so they have the option of going to their hospital health system, going to private equity, or going to a payer group. And most of the time our hospitals are stepping in to partner with those groups to ensure those services stay within the community and that involves some level of subsidy. I'll agree with Rep. Oliverson there’s probably a legitimate discussion

about how much of that actually ends up in those practices but really that is the last case to keep the ability to keep those services in the community. And so we wholeheartedly support increased physician rates for Medicare, Medicaid and in the private space to reduce that incentive for that consolidation. Because there are legitimate cases for facilities. There are not legitimate cases. But that forced consolidation is, as Rep. Oliverson pointed out, is not necessarily helpful to the overall practice of medicine.

Sen. Lang thanked Rep. Ferguson and Rep. Oliverson for bringing this Model forward. I think this is a very important Model and Mr. Hawkins, I understand what you said about these fees are necessary but quite honestly, I'm really not buying that. But I do think we need to give some consideration to the hospitals in this scenario and I'd like your input on this. I assume when you buy a practice you may base it on a multiple of earnings before interest, taxes, depreciation, and amortization (EBITDA) - let's pretend it's EBITDA. And instead of giving a six times multiple knowing you can recoup a higher investment from charging a higher facility fee you may offer an eight times EBITDA just to sweeten the pot for the practice. So, my concern and I'm assuming your pro forma is a five to seven year break even pro forma only based on my experience in the private sector. I don't understand your business model. So, these assumptions of mine may be way off. My concern is if we put this in place and we just make it across the board, we are forcing hospitals to take a loss under pro forma and it will result in cost shifting. They're not going to eat that loss. They're going to shift the cost. And Rep. Oliverson, I'd like you maybe to weigh in on this because of your private practice experience. Do we give any consideration to a grandfather clause, and I'll make these numbers up - if a practice was purchased in the last five years there's a three-year grandfather clause where they don't have to comply with any new practice and then on a go forward basis it has to comply immediately. That way we are not forcing the hospitals to lose money based on an offer they made three years ago in a pro forma based on the rules at the time that since have changed. I'd like everybody's input on that.

Mr. Hawkins stated that I think that makes. Obviously, there are business considerations that have been dealt with in those situations and sometimes that can be problematic. I would argue ultimately the market is going to normalize some of that distortion if there are folks out there who are outliers or bad actors. But again, I would certainly entertain something that would look at grandfathering. I don't want to protect necessarily bad actors, because I recognize those aren't helpful, but it's worthwhile for discussion.

DISCUSSION ON DEVELOPMENTS IN VISION CARE SERVICES LEGISLATION

Rep. Dunnigan stated that on page 49 in your binder we have laws from Texas and Oklahoma that will be referenced during this discussion. The goal of the discussion by the committee today is to get an update on these laws and see if there's an appetite to further discuss these issues next year.

Jon Pederson, O.D., State Gov't Relations at the American Optometric Association (AOA), thanked the Committee for the opportunity to speak and stated that I'll provide an introduction to the topic of vision benefit managers (VBMs). VBMs are entities that sell vision plans and utilize their market powers to gain significant control over the vision

care industry. Vision plans typically provide wellness eye exams and discounts on contact lenses and glasses. So, they are not entities that cover medical eye care, such as glaucoma, macular degeneration, diabetes, things like that. All of the medical eye care is the coverage provided through medical plans.
So right now we run into the same issue that has been discussed this morning with vertical integration in market share influencing care. Right now, there are two VBM's. They control about 70% of the market share and I think at some point there will probably be a slide shown where it shows a plethora of vision plans and there's really two of them that control the most. In over 40 states, there's one plan that has a plurality of covered lines in that state. So when the VBM's have this market share, it does dictate and limit choices for patients and providers and it interferes with the patient doctor relationship.

Tommy Lucas, O.D., Director of Advocacy for the Texas Optometric Association (TOA), thanked the Committee for the opportunity to speak and stated that definitely this is a story of vertical integration that we've spoken about this morning, and also market concentration. So what issues do us as optometrists have with the VBMs? Let me say first off that having patients that have a vision plan is generally a good thing. We want patients to have coverage to get an eye exam, because what optometrists do is detect eye disease and we help people fix their optical misalignments, their optical correction. Those are needed services obviously that are important to society for a multitude of reasons. When we have a wellness eye exam benefit it helps us detect those diseases, catch them early, save costs. All of those things. The contention between us and the vision plan industry, the VBM market, is not that vision plans are not valuable, it's the controlling techniques and the impacts on small business like my practice and practices just like mine all across the country and the patients that I serve. Knowing that vertical integration and market concentration are the main issues, the five bullet points on the screen you see there are more of the specifics of what's going on. So, we see specific instances of anti-competitive behavior towards optometry practices. VBM's have now bought up the entire supply chain from manufacturing, wholesaling, distributing, retail, and they own the vision plan that steers patients to those particular products.

When you're an independent optometrist and you're having to care for your patients in this environment, obviously those incentives to use those products impact your business and impact the quality of care that you're providing to your patients. When a VBM is dominant in a particular community or state, basically the contracts that we're presented and that's how this works, an optometrist like myself will just get on the internet and say, "I'd like a provider contract for the biggest VBM company" and I'll apply for that. They'll send us a contract in many cases and then that contract is basically non-negotiable. When I first started working in this space on vision plan reform, I did not really understand what a contract of adhesion was but it's kind of what we're dealing with here from a legal circumstance. We basically have a non-negotiable contract where if we want access to the patients that are covered under that we have a take it or leave it situation and then in that contract there are a lot of issues where the VBM will force the doctor to use a certain product that the VBM owns. They'll force the doctor to use a certain lab that the VBM owns. They will have specific auditing techniques, they'll have other provisions as well. So that's all a big problem. Access to care concerns are important, obviously, and when the VBM is controlling all of this, where does it stop?

Where does it end where we're going to have enough providers to care for the patients or are they all going to be forced to go to the locations that they own? Interference with the doctor patient relationship is also a concern. Rep. Oliverson alluded to this, when there's a financial incentive to that doctor to do a certain thing, we lose that sanctity of that doctor patient relationship where there's an incentive in the middle of that relationship and then you're not actually getting unbiased proper care in many cases or in sometimes quality care.

So those are some of the impacts on optometry practices that we're having with VBM's. And this is why VBM reform is needed. Of course we want to maintain healthy competition. We see market concentration on the retail side where the services are actually being performed. The monopoly conversation or in this conversation more of a duopoly is going on and like the last conversation we've acknowledged that there were rising rates and prices in the context of market concentration. Well, that is where this story in the vision plan market will end too, naturally. And we're obviously concerned about that. Patient choice is also a big problem. If a patient only has a certain menu of items that they can get with their care, that's a problem because it may not be appropriate for that patient. Improving transparency generally is also a problem. Sometimes the benefit plans are fairly convoluted and patients and doctors don't understand those plans and whether that's done on purpose or out of necessity, either way, it's a barrier to care. And then maintaining clinical independence is important. At some point, we have to let the doctors guide the course of care for that patient as opposed to letting an insurance company dictate that level of care. So what's been done about VBM abuses? This is not a new consideration. This has probably been about a decade long effort where states have looked at these issues and decided to make various reforms. Right now, we have 27 states across the country that have had some measure of VBM reform and of course, Texas is one of those and I want to kind of highlight that.

This is where it gets a little bit more in the weeds about the prohibitions that the Texas law and the Oklahoma law set forth, which are the two most comprehensive state laws at this point. You'll see that the law in Texas now prevents any price fixing on non-covered services. Obviously, that's very important to a small business when a plan covers what they cover for the price that they're covering it for and determining the actuarial science that goes into that. Interfering with non-covered services impacts that small business in a very significant way. The laws prevent the misrepresentation of what covered services are. Sometimes language is used that makes things seem covered when they're not. Dictating the glasses manufacturing lab is a very big deal. A lot of times, optometrists can make glasses quickly and sometimes in their own lab or a lab in the community versus a lab that's many states away that may have a lower quality of care that's being dictated. So the laws in Texas and Oklahoma and many states prevent that forced lab choice at this point. The steering of patients is a big deal. At this point we have the Texas law prevents for the first time steering to self-owned to locations. As the VBM's have started buying up retail locations, the Texas Legislature decided that having that VBM push patients into their self-owned locations is not in the best interest of access and care. So that has happened in the Texas law. The tiering and ranking of doctors was also occurring and still is occurring to this day. What will happen in this

case is on a doctor locator, the VBM will give a gold star to a certain doctor versus a silver star to another doctor. And what the gold star is based on is how much product that doctor is buying from that VBM. It's no indication of quality of care or anything like that. It's just simply how much money are you sending our direction and re-selling that to the patient. And hiding out of network benefits is a problem. What we've seen in response to the law is the two top VBM's immediately closed their panels in Texas following the passage of the law. They "evergreened" contracts as well, so most doctors are actually operating under their previous contract before the law went into effect. Now they have sued the state of Texas over this law and that's working its way through federal court. They have also threatened unintended consequences in many settings and they have purchased more large retail optical chains. About a month ago, the largest vision plan in the world bought a very large retail group that provides care at 250 locations. And you see their revenue and this probably a $1 billion to $1.5 billion transaction so the profits that these VBM's are making are being used to buy up the industry.

Dr. Pederson stated that on this slide are some of the other things that are being done on the federal level. The Dental and Optometric Care (DOC) Access Act, that is something that is being done unfortunately with a lot of these plans. Our ability to fight this at the state level is troublesome because there are Employee Retirement Income Security Act of 1974 (ERISA) plans at the national level that allow the VBM's to skirt around the issue in that sense. Congressman James Comer (KY) is opening an inquiry on his Committee into the vertical consolidation and transparency. These on that slide are some of the things that will be mentioned as reasons not to consider VBM reform. As far as cost going up for premiums, the premiums are not the profit center for these plans. As Dr. Lucas mentioned, vertical integration is the major problem here and the profit centers come from them owning retail locations, material locations, electronic health record systems, even the system that we use to file most of our claims is owned by one of the major VBM's. The premiums are not going to go up, really the cost will go to the patients because the patients will be forced into situations where they are buying products through these vertical integrated plans. In general, these are companies that are making tens of billions of dollars. We're a very small driver in the healthcare cost market.

Lisa Anne Hurt-Forsythe, Vice President of Government Affairs for the National Association of Vision Care Plans (NAVCP), thanked the Committee for the opportunity to speak and stated that I just wanted to respond to some of the comments and introduce some data that I think will be interesting for you. This is a very recent study that I think is really important because it shows the value of vision care as a critical benefit. This was a Harris Poll done recently and it showed that 94% of full-time employees age 25 and over said vision benefits were very valuable. So they see value in having vision care insurance. And 82% cited it as equally important as having general medical insurance. And I think my colleagues would agree that there is definitely value in having vision insurance. Vision health was also ranked as very important by 75% of the folks that responded to the survey. The other thing that's important is that demand for vision care is rising and quite frankly, myself included, there are a number of us in this room that fall into the category of the aging population. And screen time quite frankly, has contributed

to more of us needing optometric care. So there's a greater demand actually for the services of the folks sitting at this table. As my colleagues mentioned, regular eye exams are really important. They do detect underlying health conditions and you see several of them listed there on this slide, particularly for the high blood pressure and the heart disease. Those are some that you might not necessarily think of. If they are identified early on by practitioners, it can help when there's communication with the primary care physicians to get involved in those medical conditions early. Maybe that's something you didn't think about when you think about vision care.

In terms of access to vision care, I put a slide here to show you what percent of covered lives of folks have general health care coverage versus vision care coverage and you can see there's room for growth in the vision care market. For example, if we're looking at state government employees, 95% have some sort of medical coverage which is probably not surprising to anyone in this room. But only 42% have vision care so there's some room for growth there. And then you can see some of the other categories here as well. So here's where the rubber meets the road. Affordability is what drives the access to vision care. For the vast majority of the population, how much money someone has to pay out of pocket will determine whether they will go seek vision care or whether they won't. This is from the Kaiser Family Foundation's recent study that was trying to find out what kind of medical services by type do people forego if they don't have insurance coverage, meaning they can't afford it. The first is dental and some of us might forego dental even if we have coverage but that was the first category. The second category is vision. If they don't have that coverage, that's the second most likely category that someone is likely to forego altogether or delay if they don't have the coverage. So where vision plans add value is that we help to mitigate those out-of-pocket costs. We help people to manage those expenditures. Insurance coverage is an independent predictor of vision health, i.e. if you have that coverage, you're more likely to go and seek vision insurance and you're more likely to have better eye care and have things detected earlier. You can see here on this slide, one third of the patients surveyed reported that they had eye exams less frequently than they would have liked to simply because they didn't have the insurance to cover it. So here's an easy $0 to $20 average copay if you have vision insurance to go and get that wellness exam that my colleague mentioned. If you don't, you're looking at $200. For some people, $200 isn't a big deal. For a lot of people, $200 is a huge deal and might make the difference between making your rent payment or not making your rent payment. If you are in that category, of which there are a lot of folks, this is what leads to what I was saying on the prior slide that people just say, I can't do it cause I don't have coverage.

I want to shut down this VBM business. That is not a thing, that is a manufactured acronym that is designed to create an analogy between vision care plans and pharmacy benefits managers (PBMs) but there really is nothing similar about the two whatsoever. This slide sort of shows you the difference between the two. PBM's operate largely in a black box. People don't know what's going on. It's opaque. They don't save money for folks. They are a cost driver. And as I'll mention in a moment, our vision care plans have kept costs lower for consumers, not only for premiums, but also for their out-of-pocket expenditures. If we were to be operating as a monopoly from an economic standpoint, we are doing a horrible job because our prices have actually gone down.

When we're thinking of a monopolistic impact on an industry, we expect to see a reduced supply and increased costs and instead, we've seen the opposite in our industry. So if we were doing what has been alleged, we're doing a very poor job at it. There was some mention about vision care being a crowded field. There are lots of players in the field. There are not just two. There are many folks that are operating in this space and there's a lot to be done in this space. As I mentioned, there's a lot of room for growth and there's a lot of opportunity in this market. I mentioned vision premium rates have trended downwards. They've trended downwards because the number of lives has increased. It's basic economics, as the number of lives increases, the price per life goes down. That is not true if you look at the graph on the right hand side. And I'm sure I don't even need a graph to tell you this, healthcare expenditures overall have skyrocketed. So we're sort of one of the few bright spots in healthcare from a price and a consumer perspective. This slide is talking about the number of optometric practices. Contrary to some assertions that have been made, the number of optometric practices, this is Census Bureau data, has increased to a high level that it's never seen. It's at the highest level that it ever has been. This is in stark contrast to physician practices, which you will see on the right-hand side, many of which were discussed earlier with regards to being bought up by larger practices, etc. We're definitely seeing that consolidation in merger and acquisition activity on the physician side, but not on the optometric side. And this data bears itself out state after state. So really this is good news that we are expanding the number of practices.

We talked about legislative solutions. There can be some negotiated middle ground solutions and these are some states where that's happened, where there has been an open discussion about how to approach any issues and come to a collaborative solution. There on the slide are some states where that has been successful. The focus needs to stay on patients, access to care, and the end cost to the consumer. That's what we need to stay focused on. Patients and consumers. I want to talk a bit about the Texas legislation that was mentioned and the Oklahoma legislation. The Texas legislation was enacted last year and its constitutionality is being challenged in federal court. There is already a preliminary injunction in place and it was concerned with the anti-competitive nature of some of the terms in that legislation. So it has been prevented from being enacted at this point. We expect to see some further information over the next couple of months. There was also legislation introduced in Oklahoma. Again, there was significant opposition to many of the terms that were contained in that legislation and it was in fact vetoed by the Governor, largely over concerns again on the impacts to consumers and patients. In closing, the vision care insurance market is stable. It's affordable and it's essential. As I mentioned before, employees overwhelmingly value having vision care insurance. It's a critical healthcare need. The demand for vision care overall is increasing and there's great market expansion potential in this area. Vision insurance helps these folks to manage their out-of-pocket expenditures, which therefore makes it much more likely that they will go out and seek care. And going and seeking care is associated with better vision health and early detection of underlying medical problems. The number of optometric businesses is continually increasing as I showed on that graph before and it has outpaced in a great way the growth rate of physician practices overall. So it is an inaccurate statement to say that the number of optometric practices is going away or decreasing. The data just does not bear that out. And as I

mentioned, collaborative legislative solutions are definitely what is needed. We need to come to the table to work through any potential issues that might exist and make good public policy decisions that are data based as opposed to assertion based.

Sen. Justin Boyd (AR) stated that regarding the slide where we're increasing the number of optometric practices, we see the PBM's in pharmacy and they come in and they say pharmacies are actually not decreasing. And what's happened in the pharmacy world is now that the world is so complex with insurance and government, that many brick-and-mortar pharmacies actually have to have more than one NPI number. So are you actually measuring the number of brick-and-mortar practices when you report that? Or is optometry becoming complicated and now you have to have more than one NPI number? How are you actually getting to the number to show that the practices are increasing? Ms. Hurt-Forsythe stated that's an excellent question. I actually pulled the data directly from the Census Bureau using the county level tables and those are from tax filings of individual businesses so that is the number of optometric businesses and it's right from the census data and you can pull it all the way down to the county level.

Sen. Boyd stated that I hadn't heard of a VBM till until today, but I've certainly heard of PBM's. And the Federal Trade Commission (FTC) has come out with a report that showed there was a leukemia drug where it was $27,000 at the preferred pharmacy, $19,200 at the PBM home delivery pharmacy and $97.00 at the non-preferred pharmacy. And so when the same people who are setting the price and making the payment and own the entire supply chain, doesn't that create a lot of opportunities to have mis-incentives for the consumer? Ms. Hurt-Forsythe stated yes, theoretically, and certainly that's been seen in the PBM market. But VBM is a non-existent acronym that's been created to sort of create this artificial connection between vision care, insurance and PBM's, and sort of draft off of that type of example that you just mentioned, which is excellent. What we've actually seen in terms of pricing in the vision market is the premiums have actually decreased and prices have held very stable. So we really haven't seen that kind of variability that you're describing that definitely permeates what is seen in the PBM market.

Rep. Dunnigan thanked everyone and stated that if there are any legislators that want to continue this discussion or pursue this for next year, please contact myself or NCOIL staff.

INTRODUCTION OF HEARING AIDE CLASSIFICATION MODEL LAW CONCEPT

Rep. Dunnigan stated that last on our agenda is a brief introduction from Rep. Deanna Frazier Gordon (KY) on a potential topic for next year regarding a hearing aid classification model law.

Rep. Gordon stated that in your binders on page 77 and on the website and the app is a bill I sponsored in Kentucky that is very straightforward and is something that I'd like this committee to consider taking up next year. It deals with changing state law in light of recent regulatory change from the U.S. Food and Drug Administration (FDA) regarding a new classification of over-the-counter hearing aids, thereby making traditional hearing

aids prescription devices. That classification has resulted in confusion among practitioners and policymakers at the state level which is why the change in law is necessary to clarify things. Because the FDA does not have jurisdiction over practitioner licensure, it's up to the states to further define. I am an audiologist, so I can speak firsthand to the confusion that this has generated and I look forward to discussing the issue further here next year.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Brenda Carter (MI) and seconded by Rep. Matt Lehman (IN), the Committee adjourned at 11:30 a.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
INTERIM COMMITTEE MEETING – MARCH 14, 2025
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee held an interim meeting via Zoom on Friday, March 14, 2025 at 1:00 P.M. (EST)

Representative Michael Sarge Pollock of Kentucky, Chair of the Committee, presided.

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Rep. Edmond Jordan (LA)
Rep. Brenda Carter (MI)
Sen. Paul Utke (MN)
Asm. Jarett Gandolfo (NY)
Sen. Pam Helming (NY)
Rep. Brian Lampton (OH)
Sen. George Lang (OH)
Rep. Carl Anderson (SC)
Rep. Tom Oliverson, M.D. (TX)
Rep. Jim Dunnigan (UT)

Other legislators present were:

Sen. Eric Pratt (MN)
Sen. Gale Adcock (NC)
Rep. Mark Tedford (OK)
Rep. Greg Scott (PA)

Also in attendance were:

Will Melofchik, NCOIL CEO
Anne Kennedy, NCOIL General Counsel
Pat Gilbert, Director of Policy, Administration & Member Services, NCOIL Support Services, LLC

QUORUM

Upon a Motion made by Sen. Paul Utke (MN), NCOIL Vice President, (IN) and seconded by Rep. Brenda Carter (MI), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

INTRODUCTORY REMARKS: CHAIR POLLOCK

Rep. Pollock thanked everyone for joining and stated that the purpose of this meeting is to conduct some business before our April meeting in Charleston. This will help ensure we can efficiently address all the issues on that agenda in Charleston. We have a few Models to discuss today, but we won't be taking any votes. We'll be continuing discussion on the NCOIL Improving Affordability for Patients Model Act and taking any comments on the Models scheduled for re-adoption in Charleston.

CONTINUED DISCUSSION OF NCOIL IMPROVING AFFORDABILITY FOR PATIENTS MODEL ACT

Rep. Pollock stated that we'll begin with a continued discussion on the NCOIL Improving Affordability for Patients Model Act. We first started discussing this issue last April and a lot of work has gone into developing this Model. You can view the Model on the website with all the other materials for this meeting. Before we go any further, I'll turn things over to the sponsor of the Model and NCOIL Immediate Past President, Rep. Tom Oliverson, M.D. (TX).

Rep. Oliverson stated that I'm honored to be able to pick up the work that our former colleague and former NCOIL President, Rep. Deborah Ferguson (AR), DDS, started on this Model before she left the legislature. I'm very excited about it and I'm anxious to hear any comments that you have. I will tell you that from my perspective, both as a lawmaker and as somebody who sees the application of facility fees and what that's doing to our health care as a provider from the inside, I am very concerned about the rise of facility fee charges, particularly as it relates to physician practices that are acquired by hospital systems as part of a vertical integration strategy. Those are my primary issues. I don't have any other specific comments now but I'm happy to take questions when appropriate. I'm looking forward to the discussion as we move forward.

Lucy Culp, VP of State Gov't Affairs at the Leukemia & Lymphoma Society (LLS) thanked the Committee for the opportunity to speak and stated that in addition to my role at LLS, I'm also a consumer representative to the National Association of Insurance Commissioners (NAIC). At LLS, our mission is to cure blood cancer and improve the lives of patients and their families. We really exist to ensure that access to treatments are available for all blood cancer patients. We fund research to advance those treatments. We provide patients and families with one on one guidance and support, really from a whole team of social workers and nurse navigators and support groups. And then we also advocate for policies that protect and improve patient access to treatment. Having that kind of one on one patient connection is just so important to making sure that the policies that we pursue are in the best interest of the folks we serve. And it's with that mission in mind that we're really pleased to support this Model and I want to offer a couple of suggestions for you to consider as you consider adoption.

I know we use the term "consumers" a lot when we talk about insurance, but I'm going to use the term "patients" here because I think it's important to remember that that's who health insurance consumers are. They're patients, many of whom are dealing with really complex and chronic diseases. So I wanted to talk a little bit about why this is so important to us. Blood cancers are extraordinarily expensive to treat. As an example, the average cost to treat acute leukemia in the first year is about $500,000. And these diseases are also incredibly complex to treat. They vary wildly in their intensity and the pace of symptom onset and the length of treatment. And even patients who achieve long-term remission are often in need of heightened surveillance and monitoring throughout their lives. And what that means is lots of doctor's visits of all kinds. Hospitals, clinics, primary care, labs, you name it. And that's over years and years. So,

in short, blood cancer patients are very high utilizers of healthcare services and their health insurance plans and are therefore, really highly impacted as those markets change and shift. And we know the price of cancer care and ultimately the consumer cost of care is rising at a really alarming rate. We've all felt it in our personal lives and I think that's why you would be looking at a Model like this. Patient out-of-pocket costs are increasing through higher deductibles, co-pays, and co-insurance and patients are less able to afford the care they need, and it compels them to delay care or even forego treatment. And higher prices and extra fees become medical debt. We know that one in three Americans currently have medical debt. About half of cancer patients report having to take on debt due to their treatment, and about 42% say that they deplete their life savings in their first two years. A driver of those increased costs, and Rep. Oliverson mentioned it but of course it's not the only driver but certainly a contributing factor, is hospital consolidation. In recent years, significant consolidation has taken place in the healthcare sector, and the research is really clear that hospital mergers lead to larger entities with more market power that can then negotiate increases in their prices which then translates to higher costs for patients.

Unfortunately, what the research doesn't show us is a correlating increase in quality so we can't say that as prices go up, the care is getting better. And in fact, while there's some variation in the research, many studies are showing a reduction in quality, lower payment satisfaction, and a reduction in access to services, especially in rural communities as hospitals continue to consolidate. And the research also indicates that facility fees are one of those cost drivers. I think you all probably already know, because you've been talking about this Model for a little while now, but you know that a facility fees is a charge assessed by a healthcare provider that is separate from and in addition to charges for professional services. For an example, a person who visits a provider for, say, a routine blood draw may be charged for the blood draw itself, but then also receive a separate additional fee. And we acknowledge that there are some cases where a facility fee might make sense and we're not advocating for their full elimination. Historically, most facility fees were assessed by large standalone hospitals to cover costs associated with running the facility because that may not have been fully reimbursed through negotiated rates. So, for instance, the cost of maintaining a 24-7 emergency department, that's a frequently cited example of what facility fees may help finance. But now, patients are increasingly billed for these fees in settings where they really wouldn't have traditionally seen them. And again, that's happening because large systems are able to add fees onto bills for services provided in the outpatient settings that they own, even when they're separate and apart from the main hospital campus.

I'll throw out another example - a person who visits a primary care doctor for that routine physical every year, they could be assessed a hospital facility fee if their doctor's practice is owned by that hospital, even though they never set foot on the actual campus, which was, ostensibly the need for the fee. And this can be particularly surprising for patients whose doctors are newly acquired. You can kind of just imagine the surprise of a fee wouldn't have been assessed and then could suddenly be assessed because your doctor's office was purchased and you may not have even realized. One more example - we were recently contacted by a blood cancer patient who went to her doctor for a fairly routine visit. She wasn't surprised to receive the bill for her portion of

what was due, her co-pay, but she was very surprised when she received a facility fee for almost the same amount. So, it essentially doubled what she owed out of pocket. And it came as two separate bills.

Moving to the Model, all of that's to say that's really why we're pleased to support the Model. We would just urge the Committee to consider just a couple of modifications to ensure that it offers even stronger protections to patients. First, we'd suggest that the Model include a prohibition on those services provided through telehealth, just as it does with off-campus locations. So rather than just those outpatient services billed using evaluation management (E&M) codes, we see no reason that services provided in a virtual setting where there's no facility would be treated any differently than those provided in an off-campus setting. Second, we'd really urge you to consider whether it is ever appropriate for a facility fee to be charged directly to a patient rather than to their health insurance provider. As we've discussed, there might be places where a facility fee is allowed and appropriate and necessary, but patients and consumers pay an increasing amount in premiums each year and in return, they expect a level of reasonable cost protection when they need to access their health care along with the understanding that what they're paying will contribute to their deductibles and their out-of-pocket maxes. So when we think about this from a patient's perspective, getting billed for a facility fee outside of their health plan really feels like a surprise bill by a different name and Congress, along with numerous states, have already acted in a bipartisan manner to really rein in surprise bills. And we think this Committee could continue that progress by ensuring that allowable facility fees be included in charges sent to insurers rather than ever going directly to a consumer as an added bill. Additionally, we think health plans are probably much better positioned to evaluate and negotiate these plans than consumers are on their own. Finally, we're very supportive of the language that ensures that the provider identification number (national provider identifier/NPI) on submitted claims accurately reflect that specific site of where the person receives their care. And we would encourage the Committee to consider amending this section to require that claims provide sufficient information so that you can identify the specific site of service and the larger hospital system or organization. And our thought here is being able to identify and track those linkages between individual sites and their ownership structure will help fill the knowledge gaps of how consolidation impacts patients.

Terrance Cunningham, Director of Administrative Simplification Policy at the American Hospital Association (AHA), thanked the Committee for the opportunity to speak and stated that today, I'll quickly go through some of the overview of facility fees and what they pay for and what the purpose is. I'll talk about some of the specifics of hospital care that differentiate hospital care from other settings. I'll talk about the concept of physician acquisition and what the drivers of some of the physician acquisitions might be. I'll also talk about the NPI issue and the honest billing provisions of the Model and the need for off-campus facilities to have unique NPIs from larger facilities. And then I'll just offer some general takeaways. So, whenever you're discussing legislation like this, on the surface, I get it. Why would a specific bill for a service in one setting and a specific bill for service in another setting differ - if it's the same billed service, shouldn't they be the same? What I would offer is, I think there's a little more nuance and hopefully I'm able to convey some of the nuance that might differentiate and explain why there are different

charges in these settings. First, I want to talk about what facility fees cover, specifically as they compare to professional fees. Obviously, professional fees cover physician services. This is the general concept, you bill a specific Current Procedural Terminology (CPT) code, you've got a rate associated with that CPT, and this is what the physician is reimbursed for. Facility fees, as they are unique to hospitals, cover a lot of additional things that might not be something that is necessary in these other settings - things that hospitals need to cover in order to be a successful hospital for patients. And this includes things such as nursing and supporting medical staff, pharmacists, medical equipment and supplies, clinician training, significantly enhanced regulatory compliance. Things that are unique to the hospital setting and are one of the justifications we would offer as to why facility fees are essential parts of the care delivery system and the payment system that we have today.

I talked about how you've got two different settings and the same billed service. I would note that hospital care is inherently different than other settings of care. In terms of patient type, hospitals care for enhanced security of patients. They care for sicker patients. This is consistently supported by research and larger numbers of uninsured patients are visiting hospitals as opposed to some of these other settings. And so, with that, it causes increased costs of caring for these particular patients. Additionally, the costs for delivering care at a hospital are not equivalent to some of these other settings. For one, hospitals generally are keeping at least portions of their facility open 24-7 for care. They, as I mentioned before, have a significantly enhanced amount of comprehensive licensing, accreditation, and other regulatory requirements that they must meet in order to be a successful hospital. Another thing that hospitals provide, and I don't know if this is often talked about enough, is hospitals have settings that don't produce revenue but are essential public services. And in order to do that, one of the necessary parts of hospital financial settings is there is a certain amount of cost shift that's just inherently necessary in order to provide some of these public services. What do I mean by that? Well, there's certain things such as behavioral health, nephrology, burn units, infectious disease units where consistently the margin is below zero. They are not revenue generating. In fact, they cost more than they actually bring in for delivering that care. And in order to continue to provide these settings, hospitals often need to have higher margins in other settings such as an outpatient department that offset the losses that they're just inherently going to have with some of these settings. And so if you eliminate a lot of those margins that might exist in a hospital outpatient department or other setting that might be where revenue might be generated, it threatens the viability of the hospital to deliver these other settings.

One thing that's not on here that I do think is also worth noting is in certain settings like with maternity care, you have to deliver somewhere between 250 and 300 children a year for a hospital to kind of break even. And so in a lot of the rural settings in particular, if you've got a maternity center that's not delivering that amount of infants each year, they're going to be in the negative as well and there's going to need to be margins and cost shifting that's involved in order to keep those essential facilities open. And so one of the concerns I have when we look at these bills is not seeing the whole picture as to where some of that financial might need to be cost shifted in order to cover some of these other services. One of the things that we often hear is that the increased

outpatient rates or the increased hospital facility rates are what's driving the physician acquisition of hospitals and physicians being gobbled up by hospitals in order to charge these higher rates. And the data just doesn't support that. While there is an issue with independent physicians being acquired, it's most often private equity and health insurers, and that seems consistent. Optum is the largest employer of physicians in the country. And the data shows that while physician acquisition is an issue, it's not hospitals that are the ones who are consistently driving this. Why is this happening? I would say oftentimes it's physicians are not being reimbursed sufficiently by the health insurers in terms of their total cost for their services and the administrative complexities and needs in order to jump through the hoops necessary to receive reimbursement from health insurers, things such as prior authorization or prompt pay issues or the documentation requirements and stuff such as that, make the administrative costs continue to rise, and then you don't have a sufficient amount of reimbursement to cover those. And so what a lot of physicians are doing is employment becomes a more practical solution because that takes off that administrative headache. It is occurring, and I think there's a need to potentially address some of those issues. I just don't think this is the way to do it.

The other concern I wanted to talk about is the honest billing provisions of the Model and specifically the need for new NPIs for off-campus outpatient departments. One of the things that I've heard in discussions of this issue in other forums is there's an inability to know from a hospital's outpatient bill whether or not that was an off-campus facility or an on-campus facility. And I think a lot of this is driven because there's inherent differences between the professional claim and the institutional claim. The professional claim is what a physician will submit for their services and on that, it's going to have what's known as a place of service code and that's going to be used to clearly indicate this is an off-campus hospital, that this is an off-campus outpatient department. The institutional claim doesn't have that. So I think frequently people say, "well, there's no code to be able to identify this as an off-campus outpatient department" but that's not necessarily the case. It's just the differences in terms of how these bills are processed that might make it different to know. But there is a clear way in which a health plan or anyone else looking at these bills can tell whether or not this was care delivered at an off-campus facility or otherwise. Specifically, in order to be processed by a health plan, you're going to need to have a type of bill, which is FL-04. It's a specific segment in an institutional claim, and that's going to indicate whether it's outpatient or inpatient. There's a whole bunch of types of bills, but for the purpose of this discussion, there's an outpatient claim, so there's going to be a specific type of bill that's used. And when you put an address on a claim it has to be the service location, it's not the parent company. It's got to be the service location. In order to have an alternate from the main campus service location, those need to be registered with health plans typically and so the health plan will know right away, "oh, this is the address I have on file for that off-campus facility - this is not on-campus." And so, yes, there's a different way of determining whether or not this is on-campus versus off-campus, but that's not to say that there's not a way of determining. And health plans can clearly determine whether or not care is taking place at an on-campus facility and off-campus facility by looking at these two specific segments of the claim.

I want to leave with a couple of key takeaways of what I spoke on. Facility fees are essential to providing the unique type of care that are provided by hospitals.

Specifically, eliminating facility fees jeopardizes the financial viability of certain areas of hospitals, and it could threaten the ability to provide these non-revenue-generating services, particularly in rural settings where there might be a less in-patient population. I also will note the reduction in independent physicians is certainly something that might be concerning, but hospitals aren't the driving factor. And again, I would note that I think the driving factor on this are health insurers and other payers not paying a sufficient rate for physicians to remain financially viable and creating more complex coverage such as high deductible health plans that are shifting cost responsibility onto the patient. And again, in those situations, when you shift more onto the patient, you've got more bad debt that's inherently going to occur because you don't collect at the same rate. And so there's a lot of financial pressure on independent physicians that might be leading to them no longer being independent physicians and instead turning to employment. But the concept of hospitals driving this is not backed up by the actual data. And then finally, the NPI for off-campus departments, it doesn't seem like it's necessary because you can already determine this by looking at an institutional bill and so really requiring this is only going to add to that administrative cost that's uncompensated by the professional fees and things that providers are going to have to address and it'll make the care and the billing even less efficient than it might be today

Eric Waskowicz, Senior Policy Manager for United States of Care (USofCare) thanked the Committee for the opportunity to speak and stated that USofCare is a nonpartisan, nonprofit organization that works in the states to ensure that everyone has access to quality, affordable health care. We are new to the NCOIL world but are very interested in the work that you're all doing to address facility fees and I'm looking forward to meeting all of you in Charleston. For the most part, I'm going to align myself 100% with what Ms. Culp had mentioned related to the problem that facility fees pose to patients. First and foremost, this hits close to home for me. I received a $180 facility fee at my primary care doctor's office for a strep test – it was a bit of a shock to me. I'm certainly part of the group that really is supportive of action to address facility fees. Looking at this draft Model, we are supportive of the facility fee prohibitions and transparency requirements and we believe that this Model really does align with the approximately 18 states that have passed some sort of protections related to facility fees.

In addition to the consumer protections found in the Model, there are a couple areas of focus that I think we feel could be addressed to strengthen the Model even further. The first is something that Ms. Culp mentioned earlier regarding NPIs. We are supportive of language in the Model to require these unique NPIs for off-campus providers and I would say, on top of that, some sort of mechanism to really establish a connection between parent hospital and affiliated off-campus providers to make sure that we know where these fees are being charged. USofCare has spoken with state all-player claims databases, and they've told us it's very difficult to identify where these fees are being charged even with unique NPI language so we feel some sort of clarification is needed. And then the second item relates to data collection. USofCare has been very supportive of language in this Model requiring hospitals to submit a publicly accessible report on facility fees, at the same time, we would encourage the Committee, if possible, to think through a requirement that states complete some sort of analysis or evaluation to understand the impacts of facility fees on people's access to care, as well as the health

care system more generally so looking at providers, hospitals, consumers and the like. This has been done in several states so far that we thought has been pretty successful. And then one final thing, we want to encourage NCOIL to think through solutions beyond facility fee prohibitions, things like site neutral policy or fair billing policy, policies that address the commercial market in states. We feel like doing so would secure even more savings for people, employers and others, while also making sure to lower the cost curve for the health care system more generally.

Randi Chapman, Managing Director of State Affairs at the Blue Cross Blue Shield Association (BCBSA), thanked the Committee for the opportunity to speak and thanked Rep. Oliverson for sponsoring the Model. The policy solutions that are included in this Model can really go a long way to help consumers, patients, our members, achieve more affordability in their health care. I'm not going to reiterate all of the great information that has been shared today. I will say that I am thrilled that BCBSA is aligned with patients on this issue and we think it's essential to address what's going on in terms of helping make health care more affordable for patients. There are a lot of levers that contribute to high costs, and this is just one of them.

Sen. George Lang (OH) thanked Rep. Oliverson for bringing this Model forward. Last year in Ohio, we enacted a hospital transparency bill and included in that we wanted to include some facility fee language but it was only aspirational and at the last minute, we decided to pull it all together. This is something that we want to work on. The concern I have and a potential amendment to fix it would be when these hospitals purchase a physician's practice, I'm assuming as most business models, they use a multiple of something such as interest, taxes, depreciation, and amortization (EBITDA) to purchase that practice and this gives them the opportunity to realize they're going to have additional gains from the facilities, the tools, if you will, at the doctor's office that they currently don't enjoy. So my concern is that a hospital offers a higher multiple based on the fact that they're going to enjoy higher revenues on the facilities at that firm than the practice otherwise would have received. One potential amendment, and don't hold me to the details because I really don't know but my assumption is when a hospital buys a practice, they like to have it all paid off in five to seven years. That's just an assumption based on my businesses I operate in and when I buy a practice, I have a five-year model. When I buy a building, a seven-year model. I truly don't know what hospitals do. But if that assumption is correct, in order to give hospitals a longer runway and a softer landing, I would recommend we consider grandfathering all existing facilities in for a period of time. My opinion, that should be about three and a half years. That way, if a hospital bought a practice six years ago and they have one year to go, they're going to enjoy fees that they should not otherwise have enjoyed once that building is paid off and so they'll take advantage of it in that scenario. But a hospital that just bought a practice a year ago, they're not going to have the full seven years. They're just going to have an additional three and a half years. So that is an amendment I would like for the sponsor to consider and I'll be happy to help with some language and we're actually working on something similar to that in Ohio.

And some concerns about the testimony that we heard. I heard Ms. Culp say that we should direct the bills to the insurers, not the individuals. And if that means the

responsibility of paying those is to the insurers, we will just continue to drive up costs on the small business markets and continue to drive more of those small business markets out of the umbrella of state regulations. I know in Ohio, about 10 years ago, 20% of everybody insured was insured in a small market plan but today, that number is only 10% because these small businesses have figured out how to pool their resources, how to get to a self-funded world where they don't have to follow our directions. And for the AHA, I appreciate the fact that you have items that you lose money on. I don't understand why a hospital would do that, but I don't understand your model. I understand why a retailer would do that. I don't think it should be our responsibility to help you make up for those items that you have priced at a loss or at a lower margin. That would be my pushback there.

Rep. Brenda Carter (MI) stated that last year we were looking at introducing similar legislation in Michigan where we had substantial opposition from the hospitals. It was great to hear some of the feedback that I heard from both sides today and we're going to revisit it again. But I want to ask, how does this Model address the out-of-pocket cost for the patient? That's the primary concern that we have - the facility fees are costing the patients and the cost of health care is already rising to the point that we're increasing our pool of underinsured and uninsured people.

In response to Sen. Lang, Ms. Culp stated I think our concern in part is that, oftentimes facility fees are actually billed directly to the patient, rather than going through their insurance so it's like a separate bill entirely. They'll get their explanation of benefits. They'll get the information from their insurer. They'll pay their copay or their part of the service. And then they'll get this other separate fee. And that I think maybe in part addresses your question, Rep. Carter. But we'd be really interested to talk more about if there are additional ways to provide additional consumer protections and make sure that as facility fees go away, it's not just passed on to patients in another way. But ultimately, what these are is charging more for the same service because it's being provided in a space that's owned by a hospital versus one that isn't. And we just don't think that's fair.

Mr. Cunningham stated that I think in terms of things being not covered by a health insurer and having to go directly to patients, I think we would agree we would like things to be paid for by the health insurer. And I think that, again, might be a cause of a lot of these issues is we want facility fees and everything else to be something that's comprehensively part of your benefits package. And the fact that these benefits packages have been consistently eroding and you've got coverage that doesn't pay for what it maybe should might lead to some of these things. And in terms of services that do not generate margins, especially for specific hospitals to a specific community, they provide public health services that are essential. And I think hospitals take that seriously. And there is a certain amount of cost shift and there are non-revenue generating services because that's what hospitals are supposed to do - you generally expect a hospital to be somewhere where someone can have a baby and they don’t have to drive crazy amounts of time or have an issue to access. And so I think it's just inherent to how things are handled so that you can provide the comprehensive health care which is expected of hospitals. In order to do that, there's cost shifting and there

might be some services that generate revenue and some that don't, but we think both are essential to what it means to actually provide hospital level care.

Rep. Oliverson thanked everyone for their comments and stated that I really appreciate the good discussion, especially the comments by my colleagues. I'm happy to visit with you after. Just a couple of observations. Number one, to Rep. Carter's concern, I think it's important to understand that what we're talking about here is a facility fee that is levied when a patient goes to see a doctor in the doctor's office. And historically, when a physician contracts with a health plan, there is a certain amount of attention in that global fee that is paid to that physician for reimbursement of the cost of overhead. And so, what we have here is a scenario where essentially the cost to the patient has been doubled or tripled vis-a-vis something that 10 years ago was just included as part of the professional fee. So, it is a true doubling or tripling of the patient cost so by prohibiting these fees, which didn't exist until relatively recently I would point out, you are actually returning us to a state of normalcy. As far as the comments about hospitals and under or uncompensated care, I would just simply point out that in my experience, especially for my lawmaker friends who serve on appropriations committees in your state, our states already, and the federal government, subsidize hospitals across the board for services that they render and provide in under or uncompensated care. There are multiple buckets from both the state and federal government that are designed to account for these shortfalls. And to Sen. Lang's comments, I would say that it's not as bad in the hospital world as you think it is, because unlike a regular business as they're making these decisions, they have literally tranches of both state and federal dollars that they are entitled to. The only thing they have to do is prove that they're doing a certain amount of under or uncompensated care in certain particular areas like emergency rooms, outpatient settings, and labor and delivery specifically.

And the last thing I'm going to say is that with regard to the AHA's comments, I would just say that I don't believe in my experience and my research on this issue that the reason why hospitals acquire physician practices has much of anything to do with the actual facility fee itself, nor is that the main business model mechanism by which reimbursement is gathered. It has more to do with controlling the patient's chart and the continuity of care and the referral patterns. And you see this very clearly when you look at the types of practices that hospitals like to acquire. These are oncology practices, surgical practices, primary care practices, and OBGYN practices. And the reason they do that is because if your primary care doctor is working for the hospital and you need a stress test, guess where that stress test is going to be done? If you need a referral to see a cardiologist, guess whose cardiologist you're going to see? If you're an orthopedic surgeon and your practice is owned by the hospital or a general surgeon, guess where your surgery is going to be done? It is going to be done at the hospital. So I think one of the main driving factors and benefits for a hospital or hospital system in terms of acquiring physician practices is actually controlling the patient's chart and controlling referral patterns and making sure that the hospital is benefiting from services that may or may not be competitively priced with respect to what's available in the market. Because now it's a closed shop and a closed system, and there is no competition because essentially the referring doctor is obligated to send the patient to a practice, a facility, or a treatment that exists underneath the hospital site license. So I just want to make sure

you all have that context and all of that's being considered. I'm looking forward to working with all of you on this. I think we have a big opportunity here in terms of a meaningful Model for NCOIL that we can take back to our states and really help consumers have better affordability in health care.

Rep. Pollock thanked everyone for their comments and stated that if there are any further questions or comments, please reach out to Rep. Oliverson, myself, or NCOIL staff.

OPPORTUNITY FOR COMMENT/DISCUSSION ON MODEL LAWS SCHEDULED FOR RE-ADOPTION BY THE COMMITTEE AT UPCOMING SPRING MEETING IN APRIL

Rep. Pollock stated next on the agenda is an opportunity for comment and discussion on the two Model Laws scheduled for consideration of readoption at the Spring Meeting in April. The Models are the Transparency in Dental Benefits Contracting Model Act, originally adopted in December of 2020, and the Short-term Limited Duration Insurance Model Act, originally adopted in the September of 2020. As a reminder, per the NCOIL bylaws, all NCOIL Models are scheduled to be considered for readoption every five years. If a Model is not readopted, it sunsets. These Models will not be voted on here for readoption today. Rather, this is an opportunity for any comments or discussions in advance of the April meeting where the actual vote will take place.

Sen. Justin Boyd (AR), Vice Chair of the Committee, stated that he and Asm. Jarett Gandolfo (NY) have been in discussion with the American Dental Association (ADA) about some amendments to the Transparency in Dental Benefits Contracting Model Act. Asm. Gandolfo and I would like to sponsor amendments to existing provisions of the Model and also have the Committee consider including adding two new issues to the Model regarding assignment of benefits and limitations on recovery of insurers' erroneous payments. The specific language can be discussed further during the Committee's meeting in April.

Asm. Gandolfo stated that I appreciate Sen. Boyd taking the lead on this, and I'm happy to join him and co-sponsor the amendments. I think the amendments that we are going to be discussing will go a long way in improving the dental experience for the patient.

Chad Olson, Director of State Gov't Affairs at the ADA thanked the Committee for the opportunity to speak and thanked Sen. Boyd and Asm. Gandolfo for sponsoring the amendments. We're looking forward to working through them in the future.

Bianca Belloli, Director of Gov't Relations for the National Association of Dental Plans (NADP) thanked the Committee for the opportunity to speak and stated that I have a few comments on the potential reopening of this Model on behalf of NADP as well as Delta Dental Plans Association (DDPA). At this point, we would recommend that the Committee does not reopen this Model. The current Model was discussed and debated at length in 2020, which I know many of you are very aware of, and it contains important policies that bring a lot of legal clarity and consumer protections to the dental contracting space, including increasing transparency for providers, ensuring access to quality dental

care and network specifically for consumers, as well as providing a lot of opportunity to providers to elect participation whether that be in the virtual credit card provisions or in the network leasing provisions. And I do want to note there has been broad adoption of the current Model which to us indicates that it contains strong policies that were the right outcome five years ago when adopted. Specifically, in regards to the virtual credit card portion of this, there are 11 states that have adopted the Model or something substantially similar to it with six states following it exactly and five adopting a very similar approach. And then an additional 15 states have adopted the network leasing provisions in this Model, with six aligning exactly and nine following it very substantially. And I want to note the substantial impact that would occur from amending this Model for some of those states that have already considered it. And with that being said, we just want to note that if the Committee ultimately does decide to reopen the Model, we would respectfully request the publication of any proposed amendments, as we've not seen any to date, and allow for ample time to respond and review that text. As you're aware, NADP as well as DDPA are both member organizations, and we would want to make sure our members have the opportunity to review the potential impact of any amendments to the Model.

Rep. Pollock thanked everyone for their comments and stated that it sounds like we have a lot of discussion on this Mode that will occur between now and at the Spring Meeting. I look forward to working with everyone on this and determining what the best path forward is. Based on how the discussions are going, the Committee could readopt the Model as-is for another five years, or we can readopt it on a meeting-to-meeting basis so that interested parties can work with Sen. Boyd on the concepts that he's discussed. If anyone has any questions or comments on this, please reach out to myself, Sen, Boyd, or to the NCOIL staff.

Will Melofchik, NCOIL CEO, stated that in response to Bianca's comments, any potential amendments to the Model will be included in the Spring Meeting 30-day materials which will be distributed a couple of weeks from now. So there will be ample time for review and comments.

J.P. Wieske, on behalf of the Health Benefits Institute, thanked the Committee for the opportunity to speak and stated that we would recommend that the Short Term Limited Duration Insurance Model sunset. There's nothing substantively wrong with the Model. It's just there's a lot of uncertainty around the market right now and there's been limited adoption of this Model. There's not a lot of consensus around this as a Model going forward. There’s an ongoing lawsuit with the existing rules on this topic that the Biden Administration issued which replaced the Trump Administration rules, and the new Trump Administration is likely to act on the issue. So at this point, we think that there's enough turmoil in the market that even if it makes sense to have an NCOIL Model, it may make more sense to re-look at this down the road with a different Model.

Rep. Pollock thanked everyone for their comments and stated that when the Committee meets again in April, we'll have an opportunity to determine what the next step is with this Model. If anyone has any questions or comments on this, please reach out to myself or to the NCOIL staff.

ADJOURNMENT

Hearing no further business, upon a Motion made by Sen. Utke and seconded by Rep. Carl Anderson (SC), the Committee adjourned at 2:30 p.m.

616 Fifth Avenue, Suite 106
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CHIEF EXECUTIVE OFFICER: Will Melofchik

National Council of Insurance Legislators (NCOIL)

Prior Authorization Reform Model Act

Sponsored by Sen. Walter Michel (MS)

Draft as of March 26, 2025. To be introduced and discussed during the Health Insurance & Long Term Care Issues Committee on April 25, 2025.

Table of Contents

Section 1. Title

This Act shall be known as the "[State] Prior Authorization Reform Act."

Section 2. Purpose

The purpose of this Act is to: protect the health care professional-patient relationship from unreasonable third-party interference; prevent prior authorization programs from hindering the independent medical judgment of a physician or other health care provider; and to ensure the transparency of a fair and consistent process for health care providers and their patients.

Section 3. Applicability and Scope

This Act applies to every health insurance issuer and all health benefit plans, as both terms are defined in xxxxxx, and all private review agents and utilization review plans, as both terms are defined in xxxxx, with the exception of employee or employer self-insured health benefit plans under the federal Employee Retirement Income Security Act of 1974 or health care provided pursuant to the Workers' Compensation Act. This Act does not diminish the duties and responsibilities under other federal or state law or rules promulgated under those laws applicable to a health insurer, health insurance issuer, health benefit plan, private review agent or utilization review plan, including, but not limited to, the requirement of a certificate in accordance with xxxxx.

Section 4. Definitions

For purposes of this act, unless the context requires otherwise, the following terms shall have the meanings as defined in this section:

(A) "Adverse determination" means a determination by a health insurance issuer that, based on the information provided, a request for a benefit under the health insurance issuer's health benefit plan upon application of any utilization review technique does not meet the health insurance issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit; the denial, reduction, or termination of or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health insurance issuer that a preexisting condition was present before the effective date of coverage; or a rescission of coverage determination, which does not include a cancellation or discontinuance of coverage that is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

(B) "Appeal" means a formal request, either orally or in writing, to reconsider an adverse determination.

(C) "Approval" means a determination by a health insurance issuer that a health care service has been reviewed and, based on the information provided, satisfies the health insurance issuer's requirements for medical necessity and appropriateness.

(D) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by a health insurance issuer to determine the necessity and appropriateness of health care services.

(E) "Department" means the [State] Department of Insurance.

(F) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, such that a reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit; the denial, reduction, or termination of or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health insurance issuer that a preexisting condition was present before the effective date of coverage; or a rescission of coverage determination, which does not include a cancellation or discontinuance of coverage that is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

(i) Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

(ii) Serious impairment to bodily functions; or

(iii) Serious dysfunction of any bodily organ or part.

(G) "Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

(H) "Enrollee" means any person and his or her dependents enrolled in or covered by a health care plan.

(I) "Health care professional" means a physician, a registered professional nurse or other individual appropriately licensed or registered to provide health care services.

(J) "Health care provider" means any physician, hospital, ambulatory surgery center, or other person or facility that is licensed or otherwise authorized to deliver health care services.

(K) "Health care service" means any services or level of services included in the furnishing to an individual of medical care or the hospitalization incident to the furnishing of such care, as well as the furnishing to any person of any other services for the purpose of preventing, alleviating, curing, or healing human illness or injury, including behavioral health, mental health, home health and pharmaceutical services and products.

(L) "Health insurance issuer" has the meaning given to that term in [applicable state insurance statute]. Any provision of this act that applies to a "health insurance issuer" also applies to any person or entity covered under the scope of this act.

(M) "Medically necessary" means a health care professional exercising prudent clinical judgment would provide care to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms and that are:

(i) In accordance with generally accepted standards of medical practice; and

(ii) Clinically appropriate in terms of type, frequency, extent, site and duration and are considered effective for the patient's illness, injury or disease; and not primarily for the convenience of the patient, treating physician, other health care professional, caregiver, family member or other interested party, but focused on what is best for the patient's health outcome.

(N) "Physician" means any person with a valid doctor of medicine, doctor of osteopathy or doctor of podiatry degree.

(O) "Prior authorization" means the process by which a health insurance issuer determines the medical necessity and medical appropriateness of an otherwise covered health care service before the rendering of such health care service. "Prior authorization" includes any health insurance issuer's requirement that an enrollee, health care professional or health care provider notify the health insurance issuer before, at the time of, or concurrent to providing a health care service.

(P) "Urgent health care service" means a health care service with respect to which the application of the time periods 180 for making a non-expedited prior authorization that in the opinion of a treating health care professional or health care provider with knowledge of the enrollee's medical condition:

(i) Could seriously jeopardize the life or health of the enrollee or the ability of the enrollee to regain maximum function;

(ii) Could subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review; or

(iii) Could lead to likely onset of an emergency 190 medical condition if the service is not rendered during the time period to render a prior authorization determination for an urgent medical service.

(Q) "Urgent health care service" does not include emergency services.

(R) "Private review agent" has the meaning given to that term in [applicable statutory reference].

Section 5. Disclosure and review of prior authorization requirements.

(A) A health insurance issuer shall maintain a complete list of services for which prior authorization is required, including for all services where prior authorization is performed by an entity under contract with the health insurance issuer.

(B) A health insurance issuer shall make any current prior authorization requirements and restrictions, including the written clinical review criteria, readily accessible and conspicuously posted on its website to enrollees, health care professionals and health care providers. Content published by a third party and licensed for use by a health insurance issuer may be made available through the health insurance issuer's secure, password-protected website so long as the access requirements of the website do not unreasonably restrict access. Requirements shall be described in detail, written in easily understandable language, and readily available to the health care professional and health care provider at the point of care. The website shall indicate for each service subject to prior authorization:

(1) When prior authorization became required for policies issued or health benefit plan documents delivered in [State], including the effective date or dates and the termination date or dates, if applicable, in [State];

(2) The date the [State]-specific requirement was listed on the health insurance issuer's, health benefit plan's, or private review agent's website;

(3) Where applicable, the date that prior authorization was removed for [State]; and

(4) Where applicable, access to a standardized electronic prior authorization request transaction process.

(C) The clinical review criteria must:

(1) Be based on nationally recognized, generally accepted standards except where state law provides its own standard;

(2) Be developed in accordance with the current standards of a national medical accreditation entity;

(3) Ensure quality of care and access to needed health care services;

(4) Be evidence-based;

(5) Be sufficiently flexible to allow deviations from norms when justified on a case-by-case basis; and

(6) Be evaluated and updated, if necessary, at least annually.

(D) A health insurance issuer shall not deny a claim for failure to obtain prior authorization if the prior authorization requirement was not in effect on the date of service on the claim.

(E) A health insurance issuer shall not deem as incidental or deny supplies or health care services that are routinely used as part of a health care service when:

(1) An associated health care service has received prior authorization; or

(2) Prior authorization for the health care service is not required.

(F) If a health insurance issuer intends either to implement a new prior authorization requirement or restriction or amend an existing requirement or restriction, the health insurance issuer shall provide contracted health care professionals and contracted health care providers of enrollees written notice of the new or amended requirement or amendment no less than sixty (60) days before the requirement or restriction is implemented. Written notice may take the form of a conspicuous notice posted on the health insurance issuer's public website or portal for contracted health care professionals and contracted health care providers. A health insurance issuer shall provide email notices to health care professionals or health care providers if the health care professional or health care provider has requested to receive the notice through email. The health insurance issuer shall ensure that the new or amended requirement is not implemented unless the health insurance issuer's website has been updated to reflect the new or amended requirement or restriction. Written notice of a new, amended, or restricted prior authorization requirement, as required by this subsection (6), may be provided less than

sixty (60) days in advance if a health insurance issuer determines and contemporaneously notifies the department in writing that:

(1) The health insurance issuer has identified fraudulent or abusive practices related to the health care service;

(2) The health care service is unavailable or scarce which necessitates the use of an alternative health care service;

(3) The health care service is newly introduced to the health care market and a delay in providing coverage for the health care service and would not be in the best interests of enrollees;

(4) The health care service is the subject of a clinical trial authorized by the United States Food and Drug Administration; or

(5) Changes to the health care service or its availability are otherwise required by law to be made by the health insurance issuer in less than sixty (60) days.

(G) Health insurance issuers using prior authorization shall make statistics available regarding prior authorization approvals and denials on their website in a readily accessible format. Following each calendar year, the statistics must be updated annually by [Insert date], and include all of the following information:

(1) A list of all health care services, including medications, that are subject to prior authorization;

(2) The percentage of standard prior authorization requests that were approved, aggregated for all items and services;

(3) The percentage of standard prior authorization requests that were denied, aggregated for all items and services;

(4) The percentage of prior authorization requests that were approved after appeal, aggregated for all items and services;

(5) The percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved, aggregated for all items and services;

(6) The percentage of expedited prior authorization requests that were approved, aggregated for all items and services;

(7) The percentage of expedited prior authorization requests that were denied, aggregated for all items and services;

(8) The average and median time that elapsed between the submission of a request and a determination by the payer, plan or health insurance issuer, for standard prior authorization, aggregated for all items and services;

(9) The average and median time that elapsed between the submission of a request and a decision by the payer, plan or health insurance issuer, for expedited prior authorizations, aggregated for all items and services; and

(10) Any other information as the department determines appropriate.

Section 6. Standardized electronic prior authorizations.

(A) If any health insurance issuer requires prior authorization of a health care service, the insurer or its designee utilization review organization shall, by [Insert date] make available a standardized electronic prior authorization request transaction process using an internet webpage, internet webpage portal, or similar electronic, internet, and web-based system.

(B) Not later than [Insert date], all health care professionals and health care providers shall be required to use the standardized electronic prior authorization request transaction process made available as required by subsection (A) of this section.

Section 7. Prior authorizations in nonurgent circumstances.

If a health insurance issuer requires prior authorization of a health care service, the health insurance issuer must make an approval or adverse determination and notify the enrollee, the enrollee's health care professional, and the enrollee's health care provider of the approval or adverse determination as expeditiously as the enrollee's condition requires but no later than seven (7) calendar days after obtaining all necessary information to make the approval or adverse determination, unless a longer minimum time frame is required under federal law for the health insurance issuer and the health care service at issue. As used in this section, "necessary information" includes the results of any face-to-face clinical evaluation, second opinion or other clinical information that is directly applicable to the requested service that may be required. Notwithstanding the foregoing provisions of this section, health insurance issuers must comply with the requirements of [State Insurance Code Section] respond by two (2) business days for prior authorization requests for pharmaceutical services and products.

Section 8. Prior authorizations in urgent circumstances.

(A) If requested by a treating health care provider or health care professional for an enrollee, a health insurance issuer must render an approval or adverse determination concerning urgent health care services and notify the enrollee, the enrollee's health care professional and the enrollee's health care provider of that approval or adverse determination as expeditiously as the enrollee's condition requires but no later than forty-eight (48) hours after receiving all information needed to complete the review of the requested health care services, unless a longer minimum time frame is required under federal law for the health insurance issuer and the urgent health care service at issue.

(B) To facilitate the rendering of a prior authorization determination in conformance with this section, a health insurance issuer must establish a mechanism to ensure health care professionals have access to appropriately trained and licensed clinical personnel who have access to physicians for consultation,

Section 9. Notifications for adverse determinations.

If a health insurance issuer makes an adverse determination, the health insurance issuer shall include the following in the notification to the enrollee, the enrollee's health care professional, and the enrollee's health care provider:

(a) The reasons for the adverse determination and related evidence-based criteria, including a description of any missing or insufficient documentation;

(b) The right to appeal the adverse determination;

(c) Instructions on how to file the appeal; and

(d) Additional documentation necessary to support the appeal.

Section 10. Personnel qualified to review appeals.

(A) A health insurance issuer must ensure that all appeals are reviewed by a physician when the request is by a physician or a representative of a physician. The physician must:

(1) Possess a current and valid nonrestricted license to practice medicine in any United States jurisdiction;

(2) Be certified by the board(s) of the American Board of Medical Specialists or the American Board of Osteopathy within the relevant specialty of a physician who typically manages the medical condition or disease;

(3) Be knowledgeable of, and have experience providing, the health care services under appeal;

(4) Not have been directly involved in making the adverse determination; and

(5) Consider all known clinical aspects of the health care service under review, including, but not limited to, a review of all pertinent medical records provided to the health insurance issuer by the enrollee's health care professional or health care provider and any medical literature provided to the health insurance issuer by the health care professional or health care provider.

(B) Notwithstanding the foregoing, a licensed health care professional who satisfies the requirements in this section may review appeal requests submitted by a health care professional licensed in the same profession.

Section 11. Insurer review of prior authorization requirements.

A health insurance issuer shall periodically review its prior authorization requirements and consider removal of prior authorization requirements:

(a) Where a medication or procedure prescribed is customary and properly indicated or is a treatment for the clinical indication as supported by peer-reviewed medical publications; or

(b) For patients currently managed with an established treatment regimen.

Section 12. Revocation of prior authorizations.

(A) A health insurance issuer may not revoke or further limit, condition or restrict a previously issued prior authorization approval while it remains valid under this act.

(B) Notwithstanding any other provision of law, if a claim is properly coded and submitted timely to a health insurance issuer, the health insurance issuer shall make payment according to the terms of coverage on claims for health care services for which prior authorization was required and approval received before the rendering of health care services, unless one (1) of the following occurs:

(1) It is timely determined that the enrollee's health care professional or health care provider knowingly and without exercising prudent clinical judgment provided health care services that required prior authorization from the health

insurance issuer or its contracted private review agent without first obtaining prior authorization for those health care services;

(2) It is timely determined that the health care services claimed were not performed;

(3) It is timely determined that the health care services rendered were contrary to the instructions of the health insurance issuer or its contracted private review agent or delegated reviewer if contact was made between those parties before the service being rendered;

(4) It is timely determined that the enrollee receiving such health care services was not an enrollee of the health care plan; or

(5) The approval was based upon a material misrepresentation by the enrollee, health care professional, or health care provider; as used in this paragraph, material" means a fact or situation that is not merely technical in nature and results or could result in a substantial change in the situation.

(C) Nothing in this section shall preclude a private review agent or a health insurance issuer from performing post-service reviews of health care claims for purposes of payment integrity or for the prevention of fraud, waste, or abuse.

Section 13. Length of approvals. ‘

(A) A prior authorization approval shall be valid for the lesser of six (6) months after the date the health care professional or health care provider receives the prior authorization approval or the length of treatment as determined by the patient's health care professional or the renewal of the policy or plan, and the approval period shall be effective regardless of any changes, including any changes in dosage for a prescription drug prescribed by the health care professional. Notwithstanding the foregoing, a health insurer and an enrollee or his/her health care professional may extend a prior authorization approval for a longer period, by agreement. All dosage increases must be based on established evidentiary standards, and nothing in this section shall prohibit a health insurance issuer from having safety edits in place. This section shall not apply to the prescription of benzodiazepines or Schedule II narcotic drugs, such as opioids.

(B) Nothing in this section shall require a policy or plan to cover any care, treatment, or services for any health condition that the terms of coverage otherwise completely exclude from the policy's or plan's covered benefits without regard for whether the care, treatment or services are medically necessary.

Section 14. Approvals for chronic conditions.

(A) If a health insurance issuer requires a prior authorization for a recurring health care service or maintenance medication for the treatment of a chronic or long-term condition, including, but not limited to, chemotherapy for the treatment of cancer, the approval shall remain valid for the lesser of twelve (12) months from the date the health care professional or health care provider receives the prior authorization approval or the length of the treatment as determined by the patient's health care professional. Notwithstanding the foregoing, a health insurer and an enrollee or his or her health care professional may extend a prior authorization approval for a longer period, by agreement. This section shall not apply to the prescription of benzodiazepines or Schedule II narcotic drugs, such as opioids.

(B) Nothing in this section shall require a policy or plan to cover any care, treatment or services for any health condition that the terms of coverage otherwise completely exclude from the policy's or plan's covered benefits without regard for whether the care, treatment, or services are medically necessary.

Section 15. Continuity of prior approvals.

(A) On receipt of information documenting a prior authorization approval from the enrollee or from the enrollee's health care professional or health care provider, a health insurance issuer shall honor a prior authorization granted to an enrollee from a previous health insurance issuer for at least the initial ninety (90) days of an enrollee's coverage under a new health plan, subject to the terms of the member's coverage agreement.

(B) During the time period described in subsection (A) of this section, a health insurance issuer may perform its own review to grant a prior authorization approval subject to the terms of the member's coverage agreement.

(C) If there is a change in coverage of or approval criteria for a previously authorized health care service, the change in coverage or approval criteria does not affect an enrollee who received prior authorization approval before the effective date of the change for the remainder of the enrollee's plan year.

(D) Except to the extent required by medical exceptions processes for prescription drugs, nothing in this section shall require a policy or plan to cover any care, treatment or services for any health condition that the terms of coverage otherwise completely exclude from the policy's or plan's covered benefits without regard for whether the care, treatment or services are medically necessary.

Section 16. Effect of insurer's failure to comply.

A failure by a health insurance issuer to comply with the deadlines and other requirements specified in this act shall result in any health care services subject to review to be automatically deemed authorized by the health insurance issuer or its contracted private review agent.

Section 17. Enforcement and administration.

(A) In addition to the enforcement powers granted to it by law to enforce the provisions of this act, the department is granted specific authority to issue a cease-and-desist order or require a private review agent or health insurance issuer to submit a plan of correction for violations of this act, or both. Subject to regulations promulgated by the department under the provisions of the [State] Administrative Procedure Law and after proper notice and the opportunity for a hearing, the department may impose upon a private review agent, health benefit plan or health insurance issuer an administrative fine not to exceed xxxxxx per violation for failure to submit a requested plan of correction, failure to comply with its plan of correction, or repeated violations of this act. All fines collected by the department under this section shall be deposited into the State General Fund. The department may also exercise all authority granted to it under the [applicable Insurance Code section] to deny or revoke a certificate of a private review agent for a violation of this act.

(B) Any person or his or her treating physician who has evidence that his or her health insurance issuer or health benefit plan is in violation of the provisions of this act may file a complaint with the department. The department shall review all complaints received and investigate all complaints that it deems to state a potential violation. The department shall fairly, efficiently and timely review and investigate complaints. Health insurance issuers, health benefit plans and private review agents found to be in violation of this act shall be penalized in accordance with this section.

(C) The department shall have the authority to promulgate rules and regulations under the [applicable State administrative laws] to govern the administration of this act.

(D) There shall be no private right of action under this Act.

Section 18. Reports to the department.

(A) By June 1, 20xx, and each June 1 after that date, a health insurance issuer shall report to the department, on a form issued by the department, the following aggregated trend data, de-identified of protected health information, related to the insurer's practices and experience for the prior plan year for health care services submitted for payment:

(1) The number of prior authorization requests;

(2) The number of prior authorization requests denied;

(3) The number of prior authorization appeals received;

(4) The number of adverse determinations reversed on appeal;

(5) Of the total number of prior authorization requests, the number of prior authorization requests that were not submitted electronically;

(6) The ten (10) health care services that were most frequently denied through prior authorization;

(7) The ten (10) reasons prior authorization requests were most frequently denied;

(8) The number of claims for health care services that were examined through a post-service utilization review process;

(9) The number and percentage of claims for health care services denied through post-service utilization review; and

(10) The ten (10) health care services that were most frequently denied as a result of post-service utilization reviews.

(B) All reports required by this section shall be considered public records under the [State Public Records Act] and the department shall make all reports freely available to requestors and post all reports to its public website without redactions.

Section 19. False requests for prior authorization.

If a health insurance issuer has clear and convincing evidence that a health care professional or health care provider has knowingly and willingly submitted false or fraudulent requests for prior authorization to the health insurance issuer, the issuer shall notify and provide that information to the Commissioner of Insurance. After receipt of such notification and information, the commissioner shall forward these reports to the Board Medical Licensure or such other licensing agency with oversight of the health care provider, and the office of [relevant official authorized to prosecute/investigate insurance fraud].

Section 20. Rules

The [State Insurance Department] shall promulgate rules necessary to effectuate the purposes of this Act

Section 21. Effective Date

This Act shall take effect xxxx days after it shall have become a law.

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732-201-4133
CHIEF EXECUTIVE OFFICER: Will Melofchik

National Council of Insurance Legislators (NCOIL)

Resolution Regarding Audiology Services, Hearing Instrument Specialists Services, and Classification of Non-Over The Counter Hearing Aids as Prescription Devices

Sponsored by Rep. Deanna Frazier Gordon (KY) and Rep. Michael Sarge Pollock (KY)

Draft as of March 26, 2025. To be introduced and discussed during the Health Insurance & Long-Term Care Issues Committee on April 25, 2025.

WHEREAS, in August 2022, the United States Food and Drug Administration (FDA) promulgated regulatory changes establishing over-the-counter (OTC) hearing aids as a new category of medical devices while classifying all non-OTC hearing aids as prescription medical devices; and

WHEREAS, as a result of the FDA's actions, for the first time in the United States, consumers and patients may now only obtain a Class I and II non-OTC hearing aid (i.e., traditional hearing aids) with a prescription or other order from a state-licensed practitioner; and

WHEREAS, since 1977, these devices were regulated by the FDA as "restricted medical devices" governed by specific conditions of sale, labeling requirements, and device controls, but without the need for a prescription; and

WHEREAS, the FDA's policy shift to regulating non-OTC hearing aids as "prescription devices" has generated confusion among practitioners and policymakers at the state level; and

WHEREAS, under the FDA's "prescription device" regulation, non-OTC hearing aids may only be dispensed upon "the prescription or other order" of a practitioner licensed by law to direct the use of such device; and

WHEREAS, because the FDA does not have jurisdiction over practitioner licensure, the agency ultimately left it up to the States to define which providers are qualified to prescribe or order non-OTC hearing aids; and

WHEREAS, NOW, THEREFORE BE IT RESOLVED, that the National Council of Insurance Legislators (NCOIL) recommends that States amend applicable statutes and regulations to allow for the same professionals who recommended, selected, fitted, and dispensed restricted hearing aids before the effective date of the new FDA rules to continue to do so for prescription hearing aids after the effective date of FDA's regulatory changes; and

WHEREAS, NOW, THEREFORE BE IT FURTHER RESOLVED, as the FDA recommended to states, it is critically important to update State statutes to expressly authorize both hearing instrument specialists (also referred to as hearing aid specialists, hearing aid dispensers, among others) and audiologists to "order (or prescribe) the use of" hearing aids, consistent with the FDA's prescription device regulation (21 CFR 801.109); and

WHEREAS, NOW, THEREFORE BE IT FURTHER RESOLVED, that NCOIL finds that by adopting the statutory definitions contained in Appendix A to this Resolution, States will ensure that Audiology and Hearing Aid Specialist professions will continue to have the same authority as prior to the FDA's rule change and disruption in care for consumers will be avoided; and

WHEREAS, BE IT FINALLY RESOLVED, a copy of this Resolution shall be sent to the Chairs of the Committees with jurisdiction over healthcare, and occupational and professional licensure in each legislative chamber in each state.

APPENDIX A

Definitions

(1) "Over-the-counter hearing aid" means air conduction hearing aids that satisfy the requirements in the Over-the-Counter Hearing Aid Controls, 21 C.F.R. sec. 800.30(c) to (f), and are considered available over the counter pursuant to 21 U.S.C. sec. 360j(q)(1)(A)(v), but do not satisfy the regulatory requirements for prescription hearing aids.

(2) “Practice of audiology” means [prescribing or ordering], selling, dispensing, or fitting hearing aids to an individual for the correction or relief of a condition for which hearing aids are worn.

(3) “Practice of hearing instrument specialists” means [prescribing or ordering], selling, dispensing, or fitting suitable hearing instruments, including prescription hearing aids.

(4) “Prescription hearing aid” means a Class 1 or Class 2 device as defined in the federal Food, Drug and Cosmetic Act, 21 U.S.C. sec. 321(h), that is not an over-the-counter hearing aid as defined in Over-the-Counter Hearing Aid Controls, 21 C.F.R. sec. 800.30, or a hearing aid that does not satisfy the regulatory requirements for over-the-counter hearing aids.

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National Council of Insurance Legislators (NCOIL

Improving Affordability for Patients Model Act

Sponsored by Rep. Tom Oliverson, M.D. (TX), NCOIL Immediate Past President.

Draft as of September 16, 2024. To be discussed and potentially considered during the Health Insurance & Long Term Care Issues Committee on April 25, 2025.

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 3], 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 3] 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.

E. 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.*

F. 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 4. 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 5: 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 6. 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 7. Effective Date.

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

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National Council of Insurance Legislators (NCOIL)

Transparency in Dental Benefits Contracting Model Act

Sponsored by Rep. Deborah Ferguson (AR) and Rep. George Keiser (ND)
Adopted by the Health Insurance & Long Term Care Issues Committee on December 10, 2020; Adopted by the Executive Committee on December 12, 2020.

To be considered for re-adoption during the Health Insurance & Long Term Care Issues Committee on April 25, 2025.

Proposed Amendments sponsored by Sen. Justin Boyd (AR) and co-sponsored by Asm. Jarett Gandolfo (NY).

Contents:

A. Definitions *

*Dental coverage definitions and statutory language encompassing organizations that are engaged in financing dental care in return for a subscription fee or premium can be complex. Multiple designs of dental coverage within health insurance or benefit plans make it nearly impossible to land on one definition that covers all designs. The intent of this model is to extend the benefits of the law to all situations where a patient is deemed covered by a commercial/private third party. The definitions below are taken from existing state laws; state bill drafting efforts should ensure as broad a reach as possible consistent with existing statutory construct.

The nature of definitions should be consistent with jurisdiction in a manner that is

inclusive of all iterations of commercially available dental coverage designs and programs; definitions should be comprehensive and commensurate with state's statutory construct. Examples provided below for guidance.

"Contracting entity" means any person or entity that enters into direct contracts with providers for the delivery of dental services in the ordinary course of business, including a third party administrator and a dental carrier.

"Covered person" means an individual who is covered under a dental benefits or health insurance plan that provides coverage for dental services.

"Credit card payment" means a type of electronic funds transfer in which a dental benefit plan or its contracted vendor issues a single-use series of numbers associated with the payment of dental services performed by a dentist and chargeable to a predetermined dollar amount, whereby the dentist is responsible for processing the payment by a credit card terminal or Internet portal. Such term shall include virtual or online credit card payments, whereby no physical credit card is presented to the dentist and the single-use credit card expires upon payment processing.

"Dental benefit plan" means a benefits plan which pays or provides dental expense benefits for covered dental services and is delivered or issued for delivery by or through a dental carrier on a stand-alone basis. (Note: some health insurers or health insurance plans integrate dental benefits and should be considered dental benefits plans for the purposes of this Act and in the provisions therein.)

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

"Dental services" means services for the diagnosis, prevention, treatment, or cure of a dental condition, illness, injury, or disease. "Dental services" does not include services delivered by a provider that are billed as medical expenses under a health benefits plan.

"Dental Service Contractor" means any person who accepts a prepayment from or for the benefit of any other person or group of persons as consideration for providing to such person or group of persons the opportunity to receive dental services at such times in the future as such services may be appropriate or required, but shall not be construed to include a dentist or professional dental corporation that accepts prepayment on a fee-for-service basis for providing specific dental services to individual patients for whom such services have been pre-diagnosed.

"Dentist" means any dentist licensed or otherwise authorized in this state to furnish dental services;

"Dentist agent" means a person or entity that contracts with a dentist establishing an agency relationship to process bills for services provided by the dentist under the terms and conditions of a contract between the agent and health care provider. Such contracts may permit the agent to submit bills, request reconsideration and receive reimbursement.

"Electronic funds transfer payment" means a payment by any method of electronic funds transfer other than through the Automated Clearing House Network (ACH), as codified in 45 CFR Sections 162.1601 and 162.1602.

"Health insurance plan" means any hospital or medical insurance policy or certificate; qualified higher deductible health plan; health maintenance organization subscriber contract; contract providing benefits for dental care whether such contract is pursuant to a medical insurance policy or certificate; stand-alone dental plan, health maintenance provider contract or managed health care plan.

"Health insurer" means any entity or person that issues health insurance plans, as defined in this section.

"Prior authorization" means any written communication indicating that a specific procedure is, or multiple procedures are, covered under the patient's dental plan and reimbursable at a specific amount, subject to applicable coinsurance and deductibles, and issued in response to a request submitted by a dentist using a format prescribed by the insurer.

"Provider" means an individual or entity which, acting within the scope of licensure or certification, provides dental services or supplies defined by the health benefits or dental benefit plan. "Provider" shall not include a physician organization or physician hospital organization that leases or rents the physician organization's or physician hospital organization's network to a third party.

"Provider network contract" means a contract between a contracting entity and a provider that specifies the rights and responsibilities of the contracting entity and provides for the delivery and payment of dental services to an enrollee.

"Third party" means a person or entity that enters into a contract with a contracting entity or with another third party to gain access to the dental services or contractual discounts of a provider network contract. "Third party" does not include an employer or other group for whom the dental carrier or contracting entity provides administrative services.

B. Fair and Transparent Network Contracting Act

An Act concerning practical dental provider network administration; enhancing

contractual transparency and freedom of choice in network participation/contracting.

Section I. Responsible Leasing Requirements when Leasing Networks

A. A contracting entity may grant a third-party access to a provider network contract, or a provider's dental services or contractual discounts provided pursuant to a provider network contract if the requirements of subdivisions (B) and (C) are met.

B. At the time the contract is entered into or renewed, or a when there are material modifications to a contract relevant to granting access to a provider network contract to a third party, the dental care provider in the network chooses to allow the third party to access the dental care provider's services and discounted rates ~~dental carrier allows any provider which is part of the carrier's provider network to choose to not participate in third party access to the contract~~ or the dental care provider is allowed to enter into a contract directly with the ~~health insurer~~ third party that acquired the provider network. A contracting entity may not cancel or otherwise terminate a network provider contract with a dental care provider on the grounds that the dental care provider refuses to allow access by a third party to the dental care services and discounted rates of the dental care provider ~~If a provider opts out of lease arrangements, this shall not permit the contracting entity to cancel or otherwise end a contractual relationship with the provider~~. When initially contracting with a provider, a contracting entity must accept a qualified provider even if a provider rejects a network lease provision. Subsection I(B) shall not apply to contracting entities who are not a health insurer or dental carrier.

DRAFTING NOTE: Subsection IB is intended to apply to insurers only, and not to leasing companies. Providers contract with leasing companies with the explicit understanding and expectation that they will be leased. Because applying opt out requirements to these entities would impair their central purpose as understood by all parties, they should be specifically excluded from such provisions in legislation. However, the transparency provisions outlined in Subsection IIC are intended to apply to all contracting entities, including leasing companies.

C. A contracting entity may grant a third-party access to a provider network contract, or a provider's dental services or contractual discounts provided pursuant to a provider network contract, if all of the following are met:

1. The contract specifically states that the contracting entity may enter into an agreement with third parties allowing the third parties to obtain the contracting entity's rights and responsibilities as if the third party were the contracting entity only if~~, and~~ the dental care provider in the network chooses to allow the third party to access the dental care provider's services and discounted rates ~~when the contracting entity is a dental carrier, the provider chose to participate in third party access at the time the provider network contract was entered into or renewed. If the contracting entity is an insurer, the third-~~

~~party-access provision of any provider contract shall also specifically state that the contract grants third-party access to the provider network and, for contracts with dental carriers, that the dentist has the right to choose not to participate in third-party access~~.

2. The third party accessing the contract agrees to comply with all of the contract's terms;

3. The contracting entity identifies, in writing ~~or electronic form~~ to the provider, all third Parties to which the contracting entity has provided access ~~in existence~~ as of the date the contract is entered into or renewed;

4. The contracting entity identifies all third parties in existence in a list on its internet website that is updated at least once every 90 days;

5. The contracting entity notifies network providers that a new third party is leasing or purchasing the network at least 30 days in advance of the relationship taking effect;

6. The contracting entity requires a third party to identify the source of the discount on all remittance advices or explanations of payment under which a discount is taken. This paragraph does not apply to electronic transactions mandated by the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191);

7. The contracting entity notifies the third party of the termination of a provider network contract no later than 30 days from the termination date with the contracting entity;

8. A third party's right to a provider's discounted rate ceases as of the termination date of the provider network contract;

9. The contracting entity makes available a copy of the provider network contract relied on in the adjudication of a claim to a participating provider within 30 days of a request from the provider.

No provider shall be bound by or required to perform dental treatment or services under a provider network contract that has been granted to a third party in violation of this act.

Section II. Exceptions

The provisions of this Act shall not apply if any of the following is true:

1. Access to a provider network contract is granted to a dental carrier or an entity operating in accordance with the same brand licensee program as the contracting entity ~~or to an entity that is an affiliate of the contracting entity~~. A list of the carriers or entities with the same brand licensee program as the contracting entity~~'s affiliates~~ shall be made available to a provider on the contracting entity's website; or

2. A provider network contract for dental services provided to beneficiaries of the state sponsored health programs such as Medicaid and CHIP.

Section III. Penalties
(Establish appropriate penalties for any violation of this Act.)

Waiver Prohibited. The provisions of this section cannot be waived by contract. Any contractual arrangement in conflict with the provisions of this section or that purports to waive any requirements of this section is null and void.

C. Prior Authorizations Payments Act

An Act prohibiting dental carriers from denying, revoking, limiting, conditioning, or otherwise restricting preapproved dental care claims or claims approved in prior authorizations; exceptions.

Section I. Authorized Service(s) Claim Denial Prohibited/Exceptions

Dental benefit plans shall not deny any claim subsequently submitted by a dentist for procedures specifically included in a prior authorization unless at least one of the following circumstances applies for each procedure denied:

1. Benefit limitations such as annual maximums and frequency limitations not applicable at the time of the prior authorization are reached due to utilization subsequent to issuance of the prior authorization;

2. The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized;

3. If, subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the condition of the patient occurs such that the prior authorized procedure would no longer be considered medically necessary, based on the prevailing standard of care;

4. If, subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the patient's condition occurs such that the prior authorized procedure would at that time required disapproval pursuant to the terms and conditions for coverage under the patient's plan in effect at the time the prior authorization was used; or

5. The denial of the dental service contractor was due to one of the following:

a. another payer is responsible for payment,

b. the dentist has already been paid for the procedures identified on the claim,

c. the claim was submitted fraudulently or the prior authorization was based in whole or material part on erroneous information provided to the dental service contractor by the dentist, patient, or other person not related to the carrier, or

d. the person receiving the procedure was not eligible to receive the procedure on the date of service and the dental service contractor did not know, and with the exercise of reasonable care could not have known, of their eligibility status.

DRAFTING NOTE: Dental services are authorized through prior authorizations, not pretreatment estimates.

Section II. Penalties
(Establish appropriate penalties for any violation of this Act.)

Waiver Prohibited. The provisions of this section cannot be waived by contract. Any contractual arrangement in conflict with the provisions of this section or that purports to waive any requirements of this section is null and void.

D. Virtual Credit Card – Claim Payment/Transaction Fees Options Act

An Act concerning insurance; prohibiting certain restrictions on method of payment to health care providers; requiring certain notifications; prohibiting certain additional charges; prohibiting certain contracts, clauses or waivers; providing for enforcement by the Insurance Commissioner.

Method of Payment Option

No dental benefit plan shall contain restrictions on methods of payment from the dental benefit plans or its vendor or the health maintenance organization to the dentist in which the only acceptable payment method is a credit card payment or any other form of payment method that requires fees or similar charges.

~~If~~ A dental benefit plan or its contracted vendor or health maintenance organization may initiat~~e~~ing or chang~~e~~ing payment~~s~~ methodology to a dentist using electronic funds transfer payments, including virtual credit card payments, ~~a dental benefit plan or its contracted vendor or health maintenance organization shall~~ if:

1. The dental benefit plan n~~N~~otif~~y~~ies the dentist if any fees are associated with a particular payment method; ~~and~~

2. The dental benefit plan aAdvises the dentist of the available methods of payment and provides clear instructions to the dentist as to how to select an alternative payment method that does not impose fees or similar charges on the provider; and

3. The provider or a designee of the provider elects, through express acceptance, to accept a payment of the claim using the credit card or electronic funds transfer payment method. Violation of express acceptance nullifies any election on claim payment methodology until such time as express agreement is executed.

"Express acceptance" means a clear and direct agreement to the terms of payment method, communicated explicitly by the dental plan to the dentist, in writing, signifying acceptance of the payment method without any ambiguity or implied actions.

A health care provider's selected form of claim payment methodology remains effective until such time as the health care provider chooses an alternative method of payment or a new contract is executed.

A dental benefit plan or its contracted vendor or health maintenance organization that initiates or changes payments to a dentist through the Automated Clearing House Network, as codified in 45 CFR Sections 162.1601 and 162.1602, shall not charge a fee solely to transmit the payment to a dentist unless the dentist has consented to the fee. A dentist's agent may charge reasonable fees when transmitting an Automated Clearing House Network payment related to transaction management, data management, portal services and other value-added services in addition to the bank transmittal.

The provisions of this section shall not be waived by contract, and any contractual clause in conflict with the provisions of this section or that purport to waive any requirements of this section are void.

Violations of this section shall be subject to enforcement by the Insurance Commissioner.

E. Assignment of Benefit/Patient Directed Benefits

1. Dental benefit plan contracts may not prohibit, and claim forms must provide an option for, the payment of benefits directly to the specified dentist or a dental corporation. Dental benefit plans offering or administering dental services, may not refuse to accept or refuse to deliver reimbursement pursuant to an assignment of benefits authorization executed by a covered patient. The dental benefit plan may require written attestation of the assignment of the payment.

2. Upon a covered patient's assignment of benefit authorization, payment of benefits for covered services shall be paid directly to a dentist or a dental corporation irrespective of

dentist’s or dental corporation’s network participation or contractual status with the dental benefit plan that is covering the patient.

3. Payments made to a dentist under this section shall be at the same rate as payments made to in-network dentists.

4. An assignment made in accordance with this section may be revoked by the patient, with or without the consent of the dentist, by submitting the revocation, in writing, to the dental benefit plan.

5. A dental benefit plan that receives a revocation shall send a copy of the revocation to the dentist. The revocation made in accordance with this section shall become effective when both the dental benefit plan and the dentist have received a copy of the revocation; and only be effective for any charges incurred on or after the effective date established in the revocation.

6. If, under an assignment made in accordance with this section, a dentist collects payment from a covered patient and subsequently receives payment from the insurer, the dentist shall reimburse the covered patient, less any applicable cost sharing.

F. Post-Payment of Claim/Limitations on Recovery of Insurers’ Erroneous Payments

1. Other than recovery for duplicate payments, a dental benefit plan, whenever it engages in overpayment recovery efforts, shall provide written notice to the contracting dentist that identifies the error made in the processing or payment of the claim and justifies the overpayment recovery.

2. A dental benefit plan’s claim for overpayment to a provider may only be collected, withheld, or recouped from the provider of the service(s), or from the third party that submitted the provider's claim under the third-party provider’s identification number. The notice of withholding or recoupment by a dental benefit plan shall also inform the provider or third party of the health care service(s), date of service, and patient for which the recoupment is being made.

3. A dental benefit plan shall furnish a provider, or the third party that submitted the provider’s claim, with the opportunity to challenge an overpayment recovery, including the sharing of claims information, and shall establish written policies and procedures for providers to follow to challenge an overpayment recovery.

4. A dental benefit plan shall not initiate overpayment recovery efforts more than six months after the original payment for the claim was made. No such time limit shall apply to overpayment recovery efforts which are:

a. Based on reasonable belief of fraud, abuse, or other intentional misconduct, or

b. Required by a state or federal government plan.

5. Nothing in this section shall permit a dental benefit plan to recover an overpayment amount from a provider who is not in the dental benefit plan's network.

6. Waiver Prohibited. The provisions of this section cannot be waived by contract. Any contractual arrangement in conflict with the provisions of this section or that purports to waive any requirements of this section is null and void.

G~~F~~. Regulations

The Commissioner shall have the authority to promulgate rules that are consistent with the provisions of this Act and the laws of this State.

616 Fifth Avenue, Suite 106
Belmar, NJ 07719
732-201-4133
CHIEF EXECUTIVE OFFICER: Will Melofchik

National Council of Insurance Legislators (NCOIL)

Short Term Limited Duration Insurance Model Act

Sponsored by Rep. Martin Carbaugh (IN)

Adopted by the NCOIL Health Insurance & Long Term Care Issues Committee and NCOIL Executive Committee on September 26, 2020.

To be considered for re-adoption during the Health Insurance & Long Term Care Issues Committee on April 25, 2025.

Table of Contents

Section 1. Title

This Act shall be known as the "[State] Short Term Limited Duration Insurance Model Act."

Section 2. Purpose

The purpose of this Act is to establish standards for the regulation of short term limited duration insurance plans that may be sold in [State]. Drafting Note: States are not required to offer short term limited duration insurance plans. For states that choose to offer such plans, this Model is intended to serve as a framework that can be adjusted accordingly to meet each state's needs.

Section 3. Applicability

This Act shall apply to short term insurance plans delivered or issued for delivery to residents of this state, regardless of the situs of the contract or policy; however, nothing in this Section shall invalidate a plan validly delivered in another state.

Section 4. Definitions

For purposes of this Act:

(a) "Covered Individual" means an individual entitled to coverage under a short term insurance plan.

(b) "PPACA" means the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

(c) "Network based plan" means a type of health plan that contracts with healthcare providers to create a network of participating providers to provide healthcare services at a discounted cost to covered persons.

(d) "Short Term Insurance Plan" means a policy of health insurance that:

(1) may be renewed for the greater of:

(i) thirty-six (36) months; or

(ii) the maximum period permitted under federal law;

(2) has a term of not more than three hundred sixty-four (364) days; and

(3) has an annual limit of at least two million dollars ($2,000,000).

Section 5. Renewal and Underwriting

(a) An insurer may require an applicant for coverage under a short term insurance plan to specify, before issuance of the short term insurance plan, the number of renewals the applicant elects.

(b) After issuance of a short term insurance plan, the insurer may not require underwriting of the short term insurance plan until:

(1) all renewal periods elected under subsection (a) have ended; and

(2) the covered individual enrolls in a new short term insurance plan beyond the periods described in subdivision (1).

Section 6. Coverage Requirements

A short term insurance plan must include coverage for the following:

(1) Ambulatory patient services;

(2) Hospitalization;

(3) Emergency services; and

(4) Laboratory services

Section 7. Network Based Plan Requirements

(a) This section applies to an insurer that issues a short term insurance plan and undertakes a network based plan to render health care services to covered individuals under the short term insurance plan.

(b) An insurer described in subsection (a) shall ensure that the network based plan meets the following requirements:

(1) The network based plan includes essential community providers in accordance with PPACA.

(2) The network based plan is sufficient in number and types of providers (other than mental health and substance abuse treatment providers) to assure covered individuals' access to all health care services without unreasonable delay.

(3) The network based plan is consistent with the network adequacy requirements that:

(i) apply to qualified health plan issuers under 45 C.F.R. § 156.230(a) and 45 C.F.R. § 156.230(b); and

(ii) are consistent with subdivisions (1) and (2).

Section 8. Disclosure Requirements

(a) An insurer that issues a short term insurance plan shall disclose to an applicant, in bold, 12 point type, the following:

(1) That the short term insurance plan is not required to include coverage for all ten (10) of the essential health benefits required under the PPACA and specify the essential health benefits where no coverage is offered.

(2) That the short term insurance plan does not necessarily provide the full coverage that is required under PPACA.

(3) That the full coverage required by the PPACA may be secured during the next PPACA annual open enrollment, which typically commences on November 1 and can be found at https://www.healthcare.gov/quick-guide/dates-and-deadlines/

(b) An insurer shall obtain the signature of an applicant to whom the disclosures required by subsection (a) are made.

Section 9. Tiering/Rating

An insurer shall not, as a condition of enrollment or continued enrollment in a short term insurance plan, require an individual to pay a premium or contribution greater than the premium or contribution for a similarly situated individual enrolled in the short term insurance plan on the basis of a health status related factor in relation to the individual or a dependent of the individual.

Section 10. Discounts/Rebates/Out-of-Pocket Payment Modifications

This Act does not prevent an insurer from establishing a premium discount, a rebate, or out-of-pocket payment modifications in return for adherence to programs of health promotion and disease prevention.

Section 11. Rescission

An insurer that issues a short term insurance plan shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan involved, except for an act or practice that constitutes fraud or intentional misrepresentation of material

fact consistent with the requirements in Public Health Service Act § 2712 (42 U.S.C. § 300gg-12) and 45 C.F.R. § 147.128 or their successors.

Section 12. Rules

The Insurance Commissioner may adopt rules regulating short term limited duration plans that are consistent with this Act.

Section 13. Effective Date

This Act shall take effect [_____].

NCOIL – NAIC DIALOGUE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
NCOIL – NAIC DIALOGUE COMMITTEE
2024 NCOIL ANNUAL MEETING – SAN ANTONIO, TEXAS
NOVEMBER 23, 2024
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) NCOIL–NAIC Dialogue Committee met at The Westin Riverwalk Hotel in San Antonio, Texas on Saturday, Nov. 23, 2024 at 11:00 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:

Sen. Justin Boyd (AR)
Rep. Deborah Ferguson, DDS (AR)
Rep. Stephen Meskers (CT)
Rep. Matthew Gambill (GA)
Rep. Brian Lohse (IA)
Rep. Rod Furniss (ID)
Rep. Matt Lehman (IN)
Rep. Cherlynn Stevenson (KY)
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 (ND)
Asw. Pam Hunter (NY)
Rep. Brian Lampton (OH)
Rep. Ellyn Hefner (OK)
Rep. Dennis Paul (TX)

Other legislators present were:

Sen. Josh Carnley (AL)
Sen. Clint Penzo (AR)
Rep. Toby Overdorf (FL)
Sen. Larry Walker (GA)
Rep. Mark Hashem (HI)
Rep. Peggy Mayfield (IN)
Rep. Michael Meredith (KY)
Rep. Rachel Roberts (KY)
Rep. Cherlynn Stevenson (KY)
Sen. Mark Huizenga (MI)
Sen. Roger Hauck (MI)
Rep. Mike McFall (MI)
Del. Mike Rogers (MD)
Sen. Dennis DeBar (MS)
Sen. Hillman Frazier (MS)
Sen. Joseph Thomas (MS)
Rep. Greg Oblander (MT)
Sen. Bill Gannon (NH)
Asm. Jarett Gandolfo (NY)
Sen. Pam Helming (NY)
Sen. George Lang (OH)
Rep. Forrest Benett (OK)
Rep. Mark Tedford (OK)
Rep. Joe Solomon (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), NCOIL Immediate Past President, and seconded by Rep. Stephen Meskers (CT), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Brenda Carter (MI) and seconded by Rep. Brian Lampton (OH), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 19, 2024 meeting.

INTRODUCTORY REMARKS

Rep. Oliverson stated that before we get started, I just want to say how much I've truly enjoyed working with the NAIC Officers and NAIC staff this year in my role as NCOIL President. And in particular, I just want to thank my counterpart, NAIC President and Connecticut Commissioner Andy Mais. Working with him has just been truly a blessing and it's been fun to dialogue and share ideas back and forth. We are incredibly proud here at NCOIL of the strengthening relationship between the NAIC and NCOIL. That has happened really over the whole time that I've been here, I think going back to 2017, and we hope that continues. We do really value the partnership between our regulators and the lawmakers and making sure that we're working together to preserve the state base system of insurance regulation. Before we get started, I'm going to ask the Commissioners to introduce themselves: Oklahoma Insurance Commissioner Glen Mulready; Kansas Commissioner Vicki Schmidt; and Connecticut Commissioner and NAIC President, Andrew Mais. Rep. Oliverson also noted that Washington Senator Patty Kuderer is also here and she is now Washington Commissioner-elect.

RECAP OF NAIC'S 2024 FALL NATIONAL MEETING

Rep. Oliverson stated that the first item on our agenda is a recap of the recent NAIC Fall National Meeting in Denver, CO.

Cmsr. Mais stated that I want to echo the comments Rep. Oliverson made in terms of the relationship between our organizations. The working relationship between between our organizations has been wonderful and we look forward to it continuing. We look forward to the bonds between us being strengthened as we move along. I just want to thank you and all the members of NCOIL. This is the right way to do it and we're happy to be here. As you mentioned, we were in Denver for the actual Aurora for our Fall national meeting. At that meeting, we had 2,300 registrants and about 1,700 of those were in person. We had 24 legislators from 17 states participating in the annual state legislator program that we host. That was our 16th annual program. We've been doing this every year and we intend to keep doing it. As some of you may have been at previous events know, we sometimes had to shift tit because we do need to respect

when you're in session so we try to make it as convenient as possible. And as Cmsr. Tom Considine knows, NCOIL CEO, we work with you on meeting scheduling too so things work as well for both of us as possible. And we look forward to continuing to do that. The program. for those who haven't attended, is an opportunity for legislators involved in insurance issues to connect with each other to learn more about the NAIC's role in supporting state-based regulation because remember, the NAIC is a member organization despite what some may think. The NAIC is not a regulator. The NAIC answers to us, the members, the 56 chief insurance regulators of the 50 states, the District of Columbia, and the five territories. So we try to make sure that we explain to everyone what the role of the NAIC is, cooperating, coordinating, educating, and in addition to that, what we are doing as state insurance regulators. And at this meeting, we discussed some of the 2024 strategic priorities and that includes issues with regards to property insurance markets and catastrophe resilience and I understand that you are going to be considering a Model Act on that issue shortly which I would certainly welcome.

Health and long term care insurance continue to be concerns as does insurer financial oversight and transparency and we're going to go into more detail on that. But insurer financial oversight and transparency we've all heard about, and we all know that over the past several years of an extended low interest rate period, there has been a need to get capital into the market. There have been various ways to get capital in the market and especially in offshore and asset based asset intensive reinsurance. As regulators, we feel it is our responsibility to understand what's going on in these markets to provide transparency because that's how we can provide protection for consumers. And then and the other big issue of the day that we've been focused on is artificial intelligence and cyber. We have a letter committee that we created a couple of years ago devoted to innovation and technology because we see this as a tool to increase the availability and affordability of insurance to reduce friction. But we also know that there are concerns like any tool that can be misused or improperly used and we want to make sure that consumers are protected. And I know some legislators here have participated in some breakout sessions that were tailored to certain issues like the regulation of pharmacy benefit managers (PBMs) and heard from various Commissioners who are leading the work at the NAIC on that. Cmsr. Mulready, for instance, is a leader on the PBM issue.

I would encourage legislators who are interested in attending an NAIC meeting to take part in the state legislative program. Reach out to your Insurance Commissioner or NAIC staff and we can get you information on the program for next year. We would love to see you there. The American Indian and Alaska Native Liaison Committee held a joint panel presentation with the diversity, equity and inclusion leadership forum, and it was called Mind the Gap: Building tribal relationships, exploring and expanding medical access through education, insurance and understanding. And that was focused on issues of medical access affecting American Indian and Alaska Native communities and outreach and education strategies. And I sat through most of that and I found it fascinating what we're doing trying to make sure that all communities have the services they deserve. My state of Connecticut has two federally recognized Indian tribes. So, this is part of what we do at the NAIC and I think it's one of the most important parts of what we do as regulators. We learn from each other. We share with each other. The

reason that we think it is important to support state insurance regulation is that we at the state level are the most familiar with the issues facing our states. We have the knowledge, willingness, and ability to protect consumers and part of the way that we do that is to make sure we are aware of issues that may not necessarily affect our particular state.

I'm going through this to let you know there are broad discussions that we have at our meetings because we feel we have to inform each other. You don't want to wait until something happens to you and then wonder what everybody else is doing. We had other educational sessions, the Center for Insurance Policy and Research (CIPR), essentially the NAIC think tank for those not familiar with it, held an educational session looking at short and long term risk associated with commercial real estate investments. We've all heard the concerns that post-COVID, some commercial properties are not necessarily fully occupied or as occupied as projected and what's going to happen? So we have to address those challenges. We have to prepare for them. And the CIPR did a presentation on that. We had a number of other issues that we discussed- the producer licensing task force adopted adjustments to the Public Adjuster Licensing Model Act and that would implement a 10% fee cap for catastrophic claims and 15% for non-catastrophic claims and this is in line with the NCOIL Model that was adopted earlier this year on that issue, so we thank you for that. We're amending our Model so we can strengthen the regulatory standards especially because people who are dealing with public adjusters, it's usually in the aftermath of something horrible that has happened. People are vulnerable. We want to make sure they are protected. We want to make sure that assignment of benefits, for instance, was done appropriately, not inappropriately and that there were no excessive fees charged.

Also, this was my last national meeting as President of the NAIC. It's been a wonderful experience and part of that has been working with my fellow Commissioners. It's 56 states, we've got different geographies, demographics, and politics, but we work together because we've got that common interest and you don't see that too often and I'm glad that we've been able to do that. And similarly working here with you at NCOIL has been great. And that was one of the things that attracted me to the NAIC way back when I was a state regulator. That was one of the things that made me proud and I hope that will continue and I know that we've got new leadership next year with Utah Commissioner Jon Pike elected as NAIC Secretary-Treasurer. We've got Rhode Island Director Beth Dwyer as NAIC Vice President, Virginia Commissioner Scott White will be President-elect, and North Dakota Commissioner Jon Godfread will be NAIC President. And we talked earlier this morning about how Cmsr. Godfread will be here at NCOIL meetings as we'll do everything we can to get him here because he as committed to state insurance regulation as anyone and I know he's committed to working with you. So I'm looking forward to next year. I'm looking forward to being able to be a little bit more of a bystander. But I will also tell you I will be as involved as I can in working with you as we move forward on this great enterprise of protecting consumers.

Rep. Oliverson stated that I did want to highlight what you just said about the NAIC's legislator program. For folks that may be wondering about that, the NAIC does offer a course for lawmakers to attend their annual meeting. You can talk to your insurance

department in your state. I've done it, and many of the lawmakers here that have been here for a while have as well. It really is tremendously informative and helpful and you get a chance to not only understand the policy issues, but also sort of the structure of the NAIC and how they do the work that they do. And so I think it's tremendously valuable and I hope that everybody heard that loud and clear and that you'll contemplate it. I also want to note before we go further that we had three additional Insurance Commissioners at this meeting earlier but they had to leave: Mississippi Cmsr. Mike Chaney, North Carolina Cmsr. Mike Causey, and Texas Cmsr., Cassie Brown. We tremendously appreciate the NAIC's continuing involvement in what we do.

NAIC'S SECURITIES VALUATION OFFICE (SVO) ACTIVITIES

The next item on our agenda is a conversation and update on the activities surrounding the NAIC's SVO. I would like to say thank you to the NAIC by accommodating my request of having NCOIL leadership visit the SVO offices to look and listen and hear from their experts. To recap, there was a delegation of NCOIL leadership that went to the SVO offices in New York City and we got to see it first hand and talk to the folks that run that office and hear what their vision is and what they are trying to achieve. And I think I can speak for the lawmakers that went that we all left with a much better understanding of what the mission was. And also with the changes to the latest SVO proposal and what we were trying to achieve, we discussed that and I think that is another great example of how we can work together. And sometimes the best way to sort of close the knowledge gap is to just get everybody together to see it first hand and so I really am truly grateful to you all for giving us that opportunity to sit down with your staff and with you there and actually discuss this and see it firsthand.

Cmsr. Mais thanked Rep. Oliverson and stated that you, Sen. Paul Utke (MN), NCOIL Treasurer, Rep. Edmond Jordan (LA), NCOIL Secretary, Sen. Lana Theis (MI), Chair of the NCOIL Workers' Compensation Insurance Committee, and Asm. Jarett Gandolfo (NY), Vice Chair of the NCOIL Joint State-Federal Relations & International Insurance Issues Committee joined us in New York for that discussion. And it shows what can happen when we work together and we listen to each other. It makes the end product stronger. The idea behind this was as a universe of securities, whether private or public expands, we need to ensure that the rating agencies that are working here, we can rely on those ratings so that we know that those ratings are proper. It's been triggered in many ways by significant divergences and ratings. But the SVO is not a rating agency and it was never designed to do that. I think the best way that I heard this described was we want to move from blind reliance on rating agencies to informed reliance on rating agencies. That really is what this was all about. And the proposal we discussed gave the SVO oversight over some of the rating providers just so that we would understand the quality of the work. It was at the beginning controversial and we appreciate those who came to us with concerns and we adjusted that proposal and moved along as we listened. It took a lot of work and there were three or four different exposures and we changed a number of issues. One change focuses on it seemed as if the SVO was going to be doing the regulatory work but that will not happen. So we put in stronger language around regulatory oversight. We, the regulators, will have ultimate authority. We are not leaving this in the hands of the SVO. It comes back to us. We are

the ones that were either elected or appointed to do the job and we will be the ones to do the job.

That's why we strengthened that language about the expected involvement and we put it that way of regulators in the process so that there can be no misunderstanding. This is not the SVO talking. This is us as regulators. There were issues about the dialogue between the insurers and the SVO. We clarified that so there would be an understanding that it would be open communication. We also understood from insurers and from legislators that there was a concern that, I'm not going to call it interference, but that the intervention by the SVO would become the norm. We wanted to make sure it was clarified that it would be infrequent and we certainly expect it to be infrequent. We do not expect that to be the norm. And then we did say that the insurer may involve any authorized party in the discussion that includes a credit rating agency and any other party that the insurer may choose. And again we're all stakeholders in this. We want to work together to make sure we get the best possible product. So based on what we've done, I think we've got a better understanding of the regulation. We've got a clearer understanding of the SVO's role and we understand regulator oversight is essential. So that's what we're looking at now. One point that was brought up and I think it may have been at one of our meetings, we want to make sure that it is absolutely clear that the staff must have no conflicts of interest and no financial involvement, no financial incentives in part of what we've been looking at.

The other issue that I wanted to touch on is the framework for regulation of insurer investments and there's a framework that we're creating which modernizes the SVO's capabilities to correspond with the ever increasing complexity of insurance products. It's has to be coordination across NAIC groups when it comes to solvency and development of that due diligence program. And we've developed the first draft of the RFP for that and that was exposed at the national meeting this past summer and we sought a lot of feedback like, are the objectives clear? Are the requirements clear? And the selection process for the people that we will use, is that clear? The committee is still reviewing the comments received but we've made clear that the development of this will be a transparent process that we all are part of and we look forward to continuing discussions on that and the work will continue into next year and we hope that we will finalize the program at that point.

Rep. Oliverson stated that I just want to point out to everybody in the room that as we worked through this issue this year, there were many stakeholders that came to us as lawmakers and expressed concerns. And I believe that the NAIC has done a remarkably good job of recognizing and attempting to incorporate literally every suggestion that we brought forward. This was not sort of a take it or leave it kind of thing, it was a very collaborative effort. And I know from my perspective, I feel like all of the concerns that I brought to you were addressed and I just want to say how much I appreciate that. And in fact, earlier this morning, it was expressed to me by some of the stakeholders involved in this that at this point everybody is at a conciliatory place and feels as though it's a good point to move on.

Sen. Theis stated that I too very much value the relationship that we have which has gotten stronger and that's due in part to the dialogue that we have. I want to thank you for the invitation to New York to go over the SVO information and thank you for your kindness in hosting us. I was extraordinarily grateful for the opportunity to have the back and forth discussion. I still have a few concerns but I am grateful for the movement that you've made. My concerns are twofold. The first one still has to do with due process. If one of the credit rating agencies is determined to be far off from what it is that you're anticipating, I believe they should have a right to be at that table at the behest of the insurer and the request of them. I believe the credit rating agency has a right to defend their position. And then my secondary question is, what is it that would prohibit the SVO from using different criteria in their rating than what federal rating oversight allows?

Cmsr. Mulready stated that before I answer that, sitting here it dawned on me that what we've worked through in this process is really a lot like what all of you deal with in terms of your own legislation and you are challenged on it. You either make changes or you tweak it, or it solidifies the reasoning why you have certain things in there. And that is what we have sort of watched transpire is similar to building up a good piece of legislation that you all do every day. As far as the credit rating providers being at the table, I think our issue is that we regulate the insurance companies and we hold them accountable. That is our direct contact and I would liken it to if we had issues with their financials or other things outside of a credit rating provider, we would not be the ones to invite their auditor or their accountant to the table. That would be the insurance companies' role if they wanted to defend or explain what has happened in that audit. And certainly, we see that the same way. There's nothing that prevents them from being at the table but it would not be our role to invite that person to the table – our role is to hold the insurance company accountable. We absolutely welcome them to invite the credit rating provider to the table, but certainly we don't have a direct connection with them. Cmsr. Mulready asked Sen. Theis to repeat her second question. Sen. Theis asked what prohibits you from using criteria that that are fundamentally different from what the federal criteria are for the rating process? Cmsr. Mulready stated that I don't know that there's really anything that prevents us from doing that if we wanted to utilize that. It will be an open and transparent process though and in fact we're in the midst of an RFP with organizations to help craft the framework for that and then that information would be public information on what we're utilizing.

Cmsr. Mais stated to add to that, there has been no discussion and there is no intention and while there are no absolutes as we're not sure what's going to happen 10 years from now, we have no plans to introduce environmental, social, and governance (ESG) criteria at this point.

Sen. Theis thanked Cmsr. Mais but stated that for the legislators here, please understand that the organizations that have done investing have done fundamental transformation and what they perceive as good investing in ESG was part of BlackRock and Vanguard. They were investing based on that. They've moved away from it because of the negative implication of what was actually happening financially as well as within the public. You're probably all well aware but that's just one example of a concern that I have where an agenda driven policy could end up becoming a part of an

evaluation that may not be necessarily required. And this is me personally speaking. I again appreciate very much what you're trying to do and appreciate the efforts that you've made. I just want to note my concern.

Rep. Stephen Meskers (CT) stated first I'd like to thank the NAIC for their willingness to listen to the legislators and to NCOIL. I was invited to the meeting in New York but unfortunately for personal reasons, I wasn't able to attend. I did attend the briefing in Denver. For those of you who don't know my background, from 1983 on I was in international banking. Linchpin to the investment decisions about the mutual funds in the insurance industry were the rating agencies. If you step forward into the crisis of 1998 and the crisis of 2008, the anticipatory pressures on the rating agencies on their investment criteria are pretty overwhelmingly difficult for them to manage I think when we look at the mortgage markets and commercial real estate. I think fundamentally reaching an agreement on working with the SVO and the valuation process is a lynchpin to protecting or defending the stability and liquidity capital ratios of our insurance industry in each of our states. So I recommend that as we look forward on legislation that we make sure that we have an ally in that office and I'm glad that we're not delegating the authority but we're creating a strong unit in terms of that overview. So I just want to lend my advice be that.

Rep. Oliverson stated that we're going to move on to the next topic here which is a related one. One of the issues that we discussed during our visit to the SVO was with regards to the NAIC's framework for regulation of insurer investments and within that framework, the RFP for credit rating provider due diligence. The NAIC's stated goal here is the establishment of a robust and effective governance structure for the due diligence of CRPs. Would you provide us with some background as to why the NAIC believes that the due diligence is necessary? And also how the proposal interacts with the Federal Credit Rating Agency Reform Act? Cmsr. Mulready stated that I can't speak to the genesis of that other than to say we're at the very beginning stages of issuing that RFP. Rep. Oliverson stated that we can visit later on that. Cmsr. Mais stated that the RFP is one thing that I mentioned earlier that we're working on. We got the last request for comments I think in October and we're still discussing that and we will be working on that next year so that's not been finalized at this point. Rep. Oliverson stated that we'll continue to dialogue on that.

UPDATE ON NAIC'S PROPERTY & CASUALTY INSURANCE MARKET INTELLIGENCE DATA CALL

Rep. Oliverson stated that the next item on our agenda is an update on the NAIC's Property Casualty Market Intelligence Data Call. We talked about this earlier this morning but for the legislators here, we're all being pushed really hard to "do something". And I think many of us are hearing that and there's a million things you could do and 999,999 of them are really bad ideas. But we have to be able to articulate and push back and explain why. And at the beginning of this year when we first learned about this, it was exciting to know that you were doing this and now we're curious where you are on it and would like to know if you could provide an update and any thoughts that

you have as far as when we as lawmakers might be able to access that information in order to do the right thing in our states and not totally blow up our insurance markets.

Cmsr. Schmidt stated that I think that's a great way to look at it and it's definitely a data-driven society we live in and this data call is part of that. On March 8th, we did issue a comprehensive multi state data call and we wanted to gather granular information on the homeowners insurance market. And insurers subject to the data call were given 90 days to get their information back to us so the deadline for submission was June 6th. The data call, we want to help insurance regulators protect consumers. We want to hold our insurers accountable and we also want to ensure that we have a fair, competitive and healthy insurance market in each one of our States and our jurisdictions. The data call represents a collaborative non-partisan work that the state insurance regulators have undertaken through the NAIC process to address the critical challenges of both the availability and the affordability of property insurance. We want to look at the financial health of our companies. We want to make sure that when a homeowner has a claim that the insurance company has the ability to pay that claim. We know that as you have clearly stated, all of our states are facing an increasing severity of natural disasters. We have escalating reinsurance costs. We have continued inflationary pressures on goods. And we need more visibility into that property insurance cost and the coverage challenges that our states are facing across the nation.

The data call will provide deeper insights into the market concentrations and competitiveness and I'm sitting right next to Cmsr. Mais who's theme this year as NAIC President was “Mind the Gap.” And so we want to identify those potential coverage gaps in each one of our states and territories and then also determine where mitigation efforts and resilience efforts might come into play. The data call was gathered at ZIP code level data and we gathered information on premiums, policies, claims, losses, limits, deductibles, non-renewals and coverage types from the property and casualty insurers that represented more than 80% of the national property market by written premium. And as you might imagine, there's a lot of subsets of each one of those in the data. I think there's over 700 lines of data that were requested. Many states already do collect zip code level data on the property markets but not everybody gathers such granular information. And that translates directly into the affordability and availability of the policies. The NAIC hopes that we're going to help everyone, state legislators and us as state regulators, address that gap. Since June 6th, NAIC staff have been reviewing the data and they've been conducting quality checks and reaching out to insurers as questions have arisen. And there have been some insurers that maybe didn't understand something correctly and had to resubmit data so it's been a back and forth process and that staff has been extremely busy since June 6th.
NAIC membership has agreed to share an anonymized subset of data collected by the NAIC with the Federal Insurance Office (FIO). We would like to ensure that we don’t have undue duplication and that FIO won't go asking the same questions as that's a real compliance burden on the industry if we're asking questions and FIO is asking questions. So we are hoping that with the data that we have agreed to share that we can all be happy. Individual states haven't made any decisions about the future scope of this project or the execution of the data call for subsequent years but I think it's important for you to know that the memorandum of understanding (MOU) that the state signed with

NAIC does allow for subsequent calls. And I think the expectation is that it will be an annual effort. If we can develop this data over a period of time and look at trends and troubled spots and make progress on closing that protection gap I think this would be a highly successful while painful process.

Rep. Oliverson stated that there was obviously some interplay with FIO on this and I know we all get frustrated a little bit when they step in our space but I feel very strongly and have always felt that what you're doing is so important. I'm almost not even interested in what FIO's angle is on this because I just want to be able to have the data myself so that in my home state I can not only speak to what's going on in my state, but I can also say to people "Yes, I understand that rates are high and I understand there's some issues but look over here at this state and what's going on." So how do we as a state in the way that we have managed our insurance market, how are we doing compared to other jurisdictions? Because I think sometimes what we as lawmakers hear and you probably do too as Commissioners is that, folks back home think that it's just them and they don't realize that it's literally a nationwide issue and that in some places, they are lucky that it's not as bad there as it is over there and so I really think that this is something that we can all benefit from.

Cmsr. Mais stated that Sen. Larry Walker (GA) just asked him if the data is available yet. No, it is not. I will tell you where we are and I will tell you why. This is the largest data call we've ever done and for a number of companies, this was different data and it's not a normal data call. They're looking at different fields and all that stuff. So we knew that we had to make sure that it was correct and that involved going through various iterations. And part of what we did is we've got the data coming into the NAIC through our MOU but it also was fed back to the individual states at the beginning of the process to make sure that the data made sense. And I will tell you, I'm not sure about others, but we did get some data in Connecticut that made absolutely no sense and there were mistakes made in programming and so forth that we have to go back and fix. So it's perhaps taken a little longer than we would have expected just purely on the technical side of things. We have seen preliminary results, but those aren't the results that we're going to share yet. We want to make sure that we've got everything right before we share. What we've done internally with the regulators is just give them insight into what this data can tell you and if you see it, you will realize just how powerful a tool this can be. So, the short answer is the data is not available yet but we're going to get it out as soon as we can. Cmsr. Schmidt stated that I think going through this process this time will result in next time being much easier. And so it is a process that we're repeating over and over again as we don't want to put bad information out there for any of you or for us.

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

Rep. Oliverson stated that our next topic is an update on the NAIC's Data Privacy Protection Model Law. And if I'd like to say again, speaking to the very positive relationship that we have between the two organizations, we had asked at our last meeting if it would be possible to have a couple of lawmakers participate in the NAIC's

working group for this Model and you graciously accommodated us. And so I just want to report that Rep. Matt Lehman (IN) and Rep. Greg Scott (PA) are part of that drafting group.

Rep. Lehman stated that it's been great to be part of the working group as this is a very big issue. I think it has tentacles that go off in a million different directions and I do like that you were welcoming to allowing us to be a part of that drafting because I think it is an all hands-on deck situation. How do we get this to where we are making sure that the data that is gathered is used correctly? And then also, how is it protected? Those are key things I think we're being asked by our clients and our constituents - in this whole world of big data, how am I protected? I like the approach the NAIC is taking. It's been very deliberate and I do think we're on the right track. And I appreciate the work you've allowed us to be a part of.

Cmsr. Mulready stated that the Privacy Protection Working Group was appointed in 2019 and dedicated two years of research to talking about the collection, use and disclosure of information that's gathered in connection with insurance transactions. There's two active NAIC models that primarily play into this: The Insurance Information and Privacy Protection Model Act, Model 670 approved in 1980, and the Privacy of Consumer Financial and Health Information Regulation, Model 672. That was approved in 2000. And that was tied to the Gramm Leach Bliley Act. And while they've provided a good framework, we were moving forward due to business developments, technology developments and that sort of thing to sort of modernize and amend those Models. A lot of work was done. At the 2022 NAIC Summer National Meeting, the request was approved to draft that new Model 674 and that was worked on for a long time. Ultimately, no consensus was reached and the Innovation, Cybersecurity and Technology Committee (H) made a request to extend that work to December 31, 2024. And leadership regrouped and reconsidered what to do on that, whether to continue revising or to start new. And on June 12th, after reviewing public comments from state regulators and interested parties, the working group held an open call and basically voted to pause work on the Model and instead modernize and enhance existing Model 672. That was after lots of feedback from stakeholders. Model 672 generally provides protections for non-public, financial and personal health information about consumers that insurance companies, agents and others hold or are engaged in. The Chair draft was exposed on August 5th of this year for a 30 day public comment. This was only on Section 5 of that draft which is on third party service provider arrangements. The drafting group was formed and held open meetings to discuss Section 5 of that model on Sep. 30 and Oct. 31.

And it was that drafting group that Rep. Lehman and Rep. Scott are members of and we are very much appreciative and thankful for that input as we come up with a better product when we all work together. We held a regulator meeting on Nov. 4 to discuss next steps for the working group and the group has requested public comments on other sections of the model. Feedback on that is due by Nov. 25. On Nov. 11, the group released a revised version of Section 5 of that draft, giving consideration to those stakeholder comments. And then just in our fall meeting in Denver, the group met and a request was asked and granted to extend the continued drafting on that model and they

discussed next steps for that process. And again, I just want to reiterate that it's an open process. We certainly welcome input from all stakeholders, including everybody at this table or other legislators as your perspectives are extremely valuable. You are the ones hearing genuine concerns from individuals and constituents in your district so we need to hear that. The next call we have to review comments is scheduled for Dec. 19.

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

Rep. Oliverson stated that the last item I have on our agenda is an update on the work of the NAIC's Long Term Care Actuarial Working Group. We talked about this at our last meeting, but I understand there been some developments and for those that were not here in July, the NAIC's working group is working to develop a single long term care insurance multi state review approach which I can only imagine is not an easy task. But we were just hoping to get an update and see where you are on that and how it's going.

Cmsr. Mulready stated that to create a consistent regulatory environment in long term care has been a real problem. In 2019 we formed the Long Term Care Insurance Task Force to improve the rate review and approval processes and evaluate options for folks to reduce benefits and help them keep their coverage. In 2022, we adopted the Long Term Care Multi State Actuarial Review Framework. It is voluntary participation. I think the bottom line on this is that many states just don't have the resources to hire the specific and granular actuarial expertise that's needed to really review some of these things. And so it was sort of a pooling of resources for that. So they file with that multi state team which is made-up of insurance department actuaries, they review that and then come back with a recommendation on those rate increases for regulators. It promotes a lot of good interaction between our states. This year, the working group was charged with developing a single process. We were using Minnesota and Texas models in this so they were charged to replace that to have a single process as it was a little confusing with two different models that were being utilized. So, from that, we heard feedback from fellow state regulators, from industry, and some legislators and they largely agreed that a more transparent and explainable single methodology would be more helpful to get more buy in and adherence with different states. So we sought feedback on that. The key questions they were asked to consider were whether adjustments to the Minnesota cost sharing formula would result generally in lower future rate increases for older age policyholders than under the dual approach and whether such an adjusted Minnesota approach would align with key principles. Last month, after months of discussion and public input the working group adopted the Minnesota approach with the current cost sharing formula to be used as a single long term care multi state rate review process. There will be a call on Dec. 13. on that and the ultimate intent here is that potentially the group would disband at the end of this year.

ANY OTHER BUSINESS

Rep. Lehman stated that there's a growing issue I want to just chat about. Indiana and a lot of Midwest states have been hit really hard with hail and the response from industry has been we we're losing money we got to take rate and the Departments to their credit

have managed it very well. I'm in this business and we've seen increases of 20% or 30% in premium. There's also the shift of transfer of risk back to the insured. And we just had one of our carriers announce that they're going to a $5,000 minimum deductible and actual cash value (ACV) on all roofs regardless of the age. And so, if you play that out, if I have a 10 year old roof if it's going to be depreciated say 20% or 25% at ACV and I have a $5,000 deductible, if I lose that roof, I'm going to pay half that claim. We have other companies that are going to have a percentage deductible, some even as high as talking about 5%, so if I have an $800,000 house I'd have a $40,000 deductible on my wind and hail. When we talk about affordability of insurance, I may be able to afford the premium, but I can't afford to pay the claim. Is that a concern at all of the NAIC that we're creating a situation where we are transferring risk back? And there's no buy out, you can't buy down a lower deductible or buy it back at replacement cost. That's just what it is. And I know maybe it's just a season and carrier's may soon back off of it but during this season, I think we're creating for the consumer some difficult situations. Has that hit your radar?

Cmsr. Mulready stated absolutely, it's on our radar and our response to that is twofold. Number one is that we are focused on resilience and mitigation when it comes to specifically homeowners insurance. I can't impact the weather in Oklahoma but we can help with resilience and mitigation. And so I know that tomorrow the NCOIL Property & Casualty Insurance Committee will consider the Strengthen Homes Model Act which is similar to what we passed in Oklahoma this year. Things like that will issue grants that allow folks to afford to fortify their homes. So, resilience and mitigation is a focus, but I think the second thing is maintaining a competitive market with lots of choices. I hear what you're saying in that ultimately, that person has been carved out of roof coverage. But that's not the norm. That's not happening with all of our carriers so I think with establishing a competitive free market and allowing them to price properly their product and to rate it properly for the risk, that helps to have a competitive free market and a vibrant environment there and gives choices to folks. That's the goal is to have other choices because not everybody's going that same direction.

Rep. Lehman stated that maybe the follow up to that is several states have done passed laws similar to your Oklahoma law but Indiana has not. So my question would be, have the carriers in your state responded to that positively? Have they said we're willing to back off some of our aggressive wind hail stuff if people do take advantage of the grant program? Cmsr. Mulready replied yes and stated that they haven't come to me and said we're going to drop our rates a substantial amount. However, the vast majority of carriers in Oklahoma offer a substantial discount for a truly fortified home. And as far as industry goes, there's excitement and legitimate support for those type of programs.

Cmsr. Schmidt stated that in Kansas, we're introducing legislation this year around catastrophe savings accounts which I know NCOIL is considering passing a Resolution in support of that concept. The money could be used for catastrophes if it happens but you can also put the money away and then you can draw it down for premiums or for your deductibles. We won't put a limit on that and we're modeling it after some other legislation that we have in Kansas. So stay tuned and we'll see if we can get it done because I think it's going to take a combination of many things to help this issue. Cmsr.

Mulready noted that the NCOIL Joint State-Federal Relations & International Insurance Issues Committee will be considering tomorrow a Resolution in support of catastrophe savings accounts.

Rep. Oliverson stated that before we close things out here I want to note that I would not be here at NCOIL were it not for the fact that my office, as a new lawmaker in the Spring of 2017, received a very kind letter signed by Cmsr. Mulready who at that time was serving in the Oklahoma legislature, inviting me to join this incredible organization that dealt with insurance issues. So Cmsr. Mulready, thank you for that.

Cmsr. Mulready stated that I did want to take a couple of minutes at our last NCOIL-NAIC Dialogue with Cmsr. Considine as NCOIL CEO. He has served for nine years as NCOIL CEO and for those of you who don't know, I was a legislator for a few years in the beginning of Cmsr. Considine's service. I've really appreciated the collaboration and I just want to recognize his service and the relationship that we have enjoyed and that we've enjoyed personally. And we now look forward to working with Will Melofchik who will be succeeding Cmsr. Considine. I also want to recognize just as an update that Washington Insurance Commissioner Mike Kreidler served for 24 years in that role and was previously a state legislator and Congressman and he has retired and Sen. Kuderer is succeeding him. Also, Cmsr. Amy Beard has stepped down from her role as Indiana Insurance Commissioner and Cmsr. Holly Lambert has been appointed to that role and she was previously in the Indiana Department of Insurance as a market conduct attorney. And in Maryland, Cmsr. Kathleen Birrane has stepped down from her role as Maryland Insurance Commissioner and Cmsr. Marie Grant is the new Insurance Commissioner there and she was previously the assistant Secretary of Health in the Department of Health and previous to that had a role with a major health insurance company. And then in Massachusetts, Cmsr. Michael Caljouw was just named Insurance Commissioner there and his background is in government affairs and government relations with Blue Cross Blue Shield of Massachusetts. And then just days ago at our Meeting in Denver, Vermont Commissioner Kevin Gaffney announced his retirement at the end of this year so they will be doing a replacement there.

Cmsr. Considine thanked Cmsr. Mulready and stated that there are two things I'm most proud of here during my tenure as NCOIL CEO: the growth and stability and upward trajectory, financially and membership wise, of the organization; and the way with the support of the membership, we strengthened the relationship with the NAIC. I said when I started this job that the number one reason NCOIL exists is first to preserve state regulation of insurance and it makes no sense for the two organizations to be in conflict. I can't thank everyone enough for their work to improve the relationship and it really, NAIC and NCOIL are comrades in arms for the continuing battle for state regulation of insurance. Thank you for your kind words and thank you for your efforts. Cmsr. Mais stated that I couldn't agree with you more. I remember the old days when NCOIL and NAIC were in conflict and I never could understand why that would be would be. And I agree that people like Cmsr. Mulready from our side have done great work to build this partnership. And for those who weren't there, at our recent Meeting in Denver, Cmsr. Mulready was presented with the NAIC's Raymond G. Farmer Award for Exceptional Leadership and it's well deserved.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Meskers and seconded by Rep. Brenda Carter (MI), the Committee adjourned at 12:15 p.m.

LIFE INSURANCE & FINANCIAL PLANNING COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
LIFE INSURANCE & FINANCIAL PLANNING COMMITTEE
2024 NCOIL ANNUAL MEETING – SAN ANTONIO, TEXAS
NOVEMBER 22, 2024
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Life Insurance & Financial Planning Committee met at The Westin Riverwalk Hotel in San Antonio, Texas on Friday, November 22, 2024 at 3:45 p.m.

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

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Rep. Matthew Gambill (GA)
Rep. Rod Furniss (ID)
Rep. Matt Lehman (IN)
Del. Mike Rogers (MD)
Rep. Brenda Carter (MI)
Sen. Lana Theis (MI)
Sen. Michael Webber (MI)
Sen. Jeff Howe (MN)
Rep. Bob Titus (MO)
Sen. Walter Michel (MS)
Sen. Joseph Thomas (MS)
Sen. Charles Younger (MS)
Sen. Jerry Klein (ND)
Sen. George Lang (OH)
Rep. Forrest Bennett (OK)
Rep. Ellyn Hefner (OK)
Rep. Lacey Hull (TX)
Rep. Jim Dunnigan (UT)
Del. David Green (WV)
Del. Walter Hall (WV)
Sen. Eric Nelson (WV)
Del. Steve Westfall (WV)

Other legislators present were:

Sen. Josh Carnley (AL)
Sen. Clint Penzo (AR)
Rep. Stephen Meskers (CT)
Sen. Larry Walker (GA)
Rep. Mark Hashem (HI)
Rep. Brian Lohse (IA)
Sen. Jason Howell (KY)
Rep. Mike Meredith (KY)
Sen. Roger Hauck (MI)
Sen. Mark Huizenga (MI)
Sen. Dennis DeBar (MS)
Sen. Hillman Frazier (MS)
Sen. Paul Utke (MN)
Rep. Greg Oblander (MT)
Sen. Bill Gannon (NH)
Rep. Joe Solomon (RI)
Sen. Patty Kuderer (WA)

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. Michael Webber (MI) and seconded by Sen. Jerry Klein (ND) the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Sen. George Lang (OH) and seconded by Rep. Lacey Hull (TX), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 19, 2024 meeting.

PRESENTATION ON WELLNESS PROGRAM INNOVATIONS IN THE LONG TERM CARE INSURANCE MARKETPLACE

Michael Gugig, U.S. General Counsel for Assured Allies, thanked the Committee for the opportunity to speak and stated that as we go through the presentation, you'll learn a little bit more about what we do and how we do it. We have been able to develop a proven solution to help seniors age successfully and delay the onset of disability or chronic illness, in the way that it's discussed in long term care parlance, for a period of time to allow policyholders to stay at home independently for longer than they otherwise would have. NCOIL and the National Association of Insurance Commissioners (NAIC) have both passed model laws removing from the definition of rebating the types of wellness programs we're going to discuss today. Only about 30 states have adopted one or the other of those models so I'm here today in part to advocate for passage in other states. We've got two parts of our program. One is called Age Assured and we help in force policyholders of long-term care insurance with a wellness program and the goal again is to allow them to live independently without help for as long as possible. The other half of our business is called NeverStop. At NeverStop we currently work with one insurer. We are trying to create new innovative long term care policies so that market can become more robust. As you may know, back in the early 2000s there were about 150 or 175 long term care insurers. That number is now down to essentially a handful and we're trying to do something about that by generating new products. And finally, you'll hear this theme throughout, wellness programs create a win-win for both policyholders and their insurers and we believe that it should not be considered an illegal rebate.

So why is this important? The need is manifest. Americans are getting older. Seniors are the fastest growing population. Roughly 10,000 baby boomers a day are turning 65 and that's going to last for at least another 20 years. So we have a significant long-term care problem out there. At the end of the day when folks have to go on Medicaid, that implicates your budgets and what we are trying to do is help broaden the market for long term care insurance and keep people out of the need to become impoverished and go on Medicaid. Getting older is hard. There is a nine year gap between what we call life span and health span. Lifespan is what we all know as lifespan. Health span is how long you can live without disability. And there's a nine year gap in those two numbers. Seventy percent of seniors who turn 65 at some point in their lives will need long term care services and 80% of seniors have no way to cover that outlay of money which is

quite expensive. Long term care, aside from a couple of unique situations, is not covered by Medicare. As I mentioned before, Medicaid is the payer of last resort. Aging takes different roads for different people. As you'll see on the chart on the right, there are factors that go into making people become disabled and ready to go on claim on their long-term care insurance policies. Loneliness is certainly one of them. Falls and mobility. Cognitive decline. Hearing loss. By the way, hearing loss, for those of you who are unaware, there is a sharp connection between hearing loss and cognitive impairment and one of the things that we do as part of our wellness program is to encourage policyholders and members of our program to get their hearing aids. My father used to say he didn't want a hearing aid as he didn't want anybody to know that he couldn't hear anything because he has something in his ear. Meanwhile, he was walking around with an oxygen tank. Again, the goal of our wellness program is to help policyholders remain at home, independent for as long as possible.

Assured Allies is changing the way that aging can occur through the use of predictive analytics. How does that happen? We find the right intervention for the right person at the right time. Again, the goal is to help members stay in their homes independently for as long as possible. And by intervention, I don't necessarily mean expensive things. There are inexpensive things that can make people's lives so much easier and so much more independent. Things like, I call it a pickup stick. Things like the extended arm to pick up things off the floor. There are unique gadgets to help people put on their socks and put on their clothing if they have trouble doing that. These are inexpensive interventions but can go a long way. And again, it's tough to see the dotted line there, but our goal in our program is to try and move the dotted line as close to the solid line as we possibly can. And here's where the rubber meets the road. In a two year randomized controlled study we were able to demonstrate, this was with one insurer on their block of business, a 10% reduction in claim costs over the course of two years and an 8% reduction in incidents over the course of that two years. For those of you who are familiar with the problems of long-term care carriers, a 10% reduction, or to be frank, even a 4% or 5% reduction, will cause a massive positive effect on long term care carriers. At the end of the day, the goal would be that if we can reduce claim costs by a significant amount and we believe we can, the hope is that as time goes by, the need for rate increases or the amount of rate increases that are needed will go down by virtue of programs like ours and others that we hope will join the market soon. No other insurtech company has been able to scientifically validate this type of statistically significant claim savings on standalone long-term care insurance policies. Again, this type of performance can shift the claims curve and may reduce the need or the size of future rate increases.

My father gave me the best definition of life insurance when I was a kid that I have ever heard to this day. And I have been representing life insurers now for coming up on 30 years. And that is the insurer is betting you're going to live and you're betting you're going to die. And that's really the equation in life insurance. We are in a situation in connection with the wellness program where it is one of the only times that I can think of that insurers and their insureds have completely aligned interests. That generally doesn't happen in the business of insurance but here it does. Policyholders use our wellness program for longer than they otherwise would have and that is absolutely a win.

There is lots of research out there. Seniors would like very much to remain at home and independent for as long as they possibly can. They generally don't want people coming into their homes to help and they even more forcefully don't want to go into facilities, particularly nursing homes. By the same token, as we're helping insureds, we're helping insurers. We're doing the right thing for policyholders and carriers are providing this service for free. There is no out of pocket expense to the policyholders. All the expenses are borne by the insurance carriers so they're doing the right thing by their policyholders and at the same time, they're reducing their claim costs. This is a definitive win-win for policyholders and for insurers alike. We have some evidence of how our members like the program. Again, the services are free. Thirty percent of those eligible to join our program actually complete on boarding and go through at least part of the wellness program. And we have a net promoter score (NPS) score of 50-plus so far. A score of 50 is considered excellent in the NPS world. And basically, what NPS chooses to measure is whether you would recommend the product or service to your friends and family and it's a resounding yes from our policyholders.

The other side of our business is called NeverStop and what NeverStop does is it pairs long term care insurance and wellness programs and embeds the wellness program into the long term care policy. In this case, it's a hybrid annuity. It's a fixed indexed annuity that has with it a tax qualified long term care rider. So, there's a full panoply of long term care benefits and also a rider that specifically allows for a wellness program. And the reason that's so important is because in order to avoid rebating statutes in those states that basically still consider wellness programs to be a rebate, it wouldn't be a rebate because it's embedded in the policy. The rule for rebating is if something is something of value that you're giving it to a policyholder and it’s outside the four corners of the contract, that is a rebate. And so this takes away the need for any kind of rebating concern. The interesting part about this particular annuity is that policyholders can gain long term care coverage by engaging in healthy actions while they own the annuity and people who are buying these annuities are generally in their 50s and 60s. They're probably 20 or 30 years away from going on claim. The best time to encourage people to engage in healthy actions is when they're younger so they don't find themselves in the bad situation when they're older and they actually need care. The incentive for taking healthy actions drives more policyholders to participate in the program and they can earn up to an additional 15% of their base long term care amount by engaging in these healthy activities. For example, if somebody has $200,000 worth of coverage, if they engage in healthy activities for a period of time, they can get $230,000 worth of coverage and we have found that incentive really does drive participation in the program.

And again, I'll mention NCOIL and NAIC have each passed model laws that would remove wellness programs and other value added services from the definition of an illegal rebate. NCOIL’s model is called the Rebate Reform Model Act. The NAIC recently updated their model Unfair Trade Practices Act to put in similar language to what NCOIL has. We are agnostic as to which path states choose to go, or whether they choose to do it by bulletin out of the regulator's office, but we do believe that the 20 or so states where it's ambiguous as to whether or not a wellness program is permitted, they really should make it explicit so that we don't run around having ambiguities in our way in trying to figure out who's going to allow it and who isn’t.

Rep. Stephen Meskers (CT) asked if this was correct: the legislation that we're looking at is to reform existing contracts to allow for these types of rebates or enhancements for good performance? And you don't need that for new contracts? Or you're looking for clarity on new contracts as well? I'm trying to understand what the ask is. Mr. Gugig stated that we are asking for both. People who have policies now, one of the problems with the anti-rebating laws is that some have terms like sale, procurement, or administration of policies and some people construe the offering of a wellness program as offering something in the administration of the policy that is somehow improper as a rebate. So it's not the policies that we're looking to reform, it's the statutes that actually need to be reformed in order to expressly permit wellness programs and other value added services to be considered a non-rebate.

Rep. Meskers stated that most of the issues I hear relate to long term care products is the rich products that were written up to 20 years ago, and the rise in cost. So, the people in the nexus that I see as being conflicted are basically somewhere between 70 and 80 and they're finding an increasing cost and the inability to sustain it and figure out where they have to compromise on the benefit package or look for reductions. Are you described this as the perfect product for those aged 60 to 70. I'm dealing with the constituent base that's going to be between 70 and 80 with existing contracts. Do we think it would apply to them and what kind of either enhancement to their benefit or reduction in claims would it lead to? Mr. Gugig stated that hopefully it actually does the opposite. We want very much to be able to offer wellness programs to in force policyholders. The policyholders that get the most bang for the buck from our wellness program are over 80 and they're sort of in a time where they're deteriorating and the goal is to try to stop them from deteriorating as much as we can. So it is definitely in force business that we want to be able to offer wellness programs to without violating the law, obviously.

Rep. Meskers stated that between the insurer and the insured, the estimate is that the full amount of claims that they're going to make if we can extend the time that they're living independently is lower. So there's a mutual benefit in the program because you're not paying 100% for long term care in a nursing home for 5 or 10 years and the time in the nursing home is more restricted because they've extended their independent lifestyle. Mr. Gugig stated that is exactly right.

Del. Mike Rogers (MD) asked how do you monitor the person to make sure they're meeting the criteria to get the bonus or extra benefit? And do you see anything on the horizon that we might have to look at to say this is what we consider the proper rate to monitor somebody before that gets kind of sideways? Mr. Gugig stated that I haven't seen that part second part but how we monitor is actually exclusively with the human touch. We have people who we call allies who get on the phone or get on Zoom calls with our members and go through what they have done or what they haven't done. Part of it is trust. If they tell us they've walked 20 minutes a day, three times a week, we believe them and we give them credit for that. I don't think there would be benefit in legislating sort of what goes in on the ground level of a wellness program. I just think there are so many disparate kinds of ways to approach it. We've chosen one way and

we think it's successful but there will be other ways as well. And so sort of legislating what a wellness program would look like as much as I would love to say make mine the law, I don't think that's a good policy solution.

PRESENTATION ON LEXISNEXIS RISK SOLUTIONS' 2024 LIFE INSURANCE MORTALITY RISK MANAGEMENT STUDY

Patrick Sugent, VP of Data Science at LexisNexis Risk Solutions, thanked the Committee for the opportunity to speak and stated that I am going to talk about a white paper we recently released that shows how you can combine medical data and non-medical data to help prove the life insurance underwriting process so it benefits consumers by making the process faster, easier and more accurate. Before I get into the study, though, I wanted to give a very brief introduction to myself and my company for those who don't know. LexisNexis Risk Solutions is a data and analytics provider to insurance carriers and among other industries and I personally work in the life insurance part of the of the LexisNexis insurance category. LexisNexis is very committed to strong governance principles when it comes to the proper use of artificial intelligence (AI) as well as putting the consumer first in our products and in our solutions. As a result of that, even though I am a geeky data scientist introvert, I spend a significant period of my time talking to industry, talking to regulators and other interested parties about the advantages of data and analytics in the insurance space. And before I get into the study I talked about, I wanted to give an example of the ways in which data and analytics are benefiting consumers as we sit here today and that is by talking about the process in life insurance called accelerated underwriting. For those that don't know, accelerated underwriting is a process whereby as compared to traditional underwriting, consumers can get their life insurance faster and easier and less invasively than they can with traditional underwriting.

Traditional life insurance underwriting typically takes about 45 to 60 days. It can be very invasive, including being literally painful as you get stuck with a needle to draw blood. And by using data and analytics with accelerated underwriting it's possible for life insurance carriers to offer accelerated underwriting to their customers so they can get these policies in as little as a few minutes without those invasive requirements. The result of which has been that consumers are more likely to engage in buying life insurance where they might not before and that they are less likely to drop out at that long, more invasive process, meaning they're getting the insurance coverage they need because of the availability of these tools. So what I was going to talk about today is how we can combine both medical and non-medical data together to help with that accelerated underwriting process and it'll help consumers get their insurance quickly, more easily, and more accurately than before.

I did want to start off by saying in our study what I mean by medical data are things like vitals. That's things like your blood pressure, clinical lab results, things like your A1C, and cholesterol issues. Also, medical diagnoses which is anything from lung cancer to whatever other impairment a person may have, as well as social factors such as tobacco history and tobacco use. As we can see by the numbers on the left, all of these types of factors can be highly useful in evaluating a person's expected mortality which is

obviously very important in life insurance underwriting. Equally, when I talk about non-medical data, I'm talking about things like a person's motor vehicle record (MVR) driving history, for example, does a person have a driving under the influence (DUI) violation on their driving history? Things like public record attributes such as bankruptcies or felony convictions, I want to be clear that it's convictions, or credit based attributes, things that show an increased chance of life insurance like paying credit card bills on time, or things that show a negative relationship to mortality, such as being in collections. So, much like with the medical data, a variety of these elements are very useful in providing estimates of mortality for life insurance underwriting. In our medical paper that we have released, one of the things we talk about is a wide variety of medical impairments and how combining non-medical data to those medical impairments can help provide a more accurate assessment of a person's overall life mortality risk and helping to make some of the accelerated underwriting I talked about, the ability to get your life insurance policy easily and more quickly, more available than medical data alone. We cover a number of different types of impairments in our paper but today, I'm only going to focus on one and that is asthma.

Asthma is a condition which obviously isn't related to an incredibly high level of mortality but it's just enough that many carriers may not be willing to put a person through an accelerated underwriting program if they have it. It has, for example, a 114% Standardized Mortality Ratio (SMR) which is a traditional life actuarial technique to measure mortality and it's basically saying if a person is 100%, it means a baseline giving your age and gender you're just as likely to die as the average person given your age and gender with everything we know about you. And 114% is slightly above that. Not all carriers do this, they have different policies, but some carriers, for example, might say anything above 100% I wouldn't accelerate because I want to look at it more. And so, with something like asthma what we can see is since it's over 100%, many carriers may not be willing to accelerate people on the basis of that particular impairment. However, what this chart is showing is that if we take up individuals with asthma and we divide them into ten equal groups based on the non- medical data with the far left of the chart being the individuals who have sort of the highest risk non-medical, the far right of the chart being the individuals that have the least risky non-medical data, we actually see that there's a great deal of additional predictive value for mortality perspective by combining these two data assets together. On the far left side is a person that has asthma that also has highly risky non-medical data, that mortality jumps from 114% all the way up to 220%, nearly double. On the right hand side a person that has a very low risk from a non-medical data perspective, the mortality drops from 114% down to 67%, nearly half. And more importantly, if you think about it in terms of what this really means to an individual consumer is that maybe all these individuals wouldn't have been able to go through that accelerated program that I talked about with all the advantages you get it faster, you get it more easily, just by the fact that they have asthma. But what we see by combining the two data assets together is that as many as 60% of these individuals with asthma actually have lower expected mortality than the asthma data, the medical data alone would indicate and they could all qualify for an accelerated program if the cut off was an expectation of having 100% accepted mortality.

So this is a way of combining medical data with non-medical data together to make it so that additional consumers can get a life insurance policy more quickly and more easily than they could under traditional underwriting process. And of course we have much more extensive studies behind this but the basic message about combining medical and non-medical data is the two types of data do capture risk of mortality that is useful to a carrier, that's useful to life insurance underwriting, and that can help ensure consumers get these policies faster and more easily. The interesting thing about the data is they do measure risk differently. So, medical data and non-medical data captures different types of risk and the two data sets together capture an overall mortality risk profile of a person better than either data set alone. So it's important that they work in conjunction with each other rather than just using one or another. The last slides I have here I just wanted to talk about what is the impact to consumers of the utilization of these types of data analytics in the life insurance underwriting space. It's a very common topic in today's environment to talk about what kind of impact do these tools have in helping to reach historically underserved communities. I've already talked about some of the more obvious cases of accelerated underwriting. You can get your life insurance policy quicker, in a few minutes, rather than 45 to 60 days. You can get it less invasively rather than having to have a blood draw. But there's also a lot of benefits to it that are less obvious in that, for example, it's always been a goal of carriers utilizing these types of tools to help reach that middle market they've been having trouble reaching. And so we at LexisNexis Risk Solutions have done an analysis to see what impact are these tools are having on helping reach historically underserved communities in terms of life insurance. And I'll give you the answer now, but then I'll walk through what it is. What we find with these tools is that life insurance carriers who use these types of tools reach historically underserved communities at both greater numbers and greater rates than prior to the use of these types of tools. So these types of tools, by making life insurance more accessible, by making it so that all types of consumers are more willing and able to go through the process of buying life insurance, they provide that access to more consumers and we're seeing an increase in outreach to historically underserved communities as a result of these tools.

This is one analysis we've done showing the effects of that. This analysis is showing, according to a standard called Bayesian Improved Surname Geocoding (BISG), dividing a group of individuals by race and ethnicity, the growth by race and ethnicity of applications, compared to a baseline year 2019, of what carriers that are utilizing these types of tools in 2020, 2021, 2022 and 2023. And what we see is that there are dramatic increases, especially among historically underserved communities, for the use of these types of tools. For example, in 2020 we saw there was a 165% increase in individuals classified as black by BISG compared to 2019 and 135% percent for Hispanic. In 2021, 254% for those classified as black and 255% for those classified as Hispanic. In 2022, 359% to 334%. In 2023, 403% and 379%. So what we're seeing is that these types of tools, by making insurance more accessible, by making them less intimidating to buy, consumers who may not have wanted to go through that traditional underlying process with all the delay and invasiveness it had and not dropping out of the process because it is difficult, it has had an outreach to all types of consumers, and in particular it benefits historically underserved communities, as seen by our analysis of carriers who are utilizing these types of tools. And if you think about this on an individual level, what does

this mean to individuals? What does this mean to real people as they use this? As I talked to agents in the field, they tell stories of individuals who may not have generational wealth, maybe from historically underserved communities, who because of these types of tools, found life insurance more accessible to buy and it wasn't as hard for them to do it. So, they went ahead and bought that life insurance and then when a tragedy did occur that life insurance was there for them, despite the fact that they didn't have that generational wealth. And it allowed their children to build better lives for themselves as the parent would have wanted. And it allowed them to go out and pursue the kind of dreams that the parent might have had for their children despite not being able to pass along generational wealth when a tragedy did occur. And especially if you think about it as compared to the flip side of the coin, there's obviously an immense amount of difficulty when someone like a parent passes away and all the adversity that brings, so being able to access of life insurance, being able to utilize these types of tools to make it more accessible to all types of consumers, has really had an impact on people's lives as they go about trying to make a better for their children and making sure that they're insured against tragedies occurring.

Rep. Anderson asked how long do they look at those non-medical factors and how many times does it take to factor it in? For example, if a 50 year old had a credit problem when they were 25 or 30. Mr. Sugent replied seven years. Rep. Anderson stated or a 30 year old DUI compared to if it had happened two years ago. Mr. Sugent replied it can vary depending on the type of data source. For example, there's some medical conditions that if you have them, even if they are diagnosed early on, they're still part of your current condition. But generally speaking for the non-medical data, you're talking about a look at up to seven years with more recent data being more important to the equation. I also should probably mention since you were throwing out different ages that the look back is age and gender normalized meaning you're being compared to other people of your same age and gender group, not to people that have had for example, more opportunity to build up certain types of characteristics than others.

CONSIDERATION OF PROPOSED AMENDMENTS TO NCOIL LIFE SETTLEMENTS MODEL ACT

Rep. Anderson stated that next on our agenda is consideration of proposed amendments to the NCOIL Life Settlements Model Act (Model). We've been discussing this issue since our spring meeting in Nashville and now it appears that the amendments are ready to be considered. Before we go any further, I'll turn things over to the sponsor of the amendments, Rep. Forrest Bennett (OK).

Rep. Bennett stated that the model that we're looking at is being reauthorized and just needed some technical updates. You can find the amendments in your binders on pages 160, 165, and 170. They started out as two categories. One was modernizing the model and the other focused on whether agents should be prohibited from disclosing the option of a life settlement when a client comes to them thinking about dropping their policy. Both sides agreed to the first category and in the spirit of compromise, I agreed to withdraw the second category. I want to walk through what we do end up having. So on page 160 is an update that includes electronic delivery options and on page 165, with

respect to insurer, they can't deny the legal effect of something solely because it is an electronic signature. And then on one page 170 it just clarifies that nothing can be denied simply because it's in an e-signature format. I really do appreciate that both sides worked well together on these compromises to get something done and as sponsor of the amendments, I really did like the issue regarding an agent being able to disclose the ability to have a life settlement option but I don't want to risk getting nothing done here. So I'm endorsing all of the original proposed updates and I want to encourage my colleagues to think about taking on the other aspect of this when they take this model legislation back to the legislatures but again, I want to move forward today with the amendments in the first category that I described and I encourage my colleagues to support them.

The Hon. Nat Shapo, former Director of the Illinois Department of Insurance and now speaking on behalf of the Life Insurance Settlement Association (LISA), thanked the Committee for the opportunity to speak and thanked Rep. Bennett for his work on this. Briefly, the model is up for reauthorization and LISA members were polled and provided some suggested changes. Those have been published and discussed and Rep. Bennett explained the compromises that were made. And it was a pleasure working with the American Council of Life Insurers (ACLI) and I think that discretion being the better part of valor, we decided to avoid a big fight here and we wanted to make sure that something got done. So we were happy to agree on what we think are appropriate changes.

Jill Rickard, Regional VP of State Relations at ACLI, thanked the Committee for the opportunity to speak and stated that we appreciate the extra time that you allowed us to talk about these proposed changes with LISA and ACLI is in support of the compromise that we've come to and we think it's very reasonable to require acceptance of electronic documents and e-signature.

Hearing no questions or comments, upon a Motion made by Sen. Jerry Klein (ND) and seconded by Sen. Justin Boyd (AR), the Committee voted without objection by way of a voice vote to adopt the amendments. Then, upon a Motion made by Sen. Klein and seconded by Rep. Ellyn Hefner (OK), the Committee voted without objection by way of a voice vote to re-adopt the Model, as amended. Rep. Anderson thanked everyone and stated that the model, as amended, will now be placed on the Executive Committee agenda for final ratification.

UPDATE ON INTERSTATE INSURANCE PRODUCT REGULATION COMMISSION (IIPRC)

Karen Schutter, Executive Director of the IIPRC, thanked the Committee for the opportunity to speak and stated that the IIPRC has been in existence for 20 years. Since then, several of your states have joined this legislation. In fact, South Dakota just joined this year. I'm actually going to give credit to Sen. Klein because North Dakota joined in 2023 and South Dakota followed. So, 46 states, the District of Columbia, and Puerto Rico are part of the state based regulatory legislative partnership. New York, California, and Florida have yet to join, and we hope South Carolina will rejoin soon.

NCOIL, as many of you know, has been a longtime supporter and participant in the Compact and its activities. We have our own legislative committee, which NCOIL appoints four open seats to, as does the National Conference of State Legislatures (NCSL). Rep. Matt Lehman (IN) is the chair of that committee and Rep. Rachel Roberts (KY) and Rep. Bennett were appointed last year to that committee. And our newest appointment was Rep. David LeBeouf (MA). They join Rep. Jim Dunnigan (UT) as well as the Rep. Brian Kennedy (RI), Sen. Laura Fine (IL), and Del. Dean Jeffries (WV).

So we have a great, robust legislative committee that met in Denver with our management committee last week during the NAIC's fall meeting. We had a very good interactive conversation and in fact we also presented to the legislators at that meeting about the Compact. I'm Happy to go into more detail about what this Compact is and many of you are working with Compacts right now in the occupational licensing area. This is one of the more innovative ones in terms of insurance products and approval for life insurance, annuities, long term care and disability income. These are products that you can buy in your state, take to another state and claim on it. And they compete with the banking and securities so it really makes sense to come together and promote uniformity. One of the things the Compact has done over the past few is host Compact round tables. In fact, our first was in conjunction with the NCOIL 2022 Summer Meeting. Many of you around this table have participated in them with regulators as well as companies and consumer representatives. And we formed a committee to really look at those ideas discussed there. And I wanted to just mention that committee it's called our Adjunct Services Committee. This is a Compact that's really promoted a lot of uniformity and it's helped states not only to build robust standards, but to make sure your products are approved under those standards. And now as your states are tightening budgets and dealing with retirement, we're looking at how can the Compact office and the team help states?

And so one of the things they're looking at is building a framework to make actually not only the product approval, but before a product even gets to a department, can we help make that process more efficient? Instead of a company going state by state and giving the same presentation, can we help collaborate that? And NCOIL rightly so said, "Hey, we know you're looking at these adjunct services but we want to make sure that you're keeping in mind the authority that the legislature granted here to the Compact and to the regulators." And there is no plan to go outside the four corners of the Compact in terms of the products that we're talking about or that approval beyond those what we call uniform standards, which are what states adopt. So I'll just leave you with the Compact was really developed in the early 2000s as a response to the optional Federal Charter and for a lot of reasons you don't hear about that as much now but the Compact has made it much easier to go through the state based system for product approval. But we've preserved your filing fee so this year today we've collected and we provided $2.4 million to the States and $36 million over the history of our Compact.

UPDATE ON RESOLUTION IN FAVOR OF ENCOURAGING A REDESIGN AND THE USE OF LIFETIME INCOME INVESTMENT SOLUTIONS IN DEFINED CONTRIBUTION PLANS

Rep. Anderson stated that last on our agenda is an update on the Resolution in Favor of Encouraging a Redesign and the Use of Lifetime Income Investment Solutions in Defined Contribution Plans (Resolution). You can view this resolution in your binders on page 171. We've been discussing this issue throughout the year and it appears that we still have some work to do.

Josh Freely, Regional VP for State Gov't Relations at TIAA, thanked the Committee for the opportunity to speak and stated that we hope to have the Resolution considered by the committee in April. We think that this resolution really addresses a looming issue for our future retirees. As the population ages and 10,000 people a day retire, the U.S. really stands on the precipice of an economic and financial crisis. There is a significant gap between the amount of money that people need in their retirement and the amount they are saving. At this moment, that gap stands at about $4 trillion. If current trends continue, this gap will cost state budgets about $330 billion in additional spending by 2040 and $1.3 trillion in state and federal spending combined. But those numbers don't really tell the whole story. People are increasingly expressing anxiety over the state of retirement savings. In a recent public opinion survey, over 40% of respondents said that they were not saving enough money to meet their retirement needs. Moreover, over half of Americans over the age of 65 live on less than $30,000 a year and 20% of those live on less than $15,000 a year. And the problem is actually particularly acute for public sector workers. In a recent survey of government workers, only 9% of those workers said that their retirement benefits that they are provided through their employer are sufficient to meet their retirement needs.

Gerard Neely, Director of State Gov't Relations at TIAA, thanked the Committee for the opportunity to speak and stated that as my colleague was mentioning, we're really hearing from workers. According to recent survey data, about 70% of participants in this survey would choose to stay or work at a company that offers a guaranteed lifetime income stream in their retirement. And we're also finding that around 75% of workers would prefer lifetime income stability over principal preservation in their retirement years. So we're really starting to see that everyday American workers are realizing themselves not only that retirement savings issue, but also the lifetime income issue. With that said, the lifetime income resolution before you we think is really a great first step at continuing and taking a further dive into this issue. First, this resolution will call for legislators to understand how much, if any, lifetime income their respective state retirement plans provide to their employees. Secondly, we believe it is important that legislators examine and quantify the current amount of lifetime income for employers in the private sector. And finally, legislators should enact policies which encourage education for retirement plan participants on their investment options and how to best achieve their retirement goals.

Rep. Anderson thanked Mr. Freely and Mr. Neely and stated that we look forward to continuing to work with TIAA next year.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Boyd and seconded by Sen. Walter Michel (MS), the Committee adjourned at 5:00 p.m.

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National Council of Insurance Legislators (NCOIL)

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

Sponsored by Sen. George Lang (OH)

To be discussed and considered during the Life Insurance & Financial Planning Committee meeting on April 25, 2025.

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

The following bills/laws will be referenced throughout the agenda topic "Discussion on the use of genetic testing information in life insurance underwriting."

Nebraska LB 338

Florida Chapter 627.4301

Tennessee HB1309/SB1294

STRENGTHS, WEAKNESSESS, OPPORTUNITIES AND THREATS (SWOT) EXERCISE

Please click here to complete a brief survey about NCOIL. The responses to that survey will be compiled and used to facilitate the SWOT exercise in Charleston.

Also, as you'll see in the survey, you have the option to submit your responses anonymously or to provide your contact information and request a meeting either in advance of or at the Spring Meeting to discuss your responses.

PROPERTY & CASUALTY INSURANCE COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
PROPERTY & CASUALTY INSURANCE COMMITTEE
2024 NCOIL ANNUAL MEETING – SAN ANTONIO, TEXAS
NOVEMBER 24, 2024
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Property & Casualty Insurance Committee met at The Westin Riverwalk Hotel in San Antonio, Texas on Sunday, November 24, 2024 at 10:45 a.m.

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

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Sen. Larry Walker (GA)
Rep. Brian Lohse (IA)
Rep. Matt Lehman (IN)
Rep. Peggy Mayfield (IN)
Rep. Michael Meredith (KY)
Rep. Michael Sarge Pollock (KY)
Rep. Rachel Roberts (KY)
Rep. Cherlynn Stevenson (KY)
Rep. David LeBoeuf (MA)
Rep. Brenda Carter (MI)
Sen. Lana Theis (MI)
Sen. Michael Webber (MI)
Sen. Paul Utke (MN)
Sen. Michael McLendon (MS)
Rep. Nelly Nicol (MT)
Sen. Jerry Klein (ND)
Asm. Erik Dilan (NY)
Asm. Jarett Gandolfo (NY)
Asw. Pam Hunter (NY)
Rep. Brian Lampton (OH)
Sen. George Lang (OH)
Rep. Mark Tedford (OK)
Rep. Tom Oliverson, M.D. (TX)
Rep. Dennis Paul (TX)
Rep. Jim Dunnigan (UT)
Sen. Mary Felzkowski (WI)
Del. David Green (WV)

Other legislators present were:

Rep. Deborah Ferguson, DDS (AR)
Sen. Clint Penzo (AR)
Rep. Matthew Gambill (GA)
Rep. Rod Furniss (ID)
Sen. Jason Howell (KY)
Rep. Bill Sutton (KS)
Rep. Bob Titus (MO)
Sen. Hillman Frazier (MS)
Sen. Bill Gannon (NH)
Sen. Pam Helming (NY)
Sen. Patty Kuderer (WA)

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 Rep. Nelly Nicol (MT) 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 Rep. Brenda Carter (MI), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 20, 2024 and October 7, 2024 meetings.

CONSIDERATION OF NCOIL STRENGTHEN HOMES PROGRAM MODEL ACT

Rep. Bennett stated that we'll start today with consideration of the NCOIL Strengthened Homes Model Act (Model). You can see that on page 376 in your binders and on the website and app. Before we go any further, I'd like to recognize Rep. Jim Dunnigan (UT), the sponsor of the model, for remarks.

Rep. Dunnigan stated that I appreciate all the work that the Committee has done on the Model. The program that the Model implements is designed to incentivize, encourage, and help people strengthen their homes to have a fortified roof, and provide increased resistance to hurricane, tornado, and other catastrophic windstorm events. From the last time that we talked about the Model, I've made a few changes and I'll just do a quick run-through of those. They primarily affect Section 3, focusing on inspector and contractor eligibility requirements, which I think are good additions to the Model. I also have made a few small changes since the 30 day materials. Based on conversations with several folks, I've removed certain recordkeeping requirements as they really didn't serve enough of a purpose to justify themselves. And also I removed references to commercial standards to clarify that we're dealing with residential homes. And then I've made it clear that only upon request does a homeowner have to provide certain documents to the insurer. Many of the insurers said they already have a database that has that information. If they don't they can request it. And lastly, I've removed the provision regarding the records being subject to the audit by the Commissioner. That struck me as odd and not really necessary. The intent of this is to encourage and incentivize people to strengthen their homes so that they can have better success when these catastrophic windstorm events occur and I'm happy to answer any questions.

Rep. Matthew Gambill (GA) stated that we passed legislation similar to the Model last year in Georgia and while this Model is more specific to roofs and ours was a little broader and included construction in general, this is kind of an opportunity for a win-win-win for not only the owner of the commercial or residential property in our case, but the construction business and then also the insurance business. So this is a great Model to look at, and I'm very happy that we've brought it forward today.

Hillary Segura, VP & Counsel of State Gov't Relations at the American Property Casualty Insurance Association (APCIA) thanked the Committee for the opportunity to

speak and thanked Reps. Dunnigan and Gambill for all of the hard work that you have put into this Model. APCIA strongly supports this Model. Thank you for the changes and clarifications you've made throughout this process. I think the end product is a strong Model that will drive participation in these programs in a number of states as they adopt it.

Wes Bissett, Senior Counsel of Gov't Affairs for the Independent Insurance Agents and Brokers of America (IIABA), thanked the Committee for the opportunity to speak and stated that like APCIA, we strongly support this Model. We offer a big thanks to the sponsor and co-sponsor. It was a great initial draft and concept, but we appreciate your willingness to entertain suggestions and proposed revisions along the way. In this hard market, there are not a lot of obvious and clear public policy options for legislators to adopt but one thing you can do is to try to remove unnecessary costs from the system. And if claims never arise in the first place, that's one way to do that. And encouraging people to mitigate their roofs will hopefully take claims costs out of the system in a way that can provide relief to consumers. We strongly support both components of this Model. The first is the grant program itself. The second is the notion that if you have mitigated your roof in a way that meets the fortified standard, there ought to be some insurance benefit from that. This Model doesn't prescribe what that benefit is but does require that some benefits be provided to the consumer as well. We urge the Committee to support the Model. I want to mention two final things. The first of those is Congress will be looking at tax policy early next year and the way that state mitigation grants work now, they are taxed at the federal level. We encourage you to think perhaps in the next Congress of weighing in with the tax writing committees and urge them to make state mitigation grants tax-free. There's been legislation like that in the past and we presume that there will be again next year.

Paul Martin, VP of State Affairs at the National Association of Mutual Insurance Companies (NAMIC), thanked the Committee for the opportunity to speak and stated that some of you may have heard me say this before - simply raising rates is not going to get us out of the situation we're in in the insurance market right now. We have to stop the losses. And it's legislation like this that we're able to create what is a culture of preparedness. And this is also a personal interest of mine as well. I would point out that a lot of insurance companies are already offering discounts for many of these things. My own insurance company offers me a 10% discount on the entire premium because I have hail resistant roofing. My agent tells me that 90% of his book in Austin, TX does not avail themselves of this discount. So, anything we can do to encourage policyholders to take advantage of discounts which stop the losses is important. I know there's some questions about the proof of having the Insurance Institute for Business and Home Safety (IBHS) certificate for proof for insurance purposes. I just want to point out that I have been able to keep up with the IBHS certificate all these years, including the renewal that I just got. And I called IBHS and I said, "If I lose this certificate, will you send me another one?" And they said, "Of course, it's not a problem." To all of you that have worked on thism thank you so much. We think this is a great step in the right direction.

Joel Laucher, Program Specialist for United Policyholders (UP), thanked the Committee for the opportunity to speak and stated that UP is a non-profit that helps people with an array of insurance issues. I do want to support this Model as well on behalf of all the consumers that we work with and are having affordability issues, both with insurance but also in getting some of these mitigations accomplished. So they would benefit very much from grant programs. And these mandates not only recognize the benefits of reducing risk but they help stir the implementation of these mitigations by other consumers. And I'll use this worn-out phrase, “what gets rewarded gets repeated”. So to have insurance discounts for people who do this given the soaring cost of insurance, it's a very critical thing to be able to afford it and to get some reduction, even 10%. That's a pretty good discount actually for the coverage.
And I will say some of these mitigations are not perfect but even slowing a wildfire can allow the firefighting resources the opportunity to save many homes. We always say to consumers any work you do to help mitigate your risk is doing a favor for your neighbor as well. UP appreciates any legislation that helps move this cause forward.

Rep. Matt Lehman (IN) asked for those states that have implemented these types of programs, my question is on starting the fund. Is that by way of appropriations in the budget? Is that used by carrier assessments? How do you create the fund and what money goes into that fund? Rep. Dunnigan stated that states have funded the program differently. Some states have had a direct appropriation and some direct the Insurance Commissioner to apply for grants or funds from the federal government. The Model is drafted so as to not make it limited to one approach. There's no taxing authority set forth, the Model directs the Commissioner to seek grants from sources and then other monies as they may get from their legislature can be used.

Rep. Michael Sarge Pollock (KY), Vice Chair of the Committee, stated that I sponsored similar legislation in Kentucky. We're using funds that the Commissioner of Insurance is overseeing. Those funds are made up of fees and fines that our insurance companies pay. And that pot of funds has generated quite a bit so we felt that was a perfect way of using those fees and those fines to offset the cost in the law. We also specifically added $5 million dollars and those appropriations are used for contractors to be licensed to put a fortified roof on and then also offset the extra cost on a fortified roof through an application process throughout the state. It's starting in my state in 2025 but I will say this, I've heard from an insurance industry representative who is already getting statistics back from the different hurricanes and things that are going on and they said the fortified roof process is saving claim dollars and is definitely worth the discount that the insurance companies are providing.

Rep. Brenda Carter (MI) asked what are the requirements for this grant program? Mr. Martin stated that it's going to vary from state to state. Generally, depending on how you set this up, you would apply for a grant and the Model has some specific requirements of the contractors so that they do the right job and do it in a way that's compliant with the IBHS standard. I will tell you it is something of a laboratory. Alabama is the pioneer here. Louisiana has picked it up and they have been sharing information on what works and what doesn't. One of the pain points from my understanding is from Louisiana regarding when do you open up the grant process? Because they were opening up at

midnight which sounds great unless you are someone who for whatever reason, whether it be a medical reason, is not awake at midnight. And based on some of the feedback, they have changed the time to make it more convenient for people who may not be awake at midnight. And along the lines of what Rep. Lehman asked, the funding has varied from state to state. In Louisiana, when they first brought this on, they had some excess funds from premium taxes but because the take-up rate and the interest was so strong, they've actually moved it and now they make this a part of general revenue.

Rep. Carter asked who qualifies for the grants? Mr. Martin stated that again, that's going to vary from state to state. One of the conversations we've had is should there be some sort of means testing for this? And I think this is one of the situations where you take this Model and then you tweak it to fit your particular situation in a state. I don't know that we have a burning desire that the grant program must be a certain way. What I have told Commissioners and legislators across the country is you need to be on the phone with your colleagues in other states who are doing this to find out what works and what doesn't work and then tweak it to your situation. Mr. Bissett stated that in terms of qualifying, it has to be an owner-occupied, single-family primary residence. So it can't be a second home, vacation property, or commercial property. The other thing I would note is a lot of the rules will be established by the regulators who set up and stand up the programs but the Model does state that there is to be priority given to certain applicants such as lower-income applicants.

Rep. Mark Tedford (OK) stated that regarding Rep. Lehman's questions on funding, I sponsored similar legislation in Oklahoma. We funded the program with $10 million from premium taxes. We felt that was the appropriate mechanism to get the funding because it didn't require a state appropriation and in Oklahoma there is a resistance to public money going to private individuals and they felt like the fact that the premiums have increased so much in the state that's also increased the amount of premium tax revenue. So there's a way to return some of that tax revenue to the policyholders by virtue of these grants so that's the way we funded it.

Sen. Larry Walker (GA) stated that I'm from Georgia and in our Constitution we have gratuity clause so I don't see how we could use taxpayer dollars for this grant. Do you see that in other states or is there a way around that issue? Mr. Martin stated that we hear this from time to time, and the short answer is it may require a referendum to get around that. So again, with the Model process, we have the Model and if you need to make tweaks to it to bring it to fruition, so be it. That's not to say, however, that the state could not go out and look for other sources of funding and some of that might be at some point federal funding and that's one of the questions that we have had from regulators is how do we structure our statute and our regulations so as to meet the qualifications of whatever Congress might do? And I wish I had a crystal ball because asking me what Congress might do two years from now and how to structure your statute now to be receptive of it is really challenging. So I think that's part of the ongoing dialogue that I know that we on the trade side have had with our federal colleagues is to figure out how do we create conduits to make Model like this receptive to whatever might be coming from Congress down the road. Mr. Bissett stated that I would hate to opine on Georgia law but I guess one thing that I would wonder is if the grants came from

licensing fees and fines as we've heard about before, whether that would be viewed under your Constitution in the same way - it might be, it might not. But there might be sources of money out there that essentially would be outside of that constitutional prohibition.

Sen. Walker stated that getting back to the fortified roofs, I'm a property and casualty agent and I think bought all of my clients a new roof over the last few years so they should be in great shape for a little while, but the cost of roofs seems like to me since about 2020 have gone up 40% or 50% just for a standard roof. What is the price differential for a fortified or hail resistant, wind resistant roof? Mr. Martin stated that I can tell you that from a new construction. I don't know if this is going to be congruent but for new construction the delta between building a house with everything versus building house to the IBHS standard is about 2% or 3% more. Now, on the roof per se, the last time we did the analysis in Texas was that the recapture time of the cost just for the roof is about seven to nine years. So if you buy a 20 or 30 year roof, around the seven to nine year point you start saving money. You start actually making money by the fact that you have this endorsement on your house and you're paying less in premium because you have a hail resistant roof.

Sen. Walker stated that my last question gets to standard type roofs, asphalt shingle roofs, and the manufacturers will sell you what they call a 30 year roof or a 40 year roof. In Georgia with our climate we don't see roofs last that long. If you get 20 years out of a 40 year roof, you're fortunate. Is the quality of the roofs not as good as they used to be or is our weather just different? Should we hold manufacturers to some sort of different standard? Because our insureds, when we tell them your roof's 20 years old and we can't write your house, they come back with, “well, I bought a 40 year roof.” So it's a real misconception in the market as to what they think they have versus what they actually have. Has there been any thinking along those lines? Mr. Martin stated that the short answer is yes. I know Roy Wright, CEO of the IBHS, has been here at NCOIL and they actually grade kind of consumer reports on roofing and they've actually had situations where there was a manufacturer of roofing and they gave them a failing grade and the manufacturer called up IBHS and says, “What do I have to do to get off your bad list?” And Mr. Wright said, "You've got to make your roofing better." And they went back and pulled all of their stock currently that was in inventory, upgraded their stock, and they've actually upgraded their grade according to IBHS. And so that is why these certifications are so important is that you've got a watchdog, you've got someone setting the standard like IBHS or someone else doing the hard work and doing the research to say if you want hail resistant roofing, and if you really want a 30 year roof, well, you go to an organization that's scoring these roofs for you so that you can have a conversation with your builder, with your contractor, and make sure you're putting on the roof that will actually perform as advertised.

Rep. Bill Sutton (KS) stated that this question is actually for the legislators who have implemented similar legislation. As much as I love the idea of applying for a grant that will get me a reduction to my insurance rates, I heard one number of $5 million. I heard another of $10 million. How many people were turned away from that and how fast did that money disappear? Rep. Dunnigan stated that I think that's a good question and it

kind of goes back to Rep. Lehman's question as far as the funding. The Model provides for the Insurance Commissioner to seek grant funding by several means. It also has a drafting note pointing out that other states, as has been described, have implemented a variety of ways to get money in the pot. This is brand new so there's nothing that's been created on that. That's a good question for maybe some of the states that have done this to see how long it has lasted.

Rep. Tedford stated that Oklahoma has just started the program so the grants won't even be issued until January so I don't know how fast it will be used up. Rep. Sutton stated that he didn't realize the law had not gone into effect yet.

Mr. Martin stated that the answer is it can go very quickly. It's a function of two things and real simple math of how much money is in the pot, and what restrictions do you have on who's eligible. So the more money you put in and the more restrictions you put in, like means testing or some other restriction to make sure that you're not giving someone who's got a $2 million home $10,000 to subsidize a roof replacement is good. You could be using those funds to help people who are really struggling and some of the feedback we've received from some of these states is if the roof costs $12,000 and the grant is $10,000 and I'm a low-income person, the roof might as well cost $50,000 because I can't come up with $2,000. So I think that's something where you take this Model as legislators and you figure out what works for your constituency in terms of funding, and what makes sense in terms of qualifications and restrictions you place on the process. Rep. Sutton stated that my overall take on that is from the first sentence "it can go very quickly." And that immediately looks to me in practice for state legislation a whole lot like picking and choosing and deciding who gets his money, and it's public money, and who does not. So I have some concerns in that regard.

Rep. Gambill stated that I know that we're insurance focused today and I think that this is a little bit bigger than just the insurance component of it because when we were thinking about it in Georgia, we were thinking about it from the standard that a lot of people don't even know that this fortified construction exists. And so we wanted to create an incentive for them to know about it and we didn't appropriate funds to help provide grants through our Department of Insurance. The discount is solely left up to the discretion of the insurers in our state. I know that what we're talking about today is focused more on roofs but fortified is definitely bigger than just roofs and it's not material specific. It can be concrete, it can be wood. It can accomplished through a myriad of construction methods but the general thought is it's great if people choose to go this route. and we want more people to do it. We want better built structures.

Hearing no further questions or comments, upon a Motion made by Rep. Mike Meredith (KY), and seconded by Rep. Pollock, the Committee via a voice vote voted to adopt the amendments made since the 30-day materials were issued with Rep. Bennett determining that the yes votes clearly outnumbered the no votes. Then, upon a Motion made by Rep. Pollock and seconded by Rep. Tedford, the Model, as amended, passed via a voice vote with Rep. Bennett determining that the yes votes clearly outnumbered the no votes.

Rep. Bennett thanked everyone for their participation throughout this process. It's been a long road, and as a member of a legislature that adopted similar legislation, it was a great opportunity for bipartisan action to help people. And however you decide to design it in your states I know that it will be a benefit to our constituents. The Model will be placed on the Executive Committee agenda for final ratification.

CONSIDERATION OF NCOIL ONLINE MARKETPLACE GUARANTEES MODEL ACT

Rep. Bennett stated that next on the agenda is potential consideration of the NCOIL Online Marketplace Guarantees Model Act (Model). You can find this Model on page 383 in your binders and on the website and app. Before we go any further, I'd like to turn things over to the sponsor of the Model, Rep. Brian Lampton (OH).

Rep. Lampton stated that it's been great working with everyone on this Model. We've been discussing it since the Spring Meeting in April and I've had several meetings with interested party meetings and staff. We've heard several concerns that have been raised about the Model and I've been glad to accept amendments or language changes but I haven't seen anything specific in terms of changing or removing any language. I'd like to continue to work with everyone to address those concerns. I'm looking forward to our discussion today to find out if perhaps some specific information can be shared in terms of potential changes.

Rep. Bennett stated that there has been a lot of conversation about this Model and I want to make sure that everyone gets a word in and has their questions answered today. And in full transparency, at the conclusion of the conversation, we'll determine whether or not we're going to move forward with a vote today or whether we're going to give it more time for discussion. And I think all interested parties at the speaker table understand that at this time.

Ms. Segura thanked the Committee for the opportunity to speak and stated that APCIA does have concerns with the Model as currently drafted. I'll start off with the fact that the definition of the "online marketplace guarantee" is so broad that it creates an unlevel playing field. How it's defined, it currently falls within the definition of insurance. There are already insurance products out there which cover these property losses and this Model would allow nearly identical products to be offered in a much different regulatory structure. We have been looking for a way to kind of thread the needle to separate and clearly distinguish a guarantee from the insurance product. So far, we have not been able to find that solution. What I would say is if an NCOIL Model appears to overlap with existing regulatory framework, that could result in objections from state insurance regulators during efforts to get a Model enacted in the states. One of the concerns we have is there's an inherent conflict with the definition of "travel insurance." If you look at the National Association of Insurance Commissioners (NAIC) Travel Insurance Model, which was a seven-year process to get adopted, it is currently enacted in 37 states. In that Model, it defines "travel insurance" as "damages to accommodations or rental vehicles." In this Model that's proposed, the host protection seeks to call not insurance what is in direct conflict with what is defined in the travel insurance Model as "travel insurance." The definition in the Model that is proposed includes language saying "any

damages or loss of income arising out of the use of the online marketplace." That's really the same wording as "damages to accommodations" which is in the travel insurance Model. Again, we're trying to figure out a way to break these two apart but so far we haven't got there.

Another concern we have is with whether there are funds to meet the obligations that would be provided by these guarantees. The proposed Model allows the entities to offer the guarantee to either back them by an insurance policy or to meet certain requirements based on market capitalization of net worth. The latter two options that they propose are a form of self-funding, kind of like self-insurance. However, these two measures really are not a good indicator of the ability of the marketplace to fulfill the obligation that they are assuming under the guarantee. The measures don't reflect liquid funds that are available to pay obligations that are assumed under the guarantee. If you look at self-insurance, it is obviously permitted out there in the marketplace. It's permitted in commercial auto and workers' compensation. In both of those cases there are rigorous requirements in place. Approvals must be secured. Self-insurance exists in personal auto as well. Requirements vary state to state but they usually involve posting a cash deposit or a bond equal or greater than the financial responsibility limits. So our concern here isn't so much with the self-funding option, but rather with the measure to ensure that there's going to be funds to meet the obligations that are being promised. So that is another area that we think needs to be narrowed and clarified. We are happy to continue our discussions with the representatives of the platforms to address these concerns with the goal of making sure that we have a strong Model that comes out that provides clarity for everyone involved in the process and that we're not creating dual regulatory tracks for the same product. We want to make sure that parties to the guarantee are protected and that state insurance regulations are followed so I would say at this point we don't feel the Model is ready for a vote.

Tony Cotto, Public Policy Counsel at NAMIC, thanked the Committee for the opportunity to speak today in opposition to the Model, echoing everything Ms. Segura said. Our members support innovation and technology in insurance markets and to be clear that is exactly what we're talking about here, insurance markets. While states have some nuanced differences in specific definitions of "insurance", the notion that a transfer of risk like that contemplated by the proposed Model is not insurance because of the first sentence in section 4 that simply decrees it not insurance, strains credulity. Most of your state insurance codes lay out entire volumes of regulatory requirements for entities engaged in indemnifying others or paying specified amounts upon determinable contingencies. Again, that's what we're dealing with here. That's what we're contemplating, which is made painfully clear by the drafting note on page four. If I were still a regulator you can be certain that even with my extreme free market and limited government proclivities, I would consider this an insurance product within my jurisdiction. If, in fact, the objective of the Model is to protect consumers and promote transparency, fairness, and accountability, which is all in there, then subjecting these business practices to the same scrutiny as existing products currently filed with your departments of insurance and approved all across the country today, that's what Section 1B says, then in situations where the provider chooses to charge separate consideration and avoid premium taxes, as contemplated by Section 4C, that's another big problem. And I

suspect it's probably not just me that hears “minimum threshold” in Section 4E and thinks that looks an awful lot like a deductible which is the language in an insurance policy. So if this body is determined to pass something in this arena, the Model should be narrowed with specific applicability to short-term property rentals. That's one suggestion we'd have. Limitations or a flat-out prohibition on payment of consideration. Maybe limitation on total value. We can figure out what the number is. And additional clarity on the potential liability whether it only flows one way from the host, whether it also could include things like slip and falls. There are all kinds of questions around that. Ultimately, we can't get away from the fact that as currently contemplated these products are insurance. We're happy to work with everyone and we'll narrow the language and we'll provide some language but as it sits today, NAMIC cannot support it.

Brad Nail of Converge Public Strategies representing Airbnb thanked the Committee for the opportunity to speak and stated that I'm joined by Byron Wobeter, Associate General Counsel at Airbnb, to help answer questions that the committee might have. We’ve discussed the substance of this in multiple committee meetings so I'm not going to spend a lot of time other than to just summarize it by saying the Model itself deals with transparency, it deals with consumer protection, it deals with registration and enforcement so that the states have a proper framework to be able to understand and to control what might happen with folks who want to do these guarantees. I want to address some of the points made by Mr. Cotto. The assertion that it is clearly insurance as it is being operated today is incorrect. There are almost half the states that have statutory guidance that says that this type of guarantee is not an insurance product. If you think of it in terms of, for example, a service contract, we’ve dealt with service contracts and service contract models in the legislatures before setting out the fact that these should be able to be offered and you do not have to structure it as an insurance product. If you think about a warranty, just because you want to warranty work doesn't mean that you have to structure it as an insurance product. These types of guarantees are with that and that's why the Model that's before you is structured very similarly to the NAIC’s service contract Model that I think there's some familiarity with here. NAMIC has expressed all along just really philosophical concerns about this Model and we and the sponsor have tried to amend it to try to narrow this.

One of the concerns I think is that are there companies out there who could try to take advantage of this guarantee model being in the statute to essentially offer insurance but get around all the insurance regulations. That is not what Airbnb is doing and I don't think there's any dispute about that. But I know that the sponsor has amended this along the way to try to narrow it as much as possible to prevent that from happening and we feel like it has been sufficiently narrowed to prevent those worst-case scenarios from happening. There's very clear language in there that if you're offering this type of guarantee, it has to be ancillary to the primary business that you're conducting. You can't just come up with a guarantee company to go out and sell to people. You’re conducting business, and you're offering this guarantee. You're backing what you're doing through this guarantee. For the comments from Ms. Segura, we think that this is not in any way in conflict with travel insurance and I know that's been one of their concerns. They have members who sell travel insurance and they're concerned about that conflict. In fact, this guarantee works in conjunction with travel insurance because if

you think about it, definitionally in the Model, this has to be a two-sided marketplace. This is for the online marketplaces where, to use Airbnb as the example, you have the contract with the homeowner on one side and the contract with the person who's going to rent that property on the other side. And all that the guarantee is doing is focusing on guaranteeing any property damages, not liabilities, it's just property damage to the homeowner. So travel insurance would be sold to the renter of the property and that would cover the damage. So we would actually encourage and we think it's great for them to buy travel insurance because then there is insurance to cover those prospective damages and the guarantee doesn't have to come into play. So, they're really not in conflict with one another. They should work together and in fact, Airbnb as an example has offered travel insurance through carriers on their platform and that's something they would consider doing further.

The solvency question I think is not a real concern in that there are provisions in Section 3C as Ms. Segura was pointing out that lay out what the requirements are. You either have to back your guarantee with some type of insurance policy so the guarantor would either have to have an insurance policy to back their ability to pay what they are guaranteeing, or if they are of a certain size, then they can do this without that insurance policy. That is consistent with the service contract Model. That is consistent with other things that we have done and that we see. So I don't think that is anything unusual or raises concerns. I think that a lot of the concerns are actually based on either a misreading or a misunderstanding of the language that's in here. I think the sponsor has worked very hard to try to tailor this and narrow this and make it something that is effective. Our position is if it's the will of the committee that this needs further discussion then we will absolutely engage in those discussions. Our position as we sit here today is that if we delay this then the end result will be we're going to be back here in April with language that has had no substantive changes at all and you're going to be approving essentially the same language that's in front of you today and the only impact will have been we will have missed the opportunity to file this in states in the 2025 legislative session where it's needed in those states.

Mr. Wobeter stated that one thing brought up was the threshold or the deductible and Airbnb does not have one. The reason that is in the Model is if you go to the actual text, we do know that there could be others that might actually have a deductible and we want to make sure that those are conspicuously shown to consumers before they sign up. And so the reason that it's in there is to ensure that it's out there. If we were silent on it, we would be scared of platforms having them and then when something came up or they needed to utilize the guarantee, it would not have been clear to the consumer up front. And then to Mr. Nail's point on this, we disagree that this is clearly insurance. We have pointed to various exemptions within the state codes in approximately half of the states and then case law supports that it's not insurance elsewhere. What this does is actually give a framework for regulatory guidance and consumer protections, even though those exemptions exist and they're pure exemptions. And so we feel that it's important to have this from a consumer protection perspective.

Rep. Bennett thanked everyone for their comments and stated that there obviously needs to be further discussion on this so we won't be voting on this today.

Rep. Lehman stated that I'm hearing the comments about whether or not this is insurance - has the NAIC weighed in on this at all? Mr. Nail stated that in 2016, the NAIC came out with a white paper that really analyzed the home sharing market as a whole and it did include analysis of the guarantee that is being offered here. So they've looked at it. Our interpretation is their determination was that this was okay. This was not an insurance product. But in more recent times, there have been a couple of states that I think are revisiting that and so the impetus for this Model is to in those states that don't already have clear statutory guidance for you to be able to give those regulators the statutory guidance that this is okay and to maybe alleviate their concerns around whether they should take a look at this as being an insurance product in disguise. Rep. Lehman stated that in Indiana, we passed some pretty broad language regarding home sharing and I think the guarantees were not insurance. Over time, though, like you just said, I think that's being reviewed. Are we at a place where we should now come in and say we want to now say for a fact it's not insurance when it's moving almost kind of in the opposite direction? You're having more people look at this as maybe it is insurance and we should take a deeper look. And I'm hearing Ms. Segura say we're trying to thread this needle. Are we close to threading the needle? Mr. Nail stated that it's only when it meets very specific conditions that it is not insurance and that's what we're trying to lay out in this Model. We don't want situations where it can be interpreted broadly so that people can circumvent that system. As far as whether we're close to threading the needle, we've been talking to NAMIC for some time on this and there may just be a philosophical divide there that we'd like to overcome and our discussions with APCIA have been very recent. And we've had some exchange of language where we thought we were close and that's how that goes in the legislative process.

Rep. Lehman stated that I'm very supportive of Airbnb's platform and what you're doing but I think we're maybe getting now to a place where we need to have more conversations about this. Mr. Wobeter stated that the other thing is these could be narrowed in the states as well so we would continue to work as we would roll this out. Mr. Nail stated that I would echo Sen. Mary Felzkowski's (WI) comments from yesterday where she indicated from one of the Models up for consideration that sometimes it's okay to send something that is a little broader to the states and then narrow it there if we see that's an issue. I really think that the work that the sponsor has done on this in narrowing is the right way and that we're in a good position but we're obviously open to hearing other thoughts on that.

Mr. Cotto stated that I was part of NAIC's staff in 2016 when that white paper came out. White papers do not express the position of the NAIC and the NAIC's Service Contract Model has only been adopted by 10 states. So that agreed upon legal fiction on service contracts has only been adopted in 10 states.

Sen. Walker stated that for clarification, Airbnb doesn't require the damage waiver for your guests to purchase - it's optional, correct? Mr. Nail replied yes, and stated that this is not any kind of a damage waiver for the guests. This is only a guarantee to the host that damaged property will get compensated for. Sen. Walker asked if that's built into

the contract already for the host. Mr. Nail replied yes - any coverage for the renter would not come from us. It would come from, for example, a travel insurer.

Sen. Walker stated that I hear the eagerness to get this done today and I hear the opposition and I think they raised some real valid points. If we were to remove the ability to self-insure and required the online vendor to back this with an insurance product would that be acceptable to everyone to get this done today? Otherwise, I would be in favor of further discussion and education on the issue. Ms. Segura stated that I don't think that that would go far enough. I think we do have a disagreement regarding how much definitions have been narrowed and right now, it's like the saying "if it looks like a duck and it quacks like a duck, it's a duck." Sen. Walker stated that well if they back it with insurance, that's insurance protection so it seems like to me that's not really fair. Mr. Cotto stated that I'd say it moves it in the right direction but registration is not regulation. Mr. Wobeter stated that we would be open to it and in fact, if you look at the service contract realm, I think at least one state requires a reimbursement insurance policy for the solvency provision and we do carry a contractual liability insurance policy (CLIP), a similar type insurance policy on the back end to back us. And so we're open to that. Mr. Nail stated that we anticipated that if this Model went into the states that there would be some states that would probably want that but that it doesn't necessarily have to be a requirement so it's something we're prepared for.

Sen. Walker asked the Committee if they would be acceptable to that type of amendment? Rep. Bennett stated that it seems to me at this point that this is not going to get a vote today and so we will be working between now and the next meeting and we'll talk about that proposed amendment and make sure that everyone is engaged in the process.

Sen. Felzkowski asked if this Model has passed in any other states? Mr. Nail replied no, it's not really a Model as we sit here today. Sen. Felzkowski stated that I have a problem with the process on that one. I would think normally that a legislator passes something in a state and it's very thoroughly vetted and the Governor signs it and then a legislator brings that Model to NCOIL. I like that process much better. It would get signed off from an insurance commissioner going through the process. I think that process would have been much more palatable to a lot of us sitting here in the room instead of having a national insurance organization sign off on whether this is or is not insurance. So this process is a little uncomfortable for me as an insurance agent of 40 years and as a legislator. But in addition to that, I did go out and I googled on your website, host damage protection and as I'm reading through what host damage protection covers, I could just really put property damage in there and then loss of business income, additional living expenses - all part of the insurance product. And then the reimbursement process, I could have put claims process in there. So again, you want to tell me it's not insurance but I'm struggling.

Mr. Wobeter stated that the guarantee is structurally different than insurance. A guarantee, if you go deeper into the terms you'll see that it only includes and covers what the guest is responsible for based on our terms of service. So it's only guaranteeing what the guest is ultimately responsible for and it's different than insurance

in the structure that way because there are those three parties. The second structural difference on the reimbursement process is that the host first goes to the guest to pay for the damage that they cause and we have a whole process in our platform to do that. It's only when the guest does not pay or doesn't respond that the guarantee would come into place. And so it is structurally different than insurance, whereas insurance is generally a primary obligation where they would pay and then recover on the back end. We also recover on the back end as well from our guests based on our contractual terms.

Sen. Felzkowski stated that so then you're going to, in other words, subrogate back. We can change the terms, but the concepts are all the same. Mr. Wobeter stated that we still think guarantees are a different structure. Sen. Felzkowski stated that so that's why if you would pass this in a state and vet it through the committee process and have that insurance commissioner of a state sign off on it and have a successful bill and have a legislator introduce it at NCOIL, I think it would be a much better process and one that I think would be very palatable to a lot of us sitting in this room. Mr. Nail stated that to amend my answer to your first question, this Model has not been passed in any states but there are about half the states that have statutes that capture this but it's not as specific to this activity which is why we're seeking this Model. We think the specificity would be a benefit but it's not as though the concept has never been discussed in the legislature.

Rep. Tom Oliverson, M.D. (TX), NCOIL President, stated that this is not the first time the issue of whether something is a duck or not has come up. On the flip side, I would point out that I think everybody in this room knows that statutorily, health sharing is not considered insurance, nor are health benefit arrangements offered by farm bureau corporations, and they are not subject to state regulation. Now, you can argue whether that should or shouldn't be the case but it is the case. So this isn't like breaking through a glass ceiling that's never been broken through before and I think it's important when we talk about whether it's insurance or it isn’t insurance that we recognize the fact that there are certain circumstances under which we've already overlooked that fact simply to provide a product to consumers at a price that they can afford that makes sense for the marketplace. So I'm not in favor of preserving existing paradigms if it's just unnecessary regulation that burdens consumers. That being said, it sounds like there's a fair amount of discussion and that's healthy and I think that's good. My only caution would be if we're saying that we would like to postpone this so that we can continue to work on it, I'm going to insist that there be a good faith effort to do that because if we come back in April and there's not progress that’s been made and the insurance position is still that we hate it but we bought a few months and maybe ultimately we can just bleed it out over time, I will be voting for it just out of spite.

Rep. Bennett thanked everyone and stated that this has been a great series of conversations. It does seem to me that this needs further discussion. It seems to me that it comes down to a fundamental difference of understanding and belief in what belongs in this space. And I echo Rep. Oliverson's comments that I hope there is a good faith effort on both sides to work on this. So I'm going to make the decision that we will defer a vote to a later date.

DISCUSSION ON NCOIL MODEL ACT REGARDING INSURERS' USE OF AERIAL IMAGES

Rep. Bennett stated that next on the agenda is a discussion on the NCOIL Model Act Regarding Insurers' Use of Aerial Images (Model). You can find that it on page 390 in your binders and on the website and app. Before we go any further, I'll recognize the sponsor of the Model, Rep. David LeBoeuf (MA).

Rep. LeBoeuf stated that this Model was introduced during our interim committee meeting last month and what I referenced during that meeting was the genesis of this Model was a barrage of constituent calls but also some very statewide news stories around the use of aerial imagery and their inaccuracies. Essentially what was occurring was that even when photographs were provided, consumers were having difficulties remediating and curing the errors. Solar panels were identified that were assumed to be damage. There were inaccuracies on what the material of the roof was. And in my office I had to work very extensively with those in my district to see if there was a clear path to get that resolved. And essentially there wasn't. The point that I want to make and what I made at the interim meeting is that we're not prohibiting the practice of using aerial images. There's nothing in this Model that is looking to prohibit an emerging technology. And there are some vital uses for ariel photography. But again, there needs to be some type of guardrails to protect consumers and I'm looking forward to the continued discussion with everyone today.

Mr. Laucher thanked the Committee for the opportunity to speak and stated that as I mentioned earlier, UP is a nonprofit that helps people with an array of insurance issues, non-renewal being one of them, claims issues being another, as well as coverage issues. And I want to talk about this particular issue that mostly applies to underwriting but also plays a role in the premium the consumer pays. I was an insurance underwriter for several years. I also worked for the California Department of Insurance for 35 years, starting as a market conduct analyst, then a Division Chief of Market Conduct, a Deputy Commissioner of Rate Regulation, and Chief Deputy Commissioner. And I'm very familiar with all the issues here involved with this technology and I'm not here to say that it's the wrong thing to do but rather as mentioned, I want to talk about guardrails.

Insurance today has changed in the 40-something years that I've been involved. We use a lot more detailed risk attributes that are measured about each home or business than used to be. And insurers, because of the use of computers, are able to use that more broad data to come up with different rates for different businesses and homes based on these various attributes that have been added to the equation. And so you get higher differentials between who gets the best rate and who gets the highest rate or often doesn't qualify for a rate. These can be great things but they have major impacts on who is eligible and who is not eligible and how much they will pay. And it's all fair and good if it's done correctly but that's one of the issues that we often find and of course if you work at the Department of Insurance you hear from thousands of consumers each year who don't think the insurer gets it right. And this use of aerial imagery is one of those areas where this has been an issue for many consumers. And so the key here is to allow the consumer to have an opportunity to understand how decisions were made

and have specific details about something that can make them pay more money or have a reason that they might have lost their coverage. So one of many anecdotal examples on this. Here is a newspaper article and as already mentioned, homeowners were dropped because of aerial imagery where solar panels were seen on the roof. They come across as shadows or dark spots depending on the angle of the flyover taking thousands of images potentially for many homes. And it is just one home. And here in this case, it was mistaken for moss and the consumer got a non-renewal notice. Another example, this one with satellites which is a similar opportunity to kind of modernize how insurers inspect homes. This one through satellite imagery there was an issue with solar panels. And people object to satellite imagery and aerial imagery saying where do I get an opportunity to rebut any of this? This seems very intrusive. Well, I would say, over the years, whether this is more intrusive or less intrusive, it is hard to say. Way back when I started, all of these inspections would have been done by somebody coming onto your property. It was an expensive way to do business. Very detailed, but arguably quite intrusive. And this is much less intrusive. You don't even know that the inspection happened.

So it's painless if they get it right. I'm not here to criticize aerial imagery. Advances in underwriting that identify risk and create consistency can lower expenses. This is one of those activities that can do that. And so it provides a lot of advantages for the insurer to lower costs and get necessary information to both whether they want to keep the risk or charge it a little more or a little less. But the necessary piece of this is that anytime you use a technology, you have to get it right. I think we all would agree that getting this wrong or getting the wrong data doesn't help the insurer and it doesn't help the consumer. And the insurer may not know that it missed this opportunity. The consumer tends to feel it very directly and of course often in these cases, it leads to a non-renewal. And I will say in other markets, a non-renewal might not have been the worst thing to happen to you. You just go find another insurer who gets it right and you get coverage. But in today's marketplace where we have many catastrophic losses and where coverage is not readily available for someone seeking new coverage, it is a huge loss to be non-renewed by your insurer. I'll say that particularly in California where I live this is the major thing to not want to get that non-renewal notice. And whether the last insurer got it right or not the new insurer doesn't care. They're just not writing new business where you live.

So the key is to get it right and in fact, almost every state has a law that says underwriting has to be objective, be related to risk of loss, and you have to live by the underwriting guidelines you put in place. And if you don't honor that you are being unfairly discriminatory. So an unfair non-renewal is unfair discrimination and it is illegal. And I don't know if insurance departments are being forceful enough in making that clear to insurers. So often the consumer is the one who ends up where they didn't have enough time to make their argument and then get non-renewed. So that's why we need protections and UP has a put forth the concepts in the Model before you which I think would be very helpful. It's about fairness and notice and objectivity and that's what we are recommending. I will say in California, you get a 70 day notice of a non-renewal. That's a pretty long period compared to many states and even so, an insured might run out the clock. A lot of insurers say, “We trust our aerial image more than we trust you,

our customer", essentially although they don't put that into their comments. And it is important that the consumer have a true voice. So again, this is a great technology. It can save money. It can be a great thing that is less intrusive but the problem is when they don't get it right it has a major negative impact on the consumer.

Ms. Segura thanked the Committee for the opportunity to speak and stated that aerial imagery is used by insurers in conjunction with other risk selection tools and that includes the insured's application and building information that's provided to the insurer. Insurers are using this technology to give an underwriter a holistic view of the property in question and it's no different than hiring an adjuster or photographer to take photos of the property and provide a report. We do have some recommendations as we look at the Model that is proposed. Perhaps my first suggestion is to more narrowly address lawmaker-regulator concerns regarding consumer protections and privacy security. We would recommend the Model apply only to personal lines and admitted insurers and I'll kind of take you through some of our comments for Section 4. In Section 4A, there is a requirement that photos must have been taken in the past 12 months. I would say ensuring images are not older than 12 months is problematic. Many service providers of aerial images supply photos that are older. It doesn't mean that those photos are less accurate. Depending on the area of the country you live, whether you're perhaps in a more isolated area, the time frame of photos may differ. I hear numbers in aerial imagery where an average is perhaps 221 days. So that's seven months so it happens. But in other remote areas, perhaps the aerial imagery updates are not as often. But I will say oftentimes a single view photo is not used for non-renewal. Insurers look at the condition of the property over a longer period of time to assess the building on a holistic basis. Many different providers offer this view. They compare views as to what was received on the application or what is understood from past inspections or stated roof replacements. It's really the additional information that is used in the underwriting process.

Moving on to Section 4B regarding establishing a point of contact and process for the owners to use to provide documentation of completion. I would say that carrier's processes and point of contacts should already be established as underwriting evaluations take place with or without using aerial imagery. And usually the initial contact is the policyholder's agent. I think one of the concerns with some of this wording is it's kind of presupposing that a decision is going to be automatically reversed which could lead to inefficiency and expectations and perhaps the wording could have something about "for consideration." In Section 4C dealing with the risk scoring system criteria I would say that disclosing the risk score may be problematic as many insurers use third parties and their scoring systems may be protected by intellectual property and other contracts between the insurers and the service providers. Additionally, providing a score without context could confuse issues that have been identified as problematic. And if carriers do use some sort of risk score, that varies from carrier to carrier. I would say depending on what it is that an insurer is looking at there are different rating factors and this depends from insurer to insurer. You could have roof condition ratings and some go on five conditions of excellent, good, fair, poor, severe. Just disclosing some of these risk scores could be overly burdensome and require the disclosure of proprietary information. Moving on to Section 4D regarding the time frame for a cure period I just

wanted to comment that we don't believe there should be a separate window of cure period that is different than current existing state law. Carriers' underwriting processes are set up to comply with the states in which they operate and they should be allowed to make decisions that comply with existing laws and regulations. And then lastly, in Section 4E, requiring an insurer to offer a renewal policy to a consumer who submits proof that they've cured the defects or conditions that were identified in Section 4A, what I would say is a carrier may not want to remain on a risk that cures some if not all of the issues that were identified. They should be allowed to make appropriate business decisions within their own underwriting guidelines. We have been taking a look at some language and we have some additional changes and I'm happy to provide that to the sponsor for some consideration as well.

Susan Bow, General Counsel of Cape Analytics thanked the Committee for the opportunity to speak and stated that Cape Analytics provide services to the insurance industry regarding the condition and the characteristics of property. The way that we obtain that data is by processing the imagery that we license from various suppliers and we generate the data using machine learning processes which is a type of artificial intelligence. As Mr. Laucher went through, there are a lot of benefits to the use of aerial imagery in insurance such as cost efficiency. It also leads to improved risk segmentation that is actually a benefit to consumers because they are then the beneficiary of more precise and individualized decision making by the carrier. Overall, I have a comment on the Model which is similar to Ms. Segura's view which is that there are a lot of rules and regulations that already cover the issues that are addressed in the Model. I think requiring different processes and standards for aerial imagery could result in conflicting and confusing compliance regimes. There are really three sections of the Model that I want to focus on today. One is the requirement that the aerial imagery be automatically given to the consumer. There is no problem whatsoever in having that imagery available when necessary. I do think making it a requirement leads to higher costs. The image may not have any data in it that relates to the reason for the non-renewal or other action that is taken by the carrier. And finally, the insured may not dispute the findings. That's a relatively minor point, but one that I did want to make today.

Secondly, I wanted to address the 12-month recency. Cape processes imagery that is 80% of the time within 12 months. That is generally true of any aerial imagery from an urban area. It is the rural areas that will suffer if there is a less than 12 month age for the image that might require a more costly inspection, and things might not have actually changed. Finally, I would like to address the disclosure of the risk scoring system. Cape's scoring system and its related models are highly proprietary. They were developed over a number of years with millions of dollars. We would not want to have a requirement that those get disclosed to the consumer. Also, I don't think having a scoring system disclosed helps the consumer. I think what a consumer needs is understandable and actionable information. They need to understand why a decision was made, what were the factors, what were the conditions, etc. That is what's useful to a consumer, not a number of algorithms or possibly complex decision trees.

Mr. Bissett thanked the Committee for the opportunity to speak and stated that IIABA welcomes the introduction of this Model and we appreciate the work of the sponsor and

co-sponsor. I think it's understood that there are many benefits to the use of aerial image tools - it's really undisputed. But as the use of aerial images grows, it's inevitable that there are going to be instances where the images are not perfect and carriers will reach faulty conclusions based on those images. This isn't an imaginary concern. Mr. Laucher pointed to some articles that are already out there. I hear it from members increasingly. This is not something that is just a rare instance here or there. The volume of those numbers are increasing and as Mr. Laucher also mentioned, the consequences of these actions being taken are becoming more and more significant. It's hard in this hard market to find coverage. To be non-renewed by a homeowner's insurer is, it's not too much to say that it really can be traumatic in this environment right now. I'd also say that NCOIL has been proactive in encouraging the use of innovative underwriting and rating tools for many years. There are lots of examples of that. But at the same time, NCOIL has also always been very proactive in addressing the adverse consumer effects that also arise when new underwriting and rating tools emerge.

A great example of that is the NCOIL credit scoring model from more than 20 years ago. It was a new underwriting and rating tool but NCOIL addressed that with guardrails and consumer protections that now are non-controversial. They've been universally adopted. And to me, when I look at this Model and the feedback we've gotten from members, it's kind of a simple concept. The proposal is simply designed to ensure that homeowners who satisfy a company's underwriting and rating guidelines are entitled to a more favorable rate under those guidelines, and they get the coverage that they're entitled to under those same guidelines. It allows consumers to point out inaccuracies or to point to wrong conclusions that have been derived from the use of inaccurate aerial photos. It's the same thing that you did more than 20 years ago with regard to credit information. If there's inaccurate credit information about you, you're able to correct that. The only thing I'd mention is that state legislators and regulators are beginning to take action in this area and having a thoroughly vetted Model will be helpful and it would also promote interstate consistency. One thing I should also mention too is that there have been some statements made that there's a bunch of existing statutes and regulations that are out there that already cover this and already essentially achieve what's proposed in this Model. And if that's the case I would love to see them. Maybe some can point chapter and verse to why this is unnecessary but that's news to the agent community and I imagine to many consumers as well. So we appreciate that this is only an initial draft and there's maybe some meat that needs to be added to the bone but hopefully this is a good starting point for conversation. And to the Chair and sponsor, we look forward to having to seat at the table and being part of any conversations that ensue.

Mr. Cotto thanked the Committee for the opportunity to speak and stated that as with the previous Model on the committee's agenda, NAMIC does not support the Model in its current form. A lot's been said about insurers' use of aerial imagery, and alleged "spying" and insurers having too much information. It's been in local newsrooms and before this body and at the NAIC. We just don't see the need for this Model at this time as it's drafted. As evidenced by numerous bulletins issued by insurance commissioners within the last few months, as Mr. Bissett was talking about, we think state departments of insurance already have the authority they need, and they're already taking action to oversee insurer use of aerial imagery through their unfair insurance practice Acts. I will

skip all of the talk about the public policy behind this as it sounds like we're in a fair amount of agreement on the value of this to consumers. I just want to emphasize that aerial imagery actually enhances fairness and it's an objective measure of risk as it allows for more accuracy which is actually the best rate for consumers. We sometimes get into this mistake of saying, “the best rate is the lowest rate.” That's not quite right. The best rate is the most accurate rate. And when we have the image that shows a trampoline or the image that shows a diving board on the swimming pool, you're going to get a more accurate rate. So these images help identify less obvious predictors of future losses that can help consumers like overgrown trees, moss, roof discoloration, all of these things that are associated oftentimes also with just age of a property. So notwithstanding the absence of a need for this Model, as we see it as drafted it creates a number of operational challenges and a big trade secret exposure risk for carriers, particularly as Ms. Segura pointed out, Sections Section 4C, D and E would all drastically limit the insurer's ability to properly match rate to risk and create potential conflicts with the existing state notification laws that Mr. Bissett was talking about. I think we can probably get some of our compliance folks looking at it and get a list of all those notification standards that we think are already in place that would handle a lot of this. We do encourage a focus on Sections4 A and B if this body is determined to move ahead with the Model. There are clearly conversations to be had around things like the right to cure and the age of an image and we've seen that's kind of where insurance commissioners are focusing their look also. So we think there is common ground for potential agreement and we look forward to working with all of you and everyone here at the table to get it right because these things help consumers. They help carriers be more accurate. And to the point that was made several times, if they're wrong, we need to fix it.

Mr. Laucher stated that in California, we do have a 70 day notice requirement of non-renewal and for reason for the non-renewal, the two articles I showed were California risks that were improperly non-renewed despite our standards. So it’s obvious that more detailed requirements like those in this Model could be very helpful. We’re also not asking for any one vendor’s risk score as that would mean nothing to the consumer. We want details that are actionable and accurate so the consumer has that meaningful opportunity to cure. In the insurance marketplace, we need to be aware of these issues and be more consumer friendly.

Rep. Lehman stated that I appreciate where we're heading with this. I want to take a little bit of an exception to the issues around Sections 4C, D, and E. When we talk about disclosing of trade secrets, etc., this is very similar to what we talked about with the insurance underwriting transparency Model that I sponsored recently and that is all we're trying to get to is do I have a right to know why you're doing what you're doing to my policy? And I think it’s for a consumer to simply say disclose to me the criteria you used - did you use a polaroid from an air balloon? What did you use to get this image? And what can I do to cure it? And I'm going to add one more thing to all this that I think we're getting into and that's a concern of mine as an agent is we're seeing very short periods of non-renewal. I think in Indiana it might be 20 or 30 days but then if I get that non-renewal, then I go to another carrier to look to move it to that carrier and that carrier will tell me “We can't underwrite that risk in 30 days” because we have to go out and do an

inspection or get an aerial photograph of it. So we're putting clients, and it's much bigger in the commercial space, into a box of we don't want you anymore and no one else will take you because the time frame is too short. I want to make sure we don't create a problem where you went off the account but no one else will take it because of the timeframes. I don't know if 60 days is the right answer but I think we need to have a discussion around that. I do agree maybe on a little bit on the concerns about requiring a renewal in Section 4E. I think there could be other factors that go into that so I think we've got to tweak that one a little bit.

Rep. Dennis Paul (TX) asked if the Model includes state agencies within its scope? Because in Texas, the Texas Department of Insurance is the one looking at the people's homes and kicking them out of their policies. Rep. LeBeouf stated that was not explicit in the Model but we can continue that conversation around that. That was not taken into account when we put the Model together. Rep. Paul stated that's something you could add to make sure that they are also following the requirements.

Rep. Bennett thanked everyone for their comments and stated that there's some more work to be done on this Model but we're making progress and I appreciate everybody coming to the table. If anyone has questions or comments about this Model please let me, the sponsors or NCOIL staff know.

CONTINUED DISCUSSION AND POTENTIAL CONSIDERATION OF NCOIL MOTOR VEHICLE GLASS MODEL ACT

Rep. Bennett stated that the last thing on our agenda is the discussion of the NCOIL Motor Vehicle Glass Model Act (Model). It is on page 369 in your binders and on the website and app. Before going further, I want to address the fact that it had been inferred to some people that there would be a vote on this Model today. There have been some last minute conversations and I would appreciate that those conversations got spread out instead of brought at the last minute. As a policymaker, I like to adhere to a set of standards because it makes it easier for me to make decisions when I have a hard time choosing between the merits of one argument or another. And what this is coming down to is that NCOIL has certain some processes regarding model law development and the process is a model is introduced at one meeting, discussed at a second meeting, and voted on in a third meeting. That is, as far as I know, not spelled out anywhere in official NCOIL paperwork and I would like to see that changed, and that will be a conversation I will be having with NCOIL leadership. But to that point, I am frustrated that a delay is happening with the vote today because some people came at the last minute with concerns. I can appreciate that the concerns may be legitimate but as Chair of this committee, I would have appreciated, and I think that other legislators here would have appreciated, that those concerns be brought earlier. I understand in some cases it's not possible because those issues don't come up until the last minute and at that point, it becomes important for a good policymaker to fall back on processes. So I've determined that because the process has traditionally been three meetings, that's what we're going to follow. I will be frustrated if there's not good faith conversations between interested parties between now and when that vote happens. And if at the end of the day, we've decided to go by the process because that's the way

we've always done it, that isn't always the right reason to do something. But for lack of a better process that I can fall back on, that's what we're doing today. But I wanted everyone here to know that I would like to see our organization be more communicative about the process that we expect ourselves to operate by.

Rep. Pollock, sponsor of the Model, stated that this Model was introduced at the last NCOIL meeting in July and 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. This is a consumer protection piece of legislation. Its language and its core value is addressing the assignment of benefits issues that we have. Kentucky is a no deductible on auto glass state so in Kentucky it's going to be a little bit different on the service side of things. But each state deals with how they deal with their deductible and how the servicing end of it should appear. Nothing has changed in the Model since it was introduced but as Rep. Bennett said, consistency is what we're going to stand on today.

Mr. Cotto thanked the Committee for the opportunity to speak and stated that being from Kentucky, I am thrilled to enjoy the consumer protections brought by this Model in my home state. In brief, consumers around the country should enjoy the same. Many of you know that I spend most of my time traveling around the country talking about cars and all the external factors that drive auto insurance costs. Part of what drives that is the challenges around repairs and fraud, both of which this Model helps us address. On behalf of NAMIC members, we are happy to continue our support of this and partner with the National Insurance Crime Bureau (NICB) on all of their efforts and we encourage you to vote yes on it today. I understand there are process questions, but that would be our position and recommendation.

Eric DeCampos, Senior Director of Gov't Affairs at NICB thanked the Committee for the opportunity to speak and stated that NICB is a nonprofit organization that works with state and local law enforcement and our member insurance companies to detect, prevent, and deter insurance crimes. I'm here today to speak in support of the Model. This is a very important model that will provide critical consumer protections as well as important tools that will help fraud fighters detect, prevent, and deter insurance fraud related to vehicle glass repairs and replacements. And just a few examples of some of the important consumer protections that we see here in this model include prohibiting financial inducements, the elimination of assignment of benefits, as well as guardrails around recalibrations for advanced driver assistance systems (ADAS), those very costly and tiny sensors in your windshield, as well as guardrails around claims involving motor vehicle glass repairs and replacements. I really want to emphasize that this model is the product of communication, negotiations, and consensus across a variety of industries that have a stake in this issue. And with that said, I strongly urge this committee to move forward with adopting this incredibly important model, at the appropriate time.

Tom Tucker, Vice President of Legislative Affairs for Safelite Auto Group thanked the Committee for the opportunity to speak and stated that Safelite worked with Rep. Pollock to bring this Model to NCOIL. This model has been passed in three states across the country: Florida, Maryland, and Kentucky this year, and it has already been stated this is

sound public policy. It's good for consumers. It prohibits inducements, and the assignment of benefits issue that Rep. Pollack talked about is critical. And we have no concerns about any of these issues. As a matter of fact, we're in lockstep with our insurance partners. However, because of some late minute changes in our company and changes in the industry, we have some concerns on the notification provisions as many of our consumers and many glass customers nationwide don't come in person, it's online. So, we have a digital component and so some of the language that we have concerns with is technical in nature but overall, we are wholeheartedly supportive of this legislation, which is why we worked with Rep. Pollock to bring it to NCOIL. We certainly understand and respect the process. We certainly did not mean to come at the last minute asking for a delay. With our insurance partners, we certainly recognize we want this in the states this year. We want it as it's good public policy. I call this the three-legged stool. It's combating glass fraud. It's consumer notification for ADAS, which is critically important. And it's sound public policy. But I would close with this. We're all talking about the model, but the focus is really about the consumer, your constituents, our insurance partners, their clients, and our customers. And from a technical nature, there's some things in the model which are very minor, but we would like just a little bit of time to address them. That would make this model, which is already very good, better. Again, we apologize for coming at this very late hour. This is certainly not what we have intended but we remain committed to working with all of the partners at this table. We think that what we will propose will have no impact on our insurance partners. They will agree with it wholeheartedly. It's really about the technical nature of how to give the notice and what the repair looks like. And Rep. Bennett, regarding your opening comments about process, we couldn't be more in agreement with you and this is just the nature of it as sometimes things happen at the last minute, and we certainly regret coming to the committee at this late hour.

Sen. George Lang (OH) stated that with all respect to Rep. Bennett and to Safelite, I strongly disagree. I think we should always put good policy over process.

Rep. Bennett thanked everyone for their comments and stated that we all share a view that the consumer is the center of all of this and I am going to make a lot of effort to make this vote on the Model happen as soon as possible.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Carter and seconded by Rep. Lehman, the Committee adjourned at 12:15 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
PROPERTY & CASUALTY INSURANCE COMMITTEE
INTERIM COMMITTEE MEETING – FEBRUARY 14, 2025
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Property & Casualty Insurance Committee held an interim meeting via Zoom on Friday, February 14, 2025 at 1:00 P.M. (EST)

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

Other members of the Committee present were:

Rep. Rita Mayfield (IL)
Rep. Peggy Mayfield (IN)
Rep. Michael Sarge Pollock (KY)
Rep. John Illg (LA)
Rep. Edmond Jordan (LA)
Rep. Brenda Carter (MI)
Sen. Lana Theis (MI)
Sen. Paul Utke (MN)
Rep. Brian Lampton (OH)
Rep. Bob Titus (MO)

Other legislators present were:

Rep. Laurin Hendrix (AZ)
Rep. Erika Hancock (KY)
Rep. Ellyn Hefner (OK)
Sen. Mary Cavanagh (MI)
Asm. Jake Blumencranz (NY)
Asm. David Weprin (NY)
Rep. David Zimmermann (PA)
Rep. Barbara Dittrich (WI)

Also in attendance were:

Will Melofchik, NCOIL CEO
Anne Kennedy, NCOIL General Counsel
Pat Gilbert, Director of Policy, Administration & Member Services, NCOIL Support Services, LLC

QUORUM

Upon a Motion made by Sen. Paul Utke (MN), NCOIL Vice President, (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 and stated that it’s great to chair NCOIL's first official meeting of the year. We have two model laws on the agenda, the first being the Motor Vehicle Glass Model Act, and the second being the Online Marketplace Guarantees Model. We are going to take final comments today on the Motor Vehicles Glass Model and vote on its adoption. There will not be any action taken on the Online Marketplace Guarantees Model, just a continued discussion in an effort to hear an

update on things. As I understand, there have been additional conversations on that Model since our last meeting, and I want everybody to be brought up to date on those things. And then, finally, we'll have a presentation and a discussion on a topic that I know is probably on everyone's mind still, and that's the California wildfires and the intersection of insurance there.

CONTINUED DISCUSSION AND CONSIDERATION OF NCOIL MOTOR VEHICLE GLASS MODEL ACT

Rep. Bennett stated that we'll begin with the continued discussion and the consideration of the NCOIL Motor Vehicle Glass Model Act. For those of you who were at our last meeting in San Antonio, you may recall there was a lot of discussion about whether or not we were going to have a vote on that Model. Ultimately, I learned what the processes were and decided to not have a vote. I was back and forth on whether to have a vote on it up to and during the meeting, but I think it ended up great because I know that there were additional conversations had between then and now. The latest version of the Model has been distributed and posted on the website. Before we go any further, I'll turn things over to the sponsor of the Model, Rep. Michael Sarge Pollock (KY).

Rep. Pollock stated that as noted, we were close to voting on this at our last meeting but in an abundance of caution and in an effort to have the Model be the best it can be the Model was held to address some concerns. And I agree that it did end up being for the best that we didn't vote on it then, as we've had several conversations with interested parties since then and I really appreciate those interested parties and the conversations that we continued after our November meeting. And we were able to come to an agreement on an improved version of the Model. Nothing major has changed, rather some clarifications have been made. One of them is including a definition of the term “notice.” The second is to make some small changes to what the motor vehicle glass repair shop is required to notify the insured of. And then third, some tweaks of some things related to providing the insurer certain items such as invoices, estimates, receipts, and notice about calibration of driver assistance systems. As I've mentioned before, this Model is based on a law we recently passed here 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. Above all, this is a consumer protection piece of legislation, and I trust that the committee will support it.

Hilary Segura, VP & Counsel of State Gov’t Relations at the American Property Casualty Insurance Association (APCIA) thanked the Committee for the opportunity to speak and thanked Rep. Pollock and all of the parties that have been involved in getting the Model to where it is. We strongly support it, and we're happy where it has ended up.

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 strongly supports this Model. We thank Rep. Pollack for bringing this forward and thank everybody for their part in getting this Model to where it needs to be. And I want to echo Rep. Pollock's comments that this is an important Model for the purpose of consumer

protection. It will help protect consumers from bad actors and provide additional tools to combat insurance fraud in the auto insurance space.

Tom Tucker, AVP for Legislative Affairs for Safelite, thanked the Committee for extending the time for us to work on this Model. As I stated in November, the purpose of asking for the additional time was to make a good Model better. What we think we've come up with is an extraordinarily better piece of public policy that we all should be proud of and we just want to say thank you to all the stakeholders who participated, and we look forward to the vote and supporting NCOIL in the future.

Upon a Motion made by Rep. Bennett and seconded by Sen. Utke, the Committee voted without objection by way of a voice vote to adopt the Model. Rep. Bennett thanked everyone and stated that the Model will now be placed on the Executive Committee's agenda in Charleston for final ratification.

CONTINUED DISCUSSION ON NCOIL ONLINE MARKETPLACE GUARANTEES MODEL ACT

Rep. Bennett stated that the next topic on our agenda is a continued discussion on the Online Marketplace Guarantees Model Act. We've been having a lot of good discussions on this Model for about a year now, and there was some discussion about possibly voting on it during our last meeting in San Antonio, but it was pretty clear as the meeting went on that more discussions needed to be held. We are not voting on the Model today, but we are here to continue the discussion and hear a quick update. I'll turn it over now to Rep. Brian Lampton (OH), the sponsor of the Model.

Rep. Lampton stated that as mentioned, we have had a lot of conversations on this since it was first introduced. I want to thank everyone for their input. We have received some good feedback from everyone involved and hopefully we can get this to a point to where something can be agreed upon, I think we're working towards that end.

The question of whether or not the guarantee is insurance keeps coming up and I asked for a copy of the guarantee and I was looking at it and comparing it to the physical damage waiver that rental car agencies offer, and they looked very similar to me. And I know that the damage waiver at a rental car agency is not insurance or not regulated as such, I am encouraged by the willingness of all interested parties to continue to work together and trying to see if we can get something that we can agree on.

Rep. Bennett thanked Rep. Lampton and stated that I know this has been a complicated issue and I appreciate everybody that's weighed in. I'm hopeful that an agreement between the two sides can be reached, and I've maintained throughout the process that I'm happy to consider making changes to the Model.

Brad Nail of Converge Public Strategies, on behalf of Airbnb, thanked the Committee for the opportunity to speak and stated that just a quick reminder on what the Model addresses. It's based on prior NCOIL and National Association of Insurance Commissioners (NAIC) Models. It defines an online marketplace guarantee, and it's

limited to three-party transactions, limited to situations where the guarantee being provided as ancillary to the primary business, so it's not someone who's conducting a business in this area. It requires registration with the state so that appropriate regulators can confirm that the guarantee meets the requirements under the law. It requires that the online platform have the financial wherewithal to satisfy obligations under the guarantee, including by purchasing a reimbursement insurance policy. It clarifies that administering a guarantee under these conditions does not constitute the transaction of insurance, and it contains numerous consumer protection provisions around disclosure and communications. Following the November meeting, we've had calls with and sent emails to both APCIA and the National Association of Mutual Insurance Companies (NAMIC), and we've offered some alternative language for their consideration to try to address some of their concerns. I think the best logical way forward is for the three of us to get together at the same time for a session to hash out what would hopefully be final language. I know NAMIC replied yes to this. APCIA has in the past expressed a similar willingness and I think that there are some items that we can address to give them and their members comfort that the Model doesn't go too far, that it captures acceptable guarantee activity and makes that the standard in statute and that it thereby discourages and outlaws questionable activity. I think we can accomplish that with everyone working in good faith. We're aware of the letter that was written by the Wisconsin Department of Insurance on this issue and we're reaching out now to try to schedule a meeting with them where we can review our program, review the model language, and I believe that we'll be able to alleviate their concerns. We've met with a number of insurance departments over the past year to discuss this and have had good substantive reviews of laws and contracts currently in place and the prospective model law.

Ms. Segura stated that as Rep. Lampton said, we have had some conversations with him regarding where our concerns lay, and we've had conversations with Mr. Nail who did send us some information which was helpful, so I appreciate that very much. And I noted to Mr. Nail in response to his e-mail that it would be good to schedule a joint call perhaps with Rep. Lampton as well. Since San Antonio, we have worked closely with NAMIC and have held some joint industry calls to go through the Model in depth and try to lay out where our specific concerns are. The overarching comments that we've received from the industry are that the Model as drafted is too vague and too broad and it allows for the creation of the online marketplace guarantee but doesn't really provide rules or guidelines that providers of other products that do very similar things are subject to. Many state laws do provide an exception to insurance regulation for products offered as incidental to a business transaction, but we feel that the Model as drafted has application way beyond just incidental at this point.

Many personal lines insurers already offer home sharing endorsements for hosts, and presumably these guarantees would have coverages, exclusions, and conditions that would be like insurance but would not have any of the regulatory oversight or restrictions present in the insurance context. The guarantee itself right now contains all of the tenants of insurance, but without any of the regulation. We are concerned that the Model creates an unlevel playing field, as well as potentially leaving platform users and consumers without necessary protections that they are being promised. I look forward to

continuing conversations with Rep. Lampton, Airbnb, and NAMIC, and we'll continue to see if there are ways to tighten up the language in this Model moving forward.

Matt Overturf, Assistant VP of State Affairs, Ohio Valley, at NAMIC, stated that I agree with Ms. Segura's statements We've had several conversations since San Antonio with Rep. Lampton and Airbnb and our members and the broader industry. We've had a lot of good discussions, and we look forward to the additional meetings that we're looking to have here to react to language and see where we can land.

Rep. Lampton thanked everyone for continuing to be open to discussing things and seeing what we can do to get us all in a place of being okay with this. I hope we can all arrange a meeting soon to go over these items and ask APCIA and NAMIC for some ideas and specific language and see if we can get ready for Charleston.

PRESENTATION ON AFTERMATH OF CALIFORNIA WILDFIRES

Rep. Bennett stated that the last thing on the agenda, is a presentation and discussion on the aftermath of the California wildfires. As you know, wildfires hit California in January, and the devastation is pretty unfathomable. And for the purposes of our meeting today, insurance was in the news almost as much as the fires themselves. My wife's employer lost an entire warehouse full of stuff, which pales in comparison to the losses some folks have experienced, but it's just an anecdotal example of how far reaching these fires can be. Some estimates put the insurance losses anywhere between $20 billion to $45 billion. And we know that behind every one of those dollars is a pretty difficult story. And as insurance legislators, I think gaining an understanding of what happened in California can be helpful when any of us have to deal with natural disasters that have happened in our states. In Oklahoma, we've had tornadoes, fires, and earthquakes.

Sean Kevelighan, CEO of the Insurance Information Institute (III), thanked the Committee for the opportunity to speak and stated that I'd like to share very quickly kind of an overview of what's happening in California as it relates to the insurance market. One of the things that is important, I think, too, is to let you all know if you're not familiar with the III, we have a lot of information on the insurance market, and we've been around for over 70 years as an organization. We were founded by insurance carriers to be a trusted source of information. We try to serve a broad audience of policymakers, consumers, industry professionals, as well as the media. And your comments about the media covering insurance more and more is absolutely right. In fact, last year, III set a record with 22,000 media citations about the industry. So, there is a lot happening in our world in and around risk and that's what the III strives to do. We're a little unique as an organization. We do primarily research and communications work. We don't do any direct lobbying. I've been one in my career, so there's nothing against it, but III is not a lobbying organization. We don't sell insurance directly either. In terms of what's going on in California what we try and say at III is this is when the industry kicks in as the financial first responder. A key message for us right now as we're speaking with the media day in and day out, several times a day, is we want the consumers to understand they need to talk with their insurance professional, get a hold of them, help them

understand, get an understanding of what's available to them on such things as additional living expenses, getting out immediate payments for non-inventory items, and getting assistance with your inventory.

All of these things are happening right now. The California Department of Insurance actually released yesterday that about $6.9 billion in claims have been paid thus far. So, there is a lot of good work going on, but also equally important to understand, and I think this group probably knows it, there is capital on hand. This industry strives to make sure that it has adequate solvency in place to manage risk. This is what we've been doing for the 300-year-old history of the industry. So, a lot of that you can see in the industry's policyholder surplus, which is spread throughout the 56 insurance jurisdictions, but is right around $1 dollars for private insurers - having that capital on hand to make sure those promises are kept is critical. The state also has, and there are several states with them, a FAIR plan that when a person cannot find insurance through the traditional marketplace, a FAIR plan is set up to get that insurance. And that is a very solvent plan as well. In fact, there was an announcement that they're going to issue a $1 billion dollar assessment to the FAIR plan. Assessments are a tactic that you will see because most FAIR plans in other states don't keep the surplus on hand like a private insurer might, but they do have the assessment process in order to get more capital if needed. This happened in Florida, for example, in 2004 and 2005 when we saw record hurricane activity in that state. And then even on top of that, we've got the guaranty fund system. So in the unlikely area where we might see an insolvency of an insurance company, there's a program in place to make sure that those policyholders with insurance, their benefits and claims are paid.

What I wanted to do with you all is also just step back a little bit, because I think it's important to understand the homeowners insurance market and what's been happening there, because I think all of you across the country can appreciate that we have seen and are talking about insurance and homeowners insurance rates increasing. So, I'd like to talk to you a little bit about what's been behind that in recent years, especially. What really happened in COVID when we had the lockdowns is we also locked down supply chains and when you lock down the supply chains, it increased replacement costs on things like construction materials, things that we need to pay the claims. This illustration allows you to see through COVID primary years, 2019 through 2022, that inflation went up significantly related to insurance replacement costs. For homeowners in particular, over that three-year period, inflation replacement costs went up 55%. On average, the industry went up 40%. I think we can all agree that we saw remarkable inflation after COVID, but obviously you're seeing a significant inflation level happening there. So, what does that mean? As we have to increase, and nobody predicted the inflation rates where they were, as those prices increase, you've got to keep more capital on hand to make sure that you can pay those claims in the future.

And really what we have been seeing is the industry needing to catch up. It was a large inflationary hit. And so, they needed to begin charging more premiums and getting more premiums so that they could cover those costs in the future. We're beginning to see those inflation levels normalize. And this gives you an illustration coming out of COVID

that you see in 2022, you've got over 9% inflation rates. But for the next couple of years, we're in and around the 3% more tolerable, more normal inflation rates.

What you're not seeing, though, are many negatives in this table. So, you're not going to see inflation reduced to the likes of 55%. You're just seeing, as I think we're all seeing across all prices, that things are more expensive, and replacement costs are that. So, we've got a new level, a new normal, if you will, of replacement costs. And so to give you an illustration of how the industry has reacted to all of this, you see two things on this chart.

The first bars illustrated are what we call the combined ratio which is simply the expenses that we pay out versus the premiums that you pay. As a business, you want to be profitable. You want to make sure that gets under 100. As you can tell on the far left and the far right, when we're normalizing what you're seeing the market do, even homeowners, it tends to be a combined ratio in the high nineties. It's just because the underwriting, for a variety of reasons, is challenging. And I'll show you some long-term illustrations of that. Insurers really don't make the majority of their profit on underwriting. They actually make it through their investments. So, part of that capital that is kept on hand has to be kept on hand for the long term. So, the investment income is actually more the primary source of where insurers see their profitability. And that investment income is usually more so, in our research, around fixed investments, safe things, again, so the capital can be kept on hand. And just to give you a longer-term sense of kind of how underwriting has been working over a longer period of time with homeowners insurance, you see the red bars there that indicate a negative or a low amount of profitability, and you see the green as eight of the 28 years that are illustrated here is where you actually saw the industry in a state of profitability as it relates specifically to underwriting.

So, again, just going back to this last one, as you see those combined ratios over 100, so there in 2023, you saw for every dollar of premium that was brought in, there was $1.10 paid out in expense. So, not a sustainable path. So, you're seeing that orange line creep up in order to catch up with the inflation levels. And now last year, we saw it really at an inflection point where things and costs begin to normalize, and therefore you're beginning to see the combined ratios go down as well as the premium growth go down. So, that's really the overall cycle, longer term. But inflation is not just what goes into the cost of insurance. Natural catastrophes, I think, as we all know, are also a big driver and we have seen a steady increase in natural catastrophe insurance losses. In fact, since the 1980s, loss levels have gone up ten times. We've set records in terms of insurance costs. Nine of the top ten record years have been in the 2000s. So, a lot goes into it. Catastrophe losses are a big way. You also, though, have a trend of just where people are living. So, the table there illustrates states that have large populations. Well, those states also have high degrees of catastrophes, Texas being the number one state in terms of population growth. Texas is vulnerable to every type of natural catastrophe, with the exception of volcanoes. Florida, obviously, has large hurricanes, and California, we're talking about here today. So you've got people more and more living in areas of harm's way. But beyond that as well, we've also got legal system abuse issue in this country where people are going to litigation as a first resort instead of a last. And we're

seeing claims increase in this country significantly. We have a study out with the Casualty Actuarial Society (CAS) that shows claims related to auto, commercial auto, personal auto, for liability alone, just auto liability, in a ten-year span, went up $100 billion.

So, there's obviously normal inflation and natural catastrophe losses impacting those, but those are significant hikes. There are other things that factor into what we're seeing- regardless of how you feel about tariffs, they can drive up costs. And also, global geopolitical risks can drive up costs too. So, there's a variety of circumstances in what the industry has called a hard market, where we're seeing prices having to go up to match the level of risk. The one thing I like to say is insurance is a reflection of the level of risk. It is not the cause. So, very quickly into California and what's been happening there. This chart, and we put this together with our peer group, the Insurance Research Council (IRC), really just illustrates the price of insurance in comparison with median income. And this is a state-by-state comparison. So, you've got on the far left there, Utah, with less than 1% of the overall median income of insurance payments going there. Whereas you go to Louisiana and Florida, and you're getting 4% of that. What you see in this slide is California, and California is below average right now in its insurance costs for homeowners insurance. We would argue, though, that that is artificially low. It has been made artificially low because of regulatory restrictions that up until this year have been challenging for decades in the state in terms of being able to price the insurance in reflection to the level of risk in that state. And in fact, what's happened is when you compound the fires that we see regularly, the restrictions that you have on the regulatory side of it, and then the inflation on top of it, this is why people have been calling California an insurance crisis. It is unique as a state on the regulatory side. And again, this has changed, so we've got a new regulatory reform, a sustainable insurance strategy that is pointing things in the right direction. But since the 1980s we've had something in California called Proposition 103 that doesn't allow you to include reinsurance pricing in it. It didn't allow for modeling. And we'll put some research out here very soon with others that can really show you just how well modeling can work in managing risk and pricing risk. So, we need to have that in modern day.

And then the other part of it was being able to adjust insurance prices for times like we've seen of late with large inflationary levels or large catastrophe losses. In recent years up until this year, we didn't see a lot of wildfire activity in California but you go to 2017 and 2018, and you saw significant record years where the combined ratio was well over 200% after those record years. And so that then has created an average combined ratio in the state of California for homeowners insurance average of 120%. So, 20 cents paid out over the dollar that's paid through the premiums. So, we have seen the reform happen. Unfortunately, it's been harder to get the rate that they needed because the regulatory system wouldn't really allow you to go over a 7% increase without going through what I would consider an arduous process. And so, the anecdotes you would hear is the filings were always around 6.9%. They would file for increases so that they didn't have to go through this consumer group process to get their rates approved. Everybody's seen the light in that things needed to change. Unfortunately, they're just starting to change now. And so, insurers had to make some decisions that they couldn't operate in a level of profitability in that state with the way that things were set up.

So, I think there's hope, but up until this point, January 2025, we didn't see the changes that we needed and had been calling for in the industry for some time.

But regardless of the restrictions in California, I think an important final message I want to leave with everybody is really around how and what our future depends on right now, because risks are increasing. And I think from our perspective, we've got to focus more on resilience. The insurance industry has been shifting from one that just detects and repairs after catastrophe to actually working with customers in ways to predict and prevent the catastrophes. They're happening. We know when they're happening. We know from data that they're happening in areas that are more prone. And there are ways to adapt. But the one key to understand when we're adapting and focusing on resilience is there's a large economic ecosystem that we need to bring together so that we understand and can apply really an economic value that drives people's behaviors to change and that we can manage both personal and community risk better.

So that means looking at how are we building, where are we building, how are we selling things? You really don't get a lot of risk management in the home purchasing process right now. It comes in entirely too late. What's being incentivized? Obviously, insurance is going to play a key role in all of this, but we've done research that shows that we need everybody to recognize that, again, this ecosystem of co-beneficiaries coming together and focusing on problems together that creates some sort of market incentive to drive more resilience. And we do have success. We have seen areas that have been successful in this. California is actually part of this wildfire prepared program right now where consumers can get certificates to illustrate the mitigation efforts that they have made to make their homes more resilient. California regulators mandate that if you do make yourself more resilient and make those changes that you could apply for discounts from your insurance company.

So, this is a type of program that we need because there are careful evaluations that go along with how a home needs to be prepared and it's a standard, it's a certification process, it's something that you're going to have more incentive to get the discounts, you'll have more people wanting to be certified in some way to become wildfire prepared. And that's similar as well to what we saw and we're seeing in Alabama with their Strengthening Alabama Homes Initiative. This initiative is funded entirely by the insurance industry, but it's done in conjunction with the Department of Insurance and the University of Alabama. And essentially what it is, is you're allowing individuals to apply for a grant of up to $10,000 to mitigate risk, in particular wind risk coming from hurricanes in that area. And because it’s a public private partnership, and the III and Insurance Institute for Business and Home Safety (IBHS) are behind both of these programs and helping them happen, but because you've got a new way to become that Fortified standard, you've got contractors that want to be that way. The University of Alabama said that the home price increases about 7% after taking these mitigation efforts. So, there are successful programs in place and if you want a roadmap to how to build a program, the III and IBHS and the National Institute of Building Sciences set up just that, a roadmap, on how can you build a resilience program? How can you

incentivize a marketplace in a community so that you build out and create more action and value to the resilience?

Joel Laucher, Program Specialist at United Policyholders, thanked the Committee for the opportunity to speak and stated that I want to talk about some things that you could do for your constituents by putting in place some relevant consumer protections and coverage issues that can be addressed through legislation in your states. I work for United Policyholders. We are a nonprofit that mainly has built its reputation assisting people through the claims process after a catastrophe. We have staff and volunteers in Los Angeles now helping people work through their rebuild process and their claims process. It's an overwhelming thing. I'm a former insurance regulator myself, 35 years with the California Department of Insurance. I was always pleased to see United Policyholders at an event really trusted by people throughout the state and throughout the country. We have people in Hawaii and Florida and Colorado as well. Wherever a catastrophe occurs, United Policyholders tries to pitch in and help any way it can. We have three programs. I'm going to talk about some legislative changes here. We do spend most of our time assisting consumers. If you go to our website, you can see we have ongoing survivor-to-survivor events to help deal with some of the emotional issues and financial issues that all come about after a catastrophic event.

I want to talk about some insurance coverage reforms that can make a big difference in how easily or how well people actually recover after a catastrophic event. And most of these provisions are now in place in California due to some of the recent catastrophes we've experienced and what we've learned from those catastrophic events. Some of these are more recent in some of our neighboring states that have had more recent events and now are starting to implement these same provisions and protections. And my purpose really in appearing here is that you adopt these changes to legislation. Certainly, it's easier to pass some of these provisions after a catastrophic event, and everybody's kind of in that mode of trying to help? But obviously, it's much more valuable for your constituents if you would spare them having to go through some of these same challenges that these changes in law can help them avoid. Things such as additional living expenses, extension of time to at least 24 months and six-month extensions beyond that - it doesn't change the additional living expense limit. It just allows the more time to collect it in recognition of how long a rebuild process takes. Rebuilds can take many years and the money would likely run out for your additional living expense coverage before that but understanding that it is a multi-year process and putting timeframes in place that recognize that are important.

Another essential change that you might consider is allowing insureds to use both their dwelling and other structure benefits in rebuilding the home. We find people are underinsured maybe 80% of the time after a catastrophe for many reasons. One part is the inflation that occurs after an event. You're going to need all of that coverage and more to rebuild. And another really important one is allowing consumers to take those dwelling benefits and instead build or buy elsewhere. It can be really many months just in debris removal process. Of course, there's finding contractors, , getting bids, getting in blueprints of what you want to build. It's a long process. A lot of times, people that suffer these losses are in their 60s, 70s, 80s. It is a very challenging thing for them to do and

stay kind of in a temporary place in life while this occurs. Moving elsewhere and using those funds doesn't really cost the insurer any money. The payouts can come sooner, but it very much benefits your constituents, and it actually can end up with not ending up with sudden rebuilds in areas perhaps where there shouldn't be immediate rebuilds without consideration for changes in building codes and where rebuilding will actually be allowed to occur.

Another one is the process of collecting an inventory. I don't know if you're aware of how this works, but the standard approach is if you want to collect on your contents claim, you have to identify every item that you want to be reimbursed for, the date you bought it, the price you paid, the condition it was in at the time of loss. It is a huge inventory to put together. Obviously, if you've had a total loss, a means of being able to pay out some portion immediately right after the fire, and perhaps as much as the whole contents level at some point in time would spare the person of going through that painstaking list making that they have to do and recollection of things that they had. It would ease the whole claims process in terms of your own claims adjusters time and dedication to going through this. This is a real important benefit that can really spare people a lot of heartache of trying to list all the precious items that they had before the loss.

Again, common in many homeowners and renters and condominium policies are 12 months additional living expense. That really just won't cut it and you might not even have debris removal cleared after 12 months. I know in our Paradise Fire in 2018, debris removal was nine months right there and it wasn't as wide scale in terms of the number of homes as we just experienced here in California. Twenty-four months is kind of a minimum that additional living expense should be allowed. Again, that doesn't change the limit but it recognizes all these issues that come into play about debris removal, permitting processes, getting building plans approved, finding contractors to build what's approved. It is a long process. Some insurers have been generous enough to do things that they weren't required to do, such as allowing people to purchase and recreational vehicle or fifth wheel. Sometimes people are able to put those on their home site and in that way be able to kind of manage the rebuild process and be close by and not have to find a rental that might be 50 miles from their home site that they're rebuilding at and trying to work that building process while living far away. So there's lots of ways that you can make this an easier process and make that insurance contract respond to the realities of rebuilding.

I mentioned buying elsewhere. That speeds up people's ability to get on with their lives. Typically, there might be responsibilities like paying off a mortgage, that type of thing. Of course, that has to be dealt with, but it really kind of eases the personal burden on people. People with kids who need to put them in a school might need to move to an area that has a standing school. And as I mentioned, retirees may not be able to deal with the whole construction process. It is a major benefit to be able to move elsewhere with those recovery dollars. And one of the major benefits is reducing the trauma. Back to that inventory process, it's time consuming. People have many other things that they need to focus on after a loss. So, putting together an inventory is just a lot to ask. In most cases, they're going to use actually a lot of their contents money towards the rebuild, and generally speaking, people ultimately get the full payout so why not just max

them out without going through that process, saving everybody time. We do have a protection in California that I hope that you would consider for your states which is to have a bulk listing of items. So, things like silverware and books - you don't have to identify every title and author of each book that you want to claim. , We assume you had these or it makes sense that you would have had this much of that type of item and just pay it out without a grinding item by item listing. It saves a lot of time for your adjusters. Oftentimes, insurers are using outside adjusters to handle these claims and obviously, the costs are high if you're spending hours and hours going over each detail of every individual's claim. so you can save money on this process as well since you're likely going to get to the same outcome at the end.

In California and now in other states, we do have mandatory payouts of an immediate percentage of the additional living expense. We know that people are immediately homeless, essentially, after these events. They need to find a place to live. Inflation commonly occurs for the available rental market in the area of a catastrophe. There's typically a down payment of one or multiple months towards any rental. so you really want to give people a jumpstart on their additional living expense benefits as soon as possible. Also, building codes change. It's essential that insureds have coverage for building code changes, typically at least 10%. I know in California; we have had many code changes that have significantly delayed rebuilding in even our very residential neighborhoods where we have had fires. And that is important to do because we do want to build back better and that requires changes in codes and we want to make sure whatever new homes are placed, they are going to be more safe and more sound to recognize their environment that we are placing those homes. And these things take time to get through the permit process, the construction process, so. understanding code upgrades is very important.

And just for those who are interested, here are some references to statutes and codes that you might want to implement. I hope you will. Again, something you could give to your constituents is to enact some of these preventions in anticipation of future catastrophe events, not post event where you are having people go through these same challenges before you put these protections in place. Again, I want to remind you, please check us out at uphelp.org. We have lots of information to help people go through claims processes and rebuilding process, and we're here 100% for policyholders when they need us.

Jeff Klein, Esq. of McIntyre Lemon, stated that I do work for the American Bankers Association (ABA) in their insurance operation, and I just wanted to make two comments. This is an all hands-on deck issue. NCOIL was kind enough to pass a resolution at the last meeting in favor of disaster savings accounts so we're pursuing that with Rep. Ellyn Hefner in Oklahoma, and in California and elsewhere. So that'll be one small tool in the toolbox to help people manage their costs. We've talked to United Policyholders about it. And I think secondly, a group that we've become familiar with that may have reached out to NCOIL previously is Fortress Fire out of California, which has a very interesting scientific wildfire assessment product and set of services and they did a presentation at the NAIC recently and they may be willing to do a future presentation at NCOIL.

Rep. Pollock thanked everyone for their comments and stated that I just want to give congratulate Rep. Bennett and Rep. Jim Dunnigan (UT), NCOIL Secretary, who primarily sponsored the NCOIL Strengthen Homes Program Model Act that we adopted last year. I believe Mr. Kevelighan referenced that concept so I just wanted to echo that and let him know that NCOIL is hearing him, and we're adopting policy that I think hopefully will help so I just wanted to recognize that work that NCOIL's doing

Mr. Kevelighan stated yes, that is good work and the state of Alabama is seeing the effects of that good work as well. It has more Fortified roofs in that state than any other in the country. The insurance market, in comparison to some other neighboring states, is in a very different place. So you're absolutely right and I appreciate the good work and that's why I used it as an example. These are the types of things that is a true showing of how you can create a marketplace incentive that provides resilience across the board.

Rep. Pollock stated that I was primary sponsor of that legislation in Kentucky which did pass, and now Rep. Dunnigan has created that Model for all of us across the country. Thank you for your input today and it's important that we look at good policy and good Models to look at these situations we're dealing with.

Rep. Bennett thanked Rep. Pollock and stated that Oklahoma also passed the Strengthen Homes Program.

Mr. Laucher stated that I would just like to mention that in California, we do have mandated discounts insurers have to provide for what's called our Safer from Wildfires set of mitigations. They're almost identical to the IBHS wildfire prepared home mitigation standards. It's very important to us to rebuild with more resilient homes than our current stock.

Mr. Kevelighan stated that it's interesting on the discounts - discounts are a part of these programs and this is part of the research we did with the National Institute of Building Sciences is that it's still a part and there needs to be a more comprehensive look at how to make communities more resilient. And the sponsor of that study was Fannie Mae so that they could understand how to improve the financing process, too. There's a whole ecosystem here that if we can figure out ways to incentivize it, it can work really well. If you look at another program like Leadership in Energy and Environmental Design (LEED), for example, that is a program where you've got builders and developers wanting to be doing it. You've got sellers wanting to sell it, people wanting to occupy LEEDS buildings. That's a way I would like us to start thinking about resilience as well. And I see that Rep. Rita Mayfield (IL) has a question in the chat, and it's a good one because we get this often, which is, are California losses going to be spread to the other states? And the immediate answer is no. Ss much as I told you about policyholder surplus being a national number, the 56 jurisdictions control their own insurance and their own rates. So those rates are approved hand in hand with the regulator, and it makes sure that they are reflective of the individual state's risk levels.

Rep. Mayfield stated I have another question for Mr. Laucher. I live in a flood zone. Luckily my house doesn't flood but if you go three streets over, you get whole streets that turn into lakes, and anybody can live anywhere that they want however they flood every single year. You see the fire trucks there pumping these houses out and obviously the insurance company is paying out so at what point does this affect everybody else because the payouts do affect rates across the board. At what point do we say we're not going to pay out,, this is the value of your home today, this is what we're going to pay you, we're not going to give you the money to rebuild again because we've given you this money five, six, seven times and this is for areas whether it's tornado prone, fire prone or whatever - at some point something has to give and we say we're just not going to do these replacement costs. Because you're absolutely right the numbers are just going through the roof with the building materials and everything else. And I don't really think that's fair to all of the other individuals that are in that insurance pool to have to keep paying for these same individuals over and over again. Is there any conversation around that? Has anybody looked at that?

Mr. Laucher stated that we had a CZU fire in California a few years back. That's the Santa Cruz Mountains near the coast south of San Francisco. Because of the building codes put in place for a new building in that area, a lot of the homes weren't rebuilt. Some of the sites that they were located on were deemed not rebuildable. There are new code restrictions on where you can build and when you can build but generally speaking, an insurer owes the payout if it insured the home at the time of loss so there's no question of whether it has to give the payout. The question is really just about the underwriting standards that the insurer uses and whether they're going to choose to continue to offer coverage in certain areas that are higher risk and that clearly has been changing here in California. Insurers have done a lot of non-renewals in areas that they deem as higher wildfire risk. It's one of the reasons that our FAIR plan has increased so dramatically in numbers of policies. I think this actually aligns with some points made earlier that we're going to really be taking into consideration the insurability of where we build and how we build because as premiums escalate, this becomes something that just isn't a minor consideration in the process. It becomes essential that you need to have insurance, and it needs to be affordable so, the only way to do that is to reduce losses or build in a way that reduces the likelihood of losses. And I think we're all on that path. The challenge is we're in a built-out environment of many years that didn't necessarily make all those considerations, and those homes are having challenges finding coverage or affording that coverage. And, again, that’s why we have a FAIR plan if you can't find coverage, but the FAIR plan is very expensive coverage. So it is the underwriting rules that determine if the insurer gets to choose whether it writes a home or not.

Mr. Kevelighan stated that I would add that anytime you have one of the FAIR plans that is the number one insurance provider in a state, it's usually an indicator of market issues, market troubles. In California's case, we went through the kind of regulatory issues that they had. In a state like Florida, they've had significant legal system abuse. Before they were reformed down in that state, the state of Florida had close to 80% of all homeowners litigation for the United States in that state. Those increase your risk as well. One time I actually encountered a realtor, and we were looking at a property and

she said, “you're lucky you're on the side of the street that doesn't flood so you don't need to get flood insurance.” We actually have now done a handbook with the National Realtors Association so that realtors understand that they need to help their customers be more resilient because a realtor isn't selling that one home. They want to sell a lifetime of homes and in order to have a home for a lifetime, the area where it's building and where we're buying, needs to be sellable and survivable and insurable. So, you're absolutely right. And it's just things like the building codes, unfortunately, move at a glacial pace. And so that's why some of these strengthen home initiatives that thankfully NCOIL has been promoting, allows the constituents actually to retrofit which is one of the harder things to do is to spend the money to retrofit an existing property. That incentivization is going to be really critical to building community resilience.

Rep. Bennett stated to Mr. Laucher that in his presentation there were recommendations for coverage expansion in policies. Are there any carriers that are voluntarily adopting some of these things like the added additional living expense, because that sort of is a more competitive way of improving things for consumers, but also not doing so through sort of punitive measures from the state. As a Democrat in Oklahoma, I wish that we could do more consumer friendly stuff but I also see what happened in California and my Insurance Commissioner, Glen Mulready, has done a great job of helping me understand why there was a good spirit behind ideas there, it didn't end up being good. Are you seeing carriers voluntarily adopt this because it might make them more competitive? Or do you think it will require state regulation to get some of these policies updated?

Mr. Laucher stated that I was with the California Department of Insurance for 35 years and was sent out to assist with the claims process to many locations post wildfire. And many insurers had implemented the changes that I spoke about as part of expediting the process for people in these challenging situations. They weren't necessarily something they had implemented in their standards, but it was part of their response when they arrived at these locations, and you saw them writing checks for the contents payout. Or before it was allowed, we'll let you take your additional living expense and buy a motor home instead so that you can kind of oversee your rebuild process. A lot of this has happened and some of it's beneficial to the insurer. It just gets rid of the paperwork and the details that take up a lot of time. But it also is great customer relations. And insurers are all people and their claims adjusters are often people that live nearby the community where they are interacting. And, it doesn't take much when you visit one of these sites of a post-catastrophic event to make you want to do more or be better. And so I think a lot of insurers have responded to this. Most of these reforms that we have in place in California only got there because the industry accepted those provisions and worked with the legislators to do things they were willing to do.

Rep. Bennett thanked everyone for their comments and stated that the topic hits close to home for me. My childhood home caught fire several years ago. And while it didn't burn the whole place down, it was a total loss between smoke and fire damage and water damage. And because my parents had really good insurance coverage, I think that the most human thing that I can tell about that experience was while we are years later still realizing things that we lost in the fire, the most important thing for us was my mom was

a really good scrapbook artist. She didn't just put pictures in a folder, she added art and really beautiful stuff. And we have a cabinet full of them. And they were all in the house and all because of a specific endorsement on the policy they were able to be restored by some experts here in Oklahoma City. And my mom now has dementia, and so she is losing her memory, but all of the memories that she created for us are protected now.

ANY OTHER BUSINESS

Hearing no other business raised, Rep. Bennett stated that I would like to remind everybody that registration is open for the Spring Meeting in Charleston. And also, if you were in San Antonio, you may recall there were a couple of announcements regarding upcoming NCOIL items. One is that NCOIL will be going through a strengths, weaknesses, opportunities, and threats (SWOT) exercise this year. And the other one relates to a handbook that's now being put together by NCOIL that memorializes and formalizes certain practices that NCOIL's has been following for the last several years that longer-term members know about but new members may not know about so that everyone who comes to NCOIL has a playbook to use and is fully aware of the processes. I think both of those are great ideas, and I'm glad they're happening, and you should be getting an email about that.

ADJOURNMENT

Hearing no further business, upon a Motion made by Rep. Mayfield and seconded by Sen. Utke, the Committee adjourned at 2:30 p.m.

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CHIEF EXECUTIVE OFFICER: Will Melofchik

National Council of Insurance Legislators (NCOIL)

Online Marketplace Guarantees Model Act

***Sponsored by Rep. Brian Lampton (OH)**
***Draft as of June 14, 2024. To be discussed and potentially considered by the NCOIL Property & Casualty Insurance Committee on April 26, 2025.**

****Any proposed amendments to the Model will be distributed before the Committee's meeting in April.****

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.

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, unless guarantees (or suretyship) are specifically excluded from insurance regulation under current state law. In such instance, all references to "commissioner" should be amended to refer to the state attorney general except where noted.

B. "Online marketplace" means a person that does both of the following:

(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. The term "online marketplace" does not include

(i) any local or state governmental entity or vendor or

(ii) any entity for which the offering or sale of an online marketplace guarantee is its primary vocation and not merely incidental to another legitimate business or activity.

C. "Online marketplace guarantee" means a contract or agreement issued in connection with the 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 an online marketplace, 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 an online marketplace, 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) Providing support services to providers or platform users related to online marketplace guarantees.

(4) 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 limit amounts payable to a platform contract holder by means of a deductible, provided that such deductible is disclosed pursuant to Section 7.F of this Act.

Section 5. Additional Online Marketplace Products and Services

A. A provider may obtain one or more insurance policies that provide group or blanket liability insurance coverage (which may include medical payments coverage), business interruption or similar coverages to platform users.

(1) Such group or blanket insurance coverage may:

(a) be provided under a policy issued in this state:

(i) by an insurer authorized to transact property and casualty insurance in this state, or

(ii) in compliance with the provisions of Chapter [cite surplus lines statutes].

(b) be provided under a policy issued in another state in compliance with that state's law.

(2) The premium for such insurance policies, including certificates, may be paid by the provider from the funds contributed by the provider or platform users.

B. A provider may offer or provide value-added non-insurance products or services in connection with an online marketplace guarantee. Provision of such value-added products or services (i) may be at no or reduced cost and (ii) shall not be deemed an unfair trade practice; provided, that if such product or service is offered in connection with an insurance product, such offering shall be subject to the provisions of Chapter [cite insurance unfair trade practices statutes].

Section 6. 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. As applicable, an insurer that issues a reimbursement insurance policy shall not terminate such policy until a notice of termination in accordance with [insert citation to the law that governs the termination of insurance contracts] has been mailed or delivered to the commissioner. 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.

Drafting Note: This reference should be to the state insurance commissioner, even if other references are amended to refer to the state attorney general pursuant to the drafting note in Section 1.

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 7. 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 backed only by the full faith and credit of the provider (issuer) and are not guaranteed under a reimbursement insurance policy."

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 deductible.

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 8. 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 9. 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 9 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 10. 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 11. 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.

616 Fifth Avenue, Suite 106
Belmar, NJ 07719
732-201-4133
CHIEF EXECUTIVE OFFICER: Will Melofchik

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~~ March 26, 2025. To be discussed during the ~~interim~~ meeting of the Property & Casualty Insurance Committee on ~~October 7, 2024~~ April 26, 2025.

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

(a) "Aerial image" means an image of a named insured's property captured from an airborne platform.

(b) "Nonrenewal" means a termination of property insurance coverage that occurs at the end of the policy term.

(c) "Renewal" means:

(1) the issuance and delivery by an insurer at the end of a policy period of a policy superseding a policy previously issued and delivered by the same insurer; or

(2) the issuance and delivery of a certificate or notice extending the term of an existing policy beyond its policy period or term.

Additional definitions of other terms may be included in later versions of the Model. Comments are welcome and encouraged as to which 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). This documentation shall be used by the insurer in considering whether to uphold or reverse the non-renewal.

(c) ~~Disclose the risk scoring system criteria used and~~ Establish an appeal process so the consumer can correct any errors~~,~~ or misunderstandings related to ~~their risk score and modify the risk score where warranted~~ the non-renewal.

(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~~ have cured the defects/conditions identified in subsection (a). However, an insurer may non-renew the policy in question but only for a reason unrelated to the defects/conditions identified in subsection (a).

Drafting note: States may wish to include language clarifying that this law is applicable to a state's FAIR plan or the last-resort insurance options available in the state.

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.

Please click on this link for language that Rep. Lampton plans to offer for discussion as a potential amendment to the Model Act Regarding Insurers' Use of Aerial Images: https://ncoil.org/wp-content/uploads/2025/03/Aerial-Imaging-NCOIL-amendment-offer20250130.pdf

JOINT STATE-FEDERAL RELATIONS & INTERNATIONAL INSURANCE ISSUES COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
JOINT STATE-FEDERAL RELATIONS & INTERNATIONAL INSURANCE ISSUES COMMITTEE
2024 NCOIL ANNUAL MEETING – SAN ANTONIO, TEXAS
NOVEMBER 24, 2024
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Joint State-Federal Relations & International Insurance Issues Committee met at The Westin Riverwalk Hotel in San Antonio, Texas on Sunday, November 24, 2024 at 9:00 a.m.

Kentucky Representative Rachel Roberts, Chair of the Committee, presided.

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Rep. Deborah Ferguson, DDS (AR)
Rep. Matt Lehman (IN)
Rep. Brenda Carter (MI)
Sen. Lana Theis (MI)
Sen. Paul Utke (MN)
Rep. Bob Titus (MO)
Sen. Walter Michel (MS)
Sen. Jerry Klein (ND)
Sen. Pam Helming (NY)
Rep. Ellyn Hefner (OK)
Rep. Tom Oliverson, M.D. (TX)

Other legislators present were:

Rep. Stephen Meskers (CT)
Rep. Matthew Gambill (GA)
Sen. Larry Walker (GA)
Rep. Brian Lohse (IA)
Rep. Rod Furniss (ID)
Rep. Peggy Mayfield (IN)
Rep. Bill Sutton (KS)
Sen. Jason Howell (KY)
Rep. Mike Meredith (KY)
Rep. Cherlynn Stevenson (KY)
Sen. Mark Huizenga (MI)
Sen. Hillman Frazier (MS)
Sen. Bill Gannon (NH)
Asw. Catalina Cruz (NY)
Asm. Erik Dilan (NY)
Sen. George Lang (OH)
Rep. Mark Tedford (OK)
Sen. Patty Kuderer (WA)

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. Ellyn Hefner (OK) 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 Rep. Deborah Ferguson, DDS (AR), NCOIL Immediate Past President and seconded by Rep. Matt Lehman (IN), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 18, 2024 meeting.

CONSIDERATION OF NCOIL MODEL ACT IN SUPPORT OF MENTAL HEALTH WELLNESS EXAMS

Rep. Roberts stated that we will start today with consideration of the NCOIL Model Act in Support of Mental Health Wellness Exams (Model), a Model which I am very proud to sponsor. You can view the model on page 330 in your binders and on the website and app. To provide some brief background on where we started and where we are now, we had a great session focusing on mental health parity at our summer meeting last July in Minneapolis. And after that I decided I really wanted to keep the conversation going and hopefully have NCOIL adopt some model policy on the issue. If I'm not mistaken, that conversation last July was the first time in decades that NCOIL really had a session that focused solely on mental health and mental health coverage. That conversation initially started with a bill I sponsored in Kentucky which was very straightforward and simply requires insurance companies to provide coverage for an annual mental health wellness exam that is performed by a mental health professional.

We then decided both at NCOIL and in Kentucky to expand that legislation to include several other related provisions but it became clear the consensus on that was probably not realistic, although I do hope that you all will continue to discuss those issues which were mostly around substance use disorder treatment. So that leads us to today, and I've essentially gone back to the original version aiming to require coverage for an annual mental health wellness exam.

Thank you to everyone who has provided feedback on this throughout the past year. This has truly been a collaborative effort and I have indeed incorporated many of the requested changes. In fact, since the model was distributed in the 30 day materials, I made one technical change in the model in Section 4(b)(1) on page 332 to align it with other provisions in the model. I hope that the committee will support this model, and I look forward to the discussion we will have around it today.

David Lloyd, Chief Policy Officer at Inseparable, thanked the Committee for the opportunity to speak and stated that we're a non- partisan, a non-profit organization that works to build a future where mental health policy is advanced and where mental health is treated as a critical piece of overall health. Our main priorities are increasing access to care, addressing our youth mental health crisis, expanding the mental health provider workforce and building a crisis system that gets people the help they need and removes critical burdens that now fall primarily on law enforcement. Inseparable strongly supports moving upstream and helping identify and treat people's mental health and substance use disorder challenges earlier. And therefore, we strongly support efforts to increase access to mental health wellness exams and we thank Rep. Roberts for bringing this model forward. Approximately one in four Americans, about sixty million

Americans have a diagnosable mental health condition, but fewer than half are receiving any mental health treatment. And the numbers are particularly stark for youth. Indeed, three in four mental health conditions develop by the age of 24, and approximately 13% of youth ages 12 to 17 have reported experiencing serious thoughts of suicide based on the most recent data.

And alarmingly, one in five of our youth has had at least one major depressive episode in the past year and nearly half of those six million youths, nearly three million, did not receive any help despite having a major episode. Nearly 20% of Americans also have a substance use disorder, yet 90% of Americans don't receive any treatment. And just yesterday there was a report that alcohol related deaths have doubled since the 1980's. And unfortunately, although teenagers and young adults developing mental health and substance abuse disorders often show significant warning signs, there's really long delays in getting them the help that they need. For example, when a young person is experiencing symptoms of early psychosis, which often precedes bipolar disorder or diagnosis of schizophrenia, the average time they wait before receiving any help is 74 weeks, about a year and a half. This is really simply tragic. During this time, young people often become sicker and as time goes by, more difficult and expensive to treat. So, ensuring access to no cost sharing, mental health wellness exams just like physical health is a critical step forward. Indeed, improving affordability is one of the most important parts of mental health wellness exams. States like Colorado, Connecticut, and New Mexico have moved forward with mental health wellness exams because they want to increase affordability and get people hope early before mental health and substance abuse disorders worsen and drive overall physical healthcare costs higher.

And this is because there's overwhelming evidence that individuals with untreated mental health and substance use disorders do drive overall health care costs higher. Milliman found, based on claims data, that people with these diagnosis have between 2.8 and 6.2 times higher physical health care costs depending on the exact diagnosis, yet most receive little or no treatment. These costs also are very high because we're only intervening at very late stages and the results are frequent emergency department visits, hospitalizations, uncontrolled physical health conditions, and very often for many, incarceration, which is extraordinary costly to local and state governments. And this is perhaps not surprising given that when these illnesses are not treated, cognitive functioning is what is impaired so you often see that they are unable to control their physical health and overall well-being. So I urge the committee to take this important step forward of supporting the model. Inseparable is happy to work with legislators in your states to advance this important issue. We also look forward to being engaged in NCOIL next year and beyond on these important issues.

Sen. Bill Gannon (NH) asked what are the costs associated with this, and also, if I go for one mental checkup a year, is that really going to do anything? Mr. Lloyd stated that one visit can help identify early challenges that individuals may have so we can get them services early on when it's much more cost effective to treat these conditions.

Rep. Roberts stated that to add to that, the underlying goal of the model is to normalize mental health care, and also to make sure that patients have someone that they're

already in a relationship with so that should they get to a moment of crisis, they know who to call and we're not seeing them so much necessarily at the emergency room and those kinds of things. And then also in states like mine, we want to to help drive mental health providers to the state where we have a shortage so that they can start to build their practices there. As far as cost goes, in Kentucky, if we were to layer this over the state health insurance plan, the maximum cost that we saw would be potentially up to $3 per month per insured.

Hearing no further questions or comments, upon a Motion made by Rep. Ferguson and seconded by Rep. Lehman, the Committee voted without objection by way of a voice vote to adopt the amendment to Section 4. Then, upon a Motion made by Rep. Ferguson and seconded by Rep. Hefner, the Committee voted without objection via a voice vote to adopt the Model, as amended. Rep. Roberts thanked everyone and stated that the model will now be placed on the Executive Committee's agenda for final ratification.

CONSIDERATION OF RESOLUTION IN SUPPORT OF ESTABLISHING CATASTROPHE SAVINGS ACCOUNTS

Rep. Roberts stated that next on our agenda is consideration of the Resolution in Support of Establishing Catastrophe Savings Accounts (Resolution). You can view this in your binders on page 333 and on the website and app. We hope to be voting on this resolution today. We had a great discussion on this resolution at our last meeting. No opposition has been raised but before we go any further I will recognize Sen. Walter Michel (MS), one of the sponsors of the Resolution.

Sen. Michel stated that 'm proud to sponsor this resolution. Mississippi is one of several states that's enacted legislation for catastrophic saving accounts. Just as someone can prepare for a health savings account (HSA) for expected or unexpected healthcare costs, one can prepare a tax advantage account for natural disasters. This past year obviously, we've seen several hurricanes, storms, floods, and tornadoes, and I think it's a very appropriate time to get behind this type of legislation and I ask for the committee's support of this resolution.

Rep. Lehman, one of the sponsors of the Resolution, stated that if you were at the NCOIL-NAIC Dialogue yesterday, you heard me bring up the scenario of a situation we're seeing now in the marketplace of deductibles moving to a percentage deductible or a very high deductible and actual cash value (ACV) on the roof. And you're creating almost an exclusion in some cases of roof coverage. Give me the opportunity to create something that can backfill that and I think this is the perfect vehicle for that, and allow me to meet those deductibles and meet those criteria. I absolutely support this resolution.

Kevin McKechnie, Executive Director of the Health Savings Account Council at the American Banker's Ass'n thanked the Committee for the opportunity to speak and thanked the sponsors for all of their work on this. When we last met, we had not yet seen what happened in North Carolina and the challenges at the Federal Emergency

Management Agency (FEMA). There has been a federal disaster savings account bill introduction that occurred November 12 when newly re-elected Florida Senator Rick Scott introduced a version of a previous bill. Just as a refresher, 10 years ago the late Oklahoma Senator Jim Inhofe introduced a bill that is, I think, the comprehensive standard, which is to say, if a state experiences perils like wildfire or flood or convective storms, you're encouraged to mitigate against those things which you could spend your funds on. And then you're encouraged to remediate if you suffer from that catastrophe in a way that would be very similar to an HSA. In other words, tax advantage contributions to the account. Tax advantage build up of the assets in the account. And then tax advantage disbursements from the account for the things the Internal Revenue Service (IRS) says are either mitigation or remediation. Just like the HSA model. And again, just to refresh, three states have them now - South Carolina, Mississippi and Alabama. Several states have called in between the July meeting and now are saying they are going to introduce them and so we're consulting on that. And there is this federal legislation which will have to be reintroduced next year. Those of you who would like to read it, it is S. 5296. It will not pass this year. It's a flag in the ground, and a marker of things to come.

In July at this Committee's meeting, I was lucky enough to be joined by a friend of mine, Kirsten Trusko, Co-founder of Payments as a Lifeline (PAAL). The way we manage disasters in this country is not with the government, it is with charities first. And so, the proposals for managing disasters in this country include provisions in the disaster savings account policy, which would allow charities to put money in this account so that it could be used for these mitigation questions. The money that they put in would not be taxed advantaged. The reason the charities want these accounts is because there's no better individual verification system than the financial system, the know your customer rules in banking. And so, fraud wouldn't be eliminated, but it would be minimized if we did this. The other thing that's come up is FEMA and the small business administration (SBA) have made informal inquiries about allowing accounts for small business and sole proprietorships. As you know, a small town can't get back on its feet unless the businesses in that town get back on their feet. And so, we're willing to think about that. I haven't thought about that, but it would be something else that the policy you're putting in place today would contemplate. And I suppose I'll conclude with this. We're not voting on a bill here. We're voting on a concept. The concept would be better preparing Americans by allowing them to save tax free over time and helping them understand that vigilance begins with them, not the government, with them. And that's why HSA's are the powerful tool that they are.

Paul Martin, VP of State Affairs at the National Association of Mutual Insurance Companies (NAMIC), thanked the Committee for the opportunity to speak and stated that first, I want to thank Mr. McKechnie for his ongoing thought leadership on this topic. He and I started this conversation years ago and he was updating me in on what he's been working on for quite some time. I know from our side of the equation from our industry, we are very supportive of this. These accounts do two things. Most importantly, as Mr. McKechnie mentioned, the first thing they do is they allow consumers, your constituents, to save money by putting money into an account tax free to pay for things like deductibles. To pay for things like repairs after a disaster. So, this

is not just protection of their property. This is also financial protection for them as well. The second thing they do, and perhaps even more important than the first thing, is that they help us create a culture of preparedness and resiliency in America that we desperately need right now. My social media feed is filled with disaster after disaster. It's not just heartbreaking, and it's not just affecting their lives in terms of their homes, but it also affecting their finances. And so to the extent that we can come up with mechanisms to help them bear that burden, we should. We should be advocates for that. I'm really pleased that NCOIL is taking this up as a resolution and we should continue this conversation down the road.

Sen. Paul Utke (MN), NCOIL Treasurer, stated that we're looking at savings accounts like the HSA's where you've put money in. Let's say you had $10,000 or $15,000 in this account and you never needed to tap into it. How and when would you recoup that money when you sell your property or after 20 years? What's the end game on this?

Mr. McKechnie stated that these are bona fide trust accounts so they're operable as trust accounts under state law. They would be federally regulated. As you put money into your account, if you have to make a disbursement for a resilient roof or new base flood elevation certificate, or you would like storm resilient windows or whatever it might be, whatever is allowable under the IRS code, that spend inures to the value of the structure you're trying to protect. And so, recouping the money just means you're going to keep saving so the HSA model would apply here, meaning as you save money, by the time you get to a health event, if you spend that money to either manage your deductible or manage your recovery and then you go back into the saving mode. And so, the balances do go up and when they come down on distribution they simply go down. Recouping the money requires you to exert the same amount of diligence you used to save the money in the first place to save the same amount of money in the second place. So, no one reimburses you. It is envisioned, however, that these accounts would act just like the HAS's, they'll be an employee benefit as well. And so, while there is a maximum annual contribution into the account under the existing proposals, the distributions from that account can be whatever is required but there are limitations on what can go in because you can't just put an unlimited amount of money in the accounts but there is no limitation on what comes out depending on the scale of the calamity that you experience.

Sen. Utke stated that just for a little clarity, I like this, but I guess we would have to plan as we would downsize our account because let's say you went along and now we've reached an age where we no longer are going to own a home. We'd want that account to be zeroed out, use it for the eligible deductions up to that point. Otherwise, let's say there was $5,000 left in the account and you sold your home, what would happen to that money? Mr. McKechnie stated that I'm being placed in the position of giving unlicensed financial advice, but I will read from the bills that I know. These are bona fide trust accounts. It means you must nominate a beneficiary. Just like your HSA account has a beneficiary, it would be a disaster savings account and under the current proposals, if you passed away it would become your spouse's account. Under the Sen. Scott bill, they treated a little differently, which is to say, if your surviving spouse nominated a child, for example, as the beneficiary of the account, when those funds transferred to that

child, it becomes a taxable moment. But those funds would be available for the child to put in their disaster service account. So, generationally, the difference between the Sen. Inhofe approach and the Sen. Scott approach, the latter allows one generation of tax accumulation, then there's a tax moment, but that money can go into your children's account to protect the home they're in, so zeroed out in a way. The Sen. Inhofe bill is more permissive. It allows those accounts to go generation to generation on the assumption that the cost of repairing the damages are going to go up, not down.

Rep. Lehman stated that at age 65, I can cash out my HSA for anything I want to use it for - can I do the same thing with this? Mr. McKechnie replied, yes. You would pay income tax on that money, but no penalties.

Rep. Ferguson asked if the accounts apply to both commercial and residential properties. Mr. McKechnie stated that Sen. Inhofe bill creates a category of eligible individuals, and it says any eligible individual living in a residence. And so, what they mean is any single family, multifamily, or condominium that is your residence. And it would also apply to renters. It would not apply to commercial structures unless we were able to create an account for, as FEMA and SBA suggested, for a small business.

Rep. Ferguson asked if you have to file a claim to utilize the accounts? Because we'll have big deductibles and to fix broken glass or things like that, it's going to be way less than the deductible. Can you utilize it for those kind of repairs even though you don't file a claim? Mr. McKechnie replied yes, what you can put in the account and what you can use those dollars for in terms of mitigation and remediation act independently of how you treat the insurance product or the insurance triggers.

Rep. Ferguson asked if the account is limited to one primary residence or can it be used for multiple properties? Mr. McKechnie replied the accounts would operate like HSA's in the sense that a person owns them and the coverage they would have would either be for themselves or for a family and that really only applies in the health model. You don't have to have a property and casualty policy in place to be an eligible individual under the proposals so you'd be able to do whatever you wish with that money. So you could apply to two different residential properties.

Rep. Dennis Paul (TX) asked if you can pay your insurance premiums out of the account? Mr. McKechnie replied under the Sen. Inhofe proposal the answer is yes. Under the Sen. Scott proposal, the answer is no. And this is not an unimportant question because Sen. Bob Hackett (OH) asked a flavor of that question in July during this committee's meeting and the point would be if you had a shock increase in the amount of premium you owed, could you use those dollars to cover the delta in it and if that was a favorable amendment, we would certainly accept that. There would be difficulty defining what that meant at the federal level but we were certainly being in favor of that. Now the other way to manage that of course is if you have a shock increase in premium, can you mitigate that increase in premium by increasing your deductible? Because there's no question that you can use those dollars to pay your deductible and so that changes the algorithm, as you're all aware of what the actual product costs. Rep. Paul stated that might allow more people to buy insurance as we talk about how

important it is in making sure that we have insurance. If you're getting pre-taxed dollars you can really save a lot of money by buying insurance even if you take the high deductible on that.

Hearing no further questions or comments, upon a Motion made by Rep. Lehman and seconded by Sen. Utke, the Committee voted without opposition by way of a voice vote to adopt the Resolution. Rep. Roberts thanked everyone and stated that the Resolution will now be placed on the Executive Committee agenda for final ratification.

PRESENTATION ON PATENT PRACTICES IN THE PRESCRIPTION DRUG MARKETPLACE

Rep. Roberts stated that last on our agenda is a presentation on patent practices in the prescription drug marketplace. I do want to note that PhRMA was invited to participate in this session and they were originally scheduled to, but due to scheduling conflicts, they ended up not being able to provide a speaker.

Wayne Brough, Resident and Senior Fellow of Technology & Innovations at the R Street Institute, thanked the Committee for the opportunity to speak as I think it's an important issue that does have significant impacts on the price of healthcare and the price of health insurance and innovation itself in this space of new drugs and new treatments and therapies. I'll start with what are patents, what they do, what they're supposed to do, and where they really are. And they're sort of distinct from a property right on physical property as it's more of a regulatory framework to promote innovation. It takes a lot of capital to produce drugs and get new drugs to market. It's a lengthy process. It can take 12 to 15 years. So there's a lot of investment that goes on. The patent gives the protection of a certain period of exclusivity that allows those drug makers to then be the sole provider in that market and that generates the profits that can support the research and development (R&D) and move forward in that space. At the same time, once the patent is done, that knowledge goes to anyone and that's where the generic drugs come in where they can produce and compete with the original brand name drugs and it tends to lower prices very quickly. If one generic gets into the market, there's about a 20% or 30% percent reduction in price. With two, it comes down to 50% and you can drastically drop if you get five new generics in the market as prices can drop down by 70% or 80%.

So that's the way the market is set up. But what has happened over time is there's been a certain type of amount of gamesmanship that happens and what we're seeing is what we call patent tickets, where you'll have a blockbuster drug and that drug can have up to 100 patents on it. That makes it difficult for anybody to get into that space and compete with that brand name drug. And as these patents sort of protect that drug, you see delays in competition. You see it harder for generics to get into that market and a lot of these patents are not as inventive as the original. There's primary patents and secondary patents. The primary patent is the active ingredient, the chemical that makes the therapy happen. Secondary patents can be anything around that. It could be the manufacturing process. It could be say you change it from a tablet once a day to a twice a day tablet or you change it from a pill to a capsule. All of those things can be patented.

And they start to pile on and each one of those provides another extension of exclusivity so you end up with in a situation where we in the U.S. see drugs being delayed further than they are say in Europe where some of these practices aren't allowed, where important new drugs and biologics get into the market much quicker because they're not playing the sort of gamesmanship that we see here in this country in terms of patenting. So first of all, what does this mean? It means it has an impact on innovation because if you are a new drug company and you're trying to compete and find a way to get into the market where a brand name has a patent thicket with hundreds of patents protecting its products, it's hard for you to get into that market. It's hard for you to innovate and provide new products because there's always a threat of litigation from the brand name manufacturer. And it's a cost on consumers and taxpayers and healthcare providers because all of these things extend the higher prices because you don't really see price cuts in these markets until the generics actually get into the marketplace. And the longer you can delay the generics from getting into the marketplace, the harder it is to innovate and those are costs that are paid by taxpayers, patients and healthcare providers and healthcare programs.

And then again, there's an impact on competitors. If it's hard to get into that market, we're not going to see competition like in other markets in terms of driving prices down and just seeing how the economics play out. You don't see that in a situation where you have these patents. And for instance, Humira, which was a huge blockbuster drug. It had over 100 patents on it and 66% of those patents were filed after U.S. Food and Drug Administration (FDA) approval and it led to $87 billion in additional revenue before the patent ultimately expired. And the generics for that drug were available seven years earlier in Europe than they were here just because of the way the patent system works here. Revlimid is another one where 74% of the patent applications came after the launch of the product. So these are sort of continuation patents that you're not really inventing anything new. In fact, if you issue a continuation patent, you're not allowed to make new additions to the patent. You just say there's a new claim on that old patent. So there's a lot of things that are happening in this space. With Eliquis and Enbrel, it was a seven to ten years delay compared to Europe in getting these things into the market in the U.S. So you have all of these blockbuster drugs and we want to see the brand name manufacturers innovating because they do produce probably the best drugs in the world but when you have all these patents and sort of the gamesmanship that goes on, it makes it difficult for the providers and patients to enjoy the benefits of these and have access to drugs at an affordable price.

There are three things that are big challenges here. These patents and the patent thickets keep drug prices artificially high. That’s the first problem. The second is we delay competition and delay the entry of generics and again, that's an impact on the system of healthcare who has to pay those prices, particularly if you compare how that plays out in the U.S. versus in other countries. And the third area is you actually end up diverting resources away from real R&D to more of a monopoly protection system where you have these patents and if you have a blockbuster drug, you're talking about tens of millions of dollars for every day that patent is extended. So brand name drugs have a strong incentive to put these patents out there to keep these blockbuster drugs in place but when they do that, that's taking resources away from R&D on new and other

innovative things so you end up investing more in monopoly protection versus innovation and new therapy. So those are some of the challenges - how do we fix this? I would say there's two things. We want to make sure that when patents are issued, they're issued for real, inventive, novel uses. That's the first thing. The second is, the patent system is not perfect. We get bad patents in the system. So we need a way to find where those weak or invalid patents are and get them out of the system efficiently. So, those are the two most important things we can do, I think, to improve the way the patent system works. And then I would say another area we could look at is sort of promoting clear pathways for generics to get into the marketplace, particularly with biosimilars, which are the more complex drugs. It's not as clear cut as it is with small molecule drugs, which are the older drugs that we all are familiar with. Biologics, they're harder to manufacture. There's a lot of overlapping patents there which are probably really more valid. They're not those where we change it from a tablet to a pill so we need a new patent. These are complex manufacturing issues. But identifying a pathway to get into that space I think is very important in terms of trying to improve the process and make the system work like it's supposed to.

In terms of what's happening in DC on this, the Senate passed the Affordable Prescriptions for Patients Act in the summer and that is one way to get at the patent tickets. This is a bill by Sen. John Cornyn (TX) that was specifically addressing the role of patent tickets and how to get out of that. There's two other bills. The Patent Eligibility Reform Act which I think takes things in the wrong direction by making it harder for competitors to get into the market. That is sort of floating around. It came up for an early hearing and they were hoping it would be done by the end of the year but that has not happened so I think that'll be a live issue in the next Congress. The PREVAIL Act was passed just this past Thursday and again, I think this one takes it in the wrong direction. It makes it harder for a post patent review. There's something called the patent trial and appeal board at the patent office where if there is a problem with a patent, you can take your case to the patent trial and appeal board. It’s quicker than the court system. It’s effective as you have three patent experts on the board that make the final determination. But the Act actually limits which cases you can bring before this board. So I think that one is in my mind problematic, but it probably will move forward in the next Congress. And there's another one probably moving forward called the RESTORE Act which basically overturns some important U.S. Supreme Court decisions that sort of laid out patent policy. In the past, if you challenge a patent, you could automatically get an injunction issued by the courts. There was an important U.S. Supreme Court decision on eBay which the judges said, “No, you can't automatically do an injunction. You have to follow these processes.” The RESTORE Act would overturn that and make it much easier to get injunctions and those injunctions would impede competition in this space. And again, if all the patents are good, maybe that's not an issue but with all these patent thickets and a lot of these unnecessary, non-inventive patents, if you can get an injunction by claiming there's an infringement on a non-inventive patent, I don't think that helps in terms of innovation or moving the ball forward in terms of getting better therapies to the marketplace.

Rep. Roberts stated I’m hoping you can validate whether something I heard in a story was true - where a secondary patent was effectively issued for something like an asthma

inhaler but nothing changed with the formulation, just the cap on the inhaler had something like a tab on it that would allow the cap to not fall all the way off when you used the inhaler. Is it accurate to say that extensions of patents are issued based on something as small as that? Mr. Brough replied yes, that does happen and that's a perfect example of the secondary patents and how they're non-inventive and yet they get the same coverage as the first primary innovative patent. And it allows the extension of that exclusivity and keeps competitors out of the marketplace for a longer duration of time.

Rep. Stephen Meskers (CT) stated that in prior years, the U.S. House Ways and Means Committee has reviewed drug pricing, particularly the U.S. versus Europe, and I believe the pricing differential is about three to four times higher in the U.S. for drug prices. And it's the biggest challenge we face as legislators is working to provide affordable healthcare. But right now, we seem to be chasing pharmacy benefits managers (PBMs) but I'm not convinced that once we finish chasing the dollars from PBMs it ends up with our constituents. If we're looking at patent reform as one of the solutions of that differential in pricing between other countries and the U.S., if we tighten up our regulatory reforms, what would you expect the pricing differential to be for the same pharmaceutical drugs between the U.S. and Europe? How close could we get to parity in pricing? Mr. Brough stated it's a little bit complicated because we have drug reimportation restrictions as well, which is another area that's worth pursuing, but I think you would see substantial reductions, particularly in some of the more expensive drugs. And it does vary on some drugs. As I said, once you get competition in the marketplace, once you get more than three generics in that marketplace, you can see 50% to 70% savings on those things. The more expensive biologics are much more complicated and more expensive so you won't see as much of a drop just because even if you're a generic, it's going to cost more to produce those drugs. But I think you would see probably at least 30% drops in prices at these drugs.

Rep. Meskers stated just to quantify and I know it's a hard number but we're talking 30% if we're at a $300 premium, you'd be talking about a $210 premium instead of a $300 premium. Mr. Brough replied probably for some of the biologics, you're probably in that space. For example, when Humira extended their patents through these thickets it generated an additional $74 billion for the company so those kinds of costs would go away if you got rid of the patent thickets that you see in the market today.

Rep. Tom Oliverson, M.D. (TX), NCOIL President, stated that we've been talking about this issue at NCOIL for a while and I know that it's interesting that Rep. Meskers is asking questions and I'm asking questions but it's actually our U.S. Senators, Sen. Richard Blumenthal (CT) and Sen. Cornyn, that have really led the charge on this for years. And I guess my question is, do you know what the status is of their bipartisan bill? It's passed the Senate. Is the House going to take it up? Is it going to pass? Mr. Brough stated that there are a lot of things happening in the House right now so we're trying to figure that out. I think there is enough interest that we will see that. I will say that the bill that made it out of the Senate was watered down a little. It went after patent thickets and that is still in the bill. There's another practice called product copying where you get drug companies that make changes or they'll introduce a new version of the

drug and then go out in the market and urge doctors and providers to just make the change to the new drug. And the bill had some language in it originally where the Federal Trade Commission (FTC) would look at those practices. That part has been stripped out so now it's purely looking at the patent thicket side of things. I do see that as potentially moving forward. There's also a couple of other bills, I think Sen. Peter Welch(VT) has a bill that may move forward that looks at some of these issues. But for now, I would say troubling from my perspective is that at the top of the legislative list are the Patent Eligibility Reform Act and the PREVAIL Act and I think both of those go in the opposite direction and make it even harder to challenge some of these secondary patents that are keeping costs high.

Rep. Oliverson stated again, we've been looking at this issue for years and the reason that I mentioned Senators Cornyn and Blumenthal is because it seems like those are the guys that really have taken this issue on and have taken all the arrows and you know all the attacks and the lobbying and all that stuff and they've been working on this together for years. I don't see anything that we can actually do at the state level to address this, even though it's just crushing our patients and our consumers. And it's one of these lobbying things that just irritates me about our government system where we're just piling dollars in the corner and spontaneously combusting them to prevent something from passing that everybody knows really ought to pass. What can we do at the state level? Mr. Brough stated that patents are in the U.S. Constitution something of a creature of Congress so it is sort of a slight step away to look at what states can do. But obviously, every state can make the point that their Medicare costs or Medicaid costs are higher and let your Representatives and Senators know that it's something that you're hearing at the state level. You're hearing from patients or patient advocates who show that these costs are making it harder for people to keep their prescriptions filled. But it is a challenge. I think the debate has been dominated by Senators Thom Tillis (NC) and Chris Coons (DE) who are very much in the camp of let's make patents as strong as possible and not look at some of these problems with patent thickets. And I think last year, at least for me, it's been frustrating trying to work with them to move these bills forward and some of the problems are that patents aren't just for pharmaceutical companies, it affects all businesses. And there's sort of a tech lash going on in DC where everybody hates big tech and they are very much in play in this patent dispute over reform and unfortunately, issues that they're taking out on big tech are sort of bleeding over into the healthcare side of things.

Rep. Oliverson stated but do they have the same issues in big tech that we have in the pharmaceutical side of things where you string together essentially 500 patents on one process in an attempt ensnare competition? Because that seems to me to be pretty unique to the pharmaceutical industry. Mr. Brough stated that is very unique to the pharmaceutical industry. In the tech space, everybody has licenses and they basically license with each other, so you don't see this. You don't see patents being used as a way to keep generics out of the market, that kind of thing doesn't happen. But the bigger issue I think is just the way the committees in DC are looking at this. They're getting away from the pharmaceutical aspect and we've been sort of pushing the healthcare impacts and over the last year I've done a lot of work to show the impact on drugs and

impacts on patients are something that you should not ignore. But unfortunately, I think it is not the top issue when the people are discussing patent reform.

Rep. Oliverson stated that it's frustrating because I know the manufacturers struggle with it too, because you were talking about Humira and a company could be the beneficiary of a patent thicket on one side and then on the other side their own biosimilars are getting crushed by somebody else. So it's sort of like one day you're the robber, and the next day you're the victim. Mr. Brough stated that the pharmaceutical market itself is kind of interesting because you have all these blockbusters and when their patent goes away, everything changes drastically. So they call it a patent cliff where, say, Humira or any of these drugs, as soon as they get close to that cliff, if they don't have a drug in waiting to take its place as the next blockbuster, the company is going to have a profit drop and then they have to start thinking "well, rather than innovate do I just put all my money in protecting this monopoly through more patents?" And we do see that happening where they're investing in keeping the monopoly on the market longer rather than new innovative therapies that come to market.

Rep. Oliverson stated that the last thing I'm going to say is that this is part of the reason why in Texas we passed a bill last session establishing the Texas Pharmaceutical Initiative, which would allow Texas to basically pursue its own generic equivalents in manufacturing spaces and to explore the possibility of doing that to try to address some of these bad behaviors. It's not just the thicket issue, but people will also engage in essentially hush money payments to prevent a company from bringing a generic to market after they figure out who's going to get the license to produce the drug from the FDA. I think there was a very famous case with a calcium channel blocker that was manufactured by Eli Lilly where they basically successfully kept the generic equivalent off the market for almost a decade even though the patent had expired and there were licenses issued. And the ability to manufacture the drug, they essentially just paid them off to keep the competition out of the market. Mr. Brough replied yes, it does happen. In fact, it's called pay for delay and it's a very common practice where generics will enter these negotiations with brands and decide when they'll get come into the market or whether they'll wait so that is another issue that we do see in the marketplace.

Rep. Brenda Carter (MI) stated that along the same line as Rep. Oliverson, since patents are federally regulated, are you saying that there's nothing the states can do to regulate the cost of drugs? Mr. Brough replied not in the patent space. I'm sure there other things states have the authority to do. For instance, one of the things that happened in the past was, and I think a lot of states have their own laws on whether a generic is an acceptable substitute, this was an earlier fight in the drug space when generics were first coming into the marketplace if doctors recommended a drug, was the generic considered an effective substitute? So there are things that states can look at in terms of drug pricing but patent law, they can't really do anything.

Rep. Carter stated that in Michigan, we are considering a prescription drug affordability board (PDAB) – what are your thoughts on those? Mr. Brough stated that I think looking at these things, all of that adds to the debate and I think that moves the discussion forward in terms of focusing on the inherent issue of drug pricing and that sort of feeds

back into the whole dispute about are patents excessively monopolistic and keeping prices higher than the competitive market would? So I would encourage activities like that.

Sen. Justin Boyd (AR) stated that in my other line of work I'm a pharmacist and there has been more than one patent extension which have caused pharmacy colleagues to roll their eyes but what I've observed more is now there's this rebating game, especially with the biologics and biosimilars, where it's the pay to play like I'll pay more dollars in rebates to get on the formulary. Do you have any insight into is it really the patent issue or this rebating issue that is really driving the price of pharmaceuticals? Mr. Brough stated that I think it's both. I would say the patent issue provides that initial period of exclusivity which keeps prices higher than they could be. But then once you have that high price, you have every incentive to do everything you can to keep that price as long as possible and that gives you an incentive to do things like these rebates and getting on the right list. And those are all debates and a lot of that's more FDA related than patent related but those are real, valid issues that need to be addressed as well. Sen. Boyd stated that maybe rebating could be addressed by states. Mr. Brough stated I would think that you have a lot more authority there than in the patent space.

Rep. Meskers stated that the conversations that we've had in the past with importing drugs from other countries, it seems to be what we're talking about, ultimately, is either free trade or managed trade and we're in neither area with pharmaceuticals because the price discrepancies across the world are huge. So is there a solution within the patents or is it a solution within protecting our pharmaceutical industry with a certain level of a premium for R&D in the U.S. to continue their work but to limit the pricing differential between us and the Organization for Economic Co-operation and Development (OECD) countries. It seems to me, if we're dealing at 200% or 300%, we're subsidizing the world in R&D and drugs and the only thing we've been able to figure out at the state level is either some regulatory review of the drugs on the formularies or potentially imported drugs from Canada which are all manufactured either in India and China and they're just priced differently. What are your thoughts on drug importation? Mr. Brough stated that it's a separate issue from patents, but it's a real issue and to some extent you're right that we are choosing to subsidize lower prices in other countries by the way we price our pharmaceuticals and you can make the argument that it provides the resources for the innovation and keeps us as a leader in this industry but at the same time, you should be aware of the fact that you're doing it at the cost of higher drugs for Americans who need prescriptions.

ANY OTHER BUSINESS

Rep. Roberts stated that in response to the terrible storms that have hit several states the past few months, I do think it's a good idea to have FEMA and other related parties interact with NCOIL next year to discuss how they've responded to the storms and specifically how the National Flood Insurance Program (NFIP) is working and whether any reforms may be needed.

And as a brief point of personal privilege, this is my last NCOIL meeting and I just wanted to say thank you to everyone. This has really been one of the most enriching portions of my time in public office. Thank you to the NCOIL staff for all of your work. I would also personally just like to take this opportunity to thank the legislators that I've gotten to work with and who have been so generous in helping me. And thank you to all of my Kentucky friends and colleagues and to the interested parties who are here to make sure that we understand all points of view. This is a great collaboration. I really do believe that we do good work and that this is the best of legislation because it really is well vetted and well discussed. It has been an absolute privilege to be part of this.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Carter and seconded by Sen. Utke, the Committee adjourned at 10:15 a.m.

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CHIEF EXECUTIVE OFFICER: Will Melofchik

National Council of Insurance Legislators (NCOIL)

Health Savings Account State-Federal Regulatory Coordination Model Act

Sponsored by Rep. Jim Dunnigan (UT), NCOIL Secretary
Co-sponsored by Sen. Jerry Klein (ND) and Rep. Ellyn Hefner (OK)

To be introduced and discussed during the NCOIL Joint State-Federal Relations & International Insurance Issues Committee on April 26, 2025.

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Section 1. Title.

This Act shall be known as the "Health Savings Account State-Federal Regulatory Coordination Model Act".

Section 2. Purpose.

The purpose of this Act is to adopt a provision embedded in one or more chapters or sections* of the state insurance code to protect the efficacy of Health Savings Account ("HSA") qualified plans via a legislative exception or "safe harbor" from any state benefit mandate or copay accumulator adjustment law, due to federal law, rules, or guidance regarding "high deductible health plans". Certain state benefit mandate bills require zero cost-sharing or contain other cost-sharing restrictions which conflict with federal law, rules and guidance for such plans. In other cases, some state bills define "preventive care" differently than under federal law which also creates conflict.

Drafting Note: The term "chapter" can be used, or "section" or other term such as "title" as found in the applicable insurance law or code.

Section 3. Definitions.

(A) "Enrollee" means an individual who is enrolled in a health insurance plan, whether on an individual or a group basis, including any covered dependent.

(B) "High Deductible Health Plan" means a health insurance plan, as defined in Section 223(c)(2) of the Internal Revenue Code, Title 26 of the United States Code**.**

(C) "Health Savings Account Qualified Insurance Plan." A high deductible health plan that meets the specific requirements in Section 223 of the United States Internal Revenue Code, as interpreted and administered by the federal Internal Revenue Service ("IRS"). Individuals covered by such a plan may contribute to a Health Savings Account ("HSA")--a trust or custodial account for qualified medical expenses. However, individuals cannot contribute to an HSA unless they are covered by an HSA-qualified insurance plan and have no other disqualifying coverage. An eligible individual can deduct contributions from income taxes, and employers and employees may contribute on a "pre-tax" basis through payroll deduction. HSA owners may use deposited funds tax-free for qualified medical expenses incurred by themselves and eligible dependents.

(D) "Preventive Care" means those services defined as "preventive care" by the U.S. Department of the Treasury and the Internal Revenue Service (which includes preventive services recognized under the Affordable Care Act), pursuant to regulation or guidance issued under the authority of Title 26 of the United States Code. In general, "preventive care" does not include services that provide treatment for known illnesses, diseases or conditions. However, under IRS Notice 2019-45, "preventive care" now also includes specified products and services provided to individuals with certain defined chronic conditions (e.g., diabetes, asthma, heart disease, etc.).

(E) "Zero cost-sharing" or "cost-sharing restrictions" means prohibition outright of any deductible, copayments, or coinsurance on the part of the enrollee or certain limitations on the amount of such deductible, copayments, or coinsurance.

Section 4. Cost-Sharing for a Health Savings Account Qualified Health Insurance Plan.

Except as otherwise provided in this section, if under federal law, any amount paid by an enrollee, or on the enrollee's behalf by another person or a third party, would cause the enrollee's health savings account plan to no longer qualify as a high-deductible health plan under 26 U.S.C. § 223, then the cost-sharing requirement shall only apply to the enrollee's plan once the enrollee's health plan deductible has been applied, unless the item or service has been determined to be preventive care under 26 U.S.C. §223, in which case this exception shall not be necessary.

Section 5. Rules.

The commissioner shall promulgate rules necessary to carry out this Act.

Section 6. Effective Date

This Act shall take effect xxxxxxx.

**Drafting Note Two: States may differ on where this provision should be placed and it would be important to identify all the correct sections in the Insurance Code and in some cases, the Health and Safety Code or Health Code. As to the Insurance Code, if the state has different sections governing health plans, nonprofit hospitals, HMOs, medical service corporations, the state employee health plan (that offers HSAs coupled with a high deductible health plan), the same amendment would need to be affixed to each to ensure comprehensive treatment, as identified by the bill drafters or bill drafting commission, as the case may be.*

FINANCIAL SERVICES & MULTI-LINES ISSUES COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
FINANCIAL SERVICES & MULTI-LINES ISSUES COMMITTEE
2024 NCOIL ANNUAL MEETING – SAN ANTONIO, TEXAS
NOVEMBER 23, 2024
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Financial Services & Multi-Lines Issues Committee met at The Westin Riverwalk Hotel in San Antonio, Texas on Saturday, November 23, 2024 at 3:30 p.m.

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

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Rep. Rod Furniss (ID)
Rep. Matt Lehman (IN)
Rep. Michael Meredith (KY)
Rep. Brenda Carter (MI)
Sen. Jeff Howe (MN)
Sen. Paul Utke (MN)
Rep. Bob Titus (MO)
Rep. Nelly Nicol (MT)
Sen. Jerry Klein (ND)
Asm. Jarett Gandolfo (NY)
Sen. Pamela Helming (NY)
Asw. Pam Hunter (NY)
Rep. Brian Lampton (OH)
Sen. George Lang (OH)
Rep. Forrest Bennett (OK)
Rep. Ellyn Hefner (OK)
Rep. Tom Oliverson, M.D. (TX)
Rep. Jim Dunnigan (UT)
Del. David Green (WV)
Del. Walter Hall (WV)
Sen. Eric Nelson (WV)
Del. Steve Westfall (WV)

Other legislators present were:

Rep. Deborah Ferguson, DDS (AR)
Sen. Clint Penzo (AR)
Rep. Stephen Meskers (CT)
Rep. Toby Overdorf (FL)
Sen. Larry Walker (GA)
Rep. Mark Hashem (HI)
Rep. Brian Lohse (IA)
Rep. Peggy Mayfield (IN)
Rep. Bill Sutton (KS)
Sen. Roger Hauck (MI)
Sen. Lana Theis (MI)
Sen. Michael Webber (MI)
Asw. Catalina Cruz (NY)
Sen. Patty Kuderer (WA)

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. Forrest Bennett (OK) and seconded by Del. Steve Westfall (WV) the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Mike Meredith (KY) and seconded by Rep. Brenda Carter (MI), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 18, 2024 and September 20, 2024 meetings.

CONSIDERATION OF RE-ADOPTION OF NCOIL INSURANCE FRAUD MODEL ACT

Sen. Felzkowski stated that we will start with consideration of readoption of the NCOIL Insurance Fraud Model Act (Model). Per NCOIL bylaws, all NCOIL model laws are scheduled to be considered for readoption every five years and if it's not readopted, it sunsets. You can view the Model in your binder starting on page 283 and on the app and website. I note that more than half the states have adopted the Model either in whole or in part.

Hearing no questions or comments, upon a Motion made by Asw. Pam Hunter (NY), NCOIL Vice President, and seconded by Rep. Matt Lehman (IN), the Committee voted without objection by way of a voice vote to readopt the Model. Sen. Felzkowski thanked everyone and stated that the Model will now be placed on tomorrow's Executive Committee agenda for final ratification.

PRESENTATION ON INFLATION'S IMPACT ON THE INSURANCE MARKET – WHERE ARE WE NOW AND WHERE ARE WE HEADED?

Sen. Felzkowski stated that next is a presentation on inflation's impact on the insurance market. Some of you may recall that we had a presentation on this at our meeting last November, so it will be interesting to see what's changed since then and what the road ahead looks like.

Ed Lukco, Instructor of Insurance and Risk Management at Ohio Dominican University thanked the Committee for the opportunity to speak and stated that we'll talk about these four things that that were talked about last year - the general level of inflation has come down pretty significantly and we'll have a slide or two as we go on that illustrates that. But the general level of inflation is still going to have an impact on insurers as they go through the process of not only operating, but from a claim standpoint, the components that go into that are going to be affected by general inflation and along with that is this idea of social inflation. What we're talking about there is how the legal side of claims has changed pretty dramatically and we'll get into that as we go along and it's having a pretty negative impact on claims and how they're handled. Wage inflation is another area. What we're seeing is that wages have been keeping up with inflation over the last 15 years. And then finally, interest rates. And this has an impact on insurers from several different areas and we'll get into those as well. So, those are the four general topics. And Peter Drucker once said that "the only thing we know about the future is that it will

be different" and he compared predicting the future to driving a car down a dark country road with no lights while looking at the rear window. And the point is that I'll give you information but I cannot predict the future.

Starting with general inflation, here we have four categories where inflation applies and what it means is that the buying power of your money is dropping. You can't buy as much with the same amount of money because prices are going up. Now when we talk about inflation, not all prices are going up. The general level of prices is going up. Now, you can see on the left-hand side where it says all products. That is a year ago when my colleague was here and that is up at approaching 4%. And then we have food. We have energy. And then we have everything but food and energy. So, we see that those costs were going up pretty significantly. Well, here we are today. This is one year later. These are both as of September in 2023 and 2024. And you can see again all items were down – it was 2.4% in September. Food was a little bit less than that, I think it was 2.2% or 3%. Energy was down a negative 6.8%. So, the cost of energy was dropping. And then on the end we have all items except food and energy. And that's still right around 3%. So, that's a significant change from these same categories a year ago. We're still experiencing inflation, but it's described as disinflation which means continuing inflation but at a lower level. And then we have deflation as regards energy. So, it's still having an impact and it's still something that insurers and the industry is going to be concerned with. This is one of my colleague's slides from a year ago and you can see here we're looking at the inflation rate. This is all items here. And that takes us up to September of 2023. And here it carries on. So, we can see the impact of inflation dropping over this period of time to bring us to September of 2024.

So, why did your insurance rate go up this year if this inflation is slowed down? You would think that maybe your insurance wouldn't go up. But we have these issues. There's an increasing number of natural catastrophic events. Here in Texas, you had some and then there was another one that went up to Louisiana this year. This hurricane season there were three that hit Florida, which is a higher number than normal. So there are five catastrophic hurricanes that hit this area this year. And of course, that has a huge impact on the results of the insurers. And then they are in the market trying to buy the things they need to fix the things that were damaged and that's driving prices up as well. We have wildfires not only in California and the West Coast but this year we had wildfires in New York and New Jersey, which is pretty unusual. But that's due to the drought that hit my part of the United States, Ohio and eastward. The cost of component parts for auto repairs is continuing to go up. Many of these things are being brought in from outside the country but they're still increasing in cost and those go into the calculation and promulgation of rates by insurers. And the cost of building materials, again where these catastrophic hurricanes are hitting, those amounts are in the billions. Whether we're talking about insured loss or all loss, we're still talking about billions of dollars that they're going to have to be paid for somehow. And then finally, we have increasing wages. So, all of these combine to increase the operating costs for insurers and in order for them to be able to continue to operate, they're going to have to increase their rates to cover those costs.

Now here's the social inflation that we were talking about. And this is changing jury attitudes with larger sums that are awarded when the cases end up in court. And a part of that is this idea of third-party litigation funding. And this is quite simply someone being willing to pay the legal cost for an action that is being brought with the idea that they're going to share in whatever the award that is issued by the court. And there's more of that going on. And then we have additional capital that's coming into the plaintiff side. I don't know if any of you are in Florida or have been in Florida and if you travel around there and you see the billboards, what do they say – "Attorney Bill got me $700,000 and changed my life." So that's just telling people, "call Attorney Bill and he's going to get you a lot of money." And then we go to that third-party funding and we end up with these kinds of awards which have an impact on the rates that insurers are going to charge. The trust in institutions is also declining and I think it's continuing to decline and this will have an impact as well in terms of how people respond when they have a claim. And then there are expanding legal concepts where more and more things are being brought and argued in court and being adjudicated on behalf of the plaintiff. Here's a statistic that I found with regards to this idea of social inflation – it's been around since 2015 and Swiss Re, one of the larger reinsurers in the world said that claims costs are up by 16% over the last five years and by 57% over the last decade. Claims costs drive up insurance rates and when we see these kinds of increases, you know that insurance rates are going to be going up in an attempt to mitigate the impact.

So, related to these claims costs is the fact that we're dealing in a service. There's no tangible product. You get a piece of paper that gives you the legalese but you're buying a service. When you have a claim, you expect that service to come into play. You expect the company to take care of you and make you whole. So, with those wages going up overall in the service economy, the insurance industry is affected by that as well because it is a service, it's not a tangible product. So, here's the graph that I was mentioning earlier. This is the wage inflation and you can see the yellowish line is the nominal increase and the blue jagged line is the wage cost and then the red one is nominal as well and is the real cost. Now the difference between nominal and real is inflation. So, the nominal cost is then reduced by the amount of inflation. Now, this goes back to 2005. That's a new base year for this calculation. So in 2005 they were all equal and we can see what's happened how over the course of the last 20 years we can see that there's been a fairly significant increase in wages. And this is in the service industry but even with those increases on a real basis, there isn't much change. So, people are getting wage increases, but because of inflation, their ability to buy the same things hasn't changed at all. So, they may be getting more money, but they don't feel richer. And this is another graph that gives us the same thing. This is service industry wage changes. This just gives it to us as it happened on an annual basis. And you can see again that it's trending upward apart from the last year or so up there.

Interest rates are the last topic. The Federal Reserve has started decreasing interest rates and the impact it has is that it makes it easier for companies to raise capital because their borrowing costs of the bond market certainly is going to be lowered. And this gives them the ability to raise more capital. And as long as that continues, we'll see that as a benefit in terms of companies and how they're going to respond. As I said, the Federal Reserve seems to think they have control of it so we'll see how it is going

forward. I think that the likelihood is that in December there will be another decrease in the rates but I think after that it's going to be a wait and see attitude to see where they're going to go and what they're going to do going forward. So, what can insurance companies do about it? Well, the first issue is recognizing that there is a problem. And there is a problem that inflation is causing for insurers as it relates to rates. So, business planning and strategy is a great way for companies to address this issue. And you can see the steps that companies are going through looking at reserving and financing and how they're going to make sure they have the appropriate amount of capital. Pricing obviously is a major issue for them. And capital insolvency are clearly issues they're going to be concerned with. The outwards purchasing and adequacy we're talking about reinsurance protections that they're going to be buying as a means of smoothing out some of the large losses that they will have experienced and making sure that they're able to continue to write the amount of business they want to at rates that are appropriate. And then exposure management again, we're talking about this increase in catastrophic events and this is across the country. It's not just in Florida or just in Texas and Louisiana, or just in California. We're seeing more and more of these larger events occurring and companies have to manage their exposures. How much business are they writing? They have to aggregate that, take a look at it, then go back and look at their outwards reinsurance purchases to make sure that they have enough protection for the amount of business that they're writing in the event of one of those terrible events. And then they're going to be looking at expenses, not only wages, but all of their other expenses as a means of trying to control what's going on.

This reserving, investment pricing, and portfolio management are all a part of the strategic planning and business planning that insurers have to do. Reserving is clearly one of the major things that they are involved in from the standpoint of their financial integrity. Their investment portfolio is something that they need because we all know the people who make claims to insurers figure that they can fudge a little bit on how much it was because insurance companies have so much money. Everybody thinks that. From a pricing standpoint, they want to be fair and reasonable, but they also want to stay in business so they have those two things that they're trying to balance and then their portfolio management on the investment side is going to be important as well because they need to be able to match the maturity of their investments with the times when they're going to need those funds to pay the claims that come along. This is the second to last slide - this is how the investment categories correlate to the consumer price index (CPI) and you can see that we run the gamut. There’s some that didn't do very well and some that did very well. From an insurer standpoint, there are a lot of things that they're unable to invest in in order to be in compliance. And this slide there are some things that you can’t see very well but the reason that I have that up there is that you can see the swings in these various categories of investment and that they all go below the line at some point. So, this is an issue that insurers are going to have to deal with because they're investing funds constantly.

CONSIDERATION OF NCOIL EARNED WAGE ACCESS MODEL ACT

Sen. Felzkowski stated that up next we have consideration of the NCOIL Earned Wage Access (EWA) Model Act (Model). You can view the model in your binders on page 271

and on the website and app as well. We will be voting on this model today. Before we go any further I'll recognize Asw. Pam Hunter, NCOIL Vice President and sponsor of the Model.

Asw. Hunter thanked everyone who has participated in our discussions on this since we started last November. For all who've been involved, it's been a long year. I think we've made great progress on this Model throughout the past year and have incorporated requested changes from both industry representatives and consumer advocates. I think that we're ready for a vote today and the timing is good because it's an issue where not only states have taken different approaches, but as mentioned during our interim meeting in September, federal agencies have also stepped in here with rules that will be litigated. So, it's up to states to take action here and NCOIL can be a big part of this. I do want to point out that one issue that was brought up during the interim meeting in September was a proposal about setting up some type of database that would be able to track these types of earned wage access transactions. I don't support that type of proposal at this time. I think it's something worth discussing in your states but it's something that hasn't been included in any of these types of laws yet and we've been discussing this for over a year. So, to delay action on this Model further for something that isn't proven yet I think would be wrong since as I said, now is the time for us to provide states with guidance. I think this Model is in a good place and I think that we have incorporated as many collaborations and conversations throughout this year from everyone and I encourage the committee to support the Model.

Derek Hein of Catalyst, a multi-state government affairs firm representing EarnIn today, thanked the Committee for the opportunity to speak and stated that I think Asw. Hunter did a terrific job of expressing some of the same thoughts that I have today. This is not a perfect Model and I think there are a lot of things we would like see different about it. However, we are extremely appreciative and really have a lot of respect for the process that NCOIL has and the attention NCOIL has given to this over the last year. And I think in the interest of not letting the perfect be the enemy of the good, I believe we should probably move forward with this and truly the concept behind a model bill is to be a conversation starter in each and every state and those states can elect to move forward however they wish and we will be part of that process when it reaches states.

Sarah Mamula, Head of Government Affairs at the Financial Technology Association (FTA), thanked the Committee for the opportunity to speak and stated that FTA is an organization that represents approximately 30 digitally native financial services companies including several leading providers of earned wage access. First and foremost, we want to commend and thank NCOIL for its thorough process over the past year leading to the draft model EWA bill and for actively engaging with stakeholders in its development. There are many items in the draft Model that we believe will be beneficial to consumers and providers including: the creation of a state licensing mechanism for EWA providers; codification of EWA's consumer protective elements, including at least one no cost option, no credit checks or credit reporting and the inability to take legal action to collect payments except when fraud has occurred; and inclusion of robust and appropriate disclosures. However, there are a few provisions in the draft we would oppose if introduced in states. The first is the requirement to disclose the full cost of the

transaction as an annual percentage rate (APR). Given that EWA products are short term and do not involve interest charges, this would confuse consumers. We recommend providing the total cost in dollar terms instead as this aligns with practices for noncredit products such as ATM fees. Finally, we emphasize the importance of allowing EWA providers to access lawful remedies against fraud or malfeasance which the draft Model could further emphasize. It is crucial that fraudsters cannot exploit this non-recourse product at the expense of legitimate providers or consumers. Again, we appreciate NOCIL's thoughtful and deliberative process in drafting this model EWA legislation. We welcome the opportunity to partner with you and your states if you consider EWA legislation and we can develop a path forward that is both product enabling and consumer protective.

Hayden Cole, Director of Federal Government Affairs for the American Fintech Council (AFC), thanked the Committee for the opportunity to speak and stated that AFC's mission is to promote an innovative, transparent, inclusive and customer centric financial system by supporting responsible innovation in fintech and encourage sound public policy. AFC's members are at the forefront of fostering competition and consumer finance and pioneering ways to better understand consumer segments and geographies. We probably represent the largest number of EWA providers who combined are serving millions of employees across the United States. AFC commends NCOIL for its thoughtful approach in drafting this model EWA bill. AFC strongly supports it and respects the tireless efforts that have gone into creating the Model and we appreciate NCOIL's leadership. We look forward to collaborating to refine this legislation within states across the country.

John Barnes, Vice President of Government Relations at Catalis, thanked the Committee for the opportunity to speak. Thank you also Asw. Hunter for all the conversations. We greatly appreciate it. We know how hard you and this Committee are working to develop a Model that regulates emerging industries and to ensure that important safeguards for both consumers and providers are included. First, we know that this has been an over 15 month discussion and we are late and we understand that, but we will be back as we appreciate the value that NCOIL brings by getting to see so many legislators and states that we operate in already. It's a great value for the industry to be involved with and to have those conversations. The reason we support the database amendment is that in the 14 states we operate, it helps regulate small dollar lending in the unbanked market space and the EWA model as currently written without a database amendment would cause a gap in consumer protections and a loophole that would allow bad actors in the space to manipulate those laws. Specifically, there are no limits on the number of EWA loans a person can take out nor are there necessary enforcement tools for regulators. The reason the database is so important is that EWA loans aren't underwritten and there's no credit check involved so there's simply no way of knowing in real time as we've seen in California how many individuals are taking out these loan products and how many different providers they're getting them from. That said, we've spoken with several members of this Committee and we really appreciate the time and energy that you gave to this issue. We understand that the database is not going to be included today, but we will make sure that it is included in the conversations as states continue to move forward with EWA bills being introduced. We appreciate the

time today and we welcome the opportunity to speak with any legislators and any members of this committee as you plan for legislation to come to your state.

Rep. Deborah Ferguson, DDS (AR), NCOIL Immediate Past President, stated that I'm curious about the Consumer Financial Protection Bureau's (CFPB) interpretive rule and where you see that going in terms of saying it has to be a consumer loan. How is that changing the industry for your particular group? Do you see that standing long term and are you moving toward complying with the rule? Mr. Hein stated that I don't know that I have an appropriate response and candidly I have not had an opportunity to consult with EarnIn on their position. I don't know if either of the associations want to comment, but I'd love to have a follow up conversation with you at the appropriate time. Ms. Mamula stated that the only thing that I would add is it is a proposed rule so it's unclear at this time if it's going to be finalized before the end of this Administration into the next. It's something our association is tracking and we're happy to continue that conversation with you.

Rep. Ferguson stated that I thought that a lot of the groups were scrambling to sort of meet those needs to try to incorporate it where they could make a consumer loan into their products. Are you seeing that happening in the industry where people are trying to come up to those standards in just in case? Ms. Mamula stated that the only thing I can say at this time is that there are concerns with the proposed rule. I would have to check with our membership as a whole to get that further detail for you.

Hearing no further questions or comments, upon a motion made by Asm. Jarett Gandolfo (NY) and seconded by Del. Steve Westfall (WV), the Model passed via a voice vote with Sen. Felzkowski determining that the yes votes clearly outnumbered the no votes Sen. Felzkowski thanked everyone and stated that the Model will now be placed on tomorrow's Executive Committee agenda for final ratification.

CONSIDERATION OF NCOIL TRANSPARENCY IN THIRD PARTY LITIGATION FINANCING MODEL ACT

Sen. Felzkowski stated that last on our agenda is consideration of the NCOIL Transparency in Third Party Litigation Financing Model Act (Model). You can view the Model in your binders on page 257 and on the website and app. We will be voting on this Model today. Before we go any further, I'll turn things over to the sponsor of the Model and past NCOIL President, Rep. Matt Lehman (IN).

Rep. Lehman thanked everyone for their work on this and stated that a lot of work has gone into developing the Model. I was reminded earlier of when this issue first came up at NCOIL which was over 10 years ago. I think you heard from the earlier presenter on the issue of inflation and the impact this litigation financing is having on rates. This Model in front of you has been around for the past year. I think we made good progress. I want to thank Del. Steve Westfall (WV), co-sponsor of the Model, for his input and also others who we've had a vigorous debate with on this. And I think we're ready to move forward. I just want to talk briefly about where we have finally landed. Our goal from the start was that we wanted this to be transparent and have guardrails. I think we've begun

to see that we don't want there to be bad players in this space. And the second thing is we don't want our judicial branch to become Wall Street. And when you look at the two paths we're on in this Model, there's a consumer path and we've heard from the consumer lenders that their lending is about survival and giving money to those who need to get to the end of the process. And so with their sections of this Model, there's a lot of nuances but basically the big changes have been the rate cap that's been put in and the disclosure of the existence of an agreement. In the commercial space it's a little bit different. That has become a return on investment. That is where I want to get my money out. And here are some things we've done there. One is we have said we want no "foreign entities of concern" or "foreign countries of concern" to be a part of this. We want you to have no access to the data. You don't get to be at the table when things are disclosed that are proprietary. Another thing is that we've said you have no say in the path of the suit. You can't say "I don't want you to settle because it's not enough of my return back." And last is this disclosure of the content of the agreement – not just the existence but the contents in that commercial space. There's been some other changes in the disclosure section as well in terms of some of the nuances to correct some conflicts.

I've been around here at NCOIL for 14 years and I've heard some things in the process of this Model particularly that I have not really heard before and that is "if NCOIL doesn't do X, if NCOIL is silent on X, then it sends a message to states" but this whole process is about constructing a foundation of strong walls and a strong roof and sending this to the states and letting the states tweak it how they want. So, we do have blanks. We do have spaces. We do have things that we are silent on. That doesn't mean we condone those things. It doesn't mean we condemn those things. It means this is a Model that is a strong foundation. Go back to your states and figure out what fits in your state. I think this Model is in a good place. Does it have everything I want? No. Does it have everything others want? No. And that's probably where I think we've ended up in a good place with this Model. And I think we need to stay focused on the fact that this is a Model and let's not let perfection be the enemy of good. And I think it's going to come down to what you do in your state because you have every right to change whatever you want within this Model.

Sen. Felzkowsi thanked Rep. Lehman and stated that I am going to be introducing an amendment to the Model. I previously reached out to Rep. Lehman on this and I want to thank him for speaking with me. The proposed amendment broadens the definition of "commercial litigation financing agreement." I think it's very important that we do that. In front of you is a copy of that amendment and I know staff distributed it earlier as well. The proposed amendment is based on my conversations throughout this process and I think that the prior definition was too narrow and this revised definition better tracks with what other states have done and captures more of these types of agreements. I think if we're developing model policy, it's better to send the signal to states and be expansive with definitions and then if the states want, they can always take a more narrow definition and approach, tracking with what Rep. Lehman said.

Del. Westfall thanked Rep. Lehman for sponsoring the Model and thanked everyone for their work on the Model. As a lot of you know, we passed this Model plus a little bit extra

in West Virginia this year. As Rep. Lehman, I think it's important that you take the Model back to your states and I may like what we did in West Virginia better but this is a Model. I've taken a lot of Models from NCOIL and passed them in West Virginia but I've never passed them verbatim. We usually change them to how we need to do in West Virginia. And I really appreciate everybody looking at this Model and I think the proposed amendment helps the Model a lot and I support the proposed amendment.

Hilary Segura, VP & Counsel of State Gov't Relations at the American Property Casualty Insurance Association (APCIA), thanked the Committee for the opportunity to speak and stated that APCIA is very appreciative of the hard work and many hours that Rep. Lehman and Del. Westfall have put into this. I know it has been a tiring and sometimes tedious process. The most recent draft of the Model that was released on November 12th has moved the ball forward considerably and we are very pleased with that. Sen. Felzkowski's proposed amendment to the definition of "commercial litigation financing agreement" and removing the reference to non-recourse loans is an incredibly important addition given the evolution of the commercial litigation funding industry. We strongly support that language. In the consumer disclosure section, section 7, ideally we would have preferred to have mandatory disclosure of contents and in the spirit of compromise over the course of this process APCIA, the National Association of Mutual Insurance Companies (NAMIC), The U.S. Chamber of Commerce, and the Alliance for Responsible Consumer Legal Funding (ARC) have worked together to try to find a solution and a compromise on some language. So, if this Model comes to your state and you're introducing it, we will be reaching out to you to seek some changes in the consumer disclosure section based upon the agreement that we've come up with on language that we think will benefit everyone. And then my final comment is on the definition of "charges." We are agnostic on that and I know there's been a lot of debate on the rate caps. We're agnostic on that definition and leaving it up to each state to decide, we're okay with that as well. I appreciate your time and all of the hard work that you have put into this model.

Paul Martin, VP of State Affairs at NAMIC thanked the Committee for the opportunity to speak and stated that Rep. Lehman has worked tirelessly on this for a number of years and as we've had conversations with many of you the last couple of days, we simply refer to it as TPLF, and that's accurate. But I was noticing this afternoon as I was looking over my notes, we sometimes omit the first word of the Model and that is "transparency" when we only say TPLF. And so we think this Model with the amendment that Sen. Felzkowski has presented is a very good start. This is something that we can take back to the states. We'll probably want to push for some tweaks here and there on the consumer side but this has been a long time coming and it's our hope that by making this more transparent, we can truly understand the impact and see where there are problems and where there are not problems. That is the good thing about transparency. We appreciate the hard work of everyone who's worked on this.

Jack Kelly, Managing Director of the American Legal Finance Association (ALFA), thanked the Committee for the opportunity to speak and stated that ALFA is the consumer litigation funder's oldest association in the country, made up of the leading members of this marketplace. We have since our foundation worked very strongly for

transparency in this marketplace. We believe that consumers need protection from bad apples. Twelve years ago, Rep. Lehman and myself and others in this room started working on a Model dealing with litigation financing. That day, after two and a half years of debate, a vote was held on a Model in San Francisco, California. And the vote was tied. The model tied because everybody said, “Oh, I want this, I want that. I want the perfect.” But what happened when we sought the perfect was we lost the good. Consumers weren't protected for all that time. Some states adopted laws but consumers didn't have the basic protections. I’m on the consumer side. I'm not on the commercial market side. We provide small amounts of money to people to pay their rent. This Model achieves that balance finally. Is it perfect? No. I've been in this business for a long time and my father would tell me a good piece of legislation is when somebody looks at you on both sides and says I'm not happy. And that's where you are today. We'll take this Model back. Some states will amend it in different ways and do different things. But for the first time we'll have a foundation to protect people from bad apples and to give them transparency in their contracts and to stop bad behavior and make prohibited practices for people who do bad things like give kickbacks and pay off people and steer these cases. And that's what we care about. So, with that, I'd like to thank Rep. Lehman for his hard work on this as well as Del. Westfall. Today we need to get this done and what needs to be changed in the states, we’ll do that individually as each state decides how they want to treat this product.

Eric Schuller, President of ARC, thanked the Committee for the opportunity to speak and thanked Rep. Lehman and others for working on this. Just like Mr. Kelly said, ARC supports proper regulation of the industry. Again, just a couple of parts of the Model that we do have some concerns with, one is the definition of “charges.” The reference to the Military Lending Act was removed and a rate was inserted, but the way the language is currently drafted, it does reference “usury” and our concern is that some states may take that as this product being a loan whereas several courts recently have ruled that this product is not a loan. So, that's why we would wish that be left up to the individual states. And as Ms. Segura said on the section on consumer disclosures, the fact that it is an automatic disclosure and the contract itself could still be admissible, we think that would harm the consumer in the end. But again, we'd like to work with you all when this comes into your states to make sure we have a good piece of legislation that everybody can live with.

Will Weisman, on behalf of the International Legal Finance Association (ILFA), thanked the Committee for the opportunity to speak and stated that ILFA is the nonprofit trade association which promotes high standards in the commercial legal finance sector. While there's many areas of consensus with what's in the Model, regrettably, ILFA cannot support the Model in its present iteration and that's primarily because of Section 16, which requires the automatic unfettered disclosure of the funding agreement. I think everyone needs to be clear-eyed about what that actually means in practical terms. That will cause extreme prejudice to the plaintiff because a commercial funding agreement contains the plaintiff's litigation budget. So, you are telling the defense counsel here's precisely how much money this plaintiff has to litigate a case. You will also be telling defense counsel when you disclose that agreement at each phase of the litigation here's how much money the plaintiff and the plaintiff's counsel will make if we

resolve the case at this stage. That is highly prejudicial and does irreparable harm to plaintiffs. No one in this room would ever suggest that defendants or defense counsel should turn over their litigation budget. I worked at an insurance company for many years. You would never as an insurer say I will turn over my reserve information to the plaintiffs. You'd be laughed out of the room if you said that because it would be so harmful and prejudicial and it's also irrelevant.
And yet, that's what the Model does. So, for that reason, we're unable to support it. I also want to correct one misconception which I heard repeated several times here today which is that commercial litigation funders are contributing to social inflation and to escalating insurance costs. That is not true, and it's not true for a simple reason. Commercial litigation funders do not fund suits which are paid by insurance companies. There is not insurance for a breach of contract case. There is not insurance for patent infringement. There is not insurance for antitrust cases. We fund business to business disputes where the ultimate payer is the defendant. There is not an insurance product or an insurance company behind that. So, I want to correct that misconception. So, while we very much appreciate the opportunity to be part of this process and I think there's a number of areas where there's room for real consensus, including with respect to disclosing the case is funded and putting procedures in place to ensure that funders are not exercising control, you will find broad consensus in my corner of the world for those pieces of the Model. But disclosing the funding agreement itself causes extreme prejudice. It's putting a thumb on the scale in favor of defense counsel, and for that reason, we're unable to support it. With that said, I very much appreciate the opportunity to share these views and I've appreciated the collaborative process throughout.

Rep. Forrest Bennett (OK) thanked all of the speakers and stated that I appreciate the work that's been done on this. I recognize it's been about a long process and it seems like we'll be voting today. I've mentioned this before to Rep. Lehman and at previous meetings. I have some troubles that sort of echo what ILFA said where the disclosures to me sort of tip the scales in favor of one side over the other. And I don't love that. But I also recognize that we do need some type of framework. So I appreciate that everyone's come to the table and has been willing to negotiate and I would encourage legislators who are taking this back to their states to look at that section and determine what's best for you and your state. You may not hear me vote in favor of this but I also won't fight it.

Rep. Toby Overdorf (FL) stated that I felt like I was having flashbacks to when I was presenting a similar bill in Florida with the panel here talking about disclosure. And it was interesting. Florida discussed similar legislation and we had a big disclosure discussion back and forth that was the largest area of discussion and debate. That being said, I certainly don't want the perfect to be the enemy of the good and I think this is a very good piece of legislation that we have in front of us. I will say that one area that I think that members should be aware of is the foreign disclosure portion. And specifically, when you look at Section 3.9.(e) and looking at the individual that owns or has a controlling interest, I think that we need to look at a percentage of ownership. And the reason I say that is in Florida we passed a law regarding ownership of land associated with a foreign entity and that ownership then was looked at as there was no percentage associated with it. So, you might have an investment fund that has a foreign

national that's part of that investment fund and they may have .0001% of ownership of a parcel. Yet that funding could not be utilized because there is a foreign ownership associated with that investment fund. Alternatively, that investment fund could have disclosed all of its members and all the association with it. So, I just think that's an area to be aware of as you go forward in your specific states as to what percentage is associated with ownership. And again the disclosure portion of it is really what killed it in Florida this past time around. I look forward to presenting it again this year and finding a way to work this forward because I think there's a lot of good material within this overall Model and I look forward to talking about it next year, after we hopefully pass it in Florida.

Hearing no further questions or comments, upon a Motion made by Del. Westfall and seconded by Rep. Matt Lehman, the Committee voted without objection by way of a voice vote to adopt the amendment proposed by Sen. Felzkowski. Then, upon a Motion made by Del. Westfall and seconded by Rep. Jim Dunnigan (UT), the Committee voted without objection by way of a voice vote to adopt the Model, as amended. Sen. Felzkowski thanked everyone and stated that the Model will now be placed on tomorrow's Executive Committee agenda for final ratification[1].

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Carter and seconded by Rep. Lehman, the Committee adjourned at 5:00 p.m.

[1] Mike Lane, Associate General Counsel at State Farm Insurance Company, submitted a witness slip in support of the Model with the amendment from Sen. Felzkowski.

The following law will be referenced during the agenda topics “Discussion on state initiatives regulating the bail bond industry”: https://iga.in.gov/legislative/2022/bills/house/1300/details

EXECUTIVE COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
EXECUTIVE COMMITTEE
2024 NCOIL ANNUAL MEETING – SAN ANTONIO, TEXAS
NOVEMBER 24, 2024
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Executive Committee met at The Westin Riverwalk Hotel in San Antonio, Texas on Sunday, November 24, 2024 at 12:15 p.m.

NCOIL President, Rep. Tom Oliverson, M.D. (TX), Chair of the Committee, presided.

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Rep. Deborah Ferguson, DDS (AR)
Sen. Larry Walker (GA)
Rep. Matt Lehman (IN)
Rep. Bill Sutton (KS)
Rep. Michael Sarge Pollock (KY)
Rep. Rachel Roberts (KY)
Rep. David LeBeouf (MA)
Rep. Brenda Carter (MI)
Sen. Michael Webber (MI)
Sen. Paul Utke (MN)
Sen. Mike McLendon (MS)
Sen. Jerry Klein (ND)
Asw. Pam Hunter (NY)
Sen. George Lang (OH)
Rep. Forrest Bennett (OK)
Rep. Jim Dunnigan (UT)

Other legislators present were:

Rep. Peggy Mayfield (IN)
Sen. Bill Gannon (NH)
Sen. Hillman Frazier (MS)
Asm. Erik Dilan (NY)
Sen. Pam Helming (NY)
Rep. Dennis Paul (TX)
Del. David Green (WV)

Also in attendance were:

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

QUORUM

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

MINUTES

Upon a Motion made by Rep. Forrest Bennett (OK) and seconded by Sen. Paul Utke (MN), NCOIL Treasurer, the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 20, 2024 meeting.

FUTURE MEETING LOCATIONS

Rep. Oliverson stated that the 2025 Spring Meeting will be in Charleston, SC from April 24-27; the 2025 Summer Meeting will be in Chicago, IL from July 16-19; the 2025 Annual Meeting will be in Atlanta, GA from November 12-15; the 2026 Spring Meeting will be in Louisville, KY from April 16-19; the 2026 Summer Meeting will be in Boston, MA from July 15-18; and the 2026 Annual Meeting will be in Sanibel, FL from November 19-21.

ADMINISTRATION

Will Melofchik, NCOIL General Counsel, stated that there were 381 registrants for the Annual Meeting including 77 legislators from 32 states and of that number there were 13 first time legislators from 10 states. Additionally, six insurance commissioners participated and in all, 10 insurance departments were represented.

Mr. Melofchik then moved into the financials stating that the unaudited financials through October 31 of this year show revenue of $1,446,077.21 and expenses of $1,204,374.17 leading to a surplus $241,703.04.

CONSIDERATION OF AUDITOR

Rep. Oliverson stated that last year, we conducted a search for a new audit firm and retained Dianne Batistoni, a partner in Eisner Amper's insurance practice, for the audits of both NCOIL and the Insurance Legislators Foundation (ILF) for 2023. We were very pleased with the quality of the audits and accordingly recommend retaining Eisner Amper for another year.

Hearing no questions or comments, upon a Motion made by Rep. Deborah Ferguson, DDS (AR), NCOIL Immediate Past President, and seconded by Rep. Matt Lehman (IN), the Committee voted without objection via a voice vote to retain Eisner Amper for the 2024 NCOIL and ILF audits.

CONSENT CALENDAR

Rep. Oliverson noted that the consent calendar includes committee reports including resolutions and model laws adopted and re-adopted therein, as well as ratification of decisions made and actions taken by the NCOIL Officers and staff in the time between Executive Committee meetings.

The consent calendar included:

- The Health Insurance & Long Term Care Issues Committee adopted the NCOIL Value Based Purchasing Model Act.

- The Life Insurance & Financial Planning Committee re-adopted with amendments the NCOIL Life Settlements Model Act.

- The Financial Services & Multi-Lines Issues Committee adopted the NCOIL Earned Wage Access Model Act and the NCOIL Transparency in Third Party Litigation Financing Model Act. The Committee also re-adopted the NCOIL Insurance Fraud Model Act.

- The Joint State-Federal Relations & International Insurance Issues Committee adopted the NCOIL Model Act in Support of Mental Health Wellness Exams and a Resolution in Support of Establishing Catastrophe Savings Accounts.
- The Property & Casualty Insurance Committee adopted the NCOIL Strengthen Homes Program Model Act.

- The Articles of Organization & Bylaws Revision Committee adopted amendments to the NCOIL Articles of Organization & Bylaws.

- The Budget Committee adopted the 2025 NCOIL budget.

- Ratifications of decisions made and actions taken by the NCOIL Officers and staff in the time between Executive Committee meetings.

Hearting no questions or comments, upon a Motion made by Sen. Jerry Klein (ND) and seconded by Rep. Lehman, the Committee voted without objection by way of a voice to adopt the consent calendar.

CONSIDERATION OF RESOLUTIONS HONORING MEMBERS

Rep. Oliverson stated that pursuant to NCOIL bylaws, the Executive Committee may, at any regular meeting, confer the title of “Honorary Member” on any individual who has served in the legislature of a General Member but is no longer a member of the legislature or is leaving the legislature at the end of the calendar year in which the action is taken and who has participated in no fewer than 15 official NCOIL in-person events, and who the Executive Committee wishes to recognize for outstanding service to NCOIL.

Before the Committee are Resolutions recognizing the following legislators as Honorary Members:

- Rep. Deborah Ferguson, DDS (AR), NCOIL Immediate Past President.

- Sen. Neil Breslin (NY), past NCOIL President.

- Sen. Bob Hackett (OH).

- Del. Steve Westfall (WV).

Additionally, a Resolution is proposed to honor Rep. Rachel Roberts (KY), who will be leaving the legislature at the end of the year, for her service to NCOIL. Would anyone like to provide any comments about these distinguished members?

Rep. Lehman stated that Sen. Hackett and Rep. Ferguson have been fantastic to work with over the years but I'm going to focus my comments on Sen. Breslin. Sen. Breslin helped mold me as an NCOIL Officer. Several years ago, there was a Model at NCOIL that he and I were on opposite sides of and I was successful in defeating his position on the Model and I believe he was incoming NCOIL President at the time and I thought "there goes my chance of continuing my service as Chair of the Property & Casualty Insurance Committee." But he called me later and asked me to continue my service as Chair. I told him I was surprised but he said that I was a good Chair and that I needed to be involved in the organization. That made me re-think my feelings about how you deal with people and when I had an issue when I was NCOIL President and I needed a steady hand, I reached out to him and he helped out. Sen. Breslin has always been the model of what an NCOIL Officer should be and he was a leader and I owe a lot to him.

Asw. Pam Hunter (NY), NCOIL Vice President, stated that I would like to make some comments about Sen. Breslin as well as he's not only leaving NCOIL but he is leaving the NY legislature and he's been a fixture there for a long time. When I started coming to NCOIL, he provided me a lot of guidance and said NCOIL is a place where actual work gets done and he said I should treat it like I do my work in NY. His appreciation for the organization since its inception in NY has been important. He was part of the tough times at NCOIL and he really was a steady hand and was a part of bringing Cmsr. Tom Considine on board as CEO and he will be missed in NY and here. And to Rep. Ferguson, you are going to be missed as well. Thank you for starting the NCOIL Women's Caucus. When I started coming to NCOIL, there weren't a lot of women legislators and with the steady hand of you and others bringing in more legislators, NCOIL is really more representative of what the country and our legislatures look like. Thank you for your leadership.

Rep. Peggy Mayfield (IN) stated that I echo Rep. Lehman's comments about Sen. Breslin. I quite often was on the opposite side of Sen. Breslin on Models, but watching him with his skills in this organization, I learned so much. Rep. Mayfield then noted a word was missing in the Resolution honoring Sen. Breslin. Upon a Motion made by Rep. Forrest Bennett (OK) and seconded by Rep. Dunnigan, the Committee voted without objection by way of a voice vote to add the word "statesman" to that portion of the Resolution describing Sen. Breslin.

Rep. Michael Sarge Pollock (KY) stated that NCOIL is about value and I've been involved with other organizations but NCOIL brings the most value and what creates that value are the people and these people we are recognizing are genuine, good people. Sen. Hackett was always very kind and welcoming to me and that meant a lot. I also

want to mention Rep. Roberts who I worked with in Kentucky. I love her energy and what she stands for and I will miss her tremendously and will miss working with her to make good policy at NCOIL and in Kentucky.

Sen. George Lang (OH) stated that I would like to recognize Sen. Hackett, my dear friend. He has been a mentor to me here and with him leaving, we are losing a lot of institutional knowledge. It was always great having him at meetings because he could tell you about his experiences with almost any issue and how it was dealt with years ago. Also, people might not know what a great athlete he was and he played football at Columbia University. And I would be remiss if I didn't mention Rep. Roberts. We don't agree on a lot of policy, but I always enjoy our conversations and you will be missed.

Sen. Jerry Klein (ND) stated that I started coming to NCOIL around the same time as Sen. Breslin and when there were tough times, a lot of people turned their back on the organization but others worked to make the organization into what it is today and I have to give Sen. Breslin a lot of credit for that. For Sen. Hackett, he always asked tough questions and it was always very valuable. Everyone being recognized today deserves it as they have provided so much to NCOIL.

Rep. Oliverson stated that I think Rep. Ferguson might have been the second person I met when I first came to NCOIL and I really respect her passion and commitment to bipartisanship and growing the organization and it took me two years to realize that we had different political party affiliations. Rep. Ferguson also encouraged me to get involved with other organizations and to do other things to enrich my knowledge in many areas and I'm going to miss her. She has been a great friend and mentor. Also, when I first came to NCOIL I think the first time I spoke was with regards to NY Senator and former NCOIL President Jim Seward's Model Act dealing with surprise billing and Sen. Hackett didn't like what I had to say and I wasn't sure he trusted me but then over time I won him over and we've become great friends. And Rep. Roberts, I was sad to hear that you were leaving the legislature as I was hoping one day you would be NCOIL President as I think you earned it and everyone here respects you and sees you as someone that works well with everyone. But you've reminded us that time is limited and we shouldn't just focus on things here to the exclusion of other things in life so I respect you to returning to your family and to things that matter, but we will also miss you.

Hearing no further comments, upon a Motion made by Rep. Pollock and seconded by Sen. Klein, the Committee voted without objection by way of a voice vote to adopt the Resolutions, as amended.

OTHER SESSIONS

Rep. Oliverson stated that the Institutes Griffith Foundation delivered two great presentations. During the lunch on Friday, Scott Schackelford Provost Professor of Business Law & Ethics at Indiana University Kelley School of Business gave an interesting presentation titled "Cyber Risk: Are There Risks Beyond Ransomware?" During the breakfast earlier today, Rob Hoyt, Chair & Professor of Risk Management &

Insurance at the University of Georgia Terry College of Business gave a presentation titled “Captives in Perspective: Benefits, Questions, and Strategic Considerations.”

We also had three great and interesting general sessions: part two of our special series on preventive medicine focusing on food as medicine and advancing a healthy America; ERISA at 50: An Important Standard Setter or Roadblock to State Healthcare Innovations?; and Does SCOTUS’ *Chevron* Repal Mean a Rebirth for State Regulation?

Our featured speaker at the main luncheon was John Ashford, Chairman and CEO of the Hawthorn Group who did a great job discussing the trends and outcomes of the 2024 elections.

Asw. Hunter stated that the Griffith Foundation does an exemplary job with their presentations. They have come to New York and given “101’s” to legislators who really don’t know the acronyms or basics and foundations of insurance and being able to utilize their expertise here in a non-partisan way is great and I look forward to continue seeing them here. I also like that they added the breakfast here as a separate session as it used to be just a lunch session.

For the general sessions, being able to talk about topics that are current like the repeal of *Chevron* is great but one thing that I would add about the food as medicine session - I was surprised how the conversation went compared to what I thought it would be and if there was a way to get federal organizations involved, that would be ideal. I know that can be difficult to do sometimes but it would have been nice to talk to the Food & Drug Administration or someone in the Agriculture Department. Because if we’re supposed to be making informed decisions you have to get to the root of issues and if we can dig deep into issues I’d like to, if possible, have those voices and maybe have another conversation about food as medicine. And I’d like for federal representatives to explain things like why chemicals are in our food and why they manufacture the same products for different countries without chemicals and why we allow that. I think it’s incumbent upon us to do that, so where we can I’d like to push the envelope on those discussions.

Rep. Oliverson stated that I echo Asw. Hunter’s comments about the food as medicine session, and I would support any attempt to get that topic back as a future general session and maybe get some voices that are a bit outside the box.

NEW EXECUTIVE COMMITTEE MEMBERS

Rep. Oliverson recommended Rep. Dennis Paul (TX) to be added to the Executive Committee.

Rep. Forrest Bennett (OK) recommended Sen. Pam Helming (NY), Asm. Erik Dilan (NY), and Sen. Bill Gannon (NH) to be added to the Executive Committee.

Rep. Lehman recommended Rep. Mayfield to be added to the Executive Committee.

Hearing no questions or comments, upon a Motion made by Sen. Klein and seconded by Asw. Hunter, the Committee voted without objection by way of a voice vote to add Rep. Paul, Sen. Helming, Asm. Dilan, Sen. Gannon, and Rep. Mayfield to the Executive Committee.

NOMINATING COMMITTEE REPORT

Rep. Ferguson stated that the Nominating Committee met on Friday and voted to recommend a new slate of Officers for next year. We had an outstanding group of candidates and I encourage you all to stay involved because NCOIL has been one of the most gratifying and informative groups that I've been a part of. So I encourage everyone to apply for an Officer position and if you don't get selected, please still stay involved.

The Committee's recommendation is Rep. Jim Dunnigan (UT) as Secretary; Rep. Edmond Jordan (LA) as Treasurer; Sen. Paul Utke (MN) as Vice President, and Asw. Pam Hunter (NY), as President. I'd like to compliment Rep. Dunnigan as he has been involved at NCOIL for nearly as long as me and he's been involved in almost every aspect of the organization. He will be a great Officer and will provide good leadership.

Hearing no questions or comments, upon a Motion made by Rep. Lehman and seconded by Sen. Lang, the Committee voted without objection by way of a voice vote to adopt the new slate of Officers.

Rep. Oliverson stated that I've truly enjoyed serving as NCOIL President and I hope you enjoyed this Meeting in my home state of Texas. I'm proud of all the work we did this year and I'm excited for things going forward. I also want to thank NCOIL staff for all their work they do to make things manageable for us. Congratulations to Asw. Hunter and I look forward to your leadership.

Cmsr. Considine stated that Rep. Oliverson was an absolute pleasure to work with. He always found time to be accessible even when he had important things going on in the legislature and in the doctor's office. It's been a great year.

Asw. Hunter thanked everyone and stated that it's a privilege and honor to be NCOIL President. One never knows the path one will take and I remember after I attended my first NCOIL meeting, I was hooked. Fast forward all these years later, I've worked though the organization and it's been great getting to know all of the new legislators and welcoming Corporate & Institutional Partner (CIP) members and that's what makes NCOIL special. Seeing hundreds of people attend our Meetings speaks volumes to the quality of work and amount of Model Laws that we develop that get adopted around the country. I look forward to continuing the great work we have done. I do want to say that former NY Assemblyman, and former NCOIL Officer, Kevin Cahill, was my friend and for those who knew him, he was great. He unfortunately lost his election a couple of years ago and he would have been NCOIL President if that didn't happen. He was a great teacher and provided tough love and scrutiny in NY about legislation and that meant a lot and I think that also goes a long way here towards ensuring that NCOIL Models are great. Thank you to everyone and I look forward to seeing everyone in April.

Asw. Hunter then presented Rep. Oliverson with a plaque honoring his service as NCOIL President.

ANY OTHER BUSINESS

Rep. Bennett stated that following the meeting of the Property & Casualty Insurance Committee earlier today, I would like to introduce the idea of creating some type of manual or handbook that includes the processes for NCOIL Model Law development. Good process matters and I want to make sure that in the future when we have new member legislators and other new members, we are all on the same page. So I'd like to introduce that idea here and begin working on that process.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Ferguson and seconded by Rep. Lehman, the Committee adjourned at 12:45 p.m.

616 Fifth Avenue, Suite 106
Belmar, NJ 07719
732-201-4133
CHIEF EXECUTIVE OFFICER: Will Melofchik

NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

Motor Vehicle Glass Model Act

Sponsored by Rep. Michael Sarge Pollock (KY)

Adopted by the Property & Casualty Insurance Committee on February 14, 2025. To be considered for final ratification by the Executive Committee on April 27, 2025.

Table of Contents

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 of a motor vehicle.

(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) “Notice” means direct written communications including verifiable text, email or APP based messaging which is easily accessible by the consumer.

(G) “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.

(H) "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.

(I) "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, delegate 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 providing service to an insured for a repair or replacement of damaged motor vehicle glass, a motor vehicle glass repair shop shall notify the insured of each of the following:

(1) Whether the motor vehicle has an advanced driver assistance system; and

(2) If the motor vehicle has an advanced driver assistance system:

(a) Whether calibration or recalibration of the motor vehicle's advanced driver assistance system is needed after a windshield repair or replacement as recommended by the vehicle manufacturer;

(b) Whether the motor vehicle glass repair shop intends to calibrate or recalibrate the advanced driver assistance system in a manner that meets the motor vehicle manufacturer's specifications; and

(c) If the motor vehicle glass repair shop is not capable of performing or does not intend to perform a calibration or recalibration referenced in subdivision (A)(2)(i) 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.

(B) If calibration or recalibration of the motor vehicle's advanced driver assistance system is performed, the motor vehicle glass repair shop will provide written notice to the insured:

(1) As to whether the calibration or recalibration was successful; and

(2) If the calibration or recalibration was not successful, 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 to be paid for under a first party insurance policy until all of the following are satisfied:

(1) The person has made a first party claim for the repair or replacement of damaged motor vehicle glass under a motor vehicle insurance policy;

(2) The motor vehicle glass repair shop has received a claim or referral number for the claim referenced under subparagraph (1)(a) of this paragraph; and

(3) The requirements of Section (4)(A)(1) and (2) of this Act are satisfied.

(B) A motor vehicle glass repair shop shall:

(1) Provide the insured a good faith 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) Prior to performing service, provide the insured an updated estimate; and

(3) Not charge more than the reasonable and customary fees and costs to an insured for a repair or replacement of damaged motor vehicle glass and any associated calibration or recalibration of the motor vehicle's advanced driver assistance system as recommended by the vehicle manufacturer specifications.

(C) A motor vehicle glass repair shop shall provide the insured upon completion of a repair or replacement of damaged motor vehicle glass:

(1) An itemized invoice and, upon payment, a receipt;

(2) Notice that states whether or not the advanced driver assistance system was successfully calibrated or recalibrated; and

(3) If the calibration or recalibration was not successful, the motor vehicle glass repair shop shall advise the insured not to rely on the advanced driver assistance systems until it has been successfully calibrated or recalibrated by the vehicle manufacturer's certified dealership or a qualified specialist capable of performing the calibration or recalibration.

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 insured 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 be issued in the same size font as the invoice, estimate or receipt.

Section 7. Right to Choose Motor Vehicle Glass Repair Shop

(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 recommending a motor vehicle glass repair shop or 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].