30 DAY MATERIALS AND GENERAL SCHEDULE
NCOIL SUMMER MEETING
JULY 16 - 19, 2025

As of July 7, 2025, and Subject to Change

The Renaissance Chicago Downtown Hotel
Chicago, Illinois

NCOIL SUMMER MEETING
Chicago, Illinois
July 16 - 19, 2025
SCHEDULE

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

WEDNESDAY, JULY 16TH

Budget Committee	3:30 p.m.	-	4:00 p.m.
Audit Committee (Members Only)	4:00 p.m.	-	4:45 p.m.
Welcome Reception 99th Floor – Willis Tower (1 mile from hotel)	5:30 p.m.	-	7:30 p.m.

THURSDAY, JULY 17TH

Registration *Exhibits Open: 8:00 a.m. – 5:00 p.m.*	7:00 a.m.	-	5:00 p.m.
Welcome Breakfast	8:15 a.m.	-	9:45 a.m.
First Time Attendee Legislator & Staff Meeting	9:45 a.m.	-	10:00 a.m.
First Time Attendee Interested Party Meeting	9:45 a.m.	-	10:00 a.m.
Networking Break	9:45 a.m.	-	10:00 a.m.
Life Insurance & Financial Planning Committee	10:00 a.m.	-	11:30 a.m.

Joint State-Federal Relations & International Insurance Issues Committee	11:30 a.m.	-	1:00 p.m.
Luncheon with Featured Speakers	1:00 p.m.	-	2:30 p.m.
General Session Prescription Drug Affordability Boards (PDABs) Part 2: Perspectives on PDABs	2:30 p.m.	-	4:00 p.m.
Networking Break	4:00 p.m.	-	4:15 p.m.
Financial Services & Multi-Lines Issues Committee	4:15 p.m.	-	5:45 p.m.
Adjournment	5:45 p.m.		
CIP Member & Sponsor Reception ***Open to Public Policymakers, CIP Members, and Summer Meeting Sponsors***	6:15 p.m.	-	7:15 p.m.

FRIDAY, JULY 18th

Registration *Exhibits Open: 8:00 a.m. – 5:00 p.m.*	8:00 a.m.	-	5:00 p.m.
Workers' Compensation Insurance Committee	9:00 a.m.	-	10:30 a.m.
Networking Break	10:30 a.m.	-	10:45 a.m.
NCOIL – NAIC Dialogue	10:45 a.m.	-	12:00 p.m.
The Institutes Griffith Foundation Legislator Luncheon Parametric Insurance: A Primer for Public Policymakers ***Open to Public Policymakers and Staff Only***	12:00 p.m.	-	1:00 p.m.
General Session The Growing Risk of Wildfires: A Discussion on Prevention and Liability Issues	1:00 p.m.	-	2:30 p.m.

Health Insurance & Long Term Care Issues Committee	2:30 p.m.	-	4:15 p.m.
Articles of Organization & Bylaws Revision Committee	4:15 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 with any questions.***	5:00 p.m.	-	6:00 p.m.

SATURDAY, JULY 19TH

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 The Affordable Care Act 15 Years On: An Unbiased Examination ***Open to Public Policymakers and Staff Only***	8:00 a.m.	-	9:00 a.m.
General Session Trends and Innovations in Long Term Care Insurance Coverage and Financing	9:00 a.m.	-	10:30 a.m.
Networking Break	10:30 a.m.	-	10:45 a.m.
Property & Casualty Insurance Committee	10:45 a.m.	-	12:30 p.m.
Executive Committee	12:30 p.m.	-	1:00 p.m.

Please note all speakers listed are scheduled to speak as of July 7, 2025. There will be modifications between now and the start of the Meeting.

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

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

Wednesday, July 16, 2025

Budget Committee
Wednesday, July 16, 2025
3:30 p.m. – 4:00 p.m.

Chair: Rep. Edmond Jordan (LA) – NCOIL Treasurer
Vice Chair: Sen. Mary Felzkowski (WI)

1.) Call to Order/Roll Call/Approval of November 23, 2024 Cmte. Meeting Minutes
2.) 2026 Budget Planning Discussion
3.) Any Other Business
4.) Adjournment

Audit Committee (Members Only)
Wednesday, July 16, 2025
4:00 p.m. – 4:45 p.m.

Welcome Reception
99th Floor – Willis Tower (1 mile from hotel)
Wednesday, July 16, 2025
5:30 p.m. – 7:30 p.m.

Thursday, July 17, 2025

Welcome Breakfast
Thursday, July 17, 2025
8:15 a.m. – 9:45 a.m.

1.) **The Hon. Ann Gillespie – Illinois Insurance Director**
    -Welcome to Chicago
2.) **Will Melofchik**
    -Introductory Comments from NCOIL CEO
3.) **Asw. Pam Hunter (NY)**
    -President's Welcome
    -New Member Welcome and Introduction
4.) Any Other Business
5.) Adjournment

First time Attendee Legislators & Staff Meeting
Thursday, July 17, 2025
9:45 a.m. – 10:00 a.m.

First time Attendee Interested Party Meeting
Thursday, July 17, 2025
9:45 a.m. – 10:00 a.m.

Networking Break
Sponsored by Aflac
Thursday, July 17, 2025
9:45 a.m. – 10:00 a.m.

Life Insurance & Financial Planning Committee
Thursday, July 17, 2025
10:00 a.m. – 11:30 a.m.

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

1.) Call to Order/Roll Call/Approval of April 25, 2025 Committee Meeting Minutes
2.) Introduction and Discussion on NCOIL Model Act Regarding Life Insurers' Use of Genetic Information

Rep. Brenda Carter (MI) – Sponsor
Alex Meixner, VP, State Policy – The ALS Association
Jan Graeber, Senior Actuary – American Council of Life Insurers (ACLI)

3.) Presentation on Latest Trends in Life Insurance and Annuities

Dale Hall, FSA, MAAA, CERA, CFA, Managing Director of Research – Society of Actuaries Research Institute

4.) Update on Interstate Insurance Product Regulation Compact (IIPRC) Activities

Karen Schutter, Executive Director - IIPRC

5.) Any Other Business
6.) Adjournment

Joint State-Federal Relations & International Insurance Issues Committee
Thursday, July 17, 2025
11:30 a.m. – 1:00 p.m.

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

1.) Call to Order/Roll Call/Approval of April 26, 2025 Committee Meeting Minutes
2.) Continued Discussion and Potential Consideration of 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)

3.) Presentation on Alternative Funding Programs (AFPs)

Katelin Lucariello, Deputy VP, State Advocacy – PhRMA
Ashira Vantrees, Director of Legal Strategy and Advocacy - Aimed Alliance
Theresa Alban, JD, MPH, Director, Federal Policy & Legal Advocacy - Cystic Fibrosis Foundation

4.) Discussion on Federal Healthcare Matters including Reconciliation Bill and Kennedy v. Braidwood

Catherine Finley - Modern Medicaid

Neda Jasemi, Senior Policy Analyst - National Association of Medicaid Directors (NAMD)
Sabrina Corlette, Founder & Co-director - Center on Health Insurance Reforms (CHIR) at Georgetown University's McCourt School of Public Policy
Mila Kofman, Executive Director - DC Health Benefit Exchange Authority

5.) Any Other Business
6.) Adjournment

Luncheon with Featured Speakers
Thursday, July 17, 2025
1:00 p.m. – 2:30 p.m.

Peter Nelson
Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight (CCIIO)

Tom Ricketts
Chairman
Chicago Cubs

General Session
Prescription Drug Affordability Boards (PDABs): Part 2 – Perspectives on PDABs
Thursday, July 17, 2025
2:30 p.m. – 4:00 p.m.

Moderator: Rep. Mark Tedford (OK)

Katelin Lucariello
Deputy VP, State Advocacy
PhRMA

Mark Hobraczk
Director of Public Policy
AIArthritis

Joel Kurzman
Director, State Gov't Affairs
Nat'l Community Pharmacists Ass'n (NCPA)

Anusha Thotakura
Executive Director
Citizen Action – Illinois

Sandra Guckian
VP, State Pharmacy & Advocacy
National Ass'n of Chain Drug Stores (NACDS)

Brian Reid
Principal
Reid Strategics

Networking Break
Thursday, July 17, 2025
4:00 p.m. – 4:15 p.m.

Financial Services & Multi-Lines Issues Committee
Thursday, July 17, 2025
4:15 p.m. – 5:45 p.m.

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

1.) Call to Order/Roll Call/Approval of April 27, 2025 Committee Meeting Minutes
2.) Introduction and Discussion of NCOIL Model Act Regarding Insurers' Use of Artificial Intelligence

Asm. Erik Dilan (NY); Rep. Forrest Bennett (OK) – Sponsors
Jim McDermott, VP of R&D, Health Plan Products – Epic
Emily Carroll, Sr. Legislative Attorney - American Medical Ass'n (AMA)
Jill Rickard, Regional VP, State Relations – American Council of Life Insurers (ACLI)
Lindsey Klarkowski, Policy VP – Data Science, AI & Cybersecurity – National Ass'n of Mutual Insurance Companies (NAMIC)

3.) Discussion on Price Controls and Rate Review and their Impact on Insurance Markets

The Hon. Holly Bakke – Former New Jersey Insurance Commissioner
Sabrina Corlette, Founder & Co-director - Center on Health Insurance Reforms (CHIR) at Georgetown University's McCourt School of Public Policy

4.) Presentation on Trends and Developments in Combatting Insurance Fraud

The Hon. Tim Temple – Louisiana Insurance Commissioner
Eric DeCampos, Senior Director of Gov't Affairs – National Insurance Crime Bureau (NICB)
Brent Walker, Dir. of Gov't Relations – Coalition Against Insurance Fraud

5.) Any Other Business
6.) Adjournment

CIP Member & Sponsor Reception
Thursday, July 17, 2025
6:15 p.m. – 7:15 p.m.

*****Open to Public Policymakers, CIP Members, and Summer Meeting Sponsors*****

Friday, July 18, 2025

Workers' Compensation Insurance Committee
Friday, July 18, 2025
9:00 a.m. – 10:30 a.m.

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

1.) Call to Order/Roll Call/Approval of April 25, 2025 Committee Meeting Minutes
2.) "State of the Line" Presentation – An Update on the Status of and Trends in the Workers' Compensation Insurance Marketplace
Jeff Eddinger, Senior Division Executive – National Council on Compensation Insurance (NCCI)
3.) Continued Discussion and Potential Consideration of NCOIL Experience Rating Modification Model Act
Rep. Matt Lehman (IN) – Sponsor
Paul Martin, VP of State Affairs – National Ass'n of Mutual Insurance Companies (NAMIC)
4.) Presentation on the Latest Trends in Work Comp Claims
Max Koonce, Chief Claims Officer – Sedgwick
5.) Discussion on Developments in the Illinois Work Comp Marketplace
Michael Brennan, Chair – Illinois Work Comp Commission
6.) Any Other Business
7.) Adjournment

Networking Break
Friday, July 18, 2025
10:30 a.m. – 10:45 a.m.

NCOIL – NAIC Dialogue
Friday, July 18, 2025
10:45 a.m. – 12:00 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 April 25, 2025 Committee Meeting Minutes
2.) Recap of NAIC's D.C. Fly-in
3.) Discussion on Federal Reconciliation Bill
4.) Discussion on NAIC's Request for Information re: Possible Development of Artificial Intelligence Model Law
5.) Update on NAIC's New Asset Adequacy Testing for Reinsurance Actuarial Guideline
6.) Any Other Business
7.) Adjournment

The Institutes Griffith Foundation Legislator Luncheon
Parametric Insurance: A Primer for Public Policymakers
Friday, July 18, 2025
12:00 p.m. – 1:00 p.m.
*****Open to Public Policymakers and Staff Only*****

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

General Session
The Growing Risk of Wildfires: A Discussion on Prevention and Liability Issues
Friday, July 18, 2025
1:00 p.m. – 2:30 p.m.

Moderator: Rep. Jim Dunnigan (UT) – NCOIL Secretary

Don Griffin
Dep't VP, Policy, Research & International
American Property & Casualty Insurance Ass'n (APCIA)

Eric Macomber
Wildfire Legal Fellow
Stanford Law School Environmental and Natural Resources Law & Policy Program

Cate Paolino
Senior Policy Vice President – Natural Catastrophe Risk and Resiliency
National Ass'n of Mutual Insurance Companies (NAMIC)

Michael O'Dell
Director, Machine Learning
FortressFire

Riaz Mohammad
Wildfire Regulatory Specialist
Xcel Energy

Health Insurance & Long Term Care Issues Committee
Friday, July 18, 2025
2:30 p.m. – 4:15 p.m.

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

1.) Call to Order/Roll Call/Approval of April 25, 2025 Committee Meeting Minutes
2.) Discussion on Proposed Amendments to NCOIL Transparency in Dental Benefits Contracting Model Act
Sen. Justin Boyd (AR) – Sponsor; Asm. Jarett Gandolfo (NY) – Co-sponsor
3.) Continued Discussion on NCOIL Prior Authorization Reform Model Act
Sen. Walter Michel (MS) – Sponsor
Lucy Culp, Vice President, State Government Affairs - The Leukemia & Lymphoma Society
Emily Carroll, Sr. Legislative Attorney - American Medical Ass'n (AMA)
Terrance Cunningham, Senior Director, Administration Simplification Policy - American Hospital Association (AHA)
4.) Every Child Swimmer A Presentation
Casey McGovern, Executive Director – Every Child a Swimmer
5.) Presentation on Hospital Charity Care and Medical Debt
Tanner Aliff, Visiting Research Fellow – Paragon Health Institute
Aaron Wesolowski, VP, Policy Research - AHA

6.) Continued Discussion and Potential Consideration of 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 (KY) – Sponsors

7.) Any Other Business
8.) Adjournment

Articles of Organization & Bylaws Revision Committee
Friday, July 18, 2025
4:15 p.m. – 4:45 p.m.

Chair: Sen. Walter Michel (MS)
Vice Chair: Rep. David LeBoeuf (MA)

1.) Call to Order/Roll Call/Approval of Nov. 1, 2024 Committee Meeting Minutes
2.) Discussion on Proposed Amendments to NCOIL Bylaws
3.) Any Other Business
4.) Adjournment

Women's Caucus Reception
Friday, July 18, 2025
5:00 p.m. – 6:00 p.m.
*****Open to all Women Attendees*****
*****Please reach out to Pat Gilbert at pgilbert@ncoil.org with any questions.*****

Saturday, July 19, 2025

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

The Institutes Griffith Foundation Legislator Breakfast
The Affordable Care Act 15 Years On: An Unbiased Examination
Saturday, July 19, 2025
8:00 a.m. – 9:00 a.m.
*****Open to Public Policymakers and Staff Only*****

Tice Sermans, Ph.D., Assistant Professor of Risk Management and Insurance
Illinois State University College of Business

General Session
Trends and Innovations in Long Term Care Insurance Coverage and Financing
Saturday, July 19, 2025
9:00 a.m. – 10:30 a.m.

Moderator: Rep. Brenda Carter (MI)

Jan Graeber
Senior Actuary
American Council of Life Insurers (ACLI)

Ben Veghte
Director
WA Cares Fund

Steve Cain
Director, LTCI Partners & Chair of Finseca's LTC Working Group

Steve Schoonveld, FSA, MAAA
GCG Consultants
Member, NAIFA-Massachusetts and NAIFA's LTC Legislative Working Group

Networking Break
Saturday, July 19, 2025
10:30 a.m. – 10:45 a.m.

Property & Casualty Insurance Committee
Saturday, July 19, 2025
10:45 a.m. – 12:30 p.m.

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

1.) Call to Order/Roll Call/Approval of April 26, 2025 Committee Meeting Minutes
2.) Continued Discussion and Potential Consideration on NCOIL Insurers' Use of Aerial Images Model Act

Rep. David LeBoeuf (MA); Rep. Brian Lampton (OH) – Sponsors
Paul Martin, VP of State Affairs – National Ass'n of Mutual Insurance Companies (NAMIC)
United Policyholders Representative

3.) Discussion on Developments in Fair Access to Insurance Requirements (FAIR) Plans

Dale Porfilio, FCAS, MAAA - Chief Insurance Officer, Insurance Information Institute (III)
Kelly Campell, Executive Director – Colorado FAIR Plan
Frank O' Brien, General Counsel - Massachusetts Property Insurance Underwriting Association (MPIUA)

4.) Consideration of Re-adoption of Models

a.) Storm Chaser Consumer Protection Model Act (Adopted 7-19-15)

Colonel Simon Blank, Director – Florida Dep't of Financial Services, Criminal Investigations Division
Eric DeCampos, Senior Director of Gov't Affairs – National Insurance Crime Bureau (NICB)
Brent Walker, Dir. of Gov't Relations – Coalition Against Insurance Fraud

b.) Model Act Regarding Medicaid Interception of Insurance Payments (Adopted 11-23-14)

c.) Model Act to Regulate Insurance Requirements for Transportation Network Companies and Transportation Network Drivers (Adopted 7-19-15)

Brad Nail – On behalf of Uber
Derek Wooley – On behalf of Lyft

d.) Model Act Regarding the Use of Credit Information in Personal Insurance (Adopted 11-15-15)

5.) Discussion and Potential Consideration of Proposed Amendments to NCOIL Travel Insurance Model Act

Rep. Matt Lehman (IN) – Sponsor
Jill Rickard, Regional VP, State Relations – American Council of Life Insurers (ACLI)
Kerri Cutry, AVP, State Gov't Relations - MetLife

6.) Any Other Business

7.) Adjournment

Executive Committee
Saturday, July 19, 2025
12:30 p.m. – 1:00 p.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 April 27, 2025 Committee Meeting Minutes
2.) Future Meeting Locations
3.) Administration
    a.) Meeting Report
    b.) Receipt of Financials and Audit
    c.) Consideration of Audit
4.) Consent Calendar
5.) Other Session
    a.) The Institutes Griffith Foundation Legislator Luncheon and Breakfast
    b.) General Sessions
    c.) Featured Speakers
6.) Any Other Business
7.) Adjournment

BUDGET COMMITTEE MATERIALS

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

The National Council of Insurance Legislators (NCOIL) Budget Committee met at The Westin Riverwalk Hotel in San Antonio, Texas on Saturday, November 23, 2024 at 5:00 p.m.

Minnesota Senator Paul Utke, NCOIL Treasurer and Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Deborah Ferguson, DDS (AR)
Rep. Rachel Roberts (KY)
Rep. Mike Meredith (KY)
Rep. Brenda Carter (MI)
Asw. Pam Hunter (NY)
Rep. Forrest Bennett (OK)
Rep. Ellyn Hefner (OK)

Other legislators present were:

Rep. Brian Lampton (OH)
Rep. Tom Oliverson, M.D. (TX)

Also in attendance were:

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

MINUTES

Upon a Motion made by Rep. Forrest Bennett (OK) and seconded by Rep. Ellyn Hefner (OK), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 17, 2024 meeting.

CONSIDERATION OF 2025 BUDGET

Sen. Utke stated that we're here today to consider the adoption of NCOIL's 2025 budget. A copy of the proposed budget is before you along with: a document showing the organization's 2024 financials as of October 31; a document showing the year-end 2023 and 2022 financials; and a chart showing legislator stipend usage since the program was implemented in 2020.

As a reminder, this Committee met in July during the Summer Meeting and we discussed the proposed budget and reviewed it, and nothing has changed to the budget

since then. Before we go any further, I'll turn things over to NCOIL CEO, Cmsr. Tom Considine, for comments and to entertain any questions.

Cmsr. Considine stated that the Committee had a robust discussion on the budget at the Summer Meeting and I would stand on that as nothing has changed since then. Of course, I'm happy to answer any questions or comments if there are any. Hearing no questions or comments, Cmsr. Considine turned things back over to Sen. Utke.

Hearing no question or comments, upon a motion made by Rep. Deborah Ferguson, DDS (AR), NCOIL Immediate Past President, and seconded by Asw. Pam Hunter (NY), NCOIL Vice President, the Committee voted without objection via a voice vote to adopt the budget.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Ferguson, and seconded by Rep. Brenda Carter (MI), the Committee adjourned at 5:20 p.m.

LIFE INSURANCE & FINANCIAL PLANNING COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
LIFE INSURANCE & FINANCIAL PLANNING COMMITTEE
2025 NCOIL SPRING MEETING – CHARLESTON, SOUTH CAROLINA
APRIL 25, 2025
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Life Insurance & Financial Planning Committee met at The Francis Marion Hotel in Charleston, South Carolina on Friday, April 25, 2025 at 4:30 p.m.

Michigan Representative Brenda Carter, Chair of the Committee, presided.

Other members of the Committee present were:

Del. Mike Rogers (MD)
Sen. Lana Theis (MI)
Sen. Michael Webber (MI)
Sen. Jeff Howe (MN)
Sen. Walter Michel (MS)
Asm. Jarett Gandolfo (NY)
Rep. Brian Lampton (OH)
Rep. Carl Anderson (SC)
Del. Walter Hall (WV)

Other legislators present were:

Sen. Jesse Bjorkman (AK)
Rep. Justin Wilmeth (AZ)
Rep. Brett Barker (IA)
Rep. Elizabeth Wilson (IA)
Rep. Peggy Mayfield (IN)
Sen. Jason Howell (KY)
Rep. Robert Foley (ME)
Rep. John Fitzgerald (MI)
Sen. Paul Utke (MN)
Rep. Jennifer Balkcom (NC)
Sen. Bill Gannon (NH)
Asm. David Weprin (NY)
Rep. Meredith Craig (OH)
Rep. Perry Warren (PA)
Sen. Mike Azinger (WV)
Sen. Cale Case (WY)

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. Jeff Howe (MN) and seconded by Del. Walter Hall (WV), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Sen. Lana Theis (MI) and seconded by Sen. Michael Webber (MI), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's November 22, 2024 meeting.

DISCUSSION ON THE USE OF GENETIC TESTING INFORMATION IN LIFE INSURANCE UNDERWRITING

Rep. Carter stated that we'll start today with a discussion on the use of genetic testing information in life insurance underwriting. As you may know, this is a topic that has generated a lot of discussion in state legislatures across the country in recent years, and the issue has made somewhat of a comeback in the last couple of years. In fact, NCOIL discussed this issue a couple of times in the pre-COVID era, but no steps were taken to develop any type of model policy on the issue. But given the resurgence of the issue in legislatures, I think it's great timing for NCOIL to discuss this issue again and see where it takes us. And personally, I'm very interested in the issue and I'm willing to discuss this in my home state of Michigan as well as here at NCOIL throughout the year. Before we hear from our speakers, I want to note that in your binders starting on page 75 are a few different types of bills and laws from different states that have addressed the issue, including Nebraska, Florida, and Tennessee.

Lisa Schlager, Vice President of Public Policy for Facing Our Risk of Cancer Empowered (FORCE), thanked the Committee for the opportunity to speak and stated I wanted to explain a little bit about the current practice of medicine and how genetics and genomics is playing a role there. FORCE is a national non-profit. We are the only national organization that focuses on hereditary cancers. So, what are hereditary cancers? The people we represent are individuals with inherited genetic mutations like the BRCA mutation. There are dozens of others that have been discovered that increase risk of cancer as well as other diseases. Approximately 5% to 10% of cancers currently can be attributed to these mutations, but we're also working with other groups like the ALS Association, the American Heart Association, the Michael J. Fox Foundation, and other groups because they have discovered genetic components to those diseases as well. I want to mention that the community that FORCE serves is made up of two different types of people. One is cancer survivors - these are people who've been diagnosed and we serve them. They've got an identified mutation that increased their risk and they're doing everything they can to treat that cancer, but also to mitigate risks of additional cancers because these mutations cause risk of more than one cancer typically. The other community is what we call a "previvor" and the medical term is an "unaffected carrier." Angelina Jolie is probably the most famous one. She has a BRCA mutation and she took some proactive interventions to reduce her risk. I know that sounds crazy, but those options are available to patients and insurers, the health insurers do pay for them if you have certain mutations that raise your risk to a certain level. I happen to be a previvor. I have a BRCA1 genetic mutation so this is personal as well as professional for me.

So, this is just a little about FORCE. We provide support. We get involved in research. We do a lot of education for both patients and providers. And we also are involved in advocacy and public policy. But let's talk a little about personalized medicine. This is

something that challenges the one-size-fits all approach to medicine. We all have different genetic and genomic factors in our bodies that might predispose us to certain diseases. Genetic testing can help inform certain decisions like when to start cancer screenings, what type of cancer screenings to have, and potentially risk-reducing surgeries in certain cases. If you get diagnosed with the disease, it can actually help you determine which treatment is going to be most effective. And it reduces that trial and error component because you might find out through testing that your body will respond better to certain treatments. We now have the ability to do that. There are many studies at the state level that are looking at genetic testing. There's actually a national study called the All of Us Study, which is aiming to do whole genome sequencing on 1 million people, and they are delivering results about people who have these mutations. It's definitely being looked at the federal level and I know of efforts in Oregon, Nebraska and Nevada that are doing genetic testing for half a million or more of their citizens. And they have a very strong interest in this topic because fear of genetic discrimination is preventing people from getting tested and being proactive with their health. So, a little bit more about hereditary cancer risk or hereditary disease risk. This is back to biology 101 but there are recessive genes and there are dominant genes. In a recessive gene both parents have to carry that mutation and their chance of having a child with that mutation is one in four, so 25%. Most of those types of diseases are diseases that are going to be childhood onset like sickle cell disease. The type of diseases that we're talking about are dominant mutations. So, this is only one parent has to have a copy of the broken gene. And the other parent has a healthy copy. And their chance of a child that has that mutation is 50%, it’s like a flip of a coin. So, you may not think about inherited breast cancer risk, for instance, from a man, but I inherited my genetic mutation from my father. He had increased risk of prostate cancer and some other cancers, but for me, it manifests differently.

So, talking about adult onset disease, it's very different than the diseases that are affecting children. So of course, concerns around life insurance and other types of insurance are something that most adults deal with, but what type of diseases are we talking about? So, cancer, first of all - breast, ovarian, colorectal, endometrial, melanoma, prostate, pancreatic, all of these have genetic components. Cardiovascular disease, there's a lot of cardiovascular conditions that have a genetic foundation and with knowledge they can be easily treated and severe consequences can be prevented. And then you have neuromuscular diseases so things like ALS and Huntington's disease which are obviously some of our harder diseases to deal with but we have incredible technologies being developed in fact a new gene therapy was just developed for the genetic form of ALS and they think it's actually preventing the onset of the symptoms of the disease. Only with genetic testing are we able to develop these incredible therapies. So, we want to incentivize people to go forward with this testing to help with the research and then be candidates for the treatments that are being developed. So, what things can be done if you know you have a mutation? In the cancer space we're talking about much more intensive screenings at earlier ages so for instance, if a young woman has a BRCA mutation, she's supposed to start breast cancer screening at age 25, with an annual MRI. If you have something called Lynch syndrome, you would start colonoscopies between the ages of 20 and 25 so they catch those polyps quickly and remove them. In the cardiovascular space, there are medications people can take.

There are implantable devices, like pacemakers or defibrillators. And then worst case scenario, there are surgeries. Similarly, there are risk-reducing surgeries in cancer as well.

Currently in the neuromuscular space, they have developed medications that slow the progression of the disease. As I said, there are some new gene therapies in ALS which are suppressing the onset of the disease and the symptoms, and then there's obviously supportive care should the person develop those diseases. I think it's important to note that just because somebody has one of these mutations does not mean they absolutely get the disease. It means they're higher risk, but the person next to them might get that disease as well without a gene mutation. So, at least that knowledge helps them be proactive with their health. And this is where our motto is, knowledge is power. The genetic information is valuable for prevention, early detection, and effective treatment. Ultimately, unaffected carriers are previvors, which is who we're talking about right now, they do not manifest a disease and yet they are being denied life insurance, long-term care insurance, and disability insurance just because they have a genetic mutation and they've tried to be proactive with their health. So, this is something that we're very concerned about. And we know that there are studies that have confirmed that concerns about genetic discrimination are deterring people from acting on their medical provider's advice and getting genetic testing. I have family members who have said I don't want to get genetic testing even though we have a mutation in our family because they're fearful of how it might be used against them. And in one study, over two-thirds of respondents indicated that they are somewhat concerned or greatly concerned about the use of genetic test results to determine life insurance coverage and costs. So, we know this is playing a factor and we have actually done a national survey and collected stories.

So, let's talk about the federal laws. Most of you are probably familiar with the Health Insurance Portability and Accountability Ac (HIPAA). You sign the HIPAA release when you go in to meet with your doctor. HIPAA is great when it comes to release of medical information. So, most of you know life insurers request, especially if a policy is of a certain amount, access to an individual's medical records. The patient has to give permission to that insurance company to access their medical records in order to evaluate family health history and other things and determine eligibility for underwriting or rates. If the patient refuses to give permission then the insurance company can just say well then never mind we won't give you a policy. But we know there are protections for that. But that's pretty standard so we're seeing pieces of legislation that say that no life insurer or other type of insurer should have access to somebody's record without the patient giving consent. Well that's a given so that type of phrasing in legislation really doesn't do anything. But then we have the federal law Genetic Information Non-discrimination Act (GINA) and it's been in effect since about 2010 and essentially it prohibits two types of discrimination - discrimination by health plans and by employers based on genetic information. GINA’s definition of genetic information is very broad. It not only includes genetic test results but also relative’s genetic test results and family health history down to fourth degree relatives. So, that's pretty intense. And so, that's why they limited it just to health insurance and employment and carved out life, long term care and disability because understandably family health history should be considered in those types of policies. Also, participation in research that includes

genetic testing or counseling is also covered under GINA so that information can't be used to discriminate in health insurance and employment.

This just summarizes who these laws apply to so for instance under healthcare, GINA applies to health insurance companies which includes individual health plans, Medicaid, Medicare, and the federal health programs. There are some exclusions like the U.S. military, they have their own policy. HIPAA applies to all health plans, and their business associates. So, let's say they hire someone to help them with billing. They have to sign a contract to maintain confidentiality over that data. And employment, it only applies to employers that have over 15 employees, but it also applies to employment agencies, labor organizations, and federal, state, and local governments. So, those are the covered entities, but obviously life insurance, long-term care, and disability are not included here. So, what are the legal gaps? GINA does not apply to these other types of insurance. We're hearing more and more patients are being denied insurance, or their rates are being jacked up to astronomical rate amounts. We are also hearing of cancellations, which I'm told is not legal, but we've got several stories. We've discovered that there is what's a two-year contestability clause in a lot of states. So, if a patient gets their life insurance right before they do genetic testing and then the insurer finds out, they can claim that the patient withheld information. So what do you do? HIPAA and GINA also do not really apply to direct-to-consumer companies. Now, I'm not advocating for everybody to go out and use Ancestry.com or 23andMe, but I think given the recent bankruptcy of 23andMe, it's something we need to be aware of. How is that data going to be used, and who's going to end up with that data? It could end up in anybody's hands, and we're not sure how that data can be used. And 23andMe was doing genetic testing for the BRCA genetic mutations. So that is very sensitive data that maybe shouldn't be sold to the highest bidder.

A number of states have laws on the books. The strength of those laws really varies incredibly. And only Florida has an outright ban on the use of genetic information in any way, and that includes life, long-term care and disability. To us, that's the ideal law. But I understand viewpoints that certain information is needed to make underwriting decisions. One thing we do know is that law in Florida was passed in 2020, and the life insurance rates in that state have only increased 2% in over going on five years now and 2% is nothing. I looked up the average rate of increase, and not to say it doesn't amount to dollars out of patients' pockets or consumers' pockets, but the average rate of increase is 6% to 8%. So, it’s obvious that this law is not harming the industry in Florida. In most of the states, the laws and the language are not very convincing, unfortunately. They use terms that kind of take the teeth away from the law, but they approach things in different ways. There are three main methods: restrictions on the use of genetic information, restrictions on the use of the test or requirement of somebody taking a test, and then actuarial justification for either underwriting or policy rates. I want to note that no state prohibits the use of family history. It's only the genetic test results, and we're okay with that. We understand the value, but the fact that I may have a mutation and my friend here doesn't, doesn't mean that they aren't higher risk of disease than I am. It just means that either they're not aware of their mutation or chosen not to have genetic testing. This is all evolving, and so it's problematic that this data is being used in our minds.

These rules that the states are passing generally fall into one of three categories. So, informed consent, we talked about that. That's required under HIPAA anyway so that's not really something that's needed, and it provides no value. If you don't consent to have your medical record accessed, you just don't get a policy. That's how it works. There are anti-discrimination approaches, which we're in favor of, and then some of the states have tried some other approaches. New York, for instance, has a bill that's approaching it from a civil perspective, saying that the physician can't put the genetic test results in the patient's medical record. Well, that's not feasible because the health insurer needs that information to justify the care that the patient needs. And the patient's doctors need to see that information in the chart to know the type of care the patient needs. So, you have to have that information in the medical chart. No health insurer is going to pay for breast MRIs or risk-reducing surgeries without good reason. So, it has to be documented in the medical records. Patients really don't have a choice but to share their medical records if they want to get a policy. So, what are the weaknesses that we're seeing in the policies that are out there other than Florida's at this point? Ineffective or obscure language. So, discrimination “based solely on.” Well, that's very subjective. “Unfair discrimination” is another term that's being used and “actuarial justification.” All of these are very subjective terms and it's very hard for anybody to prove, because most of the insurers do not have to give a reason for denial or for their rates. And I think that's something else that we should strive for. If a patient is denied or a consumer is denied a policy, why? Have the insurer explain. Give a reason so that at least the consumer has the opportunity to come back and say, well, that's not fair because…. Also, most of these do allow for consideration of the individual's test results, which honestly is kind of going back and punishing the patient for trying to be proactive. So, that's something that we want to ensure that can't happen in the long run. The insurers should be required to prove actuarial burden or to document justification for their decisions. And they should, in our ideal world, be legally required to give the consumer the reason for denial or for the rates.

So, this is a Vermont law on the books, and you can see I highlighted the term “unfair discrimination.” So, that basically makes the law somewhat ineffective, because it's subjective. Again, how do you define “unfair discrimination?” Oh, you have a mutation, and it increases your risk for cancer. That's not unfair. So, that's something we're trying to shy away from. We want to have more specific guardrails. For the international approach, Canada, the UK, and Australia have all banned the use of genetic information for life insurance policies. Australia had a voluntary ban on it until recently, but one thing that they've done that's interesting is they have allowed for the use of genetic information only above a certain amount policy. So, if somebody, for instance, in Australia wants a policy under $500,000, they can't use the genetic information. If they want a larger policy, then they're allowed to use that information. We think this is a reasonable compromise. The consumer is not trying to rip off the system. They just want to provide for their families and do the right thing. They want to make sure if something happens to them that they can cover their mortgage and help pay for their kid's college. And so, we think that's a very reasonable middle ground. Again, family health history is still permitted in all these countries, and we think that's still acceptable. So I've included here real patient quotes about their stories of dealing with insurance discrimination and how it can

be used against them. And we can share these and more if anybody's interested. In summary, only 10% currently of certain diseases are linked to an inherited mutation and identification of these mutations can inform risk, but does not guarantee a diagnosis. And obviously knowledge of these mutations can help individuals be very proactive with their health. Different mutations have different levels of risk. It's a very complex thing. And so, the fact that non-medical professionals are even trying to use this in a way that would harm patients is concerning. So, we would like insurers to be transparent, show actuarial evidence, and explain why a person's being denied. But ultimately, we don't think genetic test results should be used for insurance decision-making.

Jill Rickard, Regional Vice President with the American Council of Life Insurers (ACLI), thanked the Committee for the opportunity to speak and stated that ACLI is the leading national trade organization driving public policy for the life insurance industry, and since we're in beautiful Charleston, I'll begin with some facts about our industry in the state of South Carolina. There are 417 life insurance companies licensed to do business in the state and five domestic companies. We pay out $3.7 billion each year in life insurance and annuity benefits to South Carolina families. That's $10.1 million each day, and about 3 million individual life insurance policies are in force in the state, averaging $106,000 in death benefit protection. So, this is huge financial protection and very important financial protection for the residents of South Carolina and other states as well. Life insurers are in the business of issuing policies. We want to provide life insurance to as many people as possible, but we also want and need to price products accurately and make them affordable for all consumers. We do not search for ways to deny applicants through genetic information or otherwise. In fact, the opposite is true. We are constantly searching for ways to increase the percentage of life insurance ownership. We say that life insurers get one bite at the apple. This sets us apart from health insurers because we have one chance to evaluate the risk we are being asked to assume. And we employ medical professionals, in addition to actuaries, to help evaluate each individual's risk. Even though a policy may be in effect for several decades, once we issue it, we legally cannot cancel it ever. And we cannot adjust rates if an individual's health declines.

For this reason, the voluntary individual life insurance market depends wholly on our ability to accurately assess and categorize risk. When we collect and evaluate information we must ensure that we're being fair to all of our policyholders and that each pays a premium that's proportional to their individual risk. For life insurance to be affordable for all, applicants must be honest and transparent when providing their medical information. We're not talking about 23andMe. We do not ask for this information, but if it leads to a follow-up by a person's physician and additional genetic testing is done, which gets added to their medical record, then we need to be able to take this into account, just as we do a person's smoking history, blood pressure, family medical history. In short, we need to know what the applicant knows. We do not view genetic information as a separate category from any other medical information, and it's not definitive. We don't make decisions based on any one factor. Life insurers take a holistic view and look at the entire picture of each applicant. If a person tests positive for a certain genetic condition, it doesn't necessarily mean that they will not be offered a policy. We take into account any steps that the person is taking to mitigate or manage their condition or catch the manifestation of a disease early. For example, any of the

proactive or preventative measures that Ms. Schlager mentioned. We do the same with things like high blood pressure. If you're properly managing your high blood pressure with medication, diet, and exercise, you'll be rated differently than if you're taking no steps to mitigate your risk of heart disease. Genetic testing can also work in an applicant's favor. For example, if a person's family medical history indicates an increased risk for a certain disease, like the BRCA mutation for cancer, they may be placed in a higher risk category just by virtue of the family history. However, if that person then gets genetic testing and it confirms the person doesn't have the BRCA mutation they'll be classified as low risk. So, what can happen if life insurers are prohibited from accessing applicants complete medical records including genetic testing? In short it could destabilize the life insurance market. Policy pricing assumes that the applicant has no greater insight into their chances of premature death than does the company issuing the policy. If you knew that the boat you were going to sail on would sink because you cut a hole in the hull then you have an information advantage.

A basic example of this in life insurance is if you are a smoker and you claim to be a non-smoker on your application, we know that smoking causes adverse health effects and leads to shortened lifespans. If secret smokers get added to the non-smoking risk pool then the premiums charged to the pool would be too low to account for the increased risk of the smokers. The pool would eventually become financially unsound because the insurer would not be collecting enough premium to cover the increased rate of claims from the secret smoker. Withholding genetic information is similar. If we don't have access to the same important medical information known by applicants, then insurers wouldn't be able to assume that the population that applies for coverage has the same risk as those who elect not to apply. Studies show that people with higher risks are more likely to purchase insurance. That's a given. And conversely, people with less risk are less likely. I'll note that the American College of Medical Genetics and Genomics agrees. In 2022, they put out the following statement, “While it may be inherently unfair to penalize someone for their genetic makeup, it may also be unfair when individuals learn about their own genetic makeup and then use that information to decide whether they purchase life or disability insurance while withholding this information from the insurer. Prohibiting insurers from using genetic information in life and disability insurance may thus introduce a problematic imbalance in how such information might be used. This may adversely alter insurance underwriting in a way that has unanticipated consequences for both the industry and the individuals who are or wish to be insured.” It only takes a handful of applicants to adversely select against us and for there to be a negative financial impact.

Again, if an insurer has a significant imbalance between the premiums collected and the benefits paid, it may have to raise rates for all future policyholders. In turn, this may make it less likely for healthy people to buy insurance and then that would push prices up even further. Worst case scenario, this could lead to financial instability and insurers leaving the market altogether. Today, life insurance is more widely available and affordable than ever. We want consumers to use advances in genetic science to improve their health and lifespans. And we do not want consumers to have less access to life insurance coverage because of higher prices. The continued success of the voluntary life insurance market hinges on a level playing field of information and fair risk

categorization. I just want to note Florida is the only state that bans the use of genetic testing results in life insurance as Ms. Schlager said. And even that has guardrails. We can use it if it results in a diagnosis. That law was enacted in 2020. It's been less than five years. Life insurance products are long term. These can be in place for decades and it's impossible to determine the impact on the market in such a short period of time. We will not know the impacts of adverse selection for many years in Florida. The Vermont law on the other hand has been in place since the 1990s, actually even earlier for parts of it. And unfair discrimination does have a meaning in insurance. The concept of insurance as you all know is based on fair discrimination. Unfair discrimination is where people with the same risks are classified differently based on protected characteristics or where there is no actuarial basis for the classification.

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

Next on our agenda is the consideration of a resolution in favor of encouraging a redesign and the use of lifetime income investment solutions in defined contribution plans. We've been discussing this issue since our spring meeting last year, and now it does appear that we are ready to consider the resolution. Before we go any further, I'd like to note that, unfortunately, the sponsor of the resolution, Sen. George Lang (OH), couldn't join us today, but his colleague, Rep. Brian Lampton (OH), has signed on as a co-sponsor.

Rep. Lampton stated that I'm very proud to co-sponsor this resolution in conjunction with my friend, Sen. Lang. As you can see on the app, the website, and the printout before you, the resolution ultimately deals with a very important issue facing our country, and that is retirement security. I feel very strongly that we as state policymakers have the obligation to do everything we can to make sure that we help our constituents be able to retire with adequate funds available to them. Doing so will not only help them, but it will also help our states as a whole. So, in the interest of time I won't go through the entire presentation that the resolution endorses, but I will note I certainly support steps to improve our retirement security for our constituents and encourage all of you to support the resolution. I'd like to thank the committee for considering this important resolution and encourage its passage.

Brendan McCarthy, Head of Retirement Investing for TIA-Nuveen, thanked the Committee for the opportunity to speak and stated that TIAA is the fourth largest provider of retirement plans in the U.S. We've actually been offering lifetime income solutions through defined contribution plans since 1918. Regarding the resolution, if you take defined contribution plans today, those are 401K plans, 403B plans, 457 plans where you contribute and then you accumulate retirement savings - they have been phenomenal retirement savings vehicles. They've helped the American worker accumulate close to $13 trillion in retirement savings. Now there's a few major gaps with that. They do not provide for lifetime income so this resolution is to talk about lifetime income solutions that are great. We refer to them in the industry as a great accumulation tool, but what's missing now is de-cumulation. And this is a challenge. It's a challenge for

every American worker is whether or not they're going to have enough retirement savings to support them throughout their lifetime. And unfortunately the numbers around this are frightening. The Employee Benefit Retirement Institute (EBRI) has a number out there of 40% of American households are at risk of running out of income in retirement. Now, there's a few things that are contributing to that. One is a positive thing, Americans are living longer. A 65 year old today has a 25% chance of living to age 95 or longer. A 65 year old couple it's about a 46% chance that one out of two will live to 95 or longer. That's 30 years or more in retirement. I'll just throw one other number at you - 11,000 Americans a day are turning 65.

So there is great risk right now of American workers running out of income in retirement. The three main contributors beyond that are access to retirement plans. Does the American worker have access to a workplace retirement plan? Number two is, are they saving enough? It's often referred to as the savings gap. When they do have access to that plan, are they signing up and are they saving enough? And number three, workers do not have access to lifetime income solutions within those defined contribution plans. So, the resolution in front of you highlights and outlines the steps that you can all take in your respective legislatures to help encourage looking into this and encourage ensuring that the employees in your state will have enough income in retirement to last throughout their lifetimes. I'm just going to hit a couple of key tenets here. First, it calls on legislatures to study the amount of lifetime income for public workers in retirement plans in their state. Secondly, it highlights the importance of ensuring that employees have access to education and advice tools within those plans so they can help adequately prepare for retirement. Third, we need to ensure that employer and employee contributions adequately meet the retirement saving needs of the individuals. And lastly, and this is the key component, plan sponsors should be encouraged to offer a lifetime income solution to their participants within their defined contribution plans. That does not exist today for the most part. They just offer pure investments. And then, if they want to attain lifetime income, they often then have to then go outside of the plan, seek out a financial advisor, try to purchase them on their own. So, this is just something that would make this a lot easier. It is something that, at the federal level with the SECURE Act and SECURE Act 2.0they have started to encourage the use of lifetime instruments inside of 401K plans.

Sen. Walter Michel (MS) asked if a deferred compensation plan has a required minimum distribution (RMD). Mr. McCarthy stated I'm not sure. I think they're designed differently. And deferred compensation is different than defined contribution, it's a specific type of defined contribution. Sen. Michel stated that we have a deferred compensation plan in Mississippi which is an additional opportunity for state employees to put money aside in addition to our state retirement plan. Mr. McCarthy stated I'd have to look at that specifically as it's a supplemental plan. Sen. Michel stated that your end goal then would be if someone enrolled in a deferred compensation plan like that as a state employee to annuitize that upon a certain age to pay a series of equal payments till death? Mr. McCarthy replied yes - today, these are institutionally priced annuities that are actually investments. And there's various types out there, but they generally sit inside of a target date fund. So, they're embedded inside the default fund. And the retirement plan, whatever the plan type, should work just like it does today. But what it does is

underneath the hood of that target date fund, it's allocating towards an instrument. But then they have the option at retirement of seeing that large savings balance they can walk away with it or they can convert a portion into guaranteed pension like guaranteed income. And it's an option for them. So, what you're doing is really kind of setting up almost kind of a default option for them inside the plan. It's almost automatic for them but they don't need to utilize it - it's not required and they can just treat it like the plan works today but that plan now provides that option of guaranteed income. Sen. Michel stated I support the resolution - if people are given an opportunity early in life then they can take advantage of the time value of money. That's the greatest way to create wealth and many people don't understand that concept and if they just start with a little bit early then when they make more they can contribute more. And it's amazing how quickly you can accumulate money if you start in your 20s there's no reason that most people can't retire with at least $250,000 from starting with not that much in the beginning.

Asm. Jarett Gandolfo (NY) stated that I think this is a great resolution, especially the portion on educating younger folks about what their options are and how starting early will just compound that over time. I have a question, and if you don't know the answer right now, that's fine, it's kind of on the spot. But I'm almost 35, and I know a lot of people in my age group, especially where I am, I live on Long Island in New York, and a greater percentage of their income must go towards their housing now, whether it's because of the interest rates, the cost of homes in my area, and even the rent catching up with that. It's not uncommon for people to pay 50% of their income toward their housing. Is there any data available that shows how it might affect this younger generation and how that might affect their retirement compared to, let's say, people who are a little older, and while they still might be at risk of having a cash shortage, how the difference in equity building might affect the younger age group? Mr. McCarthy stated It's hard to answer. I like how you opened the question with the financial advice and guidance. Each individual situation is different based on that particular circumstance, but that ability to save in kind of that tax-free environment through the safety of your defined contribution plan versus home equity and other options that you have there, that's something where that advice and guidance model that a lot of plans are starting to offer. It would help that individual, but I can't compare the two broadly. I live in the Boston area and we're not far off from you on housing.

Hearing no further questions or comments, upon a Motion made by Sen. Michel and seconded by Asm. Gandolfo, the Committee voted without objection by way of a voice vote to adopt the Resolution. Rep. Carter thanked everyone and stated that the resolution will now be placed on the Executive Committee agenda for final ratification.

LIFE INSURANCE 101 PRESENTATION

Leah Walters, Senior VP of State Relations at ACLI, thanked the Committee for the opportunity to speak and stated that as the topic states, I will give a Life Insurance 101 presentation today, and while many life insurance companies have the word life insurance in their name, they are so much more than just life insurance. Creating certainty is our core business. Many are surprised to learn that life insurers offer a wide range of voluntary products that empower Americans to protect themselves and those

that they love through all stages of life. People can obtain coverage through the retail market or their workplace, offering them important pathways to secure financial and retirement security. Today, life insurers not only safeguard 90 million American family finances with life insurance policies, but they keep paychecks coming in with paid leave benefits, they offer peace of mind through disability income insurance and supplemental products. And the financial stability of retirement savings through guaranteed lifetime income via annuities is critical as that was just talked about. So, I just put up a list of some of the products that we offer. We offer life insurance, retirement savings through annuities, and as you just heard, an annuity is a long-term contract between an insured and an insurance company where the company agrees to make a series of income payments to the insured in exchange for a lump sum or premiums. It allows for the insured to accumulate funds on a tax-deferred basis for a later payout in the form of guaranteed income.

Let me repeat that. Annuities offer the only guaranteed income product that an insured cannot outlive. Some other examples include we offer long-term care insurance, disability income insurance, and supplemental benefits which include critical illness, dental and vision insurance, accident only, and hospital indemnity. We also sell paid family and medical leave and workplace benefits. For more than 175 years, the life insurance industry has helped people through all stages of life. As this committee knows probably the best, we are a highly regulated industry, and we have a proven track record of effective management, ensuring we deliver out on our promises today and many years in the future. In fact, 12 of the top 15 life insurers that existed in 1880 continue to operate in some form today. The COVID-19 pandemic tested the life insurance industry's mission unlike anything witnessed in our last century, and life insurers stepped up and responded. And I think these next three words are important, without government assistance to protect American lives in their darkest hours. At the height of COVID-19, life insurers paid out $100 billion in death benefits in 2020, which was a 10% increase in benefits. In 2023, and if anyone's interested, I have individual state facts which includes these numbers for your particular state, life insurers paid out $223 billion in benefits, $89 billion in life insurance benefits, $104 billion in annuity benefits, $20 billion in disability income benefits, and $9.6 billion in long-term care benefits.

The industry's private safety net is vast and serves as an important complement to the many public programs. To get a further sense of our industry's scale and impact I think it’s helpful to compare and contrast with the public programs that are highly valued. New research from ACLI finds, and we can share this if anyone's interested, that annuity benefits enable retirees to postpone receiving Social Security payment, saving the program $100 billion as the greatest surge of baby boomers retire. $14 billion will be saved in Medicare expenditures over the next 10 years as long-term care insurance provided by life insurers eases burdens on unpaid caregivers, and prevents people from spending down lifetime savings. And $8 billion will be saved in Social Security disability income expenditures over the next 10 years as disability income insurance coverage provided by life insurers protect workers from risk and helps them maintain their lifestyle. In addition to helping people manage risk, life insurers also support essential parts of the economy. As you'll see, some of these numbers up here, we invest $8 trillion in America's economy, providing funding for factories, jobs, schools, parks, housing, you

name it. Life insurers are also the single largest investor in U.S. corporate bonds at $3.6 trillion. And in addition to providing these long-term capital investments, the life insurance industry generates 2.8 million jobs in America. Many Americans also receive benefits like 401K plans, life insurance, and dental coverage through their employer. More than 97 million workers are insured through employer-provided life insurance. These benefits provide more than just a regular paycheck and can help workers manage throughout their employment. To conclude, there is a phrase that we like to say, and it's, life insurers put life in America. We are a stabilizing force in the U.S. economy. We provide long-term stability for families, businesses, and communities. So, I just wanted to give this 101 to let you know that we are more than just life insurance, and I'm happy to answer any questions.

UPDATE ON DEVELOPMENTS IN THE LONG TERM CARE INSURANCE MARKETPLACE

Melissa Bova, Senior Vice President of State Affairs and Policy at Finseca, thanked the Committee for the opportunity to speak and stated for those of you who are not familiar with Finseca, our name stands for Financial Security for All. That is our underlying mission, and we represent the holistic financial planners that provide holistic financial security to all Americans and to your constituents. So, our members are the ones that provide your life insurance, your retirement, your investments, that you need to be prepared for anything with everything life will throw at you. I am here to level set and just prepare you for a really great in-depth session that NCOIL is planning to have at the summer meeting. So, a little bit about long-term care and why many of you in this room are beginning to think about it and talk about it, not only with your constituents, but within your legislative processes.

Americans are aging faster. You've heard that a few times today. So, the number of Americans age 65 or older is expected to increase from 58 million in 2022 to 82 million by 2050, an increase of 47%. In a poll of Americans, 57% believe that when they need long-term care coverage, it will be covered by Medicare, which is not the case. There's a knowledge gap about that when people are thinking about the needs that they will have for the future. And while most people know they need to start planning, 74% know they need to be thinking about long-term care, only 45% have done so. But the biggest pain point that is very familiar to all of you is that Medicaid is growing year over year, and the single largest payer for Medicaid is long-term care. So, we know that this is something you're thinking about and trying to get your arms around at the state level. Unlike the federal government, you all must have balanced budgets and we understand that and we understand how you're trying to do that year over year. Some states are starting to think about long-term care and have conversations. Washington state is the first and only state to have a state-funded long-term care program. I think Washington is trying to be a leader in this space and a conversation on how we think that is going may be saved for another day. But it's a payroll tax that provides $36,500 of benefits to people who need it. The average long-term care cost is well over $100,000 so while it takes a little bit of the burden off it doesn't provide the holistic long-term care coverage people will need.

But states are thinking about it - we have a number of states that have completed studies on how do we solve for the long-term care is it education of our constituents? Is it more product availability? Is it pursuing something like Washington State with some type of statewide catastrophic solution? These are things that people are thinking about. But one of the things that we're seeing people talk about is how are we incentivizing people to get that long-term care coverage that they need, that long-term care coverage that provides that full benefit that they need and that their family needs when they need it? So, these are some of the things many of you in this room and across the country are thinking about. You look at a state like Washington, which does not have an income tax, and you think about how do I do a statewide payroll tax amongst my constituents for a product that they don't even want to think about needing? How many people are saying, I want to pay a tax for long-term care? They're just not thinking about it. And that makes it more difficult. There's weighing the risk of doing nothing against doing something. But we really believe and as Ms. Walters laid out so well, there are so many product innovations for long-term care within the profession. When you think about long-term care you might hear about those old-school standalone products and now we have really innovative products that are available for people that are tied to their life insurance benefit. That provides them the coverage that they need from that life insurance benefit. And not at a large additional cost. So, our goal here within Finseca and with our trade partners that are in the room is to be a resource to you, to educate you on some of these really cool innovative products that we have as it pertains to long-term care and be part of the solution as you are trying to get your arms around what is a pretty significant problem within your states as you try to balance your budgets. And as I mentioned there is much more to come in July and this is just kind of a level set of what we're seeing and what the numbers look like across the country.

ADJOURNMENT

Hearing no further business, upon a motion made by Asm. Gandolfo and seconded by Rep. Lampton, the Committee adjourned at 5:45 p.m.

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CHIEF EXECUTIVE OFFICER: Will Melofchik

NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

Model Act Regarding Life Insurers' Use of Genetic Information

Sponsored by Rep. Brenda Carter (MI).

Draft as of June 17, 2025. To be introduced and discussed during the meeting of the Life Insurance & Financial Planning Committee on July 17, 2025.

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Section 1. Title

This Act shall be known as the [State] Act Regarding Life Insurers' Use of Genetic Information.

Section 2. Purpose

The purpose of this Act is to set forth provisions as to how life insurers may utilize genetic information.

Section 3. Definitions

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

(A) "Genetic information" means information derived from genetic testing to determine the presence or absence of variations or mutations, including carrier status, in an individual's genetic material or genes that are scientifically or medically believed to cause a disease, disorder or syndrome, or are associated with a statistically increased risk of developing a disease, disorder or syndrome, that is asymptomatic at the time of testing. The testing does not include either routine physical examinations or chemical, blood or

urine analysis unless conducted purposefully to obtain genetic information or questions regarding family history.

(B) “Life insurance coverage” means a written contractual arrangement for the provision of life insurance, as defined in [insert citation to applicable State statute].

(C) “Life insurance provider” means an insurer or other entity providing life insurance coverage.

Section 4. Life Insurers’ Use of Genetic Information

(A) A life insurance provider shall not cancel insurance coverage for an individual or a family member of an individual based solely on the individual's or family member's genetic information.

(B) A life insurance provider shall not request or require an individual to whom the insurer provides life insurance coverage, or an individual who applies for life insurance coverage, to take a genetic test as a precondition of insurability, and shall not require the complete genome sequencing of an individual's DNA.

(C) A life insurance provider shall not access sensitive medical information, including the genetic data of an individual, without first obtaining the individual's signed, written consent.

(D) This section does not prevent a life insurance provider from requesting or obtaining existing health information for underwriting, including genetic information contained within an individual's medical record.

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.

JOINT STATE-FEDERAL RELATIONS & INTERNATIONAL INSURANCE ISSUES COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
JOINT STATE-FEDERAL RELATIONS & INTERNATIONAL INSURANCE ISSUES COMMITTEE
2025 NCOIL SPRING MEETING – CHARLESTON, SOUTH CAROLINA
APRIL 26, 2025
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Joint State-Federal Relations & International Insurance Issues Committee met at The Francis Marion Hotel in Charleston, South Carolina on Saturday, April 26, 2025 at 3:15 p.m.

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

Other members of the Committee present were:

Sen. Mark Johnson (AR)
Rep. Brenda Carter (MI)
Sen. Paul Utke (MN)
Rep. Brian Lampton (OH)
Rep. Jim Dunnigan (UT)

Other legislators present were:

Sen. Jesse Bjorkman (AK)
Rep. Justin Wilmeth (AZ)
Rep. Brett Barker (IA)
Rep. Elizabeth Wilson (IA)
Sen. Donald Douglas (KY)
Rep. Vanessa Grossl (KY)
Rep. Robert Foley (ME)
Rep. Mike Harris (MI)
Rep. Jennifer Balkcom (NC)
Asw. Pam Hunter (NY)
Rep. Perry Warren (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 Rep. Ellyn Hefner (OK) and seconded by Sen. Mark Johnson (AR), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Brian Lampton (OH) 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 November 24, 2024 meeting.

PRESENTATION ON DEVELOPMENTS IN FLOOD INSURANCE AND STATE RESILIENCY INITIATIVES

Dana Sutton, AVP, Atlantic Region Flood Practice Lead NFP, thanked the Committee for the opportunity to speak and stated that I'm my company's flood practice lead. All our flood insurance that we write within my agency flows through me, and I'm very immersed in this space and interested in improving outcomes for folks post-catastrophe. I wanted to start today with this statistic. This came out of Aon's Climate and Catastrophe Insight Report for 2024. This is a report they put out every year based on the previous year's loss data and statistics and the report found that in 2024, the flood protection gap was approximately 75%, noting that flood remains an underinsured peril, as many property owners lack adequate insurance coverage despite the availability of flood insurance policies. There can often be a lack of awareness and understanding of the risk and this is really the sort of thesis of what I wanted to get at today and the crux of really my career here is this notion that we are missing the mark by 75% when it comes to insuring for flood losses. This is a chart that came out of that report illustrating economic losses on a global perspective and you can see that both Hurricanes Milton and Helene were number one and number two for 2024 in terms of global losses, which is pretty significant. Hurricane Helene became the costliest event of the year estimated at $75 billion in total direct property damage that doesn't even account for soft losses and sort of those intangible economic losses. That's probably an outdated number by this point. I suspect by now it's probably higher, but this was in early January when this information was available. It impacted Florida, as you know, but really that wasn't even the headline that came out of the storm. The headline was really what happened in western North Carolina with those folks out that way. These two graphs are cumulative global economic losses broken down by peril. So, that first graph on the left is economic losses in the billions and if you can see the peril of flood is that second line down from the top, that blue line, it's pretty significant in terms of billions of dollars of losses for flooding specifically. And then that graph on the right, that is the count of billion dollar flooding events since 2000. Again, it's that blue line that kind of crisscrosses at the very top there with the green line. So it's a really significant, steep rise in billion-dollar flooding events since 2000.

I want to go back to this and just mention that the flood insurance policies have a 4% uptake rate. And that's our issue. That's our problem with flood insurance. For every 100 properties I quote, I will write four of them. So really you might question the wisdom of someone doubling down in a space where you miss 96% of the time. But really it's an opportunity here to improve outcomes for folks. So, I guess the question then becomes "why do we have this 75% protection gap and only a 4% uptake rate?" And I really think a lot of that has to do with some of the unintended consequences of the National Flood Insurance Program (NFIP). I'm sure all of you know that program was implemented in the 1960's and was really a response to the insurance industry saying, "look, we don't know how to underwrite for this peril of flood, so we're just going to exclude it." And the

federal government really wanted to continue the growth and development of these coastal areas, so they implemented the NFIP. They used flood zones as the rating methodology to rate and assess for risk, and cut to decades later, what that's really created is this belief in people's mind that you are either in a flood zone or you're not, and you either have a risk or you don't. And what we're finding, according to the North Carolina Center for Geospatial Analytics Department, that in fact, 84.5% of flood losses are occurring outside the special flood hazard area or outside the so-called flood zone. So, while there is this belief that “I’m not in a flood zone”, in reality 84.5% of the losses are occurring where people believe they have no exposure and 51% of the population is two times more likely to have a one in 100 year flooding event than the current maps indicate - that's according to the First Street Foundation - and over eight million properties outside of the special flood hazard area are at a risk for flooding from rain which is largely unaccounted for when we talk about flood zones.

There's also very much this belief among policy holders that if your lender is not requiring you to purchase a flood policy that you don't have a risk so a lot of these subsequent federal lending regulations surrounding the mandatory purchase of flood have really led people to believe “oh my lender doesn't require it, I don't need it.” And that's a massive hurdle for me as an insurance agent. I wanted to include a copy of this letter that one of my insureds received just this past January. This is a client I've written their insurance for more than 10 years. I'm very familiar with this account and certainly consider myself their trusted advisor. They owned a home that was located in a special flood hazard area and had carried a flood policy on it. In December of last year, they were remapped into a preferred flood zone, which triggered this letter from their lending institution that says flood insurance is no longer required for your loan then it goes on to say “you're going to be responsible for paying the premiums. If we purchase the policy for you, we're going to cancel it. And if we had it paid from your escrow, we're going to quit doing that and you are now going to be responsible for making those premium payments.” This insured of mine very much took this letter as a message that they did not need the flood insurance. This home's worth about $1.5 million literally sitting in a swamp. They have tidal water on three sides of them and a pond behind them and their flood insurance premium was $800 a year. The $800 a year was not preventing anybody from going to the dentist or sending their children to school or even dinner out and no amount of explaining to the insured their actual exposure was enough for me to overcome this and they canceled their flood policy. So, that's a really tough conversation to be having. I don't have an insured that I felt more strongly should be keeping their policy than this account and I still could not convince them to do so. They also had incidentally about $1,200 worth of Risk Rating 2.0 credit on their policy that they also forego. So, by canceling the policy they wouldn't be able to get that credit back and if they needed to go back into the federal flood program at any time, they'd be going back in at the full risk rate.

Another one of those unintended consequences of the NFIP is a belief that the Federal Emergency Management Agency (FEMA) will step in and pay for losses, which probably blows everybody's mind sitting in this room right now. But I can tell you, as someone who considers myself sort of on the front lines of this, this is very much how people believe. I have a licensed insurance agent out of my South Carolina office that did not

bother selling flood insurance to any of her clients because she thought FEMA would step in and pay the losses. So that's really, again, a tough narrative to overcome. When even a licensed professional is under that impression, it's tough to convince the general public otherwise. There's a belief that coverage is included on your homeowners policy. I think that's on us as agents for not adequately explaining that exclusion to people, but still very much a strongly held belief. Again, a misunderstanding of the definition of flood. Another problem we have is there's a misunderstanding of what constitutes an adequate limit. So, in the rare occasion when I am able to convince my insured that they should carry a flood policy, more often than not, the limit they are selecting is $250,000 on the dwelling and $100,000 in contents. It doesn't matter if it's a $20 million home or a $250,000 home, that tends to be what people are opting for. And I very much believe that's sort of a byproduct of that being the maximum limit that you can purchase within the NFIP - $250,000 might have been enough back in the 1960's, but certainly under today's costs that doesn't even come close for most folks.

And then finally, there's really been a lack of confidence within the private flood market due to the federal government's financial strength and stability. The fact that people feel really strongly that the NFIP's not going to go anywhere, and that they will not default or go insolvent or be unable to pay somebody's claim. So, people are very hesitant to explore options within the private market because, by comparison, anything in the private market seems like a more risky option for people. So, despite all these challenges, and maybe the most frustrating thing for me is we do have a solution ready to go for most folks. For the overwhelming majority of people, the private market is a really great option, and there is a ton we can do within the private market space. It's growing rapidly. The surplus lines market has over $1 billion in flood insurance, most of which is on the commercial side, but certainly the residential side shares a portion of that as well. There's a ton of capacity within the private market, and there is a ton of capital in the space ready to deploy. I'm sure you all know, but many states have approved forms and rates for admitted private flood options, which is a really great option for people who are concerned about the solvency of the carrier and it also gives people a place to go if they're dissatisfied with a claims payout, they can appeal that at the state level. The private market also offers significantly broader coverages than the NFIP. So, in today's private market, we can pick up coverage for pools and landscaping and basements, loss of use, loss of income for commercial risks. There's just a ton of options right now in the private space for people.

And finally, probably my favorite part about what's happening in the flood insurance industry right now, there's been a lot of innovation within the private market flood space, even in the last five years. The use and implementation of artificial intelligence (AI) and newer technologies has really brought down barriers for us to be able to quote policies, issue coverages, bind coverages, service them, file claims. Those new technologies have done wonders in making that a significantly easier process for us. It used to be it was cumbersome and difficult to quote, and unless somebody was specifically asking you to do it, you likely weren't offering a flood quote. But with these new technologies, we can do it in a matter of seconds in many cases. I know AI is sort of a buzz term, and people are leery of it, as am I, and I think there's reason to be, but I also think there's a great opportunity here to leverage some of that to improve what we're doing. And then

finally, parametric policies - this is a relatively new development as well something we mostly see on the commercial side and not a whole lot of utilization on the residential side. I hope it trickles down to the residential side and gains some teeth in the commercial market but that's a single payout policy where once a parameter is triggered a lump sum payout is direct deposited to the insurance account within 24 hours, zero requirement to adjust the claim or file receipts so it's a really great option for municipalities, large-scale manufacturing, things like that. Post-hurricane Helene this was a difficult hurricane season for us in the insurance industry this year. I'm physically located in North Carolina and the day after Helene hit, I probably fielded 60-plus phone calls from very desperate people, only about half of which were even my insureds. The other half had just heard I was the flood person and were just desperate for a solution.

Like I mentioned, $75 billion in direct losses. Helene was among the 15th costliest natural disasters globally since 1900. And what I find super interesting about Helene is that while it was a 1,000-year flooding event, it was not the only 1,000-year flooding event we saw in North Carolina that year. Two weeks before, Tropical Cyclone 8 hit the eastern portion of North Carolina. It hit a small geographic area but caused over $100 million in flood damages and was not even a named event. So, that's pretty wild when you talk about the severity and intensity and frequency of these weather-related losses occurring, two thousand-year flooding events within two weeks in the same state is pretty substantial. Incidentally, most of my insureds with Tropical Cyclone 8 were calling me saying, “the water didn't even get close during Hurricane Florence, so we thought we were fine.” And these were people that had four feet of water in their homes. With Hurricane Helene, I had an insured with 22 feet of water in their structure. This was actually my only insurance policy I wrote in western North Carolina. So, of all those phone calls that I took, I had one policy in force. And for most of those insureds, a policy for less than $500 a year would have gone a long way in making them whole again. Before the storm, we were seeing premiums as low as $185 in western North Carolina.

Eric Fosmire, Chief of Staff and General Counsel for the South Carolina Office of Resilience (SCOR), thanked the Committee for the opportunity to speak and stated that as you all are well aware, the insurance crisis as it relates to disasters is really a risk crisis. So, let me tell you a little bit about how we deal with risk at SCOR. This is our mission statement. I'm not going to read slides to you. I have quite a few slides, and most of them are meant for reference, so I'll move through these fairly quickly. But we do three things. We have a statewide resilience and risk reduction planning mission. We deploy the disaster recovery program for housing for the Community Development Block Grant Disaster Recovery (CDBG-DR) grants that come to South Carolina. And we also deploy hazard mitigation projects with a number of different funding resources that have come into the state. So, we actually implement projects. We do the strategic planning for risk reduction in SC. Our history was really born out of the three disasters that we had between 2015 and 2018. We had the 2015 historic flood. Our office was stood up as the disaster recovery office to deploy the housing recovery. We then had Hurricane Matthew in 2016, and then Hurricane Florence in 2018, and then, as you're well aware, most recently Hurricane Helene in 2024. As a result of that series of disasters, the Governor established a flood water commission. One of the recommendations of the flood water commission was to make us a permanent office as the Office of Resilience, and that's

how we got started in 2020. In setting up our office, we were identified as the Office of Resilience but the legislature didn't define what resilience meant, which allowed us to apply our own definition, and this is it. It's the ability of communities to anticipate, absorb, recover, and thrive, when we're faced with disastrous impacts. So, I'd encourage you all to take a look at our website. This is our resilience plan. It's a data-based approach, a very collaborative approach, that we took to identifying the risks that we face in South Carolina from a range of natural disasters, primarily flooding.
So, we used the highest quality data we had available. There was a high degree of coordination. We're looking at both natural systems and then also what happens in communities, not so much from a social standpoint, but from a structural and infrastructure standpoint. And one of the key principles that we addressed, and you'll see it in a map in just a minute, is that this is not a boundary issue. We approach this on a watershed basis.

If you look at the map at the top left, that's South Carolina, North Carolina, and we drain much of central North Carolina. So, in draining much of central North Carolina, we have to deal with all the water that comes through there. And to Ms. Sutton's point with Hurricane Helene, if it had been 30 miles more to the east, we would have faced the impacts of six feet of water in our cities that North Carolina was facing in Asheville and the rest of Western North Carolina. The eastern continental divide, most of the water fell on the western side of that, so all that water went through Tennessee and on to the Mississippi River. All of this water that falls on the eastern side of the continental divide comes down through South Carolina and the vast majority of it exits in Georgetown, South Carolina. And if you'll see the very tip of our watershed, it actually starts up in Virginia. So, this is not a South Carolina problem, this is a multi-jurisdictional problem and we have deployed watershed coordinators in each of those identified watersheds to work with local governments so that we're not solving a problem with one local government, and then creating a downstream problem for the other local government. Some places to just master the obvious, you want to speed up water and in other places you want to slow it down. We have identified in there all of the various planning conditions that we utilized. We looked at land cover, we looked at population. South Carolina is a net positive growth state from a population standpoint, although it's not growing evenly. Horry County, where Myrtle Beach is, is one of the fastest growing counties in the country. It's going to be net 250,000 people by 2030. That's a lot of homes. That's a lot of surfaces. The rolling map you see on the right is a screenshot of land that is being conserved in South Carolina in an effort to add some resilience in protecting watersheds.

I just call your attention to the top left. Ms. Sutton had used some data from First Street Foundation. We love their flood modeling. We used it in our risk reduction plan because it's way more accurate than the FEMA floodplains. That map is of downtown Columbia, South Carolina. The red and orange that you see in it, if you were to see it blown up more closely, is areas that actually flood in Columbia, and the purple and blue is the FEMA floodplain - doesn't even come close to identifying all the flooding issues, and it doesn't accurately account for both either pluvial or fluvial flooding. And it's just not a good resource upon which to base your insurance decisions. The middle map is all the properties in South Carolina that are at risk in a 100-year flood event of having at least a

foot of water in their homes, if it's a concentrated event in their area. And it's over 300,000 structures. It is a high risk, and it's not just focused on the coast. It's a statewide issue. And again, you can see in the top middle map that's the entire watershed that we're dealing with. FEMA floodplains don't work for us. And so, we use the First Street modeling, which is an excellent resource. The other thing we're working on is better land cover analysis, knowing what structures, how many Walmarts do you have, how many parking lots do you have that lead to all of this runoff. And with every neighborhood that goes up, it's just more rooftops. And we're not anti-growth. We are in favor of growth, it's just let's grow smartly. Maybe not put the Walmart parking lot on the very best soil in the county, which can lead to infiltration. And it's just really simple decisions like that at the local level that can really add to that community's resilience. So, that middle red blob of stuff, that's downtown Columbia. The top data set is what we have right now. We're paying a little over $1 million to the National Oceanic and Atmospheric Administration (NOAA), which irritates me because our federal dollars already have paid for this data but nonetheless, we're paying to get one meter resolution so that we know what the land cover looks like and that will all be public information. All of our data that we have is available for free to local governments. It's up on our website. We have a resilience atlas. So, we're going to improve our land cover analysis for local governments.

On the disaster recovery side, I'll cover this very quickly. We've deployed three disaster recoveries successfully with no findings from the U.S. Department of Housing and Urban Development (HUD) which we're very proud of. We have repaired or replaced over 3,459 homes through those disasters. And we've learned some hard lessons along the way, but we have really commoditized the building of the new homes so that we can move quickly and efficiently. And as we go forward, we're making the homes more resilient by adopting the Insurance Institute for Business & Home Safety (IBHS) fortified standard, particularly as to roofing and continuous load path for the critical structures in the housing. That was to Hurricane Helene for South Carolina. It was more than triple the impact of the prior three disasters combined. We had more people register for FEMA assistance. We've had more counties involved. And the unmet needs are just incredible. It's $1.7 billion in unmet housing needs in South Carolina as a result of Helene. And we received the whopping sum and we are grateful for it but $150 million from HUD for our CDBGDR recovery. So, it's a pretty big delta between $1.7 billion and $150 million. And so, a lot of folks who are hurting are going to go unserved. I won't read that to you that just shows you the relative impact and we do understand that Congress had a difficult position last year as the data when they made their congressional allocation for the 2023 and 2024 disasters was not very well developed for all of Helene particularly in South Carolina and we came up very short compared to the prior disasters and the flood. On the far left, the CDBGDR funding covered about 38% of the unmet needs. On the far right for Helene it's 8% of the unmet needs, so what do we do about it? Let's make the housing better. Let's not put houses and people in the way of the disasters. Don't make mistakes of putting folks in known places where it's going to flood. It's really some basic things. Those are our funding for our mitigation projects. We're spread out statewide. We don't just sublet this out. We've got engineers and project managers who are actually running the projects. We have two cool projects here in Charleston. We're actually doing an environmental remediation of the USS Yorktown because it still holds fuel in it from 1974 when we accepted it from the U.S. Navy, and that's before they had any of the U.S.

Environmental Protection Agency (EPA) cleanup guidelines. So, there's over 1 million gallons of contaminated liquids inside that beautiful ship, and we're cleaning it up as we speak. We've got crews there working seven days a week on a project that just started. It's a $128 million cleanup that started in January.

We also have in the bottom, that photo is the Ehrhardt Tunnel project here in Charleston. That's in the Medical District. The top left was really just a rainfall event in April 2024 which made those streets impassable. Down below is the result of the completion of that project. It's a deep shaft tunnel that connects to a longer horizontal shaft below the Albemarle which is clay that we sit on here in Charleston. And just gravity-fed, that entire project will drain about 1 million gallons a minute every three minutes when you have a major rain event. It takes care of much of the rain flooding that we have in the Medical District but not the rest of Charleston. And we deployed that project because there was just continuous flooding down the street from here in the Medical District. There's a pregnant lady that had to be carried in the bucket of a front-end loader to get to the hospital during a rain event because it was impassable. So, mitigation works. I'm sure you know there's a 13-to-1 return. From the legislative standpoint, the more you all can encourage mitigation and fund mitigation, your dollars pay off. If you haven't seen it, the U.S. Chamber last summer identified that it is a 13-to-1 return now. It used to be 7-to-1. They reanalyzed it, and it's now put at 13-to-1 in reduction of impact and savings. That's an evacuation route that in Highway 17 in Georgetown County reduced the flooding with larger outfalls and higher-capacity piping. Flood frequency, to Ms. Suttons point she made a few minutes ago, if you're in a 500-year flood plain, you have a 6% chance of your home flooding during the term of a 30-year mortgage. Go down to a 10-year floodplain, and you have a 95% chance of your home flooding during a 30-year mortgage. Those aren't really good stats. So, we need to build better. We're not saying don't live near water, but let's be practical about it. Don't put critical resources on the first floor of a building. Elevate the building. Charleston County, tired of dealing with flooding in areas, now will not issue a building permit for a slab-on-grade home, which is a wonderful start. That gives you at least a foot or so of crawl space where water can go if you have flooding in your neighborhood.

So, simply eliminating slab-on-grade, and I get it. It has its purpose. It's cheaper construction than erecting a foundation but it just puts you automatically at risk. I know you've seen this data, it's just you look at the last two years of 190 disaster declarations in the United States. It's not going to go away. And I say this because we're not climate hysterics. It's just the data is telling you what's going on, and we have to deal with what the data is telling us. And that's why our approach is data-based. We're not going to get into a debate about the causes of why all of this is occurring, but it's occurring, and the trend is not good. In probably early 1970s, there were only about five flooding days of tidal flooding in Charleston in a year. In 2019, they had 89 flooding days. And it's clearly due to sea level rise and some other things that we're having in Charleston. Charleston is sinking, and we have to figure out why, and we have to figure out if there's anything that we can do about it. If it's because of groundwater withdrawal for water systems underneath Charleston, then maybe we can redirect where we draw the water from. So, sometimes you can solve subsidence, sometimes you can't, because there are big pieces of geological movements that can't be solved by us right now. So, again, to Ms.

Sutton's point, we saw in Debby, three out of four homes were outside of the flood zone. So, we have to identify, we have to deal with those risks. Our strategic resilience and risk reduction plan has a number of practical things that can be done to start to address those risks.

Rep. Brenda Carter (MI) stated that I grew up in Asheville and I'm very familiar with the French Broad River. What I didn't expect to happen in my lifetime is the devastation that happened from Hurricane Helene. Many of my family members are still suffering behind the impact of that hurricane as I speak today. I see this as an opportunity, but if you're familiar with Appalachia, we have a literacy problem and an economic problem there where traditional and historic ways of reaching people about insurance may not reach the ones who need it the most. So, my question is how can we convince people in historically non-traditional floodplain areas who are socioeconomically disadvantaged that just a minimum amount of flood insurance can help prevent the suffering we're seeing today? Ms. Sutton stated that's a great question and not one I have a great answer for, quite honestly. Part of the Risk Rating 2.0 legislation was aimed at trying to improve some of the outcomes for people that were more negatively impacted by these flooding events, but I think it comes down to education and I think, unfortunately, the federal lending regulations really play a role here. They really drive this narrative for people and that's a really tough hurdle to overcome. Whether you're disadvantaged or not, that message is not getting to people in general. So, as insurance agents, we are doing, at least within my agency, as much as we can to have this conversation. But if I had a dollar for every time somebody told me I'm not in a flood zone or my lender doesn't require it, we could all retire. I mean, it's just a conversation I have daily. But as far as how we reach those that might be more vulnerable, I don't have a great answer for that. I really don't. Education is the only piece I can come up with.

Ms. Fosmire stated that in our Disaster Recovery Program, we spent 100% in low-to-moderate income communities because of the rural impacts where those disasters occurred. And for folks that were in the floodplain, we paid for the first year of flood insurance thereafter. It doesn't solve it, but it at least gets them started down the path and might at least protect them for a year. But when you have folks that are faced with that difficult choice of medicine, transportation, health care, or flood insurance, it's an easy decision. It's not going to be flood insurance. So, there has to be some slight incentive, other than losing your assets, to help pay for that flood insurance. And that's why we paid for it for the first year in our program so at least there was a flood insurance policy in place at the time. We thought it would be a prudent thing to do. Ms. Sutton stated that I mentioned the parametric policies earlier, I have heard that some municipalities have considered purchasing parametric policies to help those in those types of situations so they would get a lump sum payout. And because there's no requirement for how that lump sum is used, they can use that money to help those who need it most.

Sen. Theis stated that to your point on the parametric policies, I don't know how that doesn't exacerbate the same concept as FEMA when it's government that's paying for it and you just have this assumption that they're going to cover it. Then why would you do

it yourself is kind of the perspective from the other end that I'm taking away from what it is that you're saying.

Rep. Vanessa Grossl (KY) stated that we've experienced our fair share of flooding, particularly recently. You mentioned in your data how few people actually have flood insurance and when I speak with my constituents one of the main concerns is that there are these Acts of God clauses where people feel like even if they have insurance they won't get coverage and so I wanted to hear what you make of that and how can we truly protect our constituents. Ms. Sutton stated that I hear that a lot too. Certainly, there are exclusions in insurance policies and there always will be. I think that comes down to a discussion about how we define flood insurance and what is considered a loss. I heard that a lot after Hurricane Helene - would that have even been covered on most flood policies since mudslides are excluded on a flood policy? So that's a problem for the insurance industry as a whole I think. People are very skeptical of the insurance industry but most of what we experienced with Hurricane Helene would have been rectified with a flood policy in force so I think that just comes back to the insurance industry doing a better job of explaining to people what they are getting and what they're not getting within their policies.

Rep. Jennifer Balkcom (NC) stated that I represent Henderson County, North Carolina, which was hit very hard during Helene so I'm sure I had as many phone calls as you did. I will tell you, in North Carolina, we're looking at a state plan of flood insurance. I and some of my colleagues have been to Washington DC many times advocating for that. The sad part is FEMA is only paying $45,000 as a max payout for this disaster. That is not enough for many people to get their homes back. The thing that I've heard from a lot of homeowners is they were told they were not able to get a flood insurance policy because we lived in the mountains and why would we sell you that? I understand we have a lot of education to do and this disaster has brought that about. My thought is I would love some examples, and we can always take this outside, of how you can do a better job of educating and getting more insurance agents to be able to educate their clients and what we can do for that. Ms. Sutton stated that I would love to be a part of that conversation. I think that's why jobs like mine exist as insurance agencies and companies are recognizing that this is kind of a niche line of business and most insurance agents don't know it. Because I'm located in Wilmington, North Carolina that's where this expertise has sort of developed. I wrote a lot of flood policies and that's how this has kind of evolved. But you're correct and I'm really disappointed in my industry as a whole to hear that people were being told they couldn't get it. You mentioned the limitations within FEMA. I think that's a great opportunity for the private market to respond and I think we have a massive gap in needing to improve our messaging and help people to understand there's a massive risk out there that we're just pretending isn't there, and unfortunately they are finding out the hard way using flood insurance as a reactive measure rather than a proactive tool.

Rep. Robert Foley (ME) stated that with the large number of claims that we're seeing across the country dealing with flood, at some point in time, when are we going to have that discussion about spreading the risk over all properties and maybe including flood as a peril in all homeowner property policies to spread that risk over a larger number of

policyholders? Ms. Sutton stated that I'd love for that to be the conversation. I don't think it will ever get there until those federal lending regulations change. I think we'll be sitting here 10 years having this exact same conversation until those federal regulations are updated. The NFIP has already acknowledged that the use of the flood zones is inaccurate. Risk Rating 2.0 did away with the use of flood zones. So, they have gone to this methodology of using modeling data to rate for flood insurance. So, your zone is not even a factor in your rate anymore. So, intellectually, they understand that the flood zones weren't cutting it but I think at this point it's a matter of political will. Nobody wants to be the one to start requiring more people to purchase a flood policy, but I think until that happens, as I was mentioning earlier, the objections in people's minds are almost insurmountable as an insurance agent. I am a trusted advisor to most of my clients, and no amount of showing them the data is enough to overcome, well, I'm not in a flood zone or my lender doesn't require it. So, I think until some of that starts to change, until the NFIP is no longer the backstop for everything, I think it's going to be a long road

DISCUSSION ON POTENTIAL FEDERAL TAX INITIATIVES IMPACTING INSURANCE MARKETS

Doug Lathrop, VP of Tax Advocacy at the American Council of Life Insurers (ACLI) thanked the Committee for the opportunity to speak about the upcoming congressional budget debate and give you my perspective on how the next few months may unfold regarding the big, beautiful tax bill and the potential implications for the insurance industry writ large. So, a couple weeks ago, the House passed the Senate-crafted budget. That's a significant milestone because it unlocks what is known as the budget reconciliation process. The budget reconciliation process at the federal level is a set of procedures that simply allows the majority, if it stays unified, to essentially sideline the minority party and pass legislation quickly. It was created in the 1970s as a tool to rein in spending, but it has evolved over the last 40 years, 50 years, to become this bludgeoning instrument that the majority uses to pass major policies. George W. Bush used it to pass his tax cuts in 2001 and 2003. President Obama used it to pass the Affordable Care Act (ACA). President Trump used it to pass his first batch of tax cuts, known as the Tax Cuts and Jobs Act (TCJA). And President Biden used it to pass the Inflation Reduction Act (IRA). Those are all pieces of legislation that really had nothing to do with cutting the budget. They most likely created larger budget deficits and implemented policies. So, that's where we are with the reconciliation process.

So, without delving into the nitty-gritty of how it works, the basic advantage of reconciliation is that it neutralizes all of the powers that the minority party has in the Senate, which is the real obstacle. So, you cannot slow a budget reconciliation bill down using the filibuster. It is filibuster-proof. It also has a timestamp to it, so it actually just moves along. There is nothing you can do to stop it if the metrics are met in terms of the votes. In an era of hyper-partisanship at the federal level, it's really the de facto method to pass big bills when one party controls all the levers of government at the federal level. So, this year, President Trump and the Republican Congress are going to use it to pass perhaps the most sweeping bill in recent memory, one that's going to enhance border security, expand energy production and exploration. Increase defense spending, and most importantly, cut taxes. While the other policies that are championed by President

Trump and the Republicans are worthy of conversation and noteworthy unto themselves, the tax bill is really the centerpiece of this piece of legislation that they're going to consider. Now, we don't know what's going to be in the tax bill necessarily, but the contours are pretty visible. So, the first thing they're going to do is they're going to extend everything that expires at the end of the year that was part of the TCJA. That includes all of the individual tax measures. So, an increased expanded standard deduction, all of the rates, some important small business measures, that all expires at the end of the year. So, that is going to be a key component, if not the largest component, of this bill. Next, you have President Trump's priorities, such as no taxes on tipped income, no taxes on Social Security income. No taxes on overtime perhaps. And a new deduction for loans on American-made cars. Those are things that the President talked about on the campaign trail. He's continued to talk about these tax ideas while in office. I don't know if all or maybe just only some are going to be included in this bill, but some will, there's no doubt about it. In addition to that, most likely they're going to expand the child tax credit. There is bipartisan support to do that.

Now, depending on how you do your math, the cost of extending TCJA and all these new provisions could run anywhere between $6 to $8 trillion over the next decade. Now, here's where it gets a little tricky. A large chunk of those costs are just extending the TCJA tax cuts. Roughly $4.5 trillion. The Senate, to make things easier on itself, has essentially wished those costs away by saying extending current policy has no impact on the budget. That's a deviation from how they used to do it. So, they have decided to say current policy is the baseline we will use, so that takes $4.5 trillion off the table. Fiscal hawks are aghast, as you could imagine, and we'll see if the bond market believes this kind of magic wand, but for now that solves a big political problem. Now the other stuff may have to be offset, and that's where you're going to have to have either new revenue or much deeper spending cuts in order to accomplish this mission. And here is where the life insurance industry, and frankly all insurance, might be at risk. So, before I go there, I want to just go back in time briefly and talk about what informs the current posture of the life insurance industry. The 2017 tax bill was not like something we threw a parade over. The industry was actually targeted for roughly $25 billion worth of offsets, which were included in the bill to help drive the corporate rate down to 21%. One of the offsets was a substantial change in how life insurers are able to deduct for the reserves that they hold. Before 2017, life insurance companies could essentially deduct almost 100% for the reserves that they hold. These are statutory requirements that all the states mandate that we hold. And what the federal government decided to is we’re going to haircut that. And instead of allowing you to deduct roughly .99 cents on the dollar, now you can only deduct 92.7 cents.

Now, you might say to yourself, well, what's the big deal? It's not huge, roughly 7%. Well, it applied retroactively. So, all the reserves that life insurers hold which amounts to, I think, close to $1.8 trillion, you had a haircut applied to that. So, that offset alone, and that is a permanent feature of the tax code, essentially wore away the benefit of the rate drop. So, I just talk about that briefly to say that's what informs the posture of the life insurance industry, because we were targeted. And sort of an editorial aside really quickly, insurance is state regulated, and rightly so, and that is a good thing. But when you have federal problems, because there's just a lack of familiarity with the business

and insurance we oftentimes have to do twice as much education in terms of reaching lawmakers and explaining the business model and making sure you meet them where they are. And if you have gaps and if you have sort of misunderstandings they can oftentimes turn into big problems and certainly at the tax space with the two tax committees we saw that in 2017. So, the potential threat today actually is an unusual one and again something that's unique to insurance and there have been ongoing discussion at the federal level of eliminating or curtailing the deduction that companies can take for state and local taxes it's called SALT, you might have heard about it in the press. Where that would threaten insurance, and this is everything, health, property & casualty, as well as life, is inclusion of premium taxes in that calculation. So, we're talking not just income taxes. The debate, as it's moving along in furtive ways, we're trying to figure out what they actually mean when they say they want to eliminate corporate SALT. If they did that and actually included premium taxes, we estimate that would result in essentially a four- to seven-point rate hike at the federal level for carriers because we pay a tremendous amount of premium taxes, and we will continue to pay premium taxes. That won't go away. It's a cost of doing business. It's a gross receipts tax at the state level. So, if federal policymakers decide to do that, it would have a massive impact on the federal tax burden for carriers. We're doing our best, working with the property and casualty trade associations to try to educate lawmakers as to why it's a bad idea.

And again, a disproportionate sort of hit to the insurance industry, which most likely would result much later on, but would result in an inflationary impact. If you're going to put that in motion, you can't reprice old business, at least at the life insurance level. And so that would end up being born by new policyholders at some later date. So, we're trying to educate folks that this would have a really serious impact at a time where we're already struggling with inflation on a variety of levels. So, the next few months are going to be a pretty anxious period for the life insurance industry. We have largely adopted a position when we talk to lawmakers of just leave us alone and let us do our job, trying to remind them of how we responded during COVID, our critical importance as a source of capital in the US economy. My colleague Leah Walters mentioned in a previous committee yesterday the $3.8 trillion that we hold in high-grade corporate debt and how we are essentially a shock absorber and in times of volatility we provide financial security for 90 million American families at all stages of their life. And obviously we sell products that take away risk and provide a guarantee, which is a key component for middle-class economic stability. So, that's what we're trying to just drive things home. We're obviously taking nothing for granted. Hope isn't a strategy. And as Harry Truman said, if you want a friend in Washington DC, go get a dog. So you need to operate as if everybody has two faces in some respects, but we are working our best to try to ensure that this doesn't transpire, and hopefully this is something that we can put to bed at the end of this summer.

Rep. Jim Dunnigan (UT), NCOIL Secretary, asked Mr. Lathrop if he has a crystal ball on the enhanced marketplace subsidies? Mr. Lathrop stated that I don't have any expertise in that area of the insurance space.

DISCUSSION ON FEDERAL HEALTHCARE PROPOSALS AND IMPACT ON STATE SYSTEM

Bailey Reavis, Gov't Relations Manager at Families USA, thanked the Committee for the opportunity to speak and stated that Families USA is a leading national nonpartisan voice for health care consumers that for more than 40 years has been working to achieve a vision of a nation where the best health and health care are equally accessible and affordable for all. Today I'm going to talk about what health care changes and reforms are likely this year at the federal level, including changes around Medicare, Medicaid, private insurance, as well as some potential additional reforms. So, before diving into the specific policies, I wanted to quickly set the scene just about where we are with health coverage right now in America. We know that more people are covered than ever before. Since 2010, we've seen the amount of folks without insurance drop pretty dramatically, almost in half from 49 to 26 million. And year over year, we see that the ACA marketplaces continue to reach record enrollment this most recent year with 24.3 million. However, simultaneously, we see that families are still really grappling with the cost of health care, health care bills still just are really out of reach and leading to significant medical debt for families. We see out-of-pocket costs skyrocket and know that high drug costs and hospital bills are significant drivers of those costs. Additionally, it's not just the cost of the pharmacy or the hospital bill that are creating issues, but we're seeing year-over-year increases in premiums and deductibles, which is negative in and of itself, but we also know that these costs overall have a downward pressure on wages as well. So, we can see that the cost of healthcare is also driving down families' wages.

So, all taken together, we know that getting insurance is still the best way to reduce your health costs. And being in insurance, people are still paying significantly less than uninsured, so it's critical to protect these gains that we've made. But there's also a lot of opportunity and reforms that need to be made to really bring down the cost of care. So I wanted to start first with Medicaid, given it has a significant impact on states. Thank you so much to Mr. Lathrop for starting off with the reconciliation process and kind of giving a teaser on that. We anticipate most of the changes this year being made through Congress will be through this reconciliation process. As mentioned, there's a significant amount of tax cuts that Congress will be trying to move. And they can either increase revenue or they can significantly decrease spending. And we see Medicaid as a pretty significant area that they will plan to decrease spending. So, particularly true on the House side, where the House Energy and Commerce Committee, which is the lead committee with healthcare jurisdiction, they're requiring themselves, based on this framework that they've created, to cut $880 billion over 10 years. Again, that's a floor. They could cut more than $880 billion. That will be necessary if they end up moving any provisions forward that cost money. But at minimum, they have to cut $880 billion. So, as you can see from the chart that I included on the right, given that Republicans have pledged to not make any changes to the Medicare program, based on the jurisdiction of the committee, they can really only get that number by making really significant changes to the Medicaid program.

There are a number of proposals that we know Congress is considering that I want to touch on. The first being implementation of work reporting requirements. This is

essentially just increasing the additional paperwork and bureaucracy that folks who are enrolled in Medicaid have to go through to prove that they are either working or seeking work while enrolled in Medicaid. This is despite the fact that 92% of the people who currently use Medicaid are working or are students. And those who are not are often disabled, ill, or caregivers themselves. The next reform that I'm sure the folks in this room are already more familiar with than I am would be elimination or reduction in state provider taxes. These are taxes that states levy on healthcare providers or entities, often including hospitals, nursing facilities, and managed care plans. All states except for Alaska finance some of their costs through these taxes, and approximately 17% of state Medicaid dollars are comprised of provider taxes on average. So, without these taxes states would have to cut the Medicaid spending by either lowering their payment rates to providers, cutting optional Medicaid services, this includes things like adult oral health coverage in Medicaid, or reducing program eligibility. The third potential change is reducing the federal share of Medicaid funding through the federal medical assistance percentages (FMAP) percentage. So, this also includes fully eliminating the FMAP bonus that states who have expanded Medicaid are getting. And this is not only deeply concerning for state budgets, but for at least 12 states, they currently have trigger laws in place. So, if you lower the FMAP percentage below a certain amount, those states automatically end their Medicaid expansion programs. So, it would be concerning for the budget, but it also means likely that overnight you'll see millions of people losing their Medicaid coverage.

And then finally, fourth would be eliminating some existing rules that were put in place under the last administration that essentially make the eligibility determination process less burdensome. Without this streamlined rule we see that it's likely families who are eligible for Medicaid are unlikely to stay enrolled just because they have to go through additional paperwork and process. And then finally it would be fundamentally restructuring the Medicaid program into block grants or per capita caps which would mean states get a certain amount of money each year regardless of how many people are enrolled or how much money Medicaid is costing the state that year. So, we expect that the Energy and Commerce Committee around May 7th will be putting forward the details of what they're planning to include but I just want to especially highlight that really of any of these reforms it's completely clear that they would have significant impact both on state budgets and also likely lead to millions of families losing affordable health coverage. Unless they go down a path of block grants or per capita caps it's likely that they will have to combine these provisions with work reporting requirements which we think are especially likely as that alone won't hit that $880 billion that they'll need to meet. So, they'll likely be looking at many of these provisions at once.

For private coverage, starting off with Rep. Dunnigan’s question about enhanced premium tax credits (EPTCs) we know that the tax credits are expiring at the end of this year. Those tax credits are relied on by millions of families to help reduce the monthly costs through the ACA marketplaces. As you can see from this chart I put up, the difference in what many families will be paying should these tax cuts expire for many families we will see their monthly premium costs double. We know that there is bipartisan interest in Congress to address these but we haven't seen action yet and this is a concerning ticking clock as they expire at the end of the year and I know many

states are already putting forward work to announce your premium rates and the certainty of knowing these tax credits is a significant part of that process. Additionally, some other reforms that we think are possible from Congress, based on what we've seen from previous Congresses, is around association health plans (AHPs) or short-term plans. I'll note from our perspective, these plans often allow insurers to skirt requirements for comprehensive coverage so people who are enrolled in them are not as likely to get the affordable coverage they need when they go to the doctor. I'll also note that with short-term plans, because they essentially allow plans to opt out of a lot of the essential health benefit (EHB) requirements of the ACA, it also means they are not necessarily held to state requirements for things like EHBs so it also undermines state authority over some insurance plans. Finally, we know that Congress is likely to consider reforms about expanding the use of health savings accounts (HSAs) and I'll just note that expanding of HSAs often incentivize more high-deductible plans and often lead to plans with smaller employer contribution because they're higher deductible, making monthly and annual costs for families more expensive. And then just quickly touching on a few administrative priorities around private coverage. There was a rule that was actually recently proposed by the new administration on the ACA marketplace that had a couple of key pieces I just want to lift up. The first is mandating shorter enrollment periods. This is even true for states that operate their own ACA marketplaces. They will be required to follow the new enrollment dates, which I believe is November 1st through December 15th. They cannot have a longer one, which I know many states have utilized to help get more people enrolled. That rule also included language that essentially limits states' abilities to add additional coverages based on their population, your constituents. That includes specifically coverages for Deferred Action for Childhood Arrivals (DACA) individuals as well as gender-affirming care, so it's limiting state's abilities to control the health care that they think is best for their constituents. We also know that from the administrative perspective, there have been significant reductions in funding for the navigator program, which is key to helping families who are enrolling in the federal marketplace navigate through ACA and Medicaid enrollment. And then finally, we also know that there are some risks to changes in coverage for the preventative health services. These are essentially the required preventive services at no cost that insurers have to give through the ACA. There's a pending Supreme Court case Kennedy v Braidwood Management that could potentially limit or entirely threaten that program as well.

Looking at Medicare, there's not a lot of expected reforms, candidly, both the President and many elected officials throughout their campaigns made promises not to make major reforms to Medicare, so at this time we don't anticipate anything significant, but I just wanted to quickly highlight that the Medicare negotiation program, which was recently implemented through the IRA, has gone into place. The first round of ten drugs that have been negotiated, those costs go into place in 2026. And the second round of 15 drugs, that negotiation process has begun. And we don't anticipate that the change in administration will have any impact on that process. So, we'll just be continuing to ensure robust negotiation to lower costs, both for folks at the pharmacy counter as well as for the Medicare program itself. And then I also just wanted to note that there's been an uptick in bipartisan interest around addressing some abuses occurring in the Medicare Advantage program. We've specifically seen a rise in conversation around

addressing overpayments and coding abuses that Medicare Advantage plans have been charging the Medicare program. For those that are unfamiliar these Medicare payments often cost the Medicare program billions of dollars every year. And we saw bipartisan interest in Congress with reintroduction of legislation as well as questions from both sides of the aisle around this issue during now administrative Administrator Oz's confirmation hearing. And he also remarked during that confirmation hearing that he was eager to take action on this issue. Additionally, I wanted to also highlight that we anticipate potential action around transparency in Medicare Advantage. This is especially true for things like prior authorization and supplemental benefits and just really getting an idea of what are the benefits and ensuring that seniors in Medicare Advantage are really getting the care and quality of care that they're paying for.

These no ware issues to kind of address underlying drivers of what's making healthcare costs so high. We know that there's been a lot of bipartisan interest on many of these reforms and actually several of them almost passed at the end of the last Congress and unfortunately just didn't due to nothing related to these provisions but some general larger dynamics at play there around the federal appropriations process. So, just quickly bucketing them, the first is through increased transparency, just getting a better understanding of what rates folks are actually paying at hospitals or pharmacy benefit managers (PBMs) are negotiating as well as getting an understanding of what hospitals are paying at outpatient versus inpatient settings. The second is same service, same price policy - this is just ensuring that if you have a doctor's office that gets bought by a large hospital chain that they are not suddenly charging additional or unnecessary fees. And then finally, this is really the piece that we think is most important to what is driving health care costs right now which are these anti-competitive behaviors that we're seeing across the healthcare industry either from hospitals consolidating into state driven chains or insurers vertically integrating with PBMs and pharmacies or to drug companies using the patent system to keep generic competition from entering the market. This is really what is underpinning so much of what's driving costs. And so just getting an understanding of how this consolidation is happening and taking action to really crack down on this consolidation we believe is extremely key to addressing these high costs.

Michael Cannon, Director of Health Policy Studies at the Cato Institute, thanked the Committee for the opportunity to speak and stated that I want to say a little bit on what is going on at the federal level and then give states a little bit of hope and an idea for how they can themselves make access to care better and more affordable and more secure, which is what we all want, even if we have different perspectives on how to achieve it. The federal government needs to cut health spending, and it needs to cut health spending dramatically in the near term, because if it doesn't, the federal government is going to hit a brick wall, it's going to hit a debt crisis, and when that happens it'll make any sort of cuts that Congress might be contemplating right now seem like child's play. The $880 billion that the Energy and Commerce Committee has stated, if they took all $880 billion out of the Medicaid program, that means that federal Medicaid spending, which under current law would grow at 4.5% per year over the next ten years, would instead grow at 3% per year. That's not a cut. This is hysterical, nonsensical, pearl-clutching propaganda by ideologues and an inefficient healthcare industry that wants to keep their sweet federal subsidies and keep providing people high-cost, low-quality care.

If we don't restrain federal spending far more than what Congress is contemplating right now, then you're going to see work requirements for healthcare that are far beyond any sort of work requirements they're talking about right now. In other words, if you don't work, you won't get any healthcare at all, because you're going to have the federal government dramatically cutting Medicaid, because that's where they go first to make cuts. Poor people don't vote like seniors do. That's why Medicaid is on the chopping block, not Medicare. And then state legislators are going to take the blame when the federal money disappears, and states have to decide, okay, do I raise taxes on my constituents in order to keep these programs, to keep the payment levels and the enrollment and the benefits levels as high as they are? Or am I going to have to cut? So, unless Congress gets together and does much more dramatic cuts than what they're contemplating right now, which aren't even cuts, then we're going to be in an awful place. The federal debt is 100% of gross domestic product (GDP) right now. Congress is adding another 6% of GDP every year. The main driver of that is federal health spending. Federal health spending is the largest category of federal spending, larger than the debt service, larger than Social Security, larger than the Defense Department.

And it's the only category of federal spending that is growing faster than GDP. So, that is the main driver of this debt crisis. Congress has to cut that. Now, you might think, well, those sort of cuts would jeopardize access to care for people. It would jeopardize the quality of care that people receive. Well, I would love to be able to tell you that the Medicare program and the Medicaid program do what its fans say and provide high-quality, low-cost care to enrollees. But these are wildly expensive programs that reduce the quality of care in this country. For example, the Medicare program, relative to other countries, is the most expensive part of the U.S. health sector, which is the most expensive in the world. So, I could do a little more doom and gloom. There's a lot of dispelling that needs to happen. But let me give states a little bit of hope about what they can do in a positive direction that would make health care better and more affordable and more secure. And to do that, I wanted to make a little detour to the German Democratic Republic (GDR). In the GDR, there is a compulsory system of health insurance where employers make payments into the system on behalf of their workers. It's really the workers' money, just like it is in the United States, but we pretend it's the employers. And Germany allows alongside of that a relatively free market for health insurance where people can buy lifelong insurance plans. Insurers can underwrite, which allows them to provide that sort of lifelong coverage where you don't lose your coverage if you get sick. Your premiums don't go up if you get sick. You can renew year after year. That aligns the incentives between the insurer and the insured so that the insured behave better.

Now you might think, well, if Germany allows that sort of market to exist alongside the compulsory system, won't all the healthy people go into that market? If you take a static one-year view, maybe. But when you take a longer-term view, the picture changes because those people who go into the individual market for health insurance, once they become sick, they don't want to leave their plans to go back into the compulsory system. They want to keep that guaranteed renewability protection. They want to keep the low premiums and the better access to care that those plans afford than, say, the compulsory retirement system does. And so to the extent you're keeping sick people out

of the government program, that reduces the burden of that program on taxpayers. We can do the same thing in the United States which would align the incentives of insurers with consumers and provide higher quality coverage than ACA does, and do so at a much lower cost because the premiums for insurance plans, once you strip out all the ACA regulations, can be 70% lower for most consumers. But states can enact those reforms by themselves. I have brought some handouts that explain that in 2014, the Obama administration sort of gave a gift to states. It gave a gift to states indirectly by directly giving a gift to U.S. territories. It said to U.S. territories, “we know that we are imposing all these regulations on you, or the ACA creates all of these regulations, that would destroy your health insurance markets. We're going to exempt you from those regulations.” The Obama administration did it by regulatory guidance, or a memo.

So, community rating price controls, EHBs, medical loss ratios (MLRs), single risk pool, guaranteed issue, and one other, all of the most expensive regulations in the ACA don't apply in U.S. territories. And what does that have to do with states, and how you can make health insurance more affordable and more secure? Every state has the power to remove barriers to entry into their health insurance markets for plans that U.S. territories license. At least one of those territories has much more liberal deregulatory rules when it comes to health insurance pricing than the ACA requires, the U.S. Virgin Islands. And if your state authorized for sale in your state, any health insurance plan available in any U.S. territory, the plans for the U.S. Virgin Islands could be available to all the employers and individuals in your state. Many of them could save 70% on their health insurance. They could buy guaranteed renewable lifelong policies that would stay with them between job changes and that would not create the perverse race to the bottom incentives that the ACA’s community rating price controls create. You would also allow for more innovations like the type that UnitedHealthcare introduced in 25 different states in 2009 that fill the gaps in employer sponsored insurance by offering a very low cost product to people that says to them, when you leave your employer plan, you can enroll in one of our plans no matter how sick you got in the meantime and you'll still pay healthy person premiums.

There are all sorts of ways that competition in health insurance markets can make health insurance more secure and one of the handouts that I provided was a model law that Florida legislators introduced along these lines that would allow their residents to purchase any health insurance plan available in any U.S. territory. You have major insurance companies like UnitedHealthcare, Humana, Aetna, Cigna that do business in the territories and already have networks in your states. And you don't need Washington's permission in order to do this. I've heard from at least one large insurer that if this happened, they would definitely take advantage of that. And this is something that you can do to protect your state in case there are major cuts in federal health spending, forcing you to cut people loose from the Medicaid program, such as in the Medicaid expansion population, because those are the people for whom we need to get the premiums down the most. Those are the people living at the margins and scraping by and struggling to afford health insurance. The ACA is so expensive that Congress is offering subsidies of $12,000 to people making $200,000 a year. That is not affordable coverage. We need to make coverage more affordable, and it's within your power to do that.

Sen. Theis stated that since the Committee is running against its deadline, please seek Ms. Reavis and Mr. Cannon our after the meeting if you have questions for them.

INTRODUCTION AND DISCUSSION ON NCOIL HEALTH SAVINGS ACCOUNT STATE-FEDERAL REGULATORY COORDINATION MODEL ACT

Sen. Theis stated that last on our agenda is the introduction and discussion of the NCOIL Health Savings Account State-Federal Regulatory Coordination Model Act. You can view the model in your binders on page 133 and on the website and app as well. Before we go any further, I'll recognize Rep. Dunnigan who is sponsoring the model.

Rep. Dunnigan stated that I am very pleased to sponsor this Model. In 2023, NCOIL passed a Resolution in support of embedded provisions in state insurance codes to protect HSA qualified health insurance policies from certain state benefit mandates. What that resolution did in the simplest terms is encourage an amendment to state law to help ensure that when states adopt certain types of laws, they don't inadvertently cause people to lose access to their HSAs. Since then, in the last couple of years, we've seen this issue continue to pop up in state legislatures, so I think now is a good time to go a step further and craft a model law that we can provide to states that want to look to implement this type of policy. My home state of Utah is one of several states that have addressed this issue, and I think other states would benefit from looking at the model to help them through this process. I look forward to working with the committee this year on this.

Kevin McKechnie, Executive Director of the HSA Council at the American Bankers Association (ABA), thanked the Committee for the opportunity to speak and stated that states control what is in a health insurance contract. However, the federal government has assigned what a high deductible health plan is, and states have no role in that process. And so, this is a coordination amendment. You might think of it as a technical correction in some ways, meaning whatever is in your health code and whatever you decide to put in your health insurance plan is up to you, not me. And it's not up to the federal government. What a high-deductible health plan is, is up to Congress, and so what we're trying to encourage you to do is to adapt the kind of stuff that's in Oklahoma and in Utah and in North Dakota. All those states have done what Rep. Dunnigan has suggested so that you can't inadvertently disqualify people from their contribution eligibility to their HSA. And it's astonishingly easy to do, because all you have to do is say, well, you know what, we think there should be no cost-sharing on something, and it only has to be something that's not on the U.S. preventive care list, which already allows no cost-sharing for something like that. And so, this is, we think, a consumer-friendly amendment. We think it’s something that keeps people on the kind of health insurance they picked. And of course, it's not a marketing triumph to call something the high-deductible health plan, but that was 21 years ago, and we would call it HSA qualified plans now if we had to do it all over again, and that would feel much more palatable, I think to everyone.

Sen. Thies thanked Mr. McKechnie and stated that we will be further discussing this during the Summer.

ANY OTHER BUSINESS

Sen. Theis then stated that before we adjourn we have a couple of quick pieces of business to attend to. Sen. Kirk Talbot (LA) who unfortunately had to change plans last minute and wasn't able to make it down to Charleston, has offered up a draft letter from state legislators to Congress. You can find that letter on the app or website or in your binders on page 136. This letter expresses concerns with FEMA's Risk Rating 2.0 program and urges Congress to take action on the program and reform the NFIP. If you have any questions, please reach out to Sen. Talbot, me, or NCOIL staff. I'll also now recognize Mr. McKechnie again for our last item of business.

Mr. McKechnie stated that I would like to offer a quick update on disaster savings accounts (DSAs) which NCOIL recently adopted a resolution in support of. The concept is spreading like wildfire in the states and the reason it's spreading like wildfire is because as we want solutions to all the problems you heard today. With HSAs, we have tens of millions of people storing billions of dollars for things that haven't happened yet. And that's not true in homeowners insurance. And so, it will take time, but over time, legislators and states have recognized the importance of having people prepare themselves. With DSAs, they might be able to buy new base flood elevations certifications or buy foundation vents or things like that on a tax-advantaged basis. We want to encourage all of that, and states are very interested in the concept as we look at California, Iowa, Utah, Oklahoma, and New York. And they already exist in this state, they exist in Mississippi and Alabama, and we're hoping there's going to be a federal solution soon. It has a long history. We can go into it but we are running out of time. But the long and the short of it is the late Senator Jim Inhofe asked for this idea 11 years ago and it's taken some time to matriculate, but we're finally at that spot where crisis equals pragmatism. And we think we'll get somewhere this time.

Sen. Theis thanked Mr. McKechnie and stated that reading the prior committee minutes, some were looking at a friendly amendment to the resolution that would allow the DSA to pass through family members in the event of the account owner's death and I think that's a pretty good concept that we need to discuss also over the summer.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Carter and seconded by Rep. Lampton, the Committee adjourned at 4:45 p.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 discussed and potentially considered during the NCOIL Joint State-Federal Relations & International Insurance Issues Committee on July 17, 2025.

Table of Contents

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
2025 NCOIL SPRING MEETING – CHARLESTON, SOUTH CAROLINA
APRIL 27, 2025
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Financial Services & Multi-Lines Issues Committee met at The Francis Marion Hotel in Charleston, South Carolina on Sunday, April 27, 2025 at 9:00 a.m.

New York Assemblyman Jarett Gandolfo, Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Mike Meredith (KY)
Rep. Edmond Jordan (LA)
Sen. Lana Theis (MI)
Sen. Jeff Howe (MN)
Sen. Paul Utke (MN)
Asw. Pam Hunter (NY)
Asm. David Weprin (NY)
Rep. Brian Lampton (OH)
Rep. Ellyn Hefner (OK)
Del. Walter Hall (WV)

Other legislators present were:

Sen. Steve McClure (IL)
Rep. Peggy Mayfield (IN)
Rep. Mike Clines (KY)
Del. Mike Rogers (MD)
Sen. Michael Webber (MI)
Sen. Walter Michel (MS)
Sen. Bill Gannon (NH)
Rep. Perry Warren (PA)
Sen. Cale Case (WY)

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 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. Brian Lampton (OH) and seconded by Asw. Pam Hunter, NCOIL President, (NY), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's November 23, 2024 meeting.

ALIGNING DATA SHARING WITH EXISTING PRIVACY LAWS

Ron Raether, Partner and Practice Group Leader of the Tech Privacy and Cyber Group at Troutman Pepper Lock, thanked the Committee for the opportunity to speak and stated that I've been honored to be able to practice in technology law for 30 years and in that 30 years, I have seen a lot of changes in technology. I think we all recall e-mails being new. I recall being in front of judges and having partners that would have their e-mails printed out, and then they would dictate those responses. I think it's important for us to understand that as a context as we move into telematics for usage-based insurance and as we think about the new tools that are out there to benefit society, consumers, and the industry as a whole. I do want to take a moment and talk a little bit about myself. I live in California, and that will become relevant a little bit later, and I was born in California but I moved around and I was raised by a Wisconsin dairy farmer, and I went to high school in West Virginia. So, let's talk about telematics-based driving behavior data and how it's defined. And I think before we do that, one area that I've spent a lot of time practicing is the Fair Credit Reporting Act (FCRA). And I think it's important for us to think about that statute and that regime as we think about user-based driving behavior data and user-based insurance because the fundamentals of what is understood, what is studied, what is used is regulated by the FCRA. I had the pleasure of being able to work with Ron Plesser and Rick Fisher, two of the individuals that were instrumental in getting the FCRA passed in 1972. At its core, it is a privacy statute. It is providing consumers with the level of access, transparency, correction, rights that are fundamental to privacy. Telematics-based driving behavior data is just another aspect or component of that. For over two decades, user-based insurance has been in the market. What has changed is the technology. I think likewise what has changed is the need for better consumer education, improved perceptions, and changes in how we think and look at not just the insurance side of it, but the technology side of it as well. What is driving behavior data? It's basically defined as data that identifies behaviors such as speed, hard brake, hard acceleration, trip time, and the like. What I'll tell you is those are objective data criteria points. And I think I want to plant that as a seed as we move into some of the privacy issues. It's collected from a variety of different ways. I think historically it was plug-in devices, mobile apps, but now we have connected vehicles. The technology is changing. The technology is evolving. But the basic fundamentals remain the same. It may be obtained by insurers directly. We've all seen the commercials. I won't choose one insurance company over another. Original Equipment Manufacturers (OEMs) and third parties are now releasing mobile applications to help collect data for a variety of purposes. I do want to make sure that we take a step back from a variety of purposes because there are a lot of different ways in which data is being collected and used. I think for the purposes of our discussion and what's important here is the data that's used in the context of underwriting insurance, and that's really what our focus should be on.

The benefits are there. It’s not new. I think we all see that consumers benefit from user-based insurance (UBI). What's interesting to me is because of the media attention, because of lawsuits and other inquiries into the technology itself, we've seen some recent legislation and that recent legislation has focused on two points that I want to spend just a little bit of time today with you.

The first is permissible use. So, I've seen bills introduced, again I'm not going to pick on any particular state, but they prohibit the purchasing or obtaining of telematics data, period - it can't be collected or used at all, even for insurance purposes. There's a complete ban on the use of driving behavior data for insurance purposes, for underwriting. There's a ban on being able to use the information for adverse impact. So, it can only be used to improve your rates. It can't be used as a measure to determine sound pricing policies for insurance, and I'll get to that in a moment. So, permissible use is one element. The other is consumer consent. Some are requiring consent at the OEMs. Some are requiring consent by the insurers. I want to come back to that in a moment and explain why the FCRA, in order for it to work in its current form, in order for it to provide consumer benefits, consent becomes an important key. So, let's jump into is further regulation required, and let's focus on whether UBI, whether telematics-based driving behavior data should be considered at all, or should there be limits. I think the benefits of UBI and driving behavior data are well known. They promote and encourage safe driving habits. I don't know if anyone else recognized how people forgot how to drive after COVID, but I can tell you in California it's remarkable how people forgot how to drive. One of the things that I think is key is this concept of cross-subsidizing. I don't think consumers actually realize that safe drivers are covering the risk of reckless drivers. Before UBI, we were depending on a lot of non-driving factors. They were being used to consider somebody's rates. I think a personalized, risk-based approach, where we're looking at how an automobile is actually driven, helps to eliminate that cross-subsidizing issue that I think most consumers aren't aware of, but if corrected, can help us address the increase in pricing and the reduction of availability. And I can tell you in California, we cannot consider driving behavior data because of a referendum. I can tell you that the price of insurance has gone up, the availability has gone down and it has nothing nothing to do with driving behavior data because it can't be used in California.

And I'll get to in a moment where when it is used and considered. It rewards safe drivers. So, there are premium benefits, good drivers are rewarded, and it reduces the severity and frequency of accidents. When people know that their driving behavior is being considered for insurance purposes, people begin to change their behavior. They start driving in a manner that improves road safety, improves, I think, the culture and the environment for the vast majority of your constituents. And more importantly, I think it provides new and inventive ways of being able to capture and address these issues that are emerging that are actually increasing our prices and reducing availability of insurance. So, quickly, I want to talk about the consumer consent aspect of this and a little bit more about the FCRA and whether further regulation is required. So, I've done a lot of work in the FCRA over the past 30 years and what I can tell you is, while not a perfect statute, it is working and I think it works very effectively and it does provide the framework that's needed to be able to manage this new tool, this new data, whether it comes from an OEM, whether it comes from a toggle, whether it comes from a mobile app, the rights are already embedded in the FCRA that are necessary - rights that provide consumer access, transparency, the right to correct, safety and control.

The FCRA regulates any information that goes into a consumer report. It doesn't matter what that source is. So if I use driving behavior data in a consumer report, that consumer then has the right to say to the consumer reporting agency, let me see that. So if I am a

consumer reporting agency, if I get data from an OEM, one concern might be, well, how do I know what information is actually out there about me? What information is being used? Do I know if I hard braked or not? Do I know if I went over 80 miles an hour? Under the FCRA, a regime that already applies to this data, if any data is used for underwriting purposes, the consumer gets access to that information and they get to know who the source is and they get to know who ordered or used that information for underwriting purposes. So there's no reason to change our privacy regime that applies to these data points. In fact, doing anything else would undermine the integrity of underwriting. So, let me just give you one quick example in the credit context. So let's say I don't want somebody to know that I didn't pay my mortgage. What is the consequence of me being able to say, you know what, I opt out of having my mortgage payments reported under the FCRA? We all know the answer to that. People that are writing loans and credit cards, that's a useful piece of information that will no longer be available to them. Don't do the same thing with respect to driving behavior data. There needs to be a free market with respect to that in order for UBI to actually realize and see the benefits that will happen for consumers that drive safely.

Lastly, there are FCRA preemption issues and challenges. We're seeing that already in other arenas, so there needs to be care taken. So, what do we do? How do we help consumers? How do we help your constituents? And I think the bottom line is more consumer awareness and more education is needed. You already have your Departments of Insurance, the institutions to be able to determine when it should be applied and how should it be applied are within your governance structures. But here's where I think it becomes important in terms of education because when you actually look at consumer perceptions, when they're educated, when they get an opportunity to hear about the benefits of it, people begin to opt in. People begin to realize that as a safe driver, it's to my benefit. And at the end, what we're seeing in our studies is on average a discount of 12%. So, in a world where we're seeing increasing rates, lack of availability, we know that driving behavior data, when used responsibly, when used in compliance with the FCRA, will benefit consumers. And in fact one issue that I come across all the time in my years of involvement with these issues is disparate impact and what I would say is driving behavior data actually benefits protected groups of individuals. And so here on this last slide what we're seeing is annual savings in categories that you would be surprised to see because normally we see that 18 to 25 range having higher rates but they're actually benefiting and we're also seeing that in terms of data by race.

Asm. Gandolfo asked when we're talking about the users driving data, how detailed does that get? I know the slides mentioned the time of day that you might drive. Does it go as far as the route that you usually take and certain roads are maybe more accident prone? I know down in my district we have a section of a highway that's called Blood Alley just because of how frequent accidents happen on it. It's a very windy highway. So just to clarify, what sets of data would you draw from each driver?

Mr. Raether stated let me answer that question in two parts and let me answer the second part first, which is what data is considered and how is it considered, and that process actually goes through each state's Department of Insurance. So, being able to determine the algorithm or the logic or the impact on underwriting, there is a process

already in place within your states to be able to analyze and vet that information or that question. What I'll tell you is in terms of the first part of your question, which is what is collected, and the technology is still ever evolving and changing, the biggest impediment prior was the amount of memory. Now my phone is better than my computer that I had when I was a kid. The data elements are set by each OEM. They're set by the app. So there is no uniformity right now in terms of what data is collected. It won't track, for example, necessarily what road you're at. It might track what latitude and longitude you're at. It's more centered on things like velocity, how fast you're driving. Latitude and longitude is used in an algorithmic way to determine how quickly you stop. But the criteria that's being used currently is not so specific to say you're driving on a specific road or it's not even measured enough to be able to say you're driving 30 in a 25. It's more set on are you driving faster than 80 miles an hour.

Rep. Brian Lampton (OH) stated that I tend to accelerate and brake quickly but I also consider myself a driver that pays attention. Is there any way that that data can look at how I haven't had an accident in many years compared to the driver that may drive slower and brake easier and whatnot but has more accidents because they're not paying attention and they're looking at their phone? Is there any way to kind of combine those two things together or are they doing it now? Mr. Raether stated that's a great question and the answer is yes they're doing it now. We're not talking about the elimination of traditional data that's being considered for underwriting purposes. So, to the extent that I'm getting moving violations and I'm involved in accidents and I have claims and lapses in my policy, those factors are still included in the underwriting process. What we're really discussing here is an opportunity to be able to refine and to get a little bit more detail to be able to provide I think benefits to the majority of individuals out there. Again, I don't think it's a simplistic issue of just looking at one factor and weighing that factor. My daughter is in Montana and Montana has lots of stretches of long highways and there are places in Montana where you can drive more than 80 miles an hour and it's not a violation of the law and I do think that as the technology evolves and improves, we can begin to center in on those issues. But my daughter will not be penalized. Her rates will not necessarily go up. They may not go down simply because she drives more than 80 miles an hour in Montana.

PRESENTATION ON THE NATIONAL INSURANCE PRODUCER REGISTRY (NIPR)

Karen Hornig, CEO of NIPR, thanked the Committee for the opportunity to speak and stated that for those of you who have been around for a long time, you know that NIPR was created as an affiliate organization of the National Association of Insurance Commissioners (NAIC) to solve a very distinct business problem around our state-based system of insurance regulation, and that is complexity around producer licensing. And I know that there are members of this committee who are producers and who experience this at least every two years. Because this is early on a Sunday morning, I'm going to serve as an evangelist for the importance of a continuing commitment to uniformity and reciprocity in producer licensing because ultimately it strengthens the state-based system. NIPR has had the same mission since 1996 when it was founded - it fundamentally was created to provide a cost-effective, streamlined, and uniform system of producer licensing for the benefit of state regulators and for the benefit of industry,

ultimately to protect consumers. And NCOIL has been a consistent supporter of uniformity and reciprocity in this space, because it is a multi-state system that we have tried to create to lower the cost of compliance which ultimately will lower the cost for premiums. And NCOIL has always supported the work of NIPR. We were created in the 1990s because there was a growing call for federalizing producer licensing. The industry was pointing to producer licensing as an example of inefficiency and unnecessary cost in the state-based system and the federal government went to the extent of including producer licensing in the Gramm-Leach-Bliley Act in 1990 and in that act, Congress said, "states, if you can't get it together and increase uniformity and reciprocity in producer licensing, then we're going to preempt. We are going to step in and take over producer licensing regulation." And so the states did do that and took a number of steps and the reason that industry was objecting to the state-based system was because it created so many problems within the licensing environment with different licensure requirements depending on the jurisdiction.

So, we have 56 NAIC members, the states, the District of Columbia, and the five territories. So, there's 56 different ways of doing it. And some producers had to get their license by license type or lines of authority. There were different laws and regulations in every state and obviously it was a labor and paper intensive process. When I'm doing new hire orientation, I describe paper applications with checks clipped to them and often our younger staff members don't know what I'm talking about with that. So, it was a very manual process and from a regulatory perspective, it made compliance more difficult because there was no national place to go and get compliance information about those people who sell, solicit, or negotiate insurance. So, NIPR was created to help solve that and we are a technology company and we do two primary things. We warehouse data that the insurance industry can pull. If I'm the director of compliance for a large insurance carrier, I can go to one source instead of 56 to make sure that all my folks are in compliance with state law. And we have integrated with the back-end system of 54 states and territories. The American Samoa and the Northern Mariana Islands, we still have to work with them on trying to get them on but New York and the state of Washington were our last two big states to come on, and that was just in 2024.

When I'm at a cocktail party and somebody asks me what I do or what NIPR does, I always say, NIPR is to getting a license to sell insurance what H&R Block is to filing your taxes. You can come to one place and you can file your taxes no matter where you have to do it. And so, because it's become so popular and such a multi-state industry, we're a one-stop shop for that, and insurance companies then can manage their data all in one place. So, I want to sort of tell you where we are in terms of the producer licensing market. So, we had 138 million transactions last year, and the industry pulled almost 9 million reports. This next statistic is an important one. We transmitted $1.37 billion in fees to state departments of insurance. So, producer licensing generates a high level of revenue for state treasuries and NIPR provides a customer call center that is trained in multi-state licensing issues and we helped over 300,000 producers last year. I want to talk a little bit about the fact that the sales force in the insurance industry is primarily multi-state now. The days when you held a license in one state are primarily behind us - some people still do but of the 2.8 million licenses for producers, 1.2 million of those folks hold an average of ten licenses. So, they're managing licensure in an average of 10

different states and that has to be renewed every year. And this stylized map will show your state and the percentage of your revenue for producer licensing fees that comes from non-resident licensees. And for most states it's over 75%. Now there are a few notable exceptions in light blue and they're not going to surprise you - California, Texas, Florida and New York. Those states tend to have producer licensing laws and regulations that are less uniform and not reciprocal. So it is more difficult to get and maintain licenses in those states. But you will see that for some states even the percentage is up in the 90s and that helps broaden the market for those states. If you are Montana, if you are Alaska, if you are Wyoming, you need non-resident producers in order to have a vibrant insurance market for consumers.

So, what are we continuing to see? We've been at this now since 1996, and we still don't have full uniformity and reciprocity. Only 65% of states use the same names for producer licensing. No consumer cares what the laws call agents and brokers, they just don't. And it creates complexity without delivering any result for consumers. Same kind of thing for how fees are calculated. And what we're seeing, and one of the reasons I'm here, is what we are calling regulatory backsliding. We are seeing a movement away from uniformity and reciprocity and more of a, “I don't care what you do in other states, this is what we're going to do in our state.” And it isn't just in insurance, there are other areas of legislation that impact the producer licensing system that we've created over the last 30 years and that's that growing number of state-specific questions. We have a uniform application, just like higher education has a uniform application, but we have this growing number “but in our state, you fill out the uniform app and then you have to answer all these other questions.” So the sort of call to action here is to continue to help us protect this system that has been created because it helps to protect the state-based regulatory system. And keep a look out for bills that impact how fees are collected. That's one that we're seeing because we already have a system in place for that and there are some other kinds of things coming out of committees other than insurance that can really negatively impact that.

Asm. Gandolfo thanked Ms. Hornig for being here and stated that it's great that NIPR is getting more involved with NCOIL and I’m glad you had the opportunity to share what it is you all do and showcase the impact it has on the industry as a whole.

Rep. Lampton stated that recently in our local news we had an insurance agent commit fraud and subsequently prosecuted for it. I’m sure they have or will be losing their license. How does that translate if let's say she has four other non-resident licenses? Is NIPR involved? How does that help her lose her licenses in all of the jurisdictions that she may currently be licensed in and prevent her from moving to another state and setting up shop somewhere else? Ms. Hornig stated that was one of the main reasons that NIPR was created because that's exactly what was happening before. A bad actor just could hop from state to state. So, as soon as that resident state takes down that license, it will go off in all non-resident states. So, it would flow through the system. Also, let's say her license wasn't revoked, but she was suspended for six months. That will show up in NIPR's system data, because our data is fed from state departments to the NAIC, which creates a regulatory database and then NIPR gets a version every night of the producer database, and it has to comply with the FCRA. So, there are sort of two

ways. It’s the license would come down, because no resident license, and then you can't have a non-resident license.

PRESENTATION ON DEVELOPMENTS IN THE CANNABIS AND INSURANCE MARKETS

Kevin McKechnie, Executive Director of the Health Savings Account Council at the American Bankers Association (ABA), thanked the Committee for the opportunity to speak and stated that if I could ask the indulgence of the Chair for one minute, I'd like to applaud the work of my Ms. Hornig, and here's why. Part of the mood to establish an optional federal charter arises from the fact that licensing was in such disarray and so every bit of effort you put into this keeps the federal government from exercising the law that is already passed, the National Association of Registered Agents and Brokers (NARAB). It's just waiting there. It simply hasn't been done yet, but it's not waiting to be passed. It has been enacted. And so were the licensing regime to fall off, this is coming. Were it to succeed, this is not coming. And as they say, in Hollywood, it's not about the money. It's really about the money. And that is exactly the overhead question that bank-owned insurance agents and brokers ask themselves all the time when they're dealing with this system. So, I encourage all of you to pay a lot of attention to it and if you have any questions about it, I'm obviously here. Your experts are here. But don't take your foot off the gas. It matters.

It's unusual for the ABA to be considered experts in this question around marijuana, and we're not. And so, let's draw a distinction between the legalization debate and why you asked me to come. I don't participate in the legalization debate. I am the insurance expert at the ABA, and so bankers who are operating their financial institution and the 26 interlocking liability policies that they must have in order to do so, generally call and ask for a gap analysis and they ask for the one thing that is increasingly a sticking point, and I'll tell you what it is. Were NCOIL to find an employee engaging in criminal behavior, there's insurance for that, and that's traditionally what insurance is for, third-party liability insurance for bad actors, which is to say if you receive a demand letter from someone claiming harm, your insurance policy tends to respond. But were it the case that NCOIL resolved an executive committee to engage in that criminal behavior, well, then that would be a first-party claim, and insurance generally doesn't cover those with limited exceptions in the cyber area. And it works like that in banking, meaning if there's an employee of a financial institution, we call it crime bond, something you may hear more about, but if an employee is caught doing something illegal, there's harm to a consumer or harm to the bank itself, a claim can be generated because certainly the bank was doing everything it could to avoid criminal behavior, and that's why they have this coverage. But if it's the policy of the bank to engage in this behavior, there are risks that are much larger than most people know, and that is the invalidation of your directors' and officers' coverage, the invalidation of your errors and omissions in insurance, possibly the invalidation of other liability coverage, and certainly your general liability coverage.

And so, these are the things that I discuss, and this is my interest in the subject, which is to what extent is this anomaly or this dissonance between federal statute and state

statute affecting the operations of the banks, and the answer is the risks are extraordinary.
How extraordinary? Well, meet me on the other side of Transportation Security Administration (TSA) security with your bag of cannabis, and we'll have that discussion. The federal government is crystal clear on this point. It even has a separate sentencing schedule. That's how much of a felony it is. And, of course, you're sitting in a state that is charming for its historical nature and charming because it chooses to follow federal law, which is not a choice in itself. If you're a rule follower, that is the law of the land. However, the states have democratized, thought other ways about it. Let's start at politics. The Banking Committee in the United States Senate is chaired by whom, Senator Tim Scott from this state. Is cannabis legal in this state? No. And so will the Senator be getting over his own legislature? I don't know the answer, but I suspect, and all of you do too, that probably the answer is no. The House Financial Services Committee is chaired by Representative French Hill of Arkansas. They have legalized medical marijuana. You have to get a license to engage in that. We don't see this problem being solved soon, but it's not to say the problem hasn't been addressed. Here's how in the last Congress it was addressed. The Secure and Fair Enforcement Regulation Banking (SAFER) Act is something ABA would like to see. Get all of that money and cash off the streets, make the place safer. It's bipartisan. About 130 Members of Congress supported that bill and were co-sponsors. More than 30 Senators signed on to it.

Keep this before your minds, though. So many states have legalized in one shape, form, or another cannabis that there's about a, by my math, 92-seat majority in the Senate based on the number of states who have actually done something about this and an even larger bulletproof majority in the House. So, we're at the case that states said to their Senators, please vote the way our laws look. You would win, and it wouldn't even be hard. It would be something that would be veto-proof. We haven't seen that bill reintroduced to this Congress. One of its great champions, Earl Blumenauer of Oregon, has retired. I don't think that will dampen the zeal of the 129 other co-sponsors, but one never knows. And, of course, Congress is in different hands this time. And so, the study question, to which all of us should engage, is will Republican majorities engage or will they introduce this bill and entertain some of the social questions that in my view, held this up last time. Where we started was the legalization debate and the SAFER Act. These are different questions.

One is about what should we do as a society in these substances and who should be able to use them and under what circumstances? The other is can the financial services industry reduce the risks of crime and attendant other illegalities by allowing these businesses to be banked so that we know who they are, so that the money is off the street, so that it goes into the system, and so that it's traceable and auditable? Those are different goals. And so, on this side, we think it’s going to be reintroduced and we hope that it does. For the social questions to come up again, I think that would be an impediment to passage. But the challenge is that the President, through Truth Social, seems to be a legalization, perhaps not an enthusiast, but he's okay with it. Such narrow margins in the House suggest that might be determinative. That might be something that could actually work out. Yesterday, if you were in one of the other meetings, you heard a

lot about the reconciliation process, meaning there's no space for anybody anywhere in Congress right now except for that bill. And so we'll have to wait, in my view, for this process to terminate before we see people start entertaining the committee system and looking at bills and bringing them to the floor. And that's where I think it lies. One other thing, just to note, I don't think people really know what these things cost. Do you know there's a spot price for cannabis every Friday? And one of the other things that's in the way of this is from the last year of the Obama Administration to right now, a pound of cannabis is less than half the price it used to be, meaning, this is like every other industry, it's consolidating. People that are in charge of it are getting bigger, not smaller, they're squeezing out all of the smaller players that states relied upon to legalize in the first place, and I don't know if that is taking the wind out of the sails of all of these things that we're trying to accomplish or not, but I know there's nobody pounding the desk in either body asking for this.

Chuck DeWeese, Traffic Safety Consultant at Responsibility.org, thanked the Committee for the opportunity to speak and stated that maybe this is a little different for this organization but I want to talk about the lives lost - 500,000 lives were lost in World War I and World War II but just since the year 2000 over a million people have been killed on our roadways because of car crashes. And that number may seem staggering but think about a 747 that were to crash and kill every member on board once a week in our country and the uproar that we would have. But we don't have that because car crashes occur frequently. But those numbers should be staggering to you. What I want to talk a little bit more about is drug driving because, as long as drugs have been around and cars have been around, we've had the issue of drug driving. So, the National Highway Traffic Safety Administration (NHTSA) does these surveys once in a while. The last one was done in 2014. And they basically ask people to voluntarily pull in and have an oral swab taken and a blood test. And these are the results, the amount of people who are testing positive on our roadways during the week and weekends. Again, where I come from, Responsibility.org, and I'll talk a little bit about that, we don't take a position on legalization. People have been driving high on different substances for years. Whether it's legalized or not in the state doesn't really matter to traffic safety experts. It's always been illegal to drive under the influence. NHTSA estimates that over 56% of injured or killed roadway users tested positive for one or more drugs, including alcohol. The use of drugs in driving is staggering in our country. So, Responsibility.org, the organization I work for, it's funded by the distillers, the folks who make distilled spirits. We have three main missions: lead efforts to eliminate drunk and impaired driving; lead efforts to eliminate underage drinking; and if you decide that you do want to drink, to make responsible decisions. Responsibility.org, a couple years ago, created the National Alliance to Stop Impaired Driving because we're not making a dent. We lose over 40,000 people a year, 13,000 by alcohol and drugs on our roadways.

So, what I'm here to talk about today is a tool. You probably are all familiar with roadside law enforcement officers who have this thing called a PBT or a portable breath test. They run through their standardized field sobriety testing. They determine that the operator is impaired. Now it's time to determine what's causing that impairment. Is it a medical impairment that I need to get an ambulance to the scene? Or is the impairment caused by alcohol? Or is it caused by drugs? They have a PBT that they can give to the motorist

to determine if the impairment is caused by alcohol. But what's new is a technology and thank goodness for COVID because you'll be able to understand this a little better. We use lateral flow immunoassay technology to detect drug impaired drug usage at roadside. So, think of your pregnancy test, your COVID test, or your urine drug testing. It's a very simple technology. You're basically mixing a solution which is either your nasal fluid for your COVID test, or urine for a pregnancy test. And you take that swab, you're very familiar putting that swab up your nose, you mix it with a buffer. The buffer takes the drug off of the swab. It mixes it together and it basically moves over lateral flow strips. I'm not a scientist, but it just moves over these strips, there's dried reagents on those strips and if it reacts, you'll get a positive result. So, you're all familiar with that technology. So, what I have here and what's on the screen is a technology that's similar to your COVID test, but it's going to test for drugs. The devices on the left are called analyzers because they have cameras inside, there are heaters inside. All the technology is contained inside of an analyzer. You compare that to a visually red product, that's more like your at home COVID test. The problem I have with the visually red products, for a number of reasons, is you're asking the law enforcement officer to subjectively look at a strip out in the middle of the nighttime in the dark with it snowing and looking at different colors to see is it there? How many of you have taken a COVID test? And you're like, is that line there? Is it not there? Is it positive? And I have to ask my wife to come over. Do you think this is positive? The analyzers do that for you.

So, I brought this SoToxa mobile drug test analyzer here because I want show you how it works. So, the officer pulls somebody over for a driving violation, they interview the driver, they sense that there possibly could be some impairment maybe they see a vape pipe in the car and they take the person out of the car and they still have to do their normal standardized field sobriety testing, nothing changes. They at that point detect that the person is impaired and now we're going to determine whether it's a medical impairment, an alcohol impairment, or a drug impairment. So, they do the alcohol test and it's a .02 or .01 or maybe even zeros and what they do now is they can get give motorist this swab. It's like a Q-Tip. You ask the motorist to run it in their mouth for about 30 seconds. I've already done it to save time here. You do it for 30 seconds you know you have enough oral fluid when it turns blue there's an indicator on there. The officer starts the analyzer, there is a positive and negative quality control cartridge that takes five seconds to run to make sure it’s calibrated for every test. Or you can do it once a day or once a week. Stick the cartridge into the device. It’ll give you a checkmark to tell you that it's ready in about five seconds. Once you get that, you stick this in here, and it starts working. You can set it down on your car. Officer safety is very important, so it's very small. It can keep it on the roof of their car. So, the test is now running. It's mixing that oral fluid with the buffer solution, and it's working over lateral flow strips. If you were to hold it up, you'll get an error message because, again, it's lateral flow. It needs to work on a horizontal plane. So, that's running through the test. It takes five minutes to give a result, and by the time I'm done talking, we'll have a result that's hopefully negative. I tested my son on Easter because he takes Adderall, and he was curious to see if he would test positive, and he didn't. And I wasn't surprised because he takes a therapeutic dose of it so he was not testing positive even after two hours after taking his medication. So, you collect the sample, you stick the cartridge in, and then you get your result of

either a positive or negative. And we test for up to six drug classes, cocaine, opioids, methamphetamine, THC, benzodiazepines, and amphetamines.

So, what are the benefits of oral fluid screening technology? I always like to say I'm from the Northeast and we get a lot of snow. It's a tool to do your job better. You can either get a foot of snow and shovel it and take four hours. You can use a snowblower and take an hour and a half. Or you can use a plow and take five minutes to do your driveway. Technology is intended to make our roads safer, to give the officers what they need to do their job. So, it analyzes using lateral flow. It's a simple, quick collection process. It's not invasive. You're not sticking a needle into somebody. You can see the drugs that are tested for. There's pre-set cutoff levels for each drug so you will not pick up therapeutic doses of medications. It's rapid. It gives you a result in five minutes. You can print out the result and the technology does have built-in quality control checks. This is kind of an important slide for those who aren't familiar with roadside screening. There's a difference between investigative confirmation testing that is done in a laboratory with blood or urine or oral fluid and the stuff that's done at roadside. On the right side, think of your toxicology lab. It's an evidential test. The test is done in the lab. It's tests for about 100 to 150 different substances and it's going to give you a quantitative result of a number of nanograms and it's used as evidence in court. So, think of your blood, urine, oral fluid that's tested at a lab. The screening technology like this SoToxa here is intended to be like a PBT. It's done at roadside. The analysis is conducted roadside. It's a limited test panel of only six drug classes.

However, we do pick up about 90% of the drugs that we see on the roadside and it's only going to give you a qualitative result of a positive or a negative. It's giving that officer another tool to give him or her probable cause to make the arrest. The advantages, it's a reflection of the drug that's circulating in the blood. It's taken proximate to a traffic stop. Let's think about THC. If you don't know, when you administer or take THC, it goes out of your body extremely fast. So, if there's a fatal crash and it takes three hours to get a blood sample, the roadside oral fluid test will show positive. But by the time the blood is drawn two to three hours, it may show negative. So, the benefit of doing oral fluid at roadside is it's proximate to the stop of the crash. It enhances public safety. And my favorite part is most motorists out there don't think there is any technology that law enforcement has to detect the recent use of drugs, but we do have it and it works as a general deterrent. It does not detect whether you're impaired. Impairment can only be detected through the evaluation by a drug recognition expert. There is no blood alcohol like test for THC and there never will be. We will never have a number for cocaine, a number for methamphetamine, it's just not going to happen. A toxicologist once told me unless you can suck brain tissue out of somebody's brain and put it on a slide, you'll never be able to determine a number, a per se level. We don't have that technology. Hopefully someday we do. This is an important slide that we use with legislators because a lot of times a legislator may think that when you pull somebody over you're just going to have them roll down the window and stick this swab in their mouth. That is not the case. You still have to have your vehicle in motion. You still need to see the traffic violation and pull somebody over and have your personal contact and interview the driver and do pre-arrest screening, which are those standardized field sobriety tests. Now you determine that the person is showing signs of impairment. Now you're

determining whether that impairment is medical, alcohol-related, or drug-related. And that's where the field screening comes in. Now you develop your probable cause to make the arrest. You can seek a blood warrant for evidential testing or call a drug recognition expert to the scene. How are we doing in states – 23 states authorized some type of oral fluid collection. Those numbers are growing. And I want to quickly just talk in my last five or so minutes here about some of the results. It's being used widely across the country and across the globe. Michigan was one of the first states and it ran a wonderful pilot in 2018 and 2019. And this week legislation was introduced there to make oral fluid permanent as the pilot expired. So, hopefully this session, that'll happen.

Indiana said, we don't need to do a pilot. Michigan, our partner state, just did a pilot and determined that oral fluid is a perfect matrix for determining recent use of drugs. So, in Indiana, in 2020, right after COVID, they bought 80 of these analyzers and they had 110 uses. In 2021, 200 analyzers were purchased by the Highway Safety Office and handed out to law enforcement and they did almost 900 tests. And you can see how the tests have grown over the years. As of today, there's been over 6,000 tests that have been done and you can see the number of people testing positive multiple drugs in their system is almost 50%. And THC positive is 67%. But what's more remarkable is the results of what has come from that. For those who don't know, a drug recognition expert is your green beret of law enforcement. They take a special three-week class to become a drug recognition expert (DRE). Less than 2% of police officers in this country are DREs and you can see on the left that the number of DREs in the state of Indiana decreased significantly. That's happening in every single state. As you train a class of 40, you lose a class of 40 because they get promoted. So, the number of DREs are going down. But what happened in Indiana, if you look at the right, the number of drug recognition evaluations went from 425 to 662 with fewer DREs. Why? Because your road patrol officers, your trained officers were now pulling more people over and using their oral fluid devices and detecting levels of drug impairment and then calling for a DRE to do the evaluation. So, Indiana has had great results. Their traffic fatalities have declined. So, I'll conclude by saying if you're interested in it, I'll be here. My flight's not until later. I can show you how the technology works or answer any questions. But we are at responsibility.org going around the country trying to talk about the virtues of oral fluid testing and to make things easy the nascent oral fluid working group has put together a whole host of resources so that if your state is interested you don't have to start from square one. We have an implementation guide that walks the state through how to do it. We have documents that say here's the data you should collect so that a year after you implement you can show your legislature the benefits of the program. We have a ton of resources on our website. But this technology is here, it's been proven effective and if we are ever going to make our roads safer and start saving more lives I think this technology is critical important. Lastly, I'll just say that we're working on a project now to collect information on every state's oral fluid statutes. We're asking the traffic safety resource prosecutors in every state to let us know if you have a roadside statute for oral fluid or an evidential statute and what your implementation status is in your state. Indiana has a statewide program. New York, California other state law enforcement is just buying these and it's kind of spotty or jurisdictional. So if you are a state that's interested in this there'll be a website you can go to and look at sample legislation.

Sen. Paul Utke (MN), NCOIL Vice President, stated that I was wondering what was being highlighted in one of your slides when Minnesota graphics were up there. Mr. DeWeese stated that Minnesota just concluded an oral fluid pilot program. The report was issued and delivered to the legislature in March of 2025 and as it stands right now, the hope is that a bill will be written. I know you only have a month left in your session but hopefully a bill will be written to make that pilot permanent in Minnesota.

Mr. DeWeese stated that there is a feature that some people worry about, that the result will taint the subjectivity of the DRE that comes to the scene. So, because they're going to do their full evaluation, there is a mode you can set to here that just shows that every test was done, and there was a positive for one of the categories, but it doesn't tell you which one. So, that feature is also available.

Asm. Gandolfo stated that in states that haven't really gone this route yet, whether by county jurisdiction or statewide, what seems to be the hesitancy to start using these oral roadside fluid tests? Mr. DeWeese stated that I think a lot of it is there's a lack of education or understanding on how it works. People, especially in my state of New York, think that it gives law enforcement another tool to pull people over randomly, and it has nothing to do with that. That's one piece of it. The second piece is a lot of times people think that it's an evidential tool and that it hasn't been tested in court. It's not intended to be an evidential tool, it is only for roadside uses. So, those are a couple of the reasons why it hasn't picked up steam in some states but we're in over 35 states now.

Sen. Jeff Howe (MN) asked how many different makers of those types of devices are out there? Mr. DeWeese stated that so if you remember I talked about the visually red products and then the analyzers. There are maybe 20 or so different companies that do those visually red products. Some are good, some are bad. I know one company, there's a solution on there that helps a person produce saliva and it's made with animal byproducts. So, I have a concern with that and I think you should as well. So, you have to be very careful with some of those visually red products. As far as the analyzers go, the companies that I'm most familiar with are Abbott, SoToxa, and Draeger. Those are the companies that have been doing analyzers and drug testing technology for years but I think there's a company called Randox as well.

DISCUSSION ON STATE INITIATIVES REGULATING THE BAIL BOND INDUSTRY

Asm. Gandolfo stated that before we being our last agenda topic, I'll make a couple of comments first. I know you might be seeing bail bonds on the agenda and wondering how it fits in with insurance, but in many states, bail actually is an insurance product and is regulated under that state's Department of Insurance. Second, NCOIL has made extensive efforts to have representation here today by advocates on the other side of the issue but unfortunately, they declined to participate.

Rep. Peggy Mayfield (IN) stated that I was the author of the Indiana law regulating charitable bail. I know that throughout the country it has been regulated. I know New York had it for over a decade, and we actually used their statute as the basis of our

model. And I approached this, or you could approach this in a couple different ways. You could go after the criminal aspect, and you run into a lot of roadblocks there because you have constitutionality issues and so forth. I chose to go down the regulatory path of bail in Indiana is an insurance product, and therefore it would be easier to go down the path of regulating who is able to sell an insurance product with licensure. And I ran into less roadblocks than going down the criminal path. The reason I asked about NCOIL considering this as a model act is because, one, we did pass it. Two, it was challenged in court and it withstood challenge. So, I thought I would offer this model legislation to other states that might want to go down this path. It really became an issue even prior to COVID, but especially during many of the protests during that era of organizations coming in, doing charitable bail, and putting kinks into the criminal justice system in those states.

Jeff Clayton, Executive Director of the American Bail Coalition (ABC), thanked the Committee for the opportunity to speak and stated that the ABC is a trade association of insurance corporations that underwrite criminal bail bonds throughout the nation in the 46 states where we're able to do that, and I think even some territories. I've been at this now for ten years and spend most of the time talking about criminal law. As Rep. Mayfield said, in the setting of bail, the in-cash bail debate is primarily what we work on, but we also, as Rep. Mayfield said, are regulated by state departments of insurance. Charitable bail funds, what are they, when, where, and why? They are a pool of money used to post criminal bail bonds, of course, the biggest one being the Bail Project, but you can also Google the National Bail Fund Network. There was a massive infusion of cash into these funds in the summer of 2020, and some called them Vice President Kamala Harris's bail funds. As I told reporters, she has nothing to do with these bail funds and never was involved in the bail funds, never donated to the bail funds. She put one post on Twitter to bail out peaceful protests and here we are. So, I think take her out of the debate and look at this through a different lens. I think bail funds are different than bail bondsmen because they post actual hard cash, whereas we post a written financial guarantee that's underwritten by insurance corporations, at least the bail bondsmen do. Something that the current Administration has not figured out - federal immigration bonds, we rely on the states to regulate bail bondsmen who post federal bonds, which includes federal immigration bonds. And so, the Administration hasn't quite figured that one out. We're not here to remind them of that. The definition of insurance as to whether it covers bail has been left to the states under the Comprehensive Crime Control Act. There is federal legislation pending that would define bail as insurance and then thus force all state departments of insurance to regulate bail. That would be a major shift, and that legislation made it out of the House. I have not heard yet whether it's going to proceed beyond that point. What is the charitable purpose of these funds? It’s sort of mixed. I would start with the good one. They help people who are otherwise bailable that should get out that don't have sureties – a good purpose. But the main purpose that's been articulated is a First Amendment purpose, which is to destroy the bail system, to end monetary bail, and to basically end bail. And I would posit that maybe as a different purpose than we're used to under charities, particularly having this dual purpose.

They operate generally in all 50 states. Some of them are small. They operate in a single court, single jurisdiction. Some of them operate statewide. Some of them are national.

How much assets are we talking about statewide? We don't know. We have an article from the New York Times suggesting probably in the $200 to $300 million range nationally. We don't know. The Bail Project has financial reports on their website, and you can see what their take is and how much bail they're posting. The charitable purpose of these funds has expanded in light of the fundraising from not just posting bonds, but also for lobbying to eliminate bail. And so, they've morphed into also lobbying arms for criminal justice reform and have registered to lobby in multiple states, Minnesota and Colorado coming to mind at this time. Regulation of bail bonds. How does it work – typically state insurance departments and judges. All persons are bailable by sufficient sureties means judicial regulation on a case-by-case basis. What does that mean? Well, if you stole the money to post-pay, that's bail source. That would be something that a judge can scrutinize internal to a criminal case. So, that's one way bail is regulated. Is the surety sufficient? And then most states license bail bondsmen via state departments of insurance, many of whom are required and complain about the fact that they have to get a property & casualty license. And surety regulators are regulated by state DOIs. You have property bondsmen in the southern states primarily that are self-underwritten. In other words, some are lightly licensed and underwrite themselves.

Bail funds, they send in a third-party poster so that's just a person who typically will pose as a friend and not disclose on court documents that this is corporate funds. So, we don't say it's from the bail fund. It's me posting somebody else's bond, and that's how it goes on as a court record and that technically is false swearing on a court document. Why not use a bail bondsman? Why don't these funds use a bail bondsman? As one famous activist said, a national bail fund sponsored by bail bondsman would be like a free sample of heroin from a drug dealer. And of course, my reaction to that and what something my board didn't particularly like was I said we're not against charitable bail, we just want a piece of the action. But anyway, that's beside the point. They're choosing not to use a bail bondsman to mitigate risk and that's an important distinction here. They could use a bail bondsman and if their client fled, they can have them re-arrested. They choose not to do that. So, that's a choice that they're making. Texas, you're special because you regulate bail differently. You regulate it locally, but you actually regulate it as an insurance product sort of locally. So, in Texas, none of this would work, but that's alright. They can figure it out themselves down there. States have begun to regulate charitable bail, we've seen a lot of bills that I didn't put up in here. So, a lot of them coming from Wisconsin holding charitable bail funds liable for the acts of the people they bail out and stuff like that, I'm not going to get into that. The oldest, most comprehensive law is the New York Charitable Bail Act of 2012, which requires licensure only, and allows for posting in misdemeanor bonds only. Bonds must be less than $2,000, and all persons who post are also licensed and must report. And the people that post have to get a bail license, so the actual individual that walks into the courthouse has to be licensed like a bail agent.

The Indiana Charitable Bail Act is similar, as Rep. Mayfield said. You cannot post bail in crimes of violence or in felony cases where the person has a prior crime of violence conviction. The charitable bail fund has to become licensed. There's a prohibition of public funds, and I just got a call from a judge in Cuyahoga County, Ohio, who said, "why are we using public funds to bail people out after we arrest them?" Well, that's another

pivot point, should we be using taxpayer dollars to post people's bails? As Rep. Mayfield said, the Bail Project sued the Insurance Commissioner under a First Amendment theory, and I would say lost badly in the U.S. Court of Appeals for the Seventh Circuit, although in discussing the issue with Attorney General Todd Rokita, I did point out that if they don't have to be regulated under a First Amendment theory, then we probably shouldn't have to be regulated under a First Amendment theory. But obviously, they lost badly, and they said that posting bail is protected First Amendment speech. And the Court of Appeals said no, and they said, “You’re making a financial guarantee from crowdsourced funds versus somebody's actual money”. Economic incentives are different, thus there's an important public purpose for the legislature to look at this and we find that the legislature acted appropriately under this case. In Texas, you had data reporting legislation, I wouldn't really call it much of a regulation, but it would be in the nature of some sort of sunshine and transparency. In other words, who do these funds bail out? Do they show up in court? Do they commit a new crime? That sort of thing, I think, would be a good step to say, what are these funds actually doing? But I would consider that to be mostly sort of a toothless regulation.

In Georgia, we have a case pending where we'll find out what the, what I would say the limit of legislation power is in this area. To simply ban it, in essence. You can post no more than three charitable bails per year, then you're banned, and you can no longer post charitable bails. This case is pending before the U.S. Court of Appeals for the Eleventh Circuit. But that leads to the question of, can you just simply ban charitable bail and not allow it altogether? And you have to keep in mind, there's a fundamental right to bail, and there's a fundamental right to association and right to surety. So, we run into fundamental rights when we start talking about this regulation. Is the bail industry pushing regulation? Is the ABC pushing regulation? I would say no. And what I tell our board is don't turn the sideshow into the circus. Obviously, these regulatory issues hit the for-profit and the non-for-profit industry equally in certain respects, and so we have to pay attention. But whether legislators and folks think it's important enough to regulate or not is a question we really leave to them. I don't spend time or resources trying to make the argument that it should be regulated. But to give you an example of one, and I had to hire a lawyer in order to put this slide up to chase all this down and prove all this, but the Colorado Freedom Fund in my home state where I'm a lawyer sort of proves why there's a problem with this and why people need to pay attention to it. The Colorado Freedom Fund is not registered as a charity in Colorado. It's not registered as a business entity. It has never issued an annual report. It's never disclosed the salaries of its employees, one of whom is a former state legislator and was a state legislator at the time. It is registered as a lobbying entity, but the fiscal sponsor is not registered as a lobbying entity, entity or charity, never issued an annual report, and nobody is properly registered to solicit donations for the public in Colorado. And the charitable purpose has changed from the original purpose of posting bonds to now being a criminal justice reform outfit. So, one might argue multiple complaints could solve this, but one might argue maybe some regulation might be in order. I'll leave that question ultimately to you.

So, final statement - to regulate or not to regulate, I think that is the question for you. I think there's one compelling argument that says absent regulation are charitable bail funds insufficient charities as a matter of law? And some courts have said yes. Some

courts have just said we're not going to take your bonds on a one-off basis, local courts. So, if you care about charitable bail and you want charitable bail in your state and you think it has a legitimate purpose, it's probably important to regulate it, to give it the standing of legitimacy to survive the legal challenges that it may find along the way. Obviously, as Rep. Mayfield points out, statutory controls exist that don't require legislation in the criminal context. You could limit which cases, who can post, you could prohibit taxpayer dollars, number of bonds posted, size of bonds, type of case class. All that sort of thing would be options short of regulation. The best model is probably Indiana. I think they took components of New York but kind of made it a little bit lighter. I think for a charitable organization that's serious about complying, the commissioners made it extremely easy, and if they're on the up and up and they want to do charitable bail right in Indiana, it's right there for them. In our opinion, if they're using corporate funds that's crowdsourced, there should be some regulation and I think maybe that's harder enforcement of the charitable bail laws or other sources of regulation, but we think probably in light of the hundreds of millions of dollars that are out there, that there's probably a need for oversight.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Lampton and seconded by Sen. Utke, the Committee adjourned at 10:45 a.m.

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Belmar, NJ 07719
732-201-4133
CHIEF EXECUTIVE OFFICER: Will Melofchik

NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

Model Act Regarding Insurers' Use of Artificial Intelligence

Sponsored by Asm. Erik Dilan (NY) and Rep. Forrest Bennett (OK)

Draft as of June 17, 2025. To be introduced and discussed during the meeting of the Financial Services & Multi-Lines Issues Committee on July 17, 2025.

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Section 1. Title

This Act shall be known as the [State] Act Regarding Insurers' Use of Artificial Intelligence.

Section 2. Purpose

The purpose of this Act is to set forth requirements and guidelines as to how insurers may utilize artificial intelligence in certain situations.

Section 3. Definitions

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

(A) "Algorithm" means a clearly specified mathematical process for computation which uses rules designed to give prescribed results.

(B) "Artificial intelligence system" means a machine-based system that may have varying levels of autonomy and that can, for a given set of objectives, generate outputs, such

as predictions, recommendations, or content, influencing decisions made in real or virtual environments.

(C) "Machine learning system" means an artificial intelligence system that has the ability to learn from provided data without being explicitly programmed.

(D) "Qualified human professional" means an individual who, under the [State] Insurance Code, has the authority to adjust or deny a claim or a portion of a claim and may exercise such authority over a particular claim.

Section 4. Insurers' Use of Artificial Intelligence

(A) An insurer's decision to deny a claim or any portion of a claim must be made by a qualified human professional.

(B) A qualified human professional shall, before determining whether to adjust or deny a claim or a portion of a claim, do all of the following:

(1) Analyze the facts of the claim and the terms of the insurance policy independently of any system or algorithm.

(2) Review the accuracy of any output generated by such a system or algorithm.

(3) Conduct any review of a claim adjustment or claim decision that was made by another qualified human professional.

(C) An insurer shall maintain detailed records of the actions of qualified human professionals who are required to perform the actions under subsection (B), including:

(1) The name and title of the qualified human professional who made the decision to deny a claim or a portion of a claim and of any qualified human professional who reviewed a claim adjustment or claim decision.

(2) The date and time of the claim decision and of any review of the claim adjustment.

(3) Documentation of the basis for the denial of the claim or a portion of the claim, including any information provided by an algorithm, an artificial intelligence system, or a machine learning system.

(D) An algorithm, an artificial intelligence system, or a machine learning system may not serve as the sole basis for determining whether to adjust or deny a claim.

(E) In all denial communications to a claimant, an insurer shall:

(1) Establish a point of contact and process for the claimant to use to obtain information on the decision to deny the claim or a portion of the claim; and

(2) Include a statement affirming that an algorithm, an artificial intelligence system, or a machine learning system did not serve as the sole basis for determining whether to deny the claim or a portion of the claim.

(F) An insurer that uses an algorithm, an artificial intelligence system, or a machine learning system as part of its claims handling process shall detail in its claims handling manual the manner in which such systems are to be used and the manner in which the insurer complies with this section.

(G) The Commissioner may conduct market conduct examinations and investigations or use any method it deems necessary to verify compliance with this section.

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.

The following materials will be referenced during the agenda topic "Discussion on Price Controls and Rate Review and their Impact on Insurance Markets" in the Financial Services & Multi-Lines Issues Committee:

https://api.apci.org/file/downloadnsfile?id=11269&area=s

https://www.milbank.org/publications/bringing-balance-to-the-market-a-roadmap-for-improving-health-insurance-affordability-through-rate-review/

WORKERS' COMPENSATION INSURANCE COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
WORKERS' COMPENSATION INSURANCE COMMITTEE
2025 NCOIL SPRING MEETING – CHARLESTON, SOUTH CAROLINA
APRIL 25, 2025
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Workers' Compensation Insurance Committee met at The Francis Marion Hotel in Charleston, South Carolina on Friday, April 25, 2025 at 9:45 a.m.

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

Other members of the Committee present were:

Rep. Mike Meredith (KY)
Rep. Michael Sarge Pollock (KY)
Rep. David LeBeouf (MA)
Del. Mike Rogers (MD)
Rep. Brenda Carter (MI)
Rep. Mike McFall (MI)
Sen. Lana Theis (MI)
Sen. Paul Utke (MN)
Rep. Brian Lampton (OH)
Rep. Tom Oliverson, M.D. (TX)
Del. Walter Hall (WV)

Other legislators present were:

Sen. Jesse Bjorkman (AK)
Rep. Justin Wilmeth (AZ)
Rep. Brett Barker (IA)
Sen. Steve McClure (IL)
Sen. Julie Morrison (IL)
Rep. Bill Sutton (KS)
Rep. Adrielle Camuel (KY)
Rep. Mike Clines (KY)
Sen. Donald Douglas (KY)
Sen. Rick Girdler (KY)
Sen. Franklin Foil (LA)
Rep. Robert Foley (ME)
Rep. John Fitzgerald (MI)
Sen. Michael Webber (MI)
Sen. Jeff Howe (MN)
Rep. Jennifer Balkcom (NC)
Sen. Bill Gannon (NH)
Asm. David Weprin (NY)
Rep. Forrest Bennett (OK)
Rep. Perry Warren (PA)
Rep. Alex Finkleman (RI)
Sen. Matt LaMountain (RI)
Rep. Joe Solomon (RI)
Rep. Calvin Callahan (WI)
Rep. Barbara Dittrich (WI)
Sen. Cale Case (WY)

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 Rep. Mike McFall (MI) and seconded by Del. Walter Hall (WV), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Del. Hall and seconded by Sen. Lana Theis (MI), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's November 22, 2024 meeting.

DISCUSSION ON THE USE OF ARTIFICIAL INTELLIGENCE IN THE WORK COMP MARKETPLACE

John Alchemy, M.D., Founder & CEO of RateFast, thanked the Committee for the opportunity to speak and stated that I'm here to give you a report on the use of artificial intelligence (AI) in workers' compensation. Just a few credentials about myself. I've been doing workers' comp in California for 30 years now and I have the privilege of both running a software company that utilizes AI and an actual practice where I serve as the primary treating physician. I do about 10,000 visits a year. We hold eight method patents in the area with more pending in intellectual properties out of Silicon Valley. I know that there's a lot of questions about AI and I'm doing a high level talk about it. The slides are interesting, I may or may not get through them all within the time, but what I do want to say is a couple of things. Our company manages just a sliver of California's work comp injuries. Each year we have about 600,000 claims about 30% of which will be litigated and with the application of AI, the early results we're seeing is that our company, which is extremely small, utilizing it through the actual interface in the medical practice, which works with insurance companies and the judicial system, has already saved about $3.9 million in just to date for this year. And we've saved about 333 years of litigation throughout the first quarter. These are big numbers and if we scale that to California, which is the fourth largest economy last time I checked, we're looking at a savings annually of $3.2 billion, and I calculated it this morning, 270,000 years of litigation. So, there's a lot of exciting leverage up ahead for AI. We're still in the early days and I wanted everyone to kind of think back to the year 2000, because that's where we are with AI right now, at least in workers' compensation. That's back when everyone was looking to the Internet as the new next thing and weren't really sure if it could be monetized or not. And that's exactly where we are with AI. We're trying to understand what do we do with it, how does it serve us, and how do we understand it. And if I bring one message today, I really want to bring my thoughts and ideas as to what the regulations should look like and how we should think about this going forward, because the regulation is very superficial right now. Not a lot of people understand what it's doing, and I have some thoughts that I'd like to share with you. The first experience I've had, and we've been working with AI and the company in earnest now for about 18 months, is that it's very much like trying to work with a five-year-old. You ask it some very simple questions, it can do it. Sometimes it won't. You make it more complex, it's less cooperative. And that's the age, I think, of AI right now as far as its benefit to us. As time goes on, I think that that's going to get more helpful.

The next thing I want us to think about is two types of AI. One is the generative that we're all familiar with, chat GPT. You type in something, it gives you a response. The other one that I'm much more interested in is the extractive AI and that's where AI can use its large language model and pull out the information for clarity, consistency, large data files, etc. Now, the other thing I also want us to think about when we're thinking about regulation, at least from my standpoint, is that if two cars run a stop sign, one's driven autonomously, and the other's driven with a person, do they both run it for the same reasons, and this is going to be the big problem I think with regulating AI because when the human ran the stop sign it was covered in snow and they didn't see it. But when the self-driving car ran the stop sign it ran it because it didn't see any other cars coming. So, I think we can use that as a model to think about the biggest challenge in regulation is going to be understanding the mental steps and how they match the human expert and being able to verify that as we start to integrate this into AI. I think the other big question we need to think about is intellectual property and work products of doctors. The AI regulation I think belongs more squarely in the intellectual property arena than anywhere else. And I think if we wanted to look at the canary in the coal mine we only need to look at the legislation and litigation around self-driving cars right now. So, that's what I wanted to hold out.

I'm going to run through my slides quickly and I'll take any questions. Basically, in work comp, our big challenge is getting fair benefits in a timely solution, scaling it, getting it consistent. Doctors typically tend to give variable results. They have various understanding of the rule sets, and that all translates into high friction and a lot of litigation. This is just another slide talking about the big administrative delays. In California, I've read anywhere from five to seven years is the average for a litigated case to close. So, a lot of money, a lot of delay. AI solutions, the data-driven approach is really great. We use the American Medical Association (AMA) guides fifth edition. Getting that integrated into a format that is consistently followed is very challenging. But I'm going to show you a slide how I think AI oversight really needs to be run and how we run it in our company. So, the benefit is, of course, improved data quality. I'm just going to throw this out there. California really doesn't have any insight into its impairment rating. They have boxes and boxes of scanned faxes, but they have no way of looking at the data. And once we start doing more of an automated rating system, we're going to have great insight into the efficiencies and the waste of the system. So, I think that there's a lot of great data opportunities above, and we're basically at the tip of the iceberg on that one. Stakeholder advantage. I've always thought this is interesting about Work Comp. The system is really developed for two stakeholders - the employers and the patients. And the great irony of the whole thing is that the stakeholders are the least educated of the system. It's the insurance companies, it's the doctors, it's the litigators, it's the administrative judges. So, being able to use AI to give insight and to also simplify the reports is extremely valuable for a patient to understand what a 9% means and why it's not 50%. All of these things can be clarified through AI and also reflected in the reports.

This is probably the most important slide that I'll show you, and this is how I see AI being developed in a responsible way that's consistent. Remember, when a doctor writes a report, if it has to go into AI, the real question is, is the doctor's work product being materially changed? And that's an intellectual property and a copyright question. And for

AI to be properly applied, it cannot change the work product of the doctor, in my opinion. It has to come out with their work intact, and AI is really just used to simplify and clarify the facts for all the stakeholders.
So, in this process, you can see that when a client submits data, it first goes in front of the human eyes, and then it goes into the AI system, and when it comes out, the human expert on the other side also reviews it, compares the two, and then it goes back into the AI, which is that center box if it's correct, to train the model. And then, of course, it goes back to the client.
Now, the second loop is when the client looks at that finished product is it what they want to sign their name to? Has it been changed materially? And if it has not then that definitely goes out and it gets litigated and processed and closed. But if it isn't it goes back through the system. So, this is a really important human oversight expert where the AI is the assistant. Now someday I will say that the roles may switch where AI has a human assistant instead of a human having an AI assistant. But this is the way that we develop our data cycle in AI training because we are in a very litigious interface between the medicine and the law.

This is just a case study, it was actually a real case and I'm what's called a qualified medical evaluator (QME) in California. We had a case come in a case of mine where I served as the medical legal expert and the problem was that the primary treater could not rate the case. So, in California when the doctor cannot read the case, it goes into the QME system. So, this case came to me, but because of the system I had to work in, turning around reports, getting things done so the case could be finalized, it really added 35 months and almost $150,000 to the claim file. And had we been using an AI-supported model, this could have been resolved at the primary treating physician. And when you think about 30% of 600,000 cases going through a process like this, that's a big number. And that's a very expensive proposition. Just some of the things I hope I've impressed upon you, AI is very good at administrative rule sets. It's great at pulling out the identity of cases and the data that can be distilled down for a very easy examination. The other thing that we have with AI that we've never had before is a repair list. AI can actually look at a report and it can create a list of what's missing and what's present, extremely helpful. There's also applications where AI is probably going to be guiding more and more depositions with attorneys, claim strategies, and all of these things. And then, of course, reducing bias and improving transparency, which I think everyone wants, of course, speeding up the claim resolution and getting everyone settled and happy. And then I'll leave you with a positive note that I think is happening. Over the last six months, I'm getting more referrals to the practice and to the company because insurance companies are getting reports back from their doctors in California that give them a zero impairment rating when they have clear limitations in disability. And these insurance companies that are becoming much more smart to the process are submitting this to us saying, please analyze this report. We cannot submit it for zero to the judge and what is the true claim value? And that's becoming more and more of a trend now. So, we're having AI review and support cases and insurance is already seeing the benefits of it.

Sen. Lana Theis (MI) stated that I found it interesting that you were talking about saving litigation years and I'm wondering how you came up with that estimation. Dr. Alchemy

stated that at least by California standards, the average case, when a doctor can't rate a case on their own at the primary treating level, which is legislated, actually, a doctor is required to do that if they're treating a patient. But if they can't, the average of putting that case through the qualified medical legal system that is the alternate in the state is 18 months. It's 18 months to move it through the process, about two and a half visits spread out by about six to eight months. So it's a lot of time investment when that has to happen. And I will say it's a huge inconvenience to the patient. A lot of these people don't have income coming in and putting them through another 18 months of sitting around is really a hardship.

Sen. Jesse Bjorkman (AK) stated that where I serve in Alaska we've seen the use and introduction of AI in the prior authorization space for health care and essentially, it's been an AI battle between payers and providers of who has the best AI to navigate that space and who gets paid and what care gets provided, resulting in lots of delays and things take more time. That's certainly not what I just heard from you in describing your product in the work comp space. What protects workers who are injured who need to get evaluated and hopefully back to work as soon as possible from delays caused by AI? The use of AI in health care has caused significantly longer delays and higher costs and people getting less care. Can you outline for me how we can put sideboards on this so that states don't have to build up their own AI systems to battle AI systems that are put up by payers? Dr. Alchemy stated that utilization review is a big problem in California as well and the problem is right now it's going to be AI appealing to AI. Eventually it's the way that it's going to go. The way I would like to see it is a centralized AI system where either the doctor or the insurance company could submit their files and it would be the AI that's of neutral territory, if you will, or state regulated that would determine what needs to be done on the case to either get it approved or what's missing in the case, and function in a much more neutral situation. And I was a utilization review doctor for a couple of years with the insurance company, so I've played both sides of that. But that's I think where it really needs to go. Otherwise, it's going to be who has the most money in development to get the better AI.

PRESENTATION ON IMPACT OF VERTICAL INTEGRATION ON PRICES, MEDICAL UTILIZATION, AND OUTCOMES

Sebastian Negrusa, Ph.D., VP of Research at the Workers' Compensation Research Institute (WCRI), thanked the Committee for the opportunity to speak and stated that today I'm going to talk about some work that we conducted at WCRI on the impact of vertical integration in the medical sector on various outcomes of interest for the workers' compensation industry. So, I'm going to talk briefly about three main things. What exactly do we understand by vertical integration in the medical sector? How pervasive, how widespread vertical integration was in the last few years? How is that reflected in workers' compensation? And of course, I will spend perhaps most of my time talking about our estimates of how vertical integration has been impacting the workers' compensation industry. And those outcomes are already in the title, medical utilization, medical payments, and the duration of temporary disability. WCRI is an independent, not-for-profit research organization. We only provide the facts. We are researchers who provide state legislators and public officials with information that is helpful in workers'

compensation issues. Our studies are peer-reviewed. We have no positions. We make no recommendations. We only, as I said, provide you all with the facts.

So, what is vertical integration? Vertical integration is a form of market consolidation, and as with all market consolidation situations, that can lead to a reduction in the competition in the market. In this case, the market being the healthcare market. And the ultimate consumer, which in our case would be the injured worker, might be negatively affected by this type of consolidation in the healthcare market. Now what we understand and what we have been using as an operating definition for vertical integration throughout our work was situations where a health system or a hospital takes over or purchases ambulatory service centers or independent physician practices. So this is a situation that I believe most of us encounter these days when we go to the doctor, we have a medical bill and if there's a health system logo on that bill that means we have been treated by a vertically integrated provider. And again, this is a phenomenon that's external to the workers comp system it's not necessarily happening just in the workers comp system. So, let's see how pervasive this phenomenon was over the timeframe of the study 2012-2018 just before the pandemic. To simplify things in terms of empirical estimation, we see that there is a substantial increase in the proportion of physicians providing care to injured workers within vertically integrated organizations. And the bars at the top show you the change from 2012 to 2018 for all physicians providing care to injured workers. And then at the bottom, you see similar trends for primary care and orthopedic surgery, two specialties that are of higher relevance for the workers' comp industry. So, this has been a phenomenon that has been fairly widespread and anecdotal evidence indicates that it has continued through the pandemic period. Let's move to a preview of our main results - what we find is that vertical integration leads to changes in the amount of medical care injured workers receive, that is, it increases the amount of care, and that happens through more services when a physician or a provider sees the injured worker through more visits, that is, the injured worker is seen multiple times by providers. There are more imaging services being provided.

Okay, then what are the implications in terms of per-claim medical payments? The implication is that per-claim medical payments go up as a result of vertical integration, and then we also find that this doesn't translate into faster recovery as measured by duration of temporary disability. We do not see a decrease in temporary disability when an injured worker is treated by a vertically integrated provider. So these are the three main things that I wanted to talk about. Let's get into some of the details about these main findings. Now, we are researchers, so please bear with us. We have a bunch of numbers here. Those should be fairly easy to follow. As you see on the left-hand side of this chart, we have four measures of medical utilization, services per visit, claims, number of visits per claim. And on the right-hand side, we see our estimates coming from our empirical objective work, indicating the impact of vertical integration on these measures of medical utilization. So, we see an increase in the number of services per visit, and this is all at six months maturity, so six months since the injury. We see also an increase in the number of visits per claim, something that becomes much more clear at 12 months and later in the injury. And what's also noticeable here is that there is a substantial increase in the number of evaluation and management (E&M) visits. So, at that time, six months since the injury, we go from about eight E&M visits to nine E&M

visits as a result of vertical integration. So, a substantial change that only grows larger as a claim matures. So more care is being provided. How exactly is this more care being provided? Interesting to see that it is provided through more medical providers, and that happens through more advanced practitioners like nurse practitioners and physician assistants being present in the treatment of the injured worker, but also specialists. So, specialists may be available down the hall in a vertically integrated organization, therefore there are more specialty services provided. That's one hypothesis we came up with. But definitely what we see is a substantial increase in the number of medical providers caring for the injured worker as a result of work integration. One other aspect of medical utilization, imaging services. A lot of the injuries in the workers' comp space are musculoskeletal injuries and some of them may require MRI or CT scan services. But treatment guidelines are very conservative and oftentimes they do not recommend such procedures unless really well justified. What we do see in our work is that there is a substantial increase in the number of MRIs and CT scans, so major radiology services that are provided to injured workers as a result of or after or in the aftermath of vertical integration.

Okay, so let's come back now to the details of what vertical integration in the medical sector does to medical payments in workers' compensation. So, medical payments per claim at six months' maturities are about $4,000 for claims with lost time, more than seven days of lost time. Now when a worker is treated by vertically integrated providers, that medical payment per claim goes up by about $280 so that is around 7%. This is at six months since the injury. Then when we look at the difference between vertically integrated treated versus non-vertically integrated treated injured workers, the difference in medical payments per claim goes up even more to 11% and that translates into something like $560 per claim additional medical payments. So, more care, more expensive care, in terms of per-claim terms, does that lead to a quicker recovery? Well, we do not find evidence pointing towards quicker recovery as a result of more care and more expensive care being provided to injured workers. If anything, we see that the duration of temporary disability, which is only a proxy for the actual return to work, we do not have information on the actual return to work of the injured worker, but we do have information on their duration of temporary disability. We do find that the increase in the duration of temporary disability at six months since the injury goes up by about 7%, which translates into something like 0.7 weeks, so a little less than a week. But when we go to 12 months since the injury, that difference goes up to almost two weeks. So, of course, one potential explanation here is more care is provided so that automatically takes more time. So instead of, if the injured worker receives, as I said, nine E&M visits now relative to eight, well that automatically takes more time. But what we see is definitely no evidence that a vertical integration leads to a shorter duration of temporary disability and a quicker return to work. So that's what I had on these slides and this is what I wanted to bring to your attention and these are the main conclusions coming from this study. And of course, we have a report with a lot of details and we have a lot of other studies on this topic and similar topics on our website so please feel free to reach out to us and please let me know if you have any questions or comments.

Rep. Tom Oliverson, M.D. (TX), NCOIL Immediate Past President, stated that I really appreciate this presentation and I know in Texas, this is something that we've been very

concerned about, vertical integration. The workers' comp perspective is interesting to me since the medical treatment guidelines are fairly standardized in most states, and so it's not like the doctors are really thinking outside the box. They're sort of following the protocol, right? And so, I would say that's very structured, and probably thus the amount of damage that's being done in terms of it increasing cost is probably relatively contained to what it could be if the sky was the limit, right? Because you have all of these various things. But what I'm really curious about is has WCRI looked at how many of these vertical integration type practice settings where there's an actual statement of principles or governance documents or clinical governance structure that would essentially prohibit conflicts of interest between the physician and the employer, as the physician is trying to take care of the patient? Have you studied that at all? Because that's the thing I really worry about. Dr. Negrusa stated that's a great question and this was a statistical study in which we didn't go down to that level of detail but that's definitely venue for excellent future research.

Sen. Theis stated I have a couple of questions. First, is there any evidence of improved outcomes as a result of increased costs? Dr. Negrusa stated that our data do not allow us to get into quality of care measures. We do not have information on mortality or outcomes that health services research would look at. We only have information on medical payments provided to injured workers, indemnity benefits, and a number of services. Sen. Theis stated that my second question is, are there any states where they discourage the vertical integration where you'd be able to do a side-by-side comparison? Dr. Negrusa stated that we did not take that dimension into the analysis. Something similar what we did along these lines was to look at states with and without fee schedules.

Rep. Barbara Dittrich stated that hearing this data, I think of what are possible solutions? And I know you're focused on the research but I guess that goes to what are you seeing states do with this sort of information? Dr. Negrusa stated that I'm going to resort back to our initial statement that we are an independent research organization and we do not make recommendations and we do not take positions.

INTRODUCTION AND DISCUSSION OF NCOIL EXPERIENCE RATING MODIFICATION MODEL ACT

Rep. Anderson stated that next on our agenda is the introduction and discussion of the NCOIL Experience Rating Modification Model Act. You can view the model in your binders on page 13, as well as on the website and the app. Before we go any further, I'll recognize Rep. Michael Sarge Pollock (KY) who is co-sponsoring the model.

Rep. Pollock stated that I'm pinch hitting for Rep. Matt Lehman (IN), sponsor of the Model, as he unfortunately couldn't join us due to some last minute session issues. But I'm happy to co-sponsor this model which deals with a pretty straightforward but important issue. In work comp, businesses can have experience rating modifications which involves calculating a summary of losses against what is set as expected losses in that class. If you perform better than expected, you obviously will get a credit modification. Your premium will be lower. If you perform worse than expected, you will

get a debit modification and your premium will be higher. This model deals with the situation Rep. Lehman described to me where it was a trucking risk and the company's driver was in an accident and he wasn't at fault. He had medical expenses, lost wages that were paid by work comp. But during the process with subrogation by the work comp carrier against the at-fault auto carrier, that loss hit the company's experience modification. And they were paying an additional 30% in premium through no fault of their own. Due to the extent of the injuries, it was several years until the claim was successfully subrogated. And while the carrier was made whole, the trucking company was out the additional premium during that time. So, this particular model deals with two issues against that backdrop. First, many times in an effort to limit a pool of potential bidders on a project a company may prohibit an entity from submitting a bid if they have an experience rating over a certain amount. Section 3 of the model prohibits the experience rating from being the sole basis for not bidding on a contract. Second, if the carrier is successful in their subrogation, then the governing rating bureau shall go back to the date of the loss and recalculate the client's experience rating to make the entity whole. I don't want to take up any more time, so I'll just reiterate that I'm glad to co-sponsor this model, and I look forward to this committee discussion throughout this year.

Tim Tucker, Executive Director of Legislative and Gov't Affairs at the National Council on Compensation Insurance (NCCI), thanked the Committee for the opportunity to speak and stated that I'm not here to speak to the model that's under consideration by the committee, but rather I've been asked to discuss NCCI's experience rating plan, which would be impacted should this legislation be enacted in a state. NCCI is the Workers' Compensation Statistical Agent and Rating Organization in 38 states. In addition to our role as a stat agent rating organization, we provide tools, insights, information to state and federal public policy makers. Those issues can directly or indirectly impact the state-based workers' compensation system. Like my counterpart to my left, NCCI is not an advocacy or lobbying organization. We do not take public policy positions on legislation, regulations, or model acts. So, we're really here to present some information, and answer any questions you may have. So, NCCI's experience rating plan, or ERP, is an integral component in determining the cost of workers' compensation, and it's a method for tailoring the cost of that coverage to the characteristics of an individual employer. The ERP gives employers an incentive to manage its own expenses through meaningful and measurable cost-saving programs. Experience rating recognizes the differences among employers with respect to such things as safety and loss prevention. It does this by comparing the experience of individual employers with the average employer in the same classification. So, roofers are compared to roofers, office personnel are compared to office personnel. The differences are reflected in the employer's experience modification factor, which is unique to that employer. The modification factor can result in an increase, a decrease, or no change in the premium. In Workers' Compensation experience rating the actual payroll and losses of the individual employer are analyzed over a period of time, usually the current plus the past three years. However, that can vary from state to state. Policymakers in states have taken slightly different approaches. But these look-back periods, if you will, do formulate the experience modification factor.

So, what does the ERP do? Employers are grouped according to their business operations or their classification code. Estimated losses for the group are added together

to determine an average, and then the experience rating is designed to reflect individual differences by the employer. Some have asked why even have an experience rating system. Experience rating presents a refinement in the premium determination process. It benefits employers by adjusting the premium cost, which is the best indicator of an individual employer's own potential for incurring future losses. Implicit to any form of experience rating is a prospect of both debits and credits. Experience rating also provides an incentive for employers to focus on loss prevention and claims management programs. There are three types of experience rating modification factors, unity, which is one. There's credit mods and debit mods. For example, taking $100,000 of premium, an employer with a unity mod would pay a premium of that $100,000. An employer with a credit factor or a mod of .75 would pay $75,000 in premium. And an employer with a debit modification factor of 1.25 would pay $125,000 on that premium. So, really we're looking for precision on the individual employer to provide the best indication of potential future losses. So, that's an overview of our rating plan. We have a lot of information on the formulas and the details on our website at www.ncci.com. But I'm happy to answer any questions.

Rep. Pollock thanked Mr. Tucker for the information and stated that I'd like your opinion and your thoughts on that scenario I described in my opening remarks as to whether you think that's fair or not. Mr. Tucker stated that what I will say is there is a mechanism within the experience rating plan that does account for recoveries whether it be through subrogation second funds or things like that. I think the question if I understand the intent of the model is to consider whether or not that duration of the look back is adequate or should be extended and that's a matter of public policy which of course we wouldn't opine upon.

Rep. Brenda Carter (MI) asked if these provisions create legal or administrative challenges for NCCI and would it increase potential cost to the insurers? Mr. Tucker stated that I'm not really sure but what we do look to do with our experience rating program is be as precise and reflective of actual loss as Rep. Carter stated what I'm looking for potentially is you use actuarial models to determine rates, is that true? Mr. Tucker replied yes. Rep. Carter stated and in doing so, is there a risk of exposure of the information that you receive and could that potentially lead to legal actions? That's what I'm getting at. Mr. Tucker stated that we're a little unique in the workers' compensation line as NCCI generally does not have personally identifiable information, so we wouldn't have those type of things that we usually think about as exposing to privacy issues and those type of things.

Rep. Alex Finkelman (RI) stated that if I'm not mistaken, a couple of the primary factors of an experience mod are the actual losses versus the intended or expected losses. Is there a possible way, because they bring up a great point that people are being penalized and losing out on jobs potentially because of the experience mod, that there could be a third factor of expected or intended subrogation? Mr. Tucker replied yes, states have looked at the uses of experience mods, say for contracting, which is part of the model as I understand it, but there are other factors that can indicate whether or not it's a pure threshold for employer safety. There's other things such as subrogation or other recoveries that could impact that. So, we do have some information on the use of

experience modification factors in contracting, which I'll be happy to share with the committee, which kind of looks at the other things. So, taking this on its face, there is more that you need to look at beyond just the outright modification. Rep. Finkleman stated but more so as far as the experience factor is calculated, is there a way to include the potential for subrogation factor if an insurance company could specify when they're reporting to the NCCI that this is expected to be subrogated and recovered? Mr. Tucker stated I'm not aware of that approach being applied to experience rating, but I think that's a matter of public policy.

Rep. John Fitzgerald (MI) stated just to underscore the point made by Rep. Finkelman, there are claims practices, I know in many cases where if there's an opportunity for subrogation, deductibles are waived. There's an expeditious claims process that happens. And so, when you include that exact scenario, you have the opportunity to, I think, get a better result for the consumer and for situations like the one described by Rep. Pollock.

PRESENTATION ON TRENDS AND DEVELOPMENTS IN THE SOUTH CAROLINA WORK COMP MARKETPLACE

Scott Beck, Chairman of the South Carolina Work Comp Commission, thanked the Committee for the opportunity to speak and stated that before I get started on some trends, I think it's important to have a little bit of an overview of what our commission looks like. It's substantially different than a lot of states. I've been actively involved in an organization called the Southern Association of Workers' Compensation Administrators (SAWCA) and in the National Association of Workers' Comp Judiciary and I have an opportunity to see what other states' organizational structures look like, and we're somewhat unique. We're a small agency. We have 51 full time employees (FTEs). Of those 51 FTEs, we have seven commissioners, similar to what you would refer to as an administrative law judge in other states. Those commissioners are appointed by the Governor with advice and consent of the Senate on a staggered system. We have two come up, two come up, and then the final three. So, each of those is assigned an administrative assistant that sort of serves as a clerk of court for that respective office. So, out of 51 employees, 14 of those are those Commissioners and their assistants. So, you really only have mid-30s or so really carrying the load of the work at the commission. We've got a $11.8 million budget, and I think it's important to sort of get some perspective on that. We've looked at Virginia, North Carolina, Georgia, who process roughly the same number of contested cases that we deal with. Virginia's got six times the employees, twice the budget. Georgia and North Carolina, about double to triple the budget, and about double the employees. So, I'd like to think that we're getting a pretty good return on investment for the amount of work that this small agency does. Interestingly, we're not funded by any insurance premium tax. Those are passed directly through to the General Assembly, as are all the self-insurance premium taxes as well. We're funded partially by a general fund allocation of about $6 million and the rest through earned funds, either filing fees, fines, other fees that the Commission collects. Interestingly, though, the workers' comp insurance trends are up. We had last year about almost 129,000 employers purchasing insurance in South Carolina, which was an increase of about 5.5% over the prior year, and then our employers qualifying as self-

insured entities was up almost 12% last year. So, the market's looking pretty good. Interestingly, we struggle sometimes with folks that subject themselves to our act and then believe that merely by canceling their insurance policy, they are no longer subject to it. South Carolina, I'm not sure whether it's unique or not, but we have a requirement that those employers have to take an affirmative action to come back out from underneath that umbrella.

So some interesting trends. We have a rather robust compliance program. I think it's important for the system to work fairly and efficiently and that there be a level playing field and those people that are subject to the act should have insurance. Unfortunately, that's not always the case. The role of our insurance and medical services division is sort of twofold. It's an education, public awareness role where we're going out and talking with employer groups with insurance agents, educating them on requirements under our Act. And probably the bigger role is the enforcement section. Looking for employers that are required to have insurance that don't. Those investigations are started in a variety of ways. We partner with our Department of Employment Workforce and data mine from their records. We get claims filed by employees to find out that the employer is not covered. And then oftentimes we get complaints from competitor groups, because obviously somebody is paying a workers comp premium, their cost of doing business is going to be more than somebody who's not. Our goal is to have covered employees. That's the whole purpose of the act from its very inception. From a statistical standpoint, since 2019, these numbers actually surprised me. Now, considering we're a fairly small state, since 2019, we brought into compliance 2,455 employers who were required to have insurance but did not. And as a result of bringing those into compliance, 21,248 employees obtained coverage that they did not otherwise have.

Other trends we're seeing at the commission in South Carolina, claims this year were up, we had 61,320 claims filed in South Carolina this year, which was about a 6.5% increase over the prior year. This is a big industry. Last year, between indemnity and medical, we were over $1 billion dollars paid out in benefits. Of that, about $677 million went to indemnity, $336 million went to medical. Now, we've done some major adjustments over the years on our medical fee schedule. In 2011, which is a few years after I came on to commission, we went, from a hospital fee schedule standpoint, from a discount-to-charge system to a Medicare plus 40 and it saved us about $100 million a year just converting to that system. The other issue that we try to keep a lid on is the annual update to our fee schedule. We have a Medicare-based system. It's an Resource-Based Relative Value Scale (RBRVS) system with a conversion factor. That's important. We were prohibited from utilizing multiple conversion factors in our system for now. So, when we look at that system every year, we're also bound to a 10% swing in the practice groups from one practice group to another. So, if we see something go above 10% up or down, we have a contractor that does our fee schedule work for us. We normalize to 9.5% because the current legislation in South Carolina gives any practice group the right to sue us before the Administrative Law Court if those swings go up or down greater than that 10% swing. The balancing act is controlling cost but also making sure that we have access to care for the injured workers that we serve. And that's sometimes difficult. We struggle in a couple of practice areas in South Carolina.

Neurologists are difficult to find practitioners that want to play in the comp sandbox, and psychiatrists.

There is some current legislation pending in both the House and the Senate here that would give the Commission some additional freedom to factor in adjustments for those types of practice areas. One would eliminate the single conversion factor requirement. The second would eliminate that 10% swing that causes us to try to normalize to avoid litigation costs. I've been on a commission 17 years and I can only recall two years where our loss costs was in the plus category. We've typically been in the minus category most of those years. Some perspective, out of the 61,000 claims we docket over 10,000 of those for single Commissioner hearings. So, administrative law judge (ALJ) type hearings. Where South Carolina's a little bit unique is we're also the first level of appeal where most states have an ALJ and then they have three commissioners that hear the appeals - the seven of us do both. So, if I have a single Commissioner hearing and that gets appealed it goes to three of my colleagues for that first appellate level hearing before it leads to the Court of Appeals in the Supreme Court. Many would think, well, they're just going to get rubber-stamped because they're your colleagues. I assure you there's probably more robust debate in those appellate hearings than maybe at the appellate courts. Interestingly, out of those 10,000 that were docketed, only about 630 were actually tried among the seven. And out of those, last year we only had 64 full commission appeals, which was down 11% from the prior year. And only 13 left the Commission to go to the Court of Appeals. When I came on to Commission in 2008, that number was in excess of 200. So, we've seen quite a reduction in the amount of cases that are leaving the Commission going up through appeal.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Carter and seconded by Rep. Oliverson, the Committee adjourned at 11:15 a.m.

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732-201-4133
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 discussed and potentially considered during the Workers' Compensation Insurance Committee on July 18, 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.

NCOIL – NAIC DIALOGUE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
NCOIL – NAIC DIALOGUE COMMITTEE
2025 NCOIL SPRING MEETING – CHARLESTON, SOUTH CAROLINA
APRIL 25, 2025
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) NCOIL – NAIC Dialogue Committee met at The Francis Marion Hotel in Charleston, South Carolina on Friday, April 25, 2025 at 2:00 p.m.

New York Assemblywoman Pam Hunter, NCOIL President and Co-Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Brenda Carter (MI)
Sen. Paul Utke (MN)
Rep. Brian Lampton (OH)
Rep. Tom Oliverson, M.D. (TX)
Rep. Jim Dunnigan (UT)
Del. Walter Hall (WV)

Other legislators present were:

Sen. Jesse Bjorkman (AK)
Rep. Justin Wilmeth (AZ)
Rep. Eddie Lumsden (GA)
Rep. Brett Barker (IA)
Rep. Elizabeth Wilson (IA)
Rep. Peggy Mayfield (IN)
Rep. Vanessa Grossl (KY)
Sen. Donald Douglas (KY)
Sen. Franklin Foil (LA)
Rep. Robert Foley (ME)
Del. Mike Rogers (MD)
Rep. Jennifer Balkcom (NC)
Sen. Bill Gannon (NH)
Rep. Kristian Grant (MI)
Rep. Meredith Craig (OH)
Rep. Perry Warren (PA)
Rep. Sean Bennett (SC)
Rep. Barbara Dittrich (WI)
Sen. Mike Azinger (WV)
Sen. Cale Case (WY)

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 Rep. Brenda Carter (MI) and seconded by Rep. Tom Oliverson, M.D. (TX), NCOIL Immediate Past President, the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Oliverson and seconded by Del. Walter Hall (WV), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's November 23, 2024 meeting.

INTRODUCTORY REMARKS

Asw. Hunter stated before we get started I'd just like to say I really appreciate you all being here today on behalf of the National Association of Insurance Commissioners (NAIC) and I look forward to our organizations continuing to strengthen our relationship. When our organizations are in positions of strength and are able to cooperate with each other that ultimately benefits consumers in our state-based system of insurance regulation. So thank you and I appreciate your large group of commissioners being here today. And fitting with that theme, I'd like to mention that printed out before you is an op-ed that was authored by myself and NAIC President and North Dakota Insurance Cmsr. Jon Godfread celebrating the state-based system of insurance in light of this year being the 80th anniversary of the McCarran-Ferguson Act. You can also view it on the app and the website. And I do think that this op-ed is a great example of how the relationship between our organizations has improved over the years and it's a strong foundation for us to keep moving forward. Before we get started, can you all please introduce yourselves: Cmsr. Godfread; Utah Commissioner and NAIC Secretary-Treasurer Jon Pike; Florida Commissioner Mike Yaworsky; Georgia Commissioner John King; Oklahoma Commissioner Glen Mulready; South Carolina Director Michael Wise; Washington Commissioner Patty Kuderer; and Wisconsin Commissioner Nathan Houdek.

RECAP OF NAIC SPRING MEETING AND DISCUSSION ON NAIC 2025 PRIORITIES

Asw. Hunter stated that last month, the NAIC concluded its spring meeting in Indianapolis and as usual, there were many items discussed and actions taken that have a major impact on the insurance marketplace. And also, earlier this year, the NAIC set forth its priorities at both the state and federal level. So, can you touch on some of the highlights from your spring meeting and also discuss the NAIC priorities for this year?

Cmsr. Godfread stated that before I get started, I just want to say thank you for hosting us and having us here. I agree with your comments about when we work together, everything's a lot better. This is my first NCOIL meeting, and I'm going to give a little bit of a background on why that is. Prior to my being elected North Dakota Insurance Commissioner, the late George Keiser, who was a strong force in this organization for a number of years, met with me, and he said we're not joining The Compact and you don't need to worry about going to NCOIL because I've got that covered. And at that point I wasn't sure what those two things were but I said I'll respect your wishes. Now I think he was keeping a secret from me and I'm happy to be here and happy to be a part of the Compact. And an opportunity for us to meet with policymakers and talk to these issues is so critically important, and the closer our organizations can be, the better that is for the

states, and the better it is for state-based regulation. And I think that the op-ed that we were able to author together really outlines that.

But jumping into the Indianapolis Spring National Meeting we had back in March, we had a very good turnout. I know it wasn't quite a record-setting turnout like your meeting here, but we had good participation from across the industry as well as from regulators and we've really hit the ground running this year. We've reorganized how we're doing some of our priorities and how we're kind of outlining some of our governance within the NAIC. We are really taking a hard look at governance and really taking a look at the hard work of the different parent committees that we have across the association, and trying to give them some more directives and some more key working opportunities. Again, getting back into what is the value of bringing stakeholders together is doing the work in front of them and having that robust discussion as much as we possibly can. And so, continue down that road, some of the highlights from the meeting were the kicking off and deployment of our Risk Based Capital (RBC) Model Governance Task Force. That's being led by Cmsr. Houdek who's also here at the table as well as Ohio Director Judi French. They've been tasked with doing a pretty comprehensive analysis of our RBC framework and looking at some principles behind the RBC framework. This is one of the key tools we use for financial regulation. I would stand it up against any financial regulatory tool across the world. And a part of this process is to conduct a gap analysis to make sure when we want to make changes to the RBC or changes to our analysis that we've got some principles behind it. I think it's important as the investment landscape evolves and changes that the insurance industry needs to be responsive to that. The regulators also need to be responsive to that to make sure that we're allowing reasonable and responsible capital into the market.

I think there's a great opportunity here when we talk about closing coverage gaps or serving underserved communities. It's really hard to, if not impossible, do that without additional capital. And that's on all lines of insurance. And so, our capital regulation must be flexible. It must be certainly responsible. But as our markets change, we've got to be able to take a look at how we evolve as an industry in allowing those capital formations into our industry where they fit and where they are appropriate. So, Cmsr. Houdek and Dir. French are certainly leading that effort. Dir. Wise is also a co-vice chair. I like to say we've got the “who's who” of financial regulation leading that work and I'm really excited about the work they're doing. Another key point is through our C-Committee, our Property and Casualty Committee, and there's been a lot of work done by Cmsr. Yaworsky on data collection. You may remember there was a lot of talk last year about the property & casualty insurance data call and some of the interactions with the Federal Insurance Office (FIO) and what that means for our market. I think we can all agree, there's probably a lessening of some pressure coming from FIO on that piece. It gives us an opportunity to collectively come together as regulators and figure out how we want to do this going forward. The data is necessary. We need to have the data on our markets. We need to have an understanding of what's going on in our marketplaces so we can provide that to you all as policymakers when you have questions. I often get questions from my legislators on how many homeowners have insurance. And for a state like North Dakota, where we're really rural, that would mean doing a data call to get that information. I don't have access to that information or if I do, it's likely two years old. As

we all look at making policy decisions, they're driven by data, and we've got to have that fundamental underlying data to make those policy decisions. Colorado Commissioner Mike Conway is the chair of the C-Committee. Cmsr. Yaworsky is one of the co-vice chairs, and he and Cmsr. King have been also tasked with trying to come up with what a data call model looks like going forward so we can be a little bit more uniform and standardized so that when we do a data call as an industry, we're not trying to reinvent the wheel in every state. That becomes a costly process. One of the other pieces on the agenda was looking at the affordability and availability of insurance. We may touch on that a little later, but that's another priority of the C-Committee. Touching on big data and artificial intelligence briefly, we presented a roadmap to responsible AI use. We're also looking at in the G-Committee, which is our international insurance committee, the implementation of the insurance capital standard and the AI creation method and how that's going to work internationally. That will be led by Nebraska Director Eric Dunning, who is our G-Committee chair.

I do want to jump into our federal priorities. Touching on the federal claims filing deadline extending a two-year deadline for the federal government to file claims against insurance receiverships, and really looking at supporting natural catastrophe mitigation. There's been a lot of discussion around The Federal Emergency Management Agency (FEMA) and around the National Flood Insurance Program (NFIP), around what dollars are going into disaster recovery, and I was fortunate enough to sit on a wildfire roundtable back in January with the U.S. House Financial Services Committee and I was a little surprised at how the discussion went. It really shifted to mitigation and how we use federal dollars to enhance community mitigation, and where can that go. There's a lot of federal bills out there right now dealing with that issue. I don't think we have a list of favorites yet, but the mentality of driving mitigation down into the communities through the states is a really good first step into preventing loss in the long term. This isn't something you do overnight. We're not going to be able to change building codes or implement significant mitigation across our communities overnight. It's a step that we've got to continue to take so we can make our communities resilient for the long term. We also continue to oppose any federal preemption on privacy, cybersecurity and AI. If there's one area I think that Congress will eventually come to some agreement on it is on privacy. The threat of Congress coming together and coalescing around some privacy model is very real and it's why we continue to work on our privacy model law at the NAIC. Also on the federal side, the extension of the premium tax credits is another key issue. I don't think I know a commissioner who is opposed to extending those tax credits and giving the access that they provide to our consumers in our states to receive healthcare and have access to health insurance. We are always looking for more market flexibility on the health side anywhere we can get it. And then also working with the Centers for Medicare & Medicaid Services (CMS), The Center for Consumer Information and Insurance Oversight (CCIIO), and the U.S. Department of Health and Human Services (HHS) to really look at Medicare Advantage oversight. We've been asking to pull that back into the states to allow us to enforce regulations on some of the bad actors that are operating in that space. I think there's some understanding around that and some agreement to that. It's just a matter of getting over that hurdle.

The last federal priority we came to consensus around is calling for the elimination of FIO. That is a new step for us. We've often talked about FIO and what role it plays in the industry, but we were able to get to a point where there was bipartisan agreement on calling for its elimination. In my opinion, it hasn't been a very successful partnership. I think the data call that I mentioned is a prime example of that, and I don't need to get into rehashing of all that but there wasn't a feeling of true partnership around how we're sharing information, how we're sharing data, and how we're analyzing it. And so given the direction of where we are going, there could be an opportunity for us to support Montana Congressman Troy Downing's new bill to call for the elimination of FIO. That's a real quick overview. There's one other issue I'd like to bring up, and it's one of the model laws that you all have before you at this meeting. I think as state insurance regulators one of our core responsibilities is to continue to ensure that our consumers are protected and we all share in that goal of ensuring that markets remain stable and our companies operate within a fair and transparent regulatory framework. With regard to the revised Rental Home Marketplace Guarantees Act, I think we can understand the intent behind it. We can understand the desire behind trying to address some of the innovation in the sharing economy, but it does continue to raise some fundamental concerns for us. I'd like to turn over to Cmsr. Kuderer to walk us through some of those concerns.

Cmsr. Kuderer stated I just want to start by saying it's an honor to be here. I've been here before as a legislator and I'm here now as a commissioner of insurance, and I also want to say that South Carolina's slogan is, "Made for Vacation," but its motto is, "Be prepared in mind and resources." And that all feels very appropriate for this discussion because both are foundational to my remarks today. We can all enjoy a vacation rental but we can also be prudent in how to legislate it. And that's how my office regulated Airbnb when we took legal action against it a few years ago. I'm still a little new to my role as a regulator but I'm consistently impressed by the work of our legal affairs team and the standard that they've set for proactively regulating corporations that engage in the insurance business but don't consider themselves within our authority. We started looking into Airbnb's host damage protection program in 2022, as a result of a consumer complaint alleging that the $1 million in coverage for host property damage was merely a marketing scheme. Airbnb had been offering this coverage since 2012. That coverage was meant to cover up to $1 million in guest damages to the host property. The same bucket of coverage offered host and experience liability coverages all under a general commercial liability policy issued to Airbnb and then extended to the host.

In addition to misrepresenting the coverage offered to consumers, Airbnb wasn't licensed in Washington, so this was an issue with us as a regulator. In the end, Airbnb admitted it violated our insurance code and agreed to a $20,000 fine and to secure a surplus lines policy through a broker licensed in Washington. And we also made the company review 1,168 denied claims from January of 2021 to August of 2023 and pay out all improperly denied claims to date. Moving forward, the company agreed that all future claims paid out would be determined by an insurance adjuster licensed in Washington. The proposed model law before you now, as written, takes a large step backwards from the work we did in Washington and will codify into law the idea that rental home marketplace entities can operate outside the insurance code without regard to the negative impact on

consumers. From my perspective, the revised model law is a direct response to Washington holding them accountable for violating our insurance laws. It is too broad, it cuts important consumer protection language, and it restricts our ability to create rules that govern these entities despite them operating in our field of regulation. Section 4 alone establishes that these businesses would be outside the insurance code in Washington, and the revisions in Section 6 gut what little consumer protection language this bill had, including disclosures on whether the guarantee is covered under a reimbursement insurance policy, disclosures identifying who provides payment under the contract, disclosures on the purchase price in terms of policies sold separately, disclosures on any damage recovery minimums, disclosures on cancellation and refund policies, and notification requirements prior to contract terminations. The proposed legislation establishes something resembling travel insurance, a product that already exists and that we already regulate, and rebrands it as a rental home marketplace guarantee. And it's labeled a guarantee despite repeatedly using the term insurance to describe the product that would pay the damages covered by the guarantee. This proposed model legislation eliminates accountability by taking their insurance product out of our scope of authority. It's not in our consumer's best interest to accept this, and as a state insurance regulator, I will do everything in my power to ensure that, as currently written, it is not enacted into law into Washington.

Asw. Hunter stated that your comments are timely as we do have this as an agenda item for our Property & Casualty Insurance committee meeting tomorrow, so thank you for bringing that forward. Asw. Hunter then stated to Cmsr. Godfread you mentioned FIO and your conversations about the potential elimination of it - would the elimination of FIO cement McCarran-Ferguson as the basis for state-based insurance regulation? Cmsr. Godfread stated I think it certainly helps with that, or I think it removes some of the duplicative touch points on what happens, especially internationally. When we go out and deal internationally with the International Association of Insurance Supervisors (IAIS) or with the other international forums, as it stands right now, a lot of our international colleagues defer to FIO because they're the federal regulator, not understanding that under our state-based system, they don't really regulate much of anything. And so, I think removing that distinction and removing that potential confusion really goes a long way not only domestically, but also certainly on the international stage. So, I think it's a good step. And the U.S. Treasury Department will always have the authority to look at the insurance marketplace. They're always going to have an angle or an ability to understand and look at the insurance marketplace. But when you get into the discussions around what FIO has been utilizing their power or authority for, I think I've been left a little less than impressed by how that partnership has evolved. And so, political realities being what they are, I'm not sure if FIO will be eliminated. But I think it's also an important signal to send to the new administration that this is kind of where we're at if you want to have a conversation about what the appropriateness of FIO looks like.

Asw. Hunter stated you mentioned mitigation issues - we've had wildfires in New York. You wouldn't think that would be something happening, but it absolutely has. Relative to mitigation, who's responsible ultimately for mitigation? I know some of the conversation was about some of the carriers that were coming out of California who were turned off by the fact that California wasn't doing what they needed to do to mitigate some of the

wildfire risks. Cmsr. Godfread stated I think ultimately who's responsible is the communities. I'll happily defer to my other colleagues. We've had wildfires in North Dakota. Thankfully we've got a lot of wide open spaces, so it doesn't necessarily impact buildings or structures but when you look at wildfire mitigation, I can mitigate my home with regard to wildfires, but if my neighbor doesn't, it doesn't really matter. It's got to be a community-wide effort and I think where some states are running into those issues is in the building code or land use regulations. Those type of discussions are a political third rail. It's a bipartisan issue. I think everybody gets mad at everybody if you start talking about land use and you start talking about local regulations. I think what the U.S. House Financial Services Committee has signaled is that this is more than the insurance industry's discussion. This is the builders, this is the communities, this is local government. It's really going to take all of us to become a resilient country and address the risk. I think of North Dakota as a prime example of how to build against wind and hail, but we don't do it because of the building code. There isn't an incentive there for our builders to build to that level of protection. We're often very focused on that first dollar cost of the home versus the lifetime cost of the home. I think you're seeing that conversation evolve and shift. It's not going to happen overnight, but I'm encouraged by that roundtable discussion. It was not about how terrible the insurance industry is. It was more about, "Okay, the federal government's going to pay for the post-disaster or pre-disaster. What do we want to look at investing into?" And that is actually a helpful conversation.

Cmsr. Mulready stated with regard to the mitigation question, we've got a number of states with legislation, certainly led by Alabama with their Strength Alabama Homes Act that the state of Oklahoma 100% copied. We have just recently launched that but we've got Louisiana, we've got Florida, we've got South Carolina that have similar programs. And tthere are almost 40 states engaged in conversations about moving forward with a similar mitigation program so a lot's happening there.

UPDATE ON NAIC'S "FRAMEWORK FOR REGULATION OF INSURER INVESTMENTS" INCLUDING REQUEST FOR PROPOSAL FOR CREDIT RATING PROVIDER DUE DILIGENCE

Asw. Hunter stated next up is an update on the NAIC's Framework for Regulation of Insurer Investments, including its request for proposal for credit rating provider due diligence. We've had very productive discussions with the NAIC regarding its framework, specifically the part of the framework that dealt with the Securities Valuation Office (SVO) ratings discretion process. Ultimately, we feel the ratings discretion proposal ended up in a good place, and we appreciate you working with us on that. Now we're interested in this request for proposal for credit rating provider due diligence. The NAIC's stated goal here is the establishment of a robust and effective government structure for the due diligence of credit rating providers (CRP). Can you provide us with an update on your work on this and also give some background as to why the NAIC believes this due diligence is necessary and also how does the proposal interact with the Federal Credit Rating Agency Reform Act?

Cmsr. Houdek stated back in 2023, we released the Framework for Insurer Investments, or what we call the Investment Framework, and a key part of that was enacting more oversight over ratings provided by CRPs. The last couple of years, we've been moving forward on two separate initiatives relating to that oversight. The first one we adopted last year, which you mentioned, was the discretion over the ratings from the SVO. Under certain circumstances and following the parameters that have been established that will go into effect probably January of next year as it takes a little bit of time to update the computer systems and other things that need to happen. That process played out for about over a year. There were three different exposure periods where we received a lot of stakeholder interested party feedback and input. Ultimately, we ended up making a number of changes to address the feedback that we have received including, as you mentioned, comments from NCOIL, where we made sure that there were regulators who had the ultimate decision-making authority at the end of that process. So now we are moving on to kind of the next phase of that CRP oversight, which is to develop a due diligence framework basically establishing qualitative and quantitative factors that the CRPs would have to meet in order to be able to participate as CRPs that can provide ratings which then track to NAIC designations. We are in the process of hiring a consultant. We had issued a request for proposal last year and then revised it based on comments, and we've now gotten to the point of finalizing an agreement with the consultant who will then work with us to develop that due diligence framework.

And the goal is moving from blind reliance to informed reliance on the ratings that are provided by the CRPs. It's just been a recognition among regulators that because of the complexity of investments, and the shift in terms of the types of investments that we've been seeing, and also a shift in more private ratings that are being provided, there was a feeling that we needed to have more oversight in terms of those ratings and have informed reliance in terms of how those ratings tracked with NAIC designations and our accounting standards. And so that's really the motivation and driving force behind this work and as we move forward on engaging with this consultant and developing the due diligence framework, the same as we did with the discretion proposal last year, there will be multiple opportunities for comment. We will expose our work along the way and really encourage NCOIL and all other interested parties to stay involved in the process and provide any feedback and ask questions throughout the process.

Asw. Hunter asked if there is an example that you could give that relates to a smaller agency rating that had some sort of shift, maybe monetarily, that had you had these parameters in place, it would have made something different? Cmsr. Houdek stated it's hard to call out specific examples. I think part of the motivation and why this is being done is the shift that we're kind of seeing in the market. It's the shift in the types of investments where we're seeing more private investments, more private credit and just private capital in general. And related to that, the ratings are more private. So typically, when we had treasuries or other securities that were public and then the ratings were public, you had kind of a market validation process. You had multiple ratings that were seen by everyone in a public forum and as the assets have moved into more of the private side and then the ratings have become more private, you don't have that same type of market transparency and validation. So, developing this type of framework and putting in place these qualitative and quantitative factors is really critical for ensuring the

quality and validating the quality of the ratings. So, I can't really speak to a specific example, partly because that's often confidential and proprietary information, but it's really a lot of it is driven by the shift that we're seeing in terms of more private investments and more private ratings. Asw. Hunter asked how long do you think this is going to take? Cmsr. Houdek stated hopefully as quickly as possible but with enough time to make sure everyone has the opportunity for input and we're just getting the consultant on board in the next month or two and then it'll take some time to engage with stakeholders. It won't be finalized by the end of this year, but we're hoping by the end of the year to be making good progress going into next year.

Rep. Oliverson stated I just wanted to thank you all, particularly Cmsr. Houdek, for inviting us to tour the SVO last year. I felt like that was very informative. I hope that we continue to have opportunities to learn from each other and I thought that was very good in terms of helping us to understand the importance of what you're talking about - creditworthiness. There really is a lot that goes into it and I think I can speak for the other members that went to the SVO that we sort of understood that, but having gotten a chance to put our arms around it and realize just how big of an operation that actually is, we appreciate it. Cmsr. Houdek replied thank you and stated one last point that we made last year and we will continue to make as we're working through this due diligence framework process is the intention is to continue to rely on ratings that are provided by CRPs. The filing-exempt process is critical and the involvement of CRPs in that process has worked well. We're just adding some layer of oversight from the regulatory standpoint but we still very much want the CRPs to be involved in this.

DISCUSSION ON ARTIFICIAL INTELLIGENCE (AI) INCLUDING PREVIEW OF NCOIL GENERAL SESSION AND UPDATE ON THE NAIC'S AI-RELATED ACTIVITIES

Asw. Hunter stated that we're going to go to one of my favorite topics, AI. As we're all well aware on both the legislative and regulatory levels, AI does continue to impact the insurance industry and in response to that, seemingly every state feels a sense of urgency to enact laws on AI that strike a balance between making sure that consumers are protected and not hindering innovation. Tomorrow afternoon, we will be having a general session on this topic, titled "AI in Insurance: What is the Impact of Losing the Human Element?" The goal of our session is to gather some information as to how each line of insurance is utilizing AI and how each line views AI's benefits as well as problems. Afterwards, it's likely that our multi-lines issues committee will start discussing some potential model legislation to develop based on some laws that have been passed or introduced in several states. And I know from my perspective, I'm extremely interested in this because I do have a few bills in New York relative to AI. One requires insurers to notify insureds about the use or lack of use of AI-based algorithms in the utilization review process, and requires the insurance department to certify that these AI-based algorithms have minimized the risk of bias, based on certain things like the covered person's race, religious affiliation, age or gender. So, before we get into the NAIC's work in AI, I wanted to see if any of you would like to comment on what you have been seeing in your states in terms of AI-related legislation or regulation?

Cmsr. Yaworsky stated that generally speaking, there continues to be an extreme interest in what AI is doing within a lot of landscapes, including the insurance space. There's a lot of activity that is traditionally human-oriented with human knowledge and skill sets that is moving into an AI framework or another type of tool that can appear like AI. In Florida this past session, there are bills that ensure that there's a human component that remains in after any initial screening. For example, in a claim denial that might take place, if an AI process denies a claim, there must still ultimately be a human element involved in that process that ultimately is making the decision. And I think we're seeing laws like that attempt to generally ensure that there is a human piece of the puzzle that remains throughout the process. So, that's for the benefit of ultimately the consumer.

Asw. Hunter stated that the NAIC did have a model bulletin on the use of AI. Can you share an update with us of how many states have adopted the bulletin and then also touch on what the NAIC's next steps are related to AI in terms of other model bulletins or regulations or laws. Cmsr. Yaworsky stated that the overall work of the NAIC on AI sits on the H-Committee and is in really primarily two working groups. The first one is big data and artificial intelligence directly. The second major working group within that committee is the third-party modeling working group. Each one has some overlap on the other but when we get to the model bulletin that was issued, 24 states have adopted that model bulletin. We think there will probably be more that use it along the way. The NAIC at this time has opted to move in the bulletin direction for this kind of issue. As we look at the big picture about how things are going, one thing that we're very conscious of is not over-prescribing a model law immediately that would suppress innovation. We do generally think that AI has great potential to reduce costs and claims handling and other things, but it's ensuring at the same time that that human element remains present and there's ownership over the technologies being employed. So I think the principles were the next step for the NAIC in terms of how it's going to look into this space and then separately, we have the third party modeling group. We'll see what develops with that over time. That is a huge other component that's related to AI and it's the modeling that goes into it with so many different outcomes and determinations that really breaks into the work of insurance and predicting what the future looks like to the best of its ability. And so, as we do that, we're going to try and do this thoughtfully, carefully, smartly, but appropriately. We're going to take the steps we need over time to put things forward that we think benefit the consumer.

Cmsr. King stated one of the things that we are also seeing is a tremendous amount of filings. And so the length of the filings are getting more and more complex and I see a world relatively soon where regulators will have to start using machine learning tools to go through these filings to determine what the difference is between this filing and the previous filing, because we can't staff human beings at the rate. The budgets of our states would not allow us to. And so we're going to have to start looking at the use of these tools to screen out things that we're sensitive to such as discrimination, redlining, and things like that. We're looking really hard at how to appropriately use those tools as regulators. Asw. Hunter stated anecdotally, I was actually a computer science major and in the first class that you take, they say, GIGO - garbage in, garbage out - when you're writing code. And my concern always with AI is that it's great when you're watching the

videos online and it looks fun but if I use this in a health scenario you need to have eyes on a claim. If there's a denial, you need eyes on it because your provider knows you better than a computer algorithm will. And so, the garbage in or the information in will dictate what comes out relative to your claim. For example, you broke your neck, the algorithm says you need six physical therapy sessions, but your doctor knows you're not a very compliant patient and you're really going to need 12. These are the kind of intricacies that I am concerned about in spite of the great things that technology has done. Following up on one of the things mentioned, by the time we enact something, the technology is already ahead of us so how are we trying to combat this and still use technology to our advantage?

Cmsr. Yaworsky stated I think that's a great point and I think that's part of the NAIC's approach in this is to make sure that we're moving in a direction that doesn't overcompensate to the point that whatever it is we pass isn't irrelevant by the time it gets there. One thing in your comments that strikes me is that Florida is a state that has a modeling commission around hurricane catastrophe models. A number of agencies are a part of that, as well as private contractors, that actually unpack hurricane catastrophe models to understand what it is they're doing and then certify them. To your point about garbage in, garbage out, it doesn't necessarily certify the validity of the data or the uses of it, but it at least validates what it is saying it is doing all throughout that process. That data is providing a genuine outcome from that front and so I think that it's such a complicated discovery. You add an AI layer on say a model that is then using generative AI and making its own determinations about what is the weighting data and making its own sentiment about what is the most appropriate data to utilize. That would be an additional layer that is going to be a regulatory challenge in the coming decades. What we want to do in this space is be fully informed about what is taking place in the AI realm and then also about what the hazards are around that for the consumer or the market or the industry. And that's going to take a significant devotion of resources at the state level, the NAIC level, the NCOIL level and all these entities, perhaps at the federal level. But the bottom line is it needs to be monitored and we need to be aware and we need to know, at a minimum, that the things that that these AI tools or models are doing is appropriate and consistent with existing laws.

Cmsr. Godfread stated that I've been involved in this discussion really since the beginning of the NAIC’s innovation task force and I think we're seeing the conversation evolve to all those points that we've discussed today but I think that it has also continued to evolve and I don't want to lose sight of that third-party vendor portion. We can pass insurance regulatory schemes, but we haven't really been able to find a good way to pierce that veil to get into that third-party vendor who is subject to our authority. We don't have authority over those technology providers and we're seeing a significant amount of growth in that space, and it's challenging to our industry. It's putting us as regulators in a challenging situation because we don't know quite how to get through that third-party piece yet. We have an entire working group that is tasked with trying to come up with that and again, I think we've kind of honed in on the point that the buck stops with the insurer, so you're responsible for your vendors' access and all those things but when it gets into wanting to see the contracts and what kind of things they've entered into for services with that third-party vendor, we've been pretty shielded from the confidentiality

and proprietary pieces. And so it’s somewhat naive of us to think that because we pass certain insurance-specific regulations on AI that it's going to somehow affect that broader service market. And I think you're seeing that all over the place. We just passed a law in North Dakota on prior authorization which has an AI piece in it stating that you cannot have prior authorizations done solely by AI. And I think we're seeing it cross lines now, too. It's traditionally in the property & casualty space and a little bit in the life insurance space. On the health insurance side it’s really complex for us but it's coming. This will continue to grow and continue to evolve we've been working on this for the past eight years. You see the evolution over time and it's that third party vendor piece that is going to be a big question we all have to answer.

Rep. Oliverson stated that I think one of the questions that I always ponder on with this is that so many of these decisions that we talk about with regards to what AI may or may not be able to do, we sort of just say, “Well we're going to hold the insurance company accountable.” The reality is when we talk about third parties, so much decision making is actually done by licensed professionals. Those are individuals who have demonstrated competency in an area and received training, but they also have a certain self-preservation motivation. If I'm an engineer and I review the plans for a condominium complex that ultimately collapses and takes a bunch of lives, I have civil liability, but my professional license is also on the line. And I just wonder, if you're making a decision about medical necessity on an insurance claim, that's the practice of medicine 100% every time and it can't be avoided. So, does a machine have self-preservation instincts when it comes to the importance of preserving its own licensure? And could you even license a machine? And if not, do we even have a system that exists from a regulatory framework to ensure that there actually are checks and balances with regards to good decision-making, whether you're an accountant or whether you're an engineer or a dentist or you're cutting people's hair? As human beings, that comes into play and I'm not sure that it does with machine learning. So, I'm just curious, have you all contemplated the regulatory aspects of how licenses for individuals that may be consulted play into what AI can and can't do safely?

Cmsr. Yaworsky stated that those are great thoughts and great points, and I think the answer is yes. And when we talk about ownership of that in the insurance space, let's take an actuary that is utilizing some sort of AI technology to help that actuary make a determination about something. In that case, the important feedback ultimately that we would probably want to find ourselves ending up at from a regulatory space is that's great that the actuary used that tool to help them, but at the end of the day, they could have utilized an abacus to find their determination. Either way, the determination is still from a learned professional, and in that case, that would be the actuary. When we talk about the development of this, both within companies or as regulators or as others, one of the key terms that keeps on coming up is “ownership of the tool.” Rep. Oliverson stated I get that, but we're talking mechanistically about AI and what I'm saying to you is that so much of what happens is based on someone's “professional opinion.” That doesn't strike me as being something that you can license a machine to do because there's no accountability. Cmsr. Yaworsky stated I think you're correct and that's why when we talk about that ownership, just because the learned professional, the licensee, utilized AI as part of their mechanic, they are still responsible for the ultimate outcome

that it’s determining. It's that human factor. You can't place an AI in prison, at least not yet, or fine them a fee, but you can go back to the individual that employed that tool or utilization, and I think that's the framework that we would look at. Rep. Oliverson stated so your insurer would still need to have actuaries as human beings that are licensed professionals within that space in order for that to work - that's what I'm getting at.

Cmsr. King stated that the way we communicated this is, you can use the tools, but ultimately the company and the individual is who’s feet we're going to hold to the fire. That's who we're going to go sanction, and that's who’s license we're going to go after if they mis-use these mechanical tools and the way I see this is the mechanical tools are there to take care of routine, repetitive tasks but there still has to be a human being that is accountable whether they use a calculator or something else. That's just a tool. It's the individual, the company, the person that we've licensed is who we're going to hold accountable. Cmsr. Yaworsky stated I would just add to that, similar to what Cmsr. Godfread mentioned earlier about third-party models, it's a similar concept if you just take the AI term out of that and replace it with a third-party model of some kind. Ultimately, in our view, if we receive a rate filing that has data or some sort of calculation that can implement a third party model, at least in Florida and a number of other states, it's not the third party model that's accountable for that, it's the insurer. But it gets very complex when you start asking “well who's watching the modeler that is building that model to make sure that that model is providing the product that the insurer thinks it’s getting at and they're providing to us for use?” All this is making sure that we're moving in a direction where we are encouraging its use but also that there are appropriate internal company safeguards and also regulatory safeguards in place along the way.

DISCUSSION ON INSURANCE AFFORDABILITY AND AVAILABILITY ISSUES

Asw. Hunter stated that the next thing I wanted to bring up relates to insurance affordability and availability issues and I think that's at the forefront of every person's mind and something that comes to us via our constituents. And I'm sure you know with your conversations with insurers, things haven't gotten better right now and the headlines about insurance rates and insurers leaving markets started appearing in national news outlets. Obviously, we're all a little shocked. I know I got a little gut punch with my increased premium from my property & casualty policy but I think we'd all be hard-pressed to say things have improved a lot and in some instances, things have probably gotten worse particularly out in California due to the wildfires earlier this year. Tomorrow, during our Property & Casualty committee we'll be hearing from Cmsr. Yaworsky about some steps Florida's taking to improve the property insurance markets there but before that I think it's a great opportunity for us all together here to share some experiences you've been seeing in your states and some work they've been doing on these issues both from an individual state and NAIC perspective.

Cmsr. Yaworsky stated the issue I think we all face is the viability of property insurance within our states. It has been a pressing issue. I think Florida probably experienced the impact first, but it is spreading to other areas of the country as well in a concerning fashion. The NAIC has taken this issue on under Cmsr. Godfread’s term as President. One initiative particularly revolves around an affordability playbook that is designed to

ultimately be a product that can be given at the consumer level to help them understand what is driving the insurance cost, what could be done about it, and what can you do in your own arena to provide a matrix to help explain the situation around insurance. More broadly speaking, when it comes to insurance, the capital must come from somewhere to cover a loss and what we are experiencing in the property space, as well as the auto space, is the inflation-driven performance that we have seen over the past several years has been remarkable. Just to give a Florida example, the total insured value of Florida's property insurance market, which is how much it would cost to replace the totality of that marketplace, has nearly doubled in four years. And with that comes along the labor and goods and everything to put someone in that home. When you're buying more bricks of insurance at a certain rate, your premium is going to go up. And that's what a number of consumers are experiencing. And you combine that with state-by-state experiences, it has been a challenging marketplace for companies to operate in. It's been a challenging environment for consumers to purchase insurance. But I think longer term, when we spoke about mitigation or resiliency earlier, it is truly the thing that I think we need to be focusing on as regulators. It's probably the most important, but it's also the thing that is not the easy win. Since I've started talking about this in Florida and elsewhere, I'm always reminded of a quote that “societies grow great when people plant trees which they will never sit in the shade of.” And that is really the story of mitigation and resiliency. Just looking at Florida's history, we're just now seeing some of the benefits of hardening our building code in 2003. We're just now seeing that building inventory be significant enough where the state can move in a direction of potentially having a viable insurance market. It's kind of hard to imagine what Florida's market would be like without that but I think broadly, this is top of mind for all of us – it’s affordability and availability and I would also add reliability. The only thing worse than a consumer's insurance rates going up is a consumer's insurance rates going up and then that company not fulfilling that obligation to make someone whole again on the worst day of their life. And so, there's multiple elements to this. It's extraordinarily complicated.

Cmsr. Godfread stated I'm not sure what levers we can pull at the state level to have that immediate impact but I think as we look at the structure of our market, you're seeing more discussion around the cost of insurance and it may even be starting to impact the ability to purchase a home. To Cmsr. Yaworsky’s point, you've got to look at the underlying cause of some of that. In North Dakota alone, our materials are up 30%, our labor is up 20%. That's going to be reflected back in rate. It just has to be and there's nowhere else for that to go and that's a really hard conversation to have with the consumer. In North Dakota, it's really hard for me to say, “Well, at least it isn't 40%.” I mean, a 20% rate increase is a 20% rate increase. I don't care what's going on in other states. And that's on top of other inflationary pressures they've been feeling at the grocery store. Now all of a sudden I have another 20% on my home, and how am I going to continue to afford to do this? And so we're trying to have that conversation. It's really hard in a state like North Dakota to have that conversation around mitigation because we don't even have that catastrophe and I think that's an opportunity for us to come together and have that conversation before the disaster happens. How do we have that broader discussion of if we start taking the steps now in the Midwest or we start taking the steps now in wherever your state is, it will benefit everyone. Again, you're planting that tree that you'll never enjoy the shade of. And we're eventually going to get there.

We're eventually going to have to get to the point where you've got hardened homes or fortified homes or whatever tool you want to use to have that resilience to be able to have and maintain a viable insurance market. It's a matter of when do you want to start that discussion, and that's a challenge.

Asw. Hunter stated I think some of the conversation needs to include neighborhoods being responsible for mitigation. I think that's very important. And building codes need to be changed. There are a lot of people and influence out there that want things to remain the way that they are and one of the things that we find, especially as we're passing state laws for the lawmakers here, is that municipalities want to be able to do what they want to do in their neighborhood to keep it however it is, whether it's a “not in my backyard approach” or whether they like the neighborhood the way that it looks. But we can't force them to do something and I think it's getting to the point where I can't force you to be a good neighbor and really take into consideration mitigation because they're worried about school budgets, they're worried about picking up trash and police and fire, but really at the local level there needs to be some sort of responsibility, accountability, and conversation relative to that's where it starts.

Cmsr. Godfread stated I think you see how this plays out long-term and I'm not here to pick on any particular state, but you see how this can play out in California and then your insurers leave. If there isn’t an incentive, if there isn't a risk mechanism, if the community hasn't taken the appropriate steps to protect that risk or to mitigate that risk or that community, there is little to no incentive for an insurer to invest in that community. And so that's how that plays out long-term, and that's a challenging conversation to have because until it's a problem, it's not a problem. Until it's immediate and then it’s, “Commissioner, why are you letting this insurer leave?” Well, I don't have a law in my books that says “thou shall write certain risk.” Nobody has that law, and nobody should have that law. But it's understanding that's a risk transfer. There's an investment there being made by the insurance industry, by the community, and by the consumer, but they all have to play together, and if one of those three legs of that stool falls over, it's a challenge to have a market there.

Cmsr. King stated that in Georgia, we pursue all these great levers, but what we've done is we share half of the insurance premium tax with every city and county in the state. I've gone around the state advocating for our legislature to start putting some strings on that money and how that money is distributed back to local communities so we know how that mechanism works. Communities will do things when they know that there's something at stake. And I used to be a local police chief and I used to hear all the folks talking about affordable housing but there was a sense of “not in my neighborhood.” So I get it but I think once you start putting that carrot and stick out there, that's how we're going to get movement. That's where the legislature has got plenty of levers because I think that's the only way that we're going to get moving in the right direction. The premium insurance taxes of insured local communities ought to be used to reduce overall risk because we know that if we reduce risk it is going to lower insurance rates for their properties. Those are the things that I would recommend taking a look at.

Asw. Hunter stated that our last agenda topic is long-term care insurance and a multi-state review approach that the NAIC is currently working on. This is the biggest cost related to Medicaid in New York and probably across the country so I'd like to hear what you all are working on relative to this in your working group.

Cmsr. Mulready stated that before I cover that issue I just want to acknowledge the progress we've made with our two organizations. I know I sound like a broken record and I say this a lot, but we have made great progress. We have eight commissioners here and we have two of our Officers here so I just want to acknowledge that. With long-term care, it's been a big issue. Everyone's trying to get a grip on that important coverage and rising premiums. In 2022, the NAIC established this long-term care insurance multi-state actuarial review framework. Basically, the thought is they file with that group because many of us don't have those individual resources within our departments, then they develop some recommended rate increases. The states are then allowed to use those or not. It's not a mandatory thing, but there's a centralized resource of multi-state actuarial processes. In 2024, the Long-Term Care Working Group was charged with developing a single long-term care multi-state review process. At the time, there were two. We had Minnesota and Texas and they were two different approaches. That seemed a little bit confusing for folks so then there was the attempt to move to one approach and have a more transparent and explainable single methodology. And Minnesota's approach was chosen. The Working Group now has some open comments on some proposed sets of modifications. The comment period is open until May 12th throughout this year. That will then go through the Task Force and under the B Committee, which I chair at the NAIC this year. Then ultimately the proposal will go to our Executive Committee and plenary, and hopefully be approved there.

Asw. Hunter stated that in either our summer or fall meeting we'll be having a panel on developments in long-term care insurance, and we'd definitely like for the NAIC to be part of that conversation and share your perspective and the work that you've been doing with the framework. This is a huge cost to all of us in all of our states and we definitely need to get a handle on this the best way we can.

ANY OTHER BUSINESS

Brad Nail, representing Airbnb, thanked the Committee for the opportunity to speak and stated that Airbnb was directly referenced earlier in the comments around the rental home marketplace model act and I just would like to point out that we look forward to addressing these issues that were raised during the committee tomorrow. And the model itself is in fact the product of extensive discussions with insurance trade groups and is really tailored also to meet the concerns of the insurance industry. We look forward to speaking about this further tomorrow.

ADJOURNMENT

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

MATERIALS FOR GENERAL SESSION - “THE GROWING RISK OF WILDFIRES: A DISCUSSION ON PREVENTION AND LIABILITY ISSUES”

Wyoming HB 0192:
https://wyoleg.gov/2025/Enroll/HB0192.pdf

Oregon HB 3666:
https://olis.oregonlegislature.gov/liz/2025R1/Measures/Overview/HB3666

Montana HB 490:
https://bills.legmt.gov/#/laws/bill/2/LC0224?open_tab=bill

Arizona HB 2201:
https://www.azleg.gov/legtext/57leg/1R/laws/0167.pdf

White Paper: “Wildfire: Assessing and Quantifying Risk Exposure and Mitigation Across Western Utilities” ---
https://woodsinstitute.stanford.edu/system/files/publications/Woods_CEPP_Wildire_White_Paper_FINAL.pdf

HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
2025 NCOIL SPRING MEETING – CHARLESTON, SOUTH CAROLINA
APRIL 25, 2025
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee met at The Francis Marion Hotel in Charleston, South Carolina on Friday, April 25, 2025 at 11:15 a.m.

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

Other members of the Committee present were:

Sen. Mark Johnson (AR)
Rep. Bill Sutton (KS)
Sen. Julie Raque Adams (KY)
Rep. David LeBeouf (MA)
Rep. Brenda Carter (MI)
Rep. Mike McFall (MI)
Sen. Lana Theis (MI)
Sen. Michael Webber (MI)
Sen. Jeff Howe (MN)
Asm. Erik Dilan (NY)
Asm. Jarett Gandolfo (NY)
Rep. Brian Lampton (OH)
Rep. Carl Anderson (SC)
Rep. Tom Oliverson, M.D. (TX)
Rep. Jim Dunnigan (UT)
Sen. Mary Felzkowski (WI)
Del. Walter Hall (WV)

Other legislators present were:

Sen. Jesse Bjorkman (AK)
Rep. Justin Wilmeth (AZ)
Rep. Eddie Lumsden (GA)
Rep. Brett Barker (IA)
Rep. Elizabeth Wilson (IA)
Rep. Rita Mayfield (IL)
Sen. Julie Morrison (IL)
Rep. Adrielle Camuel (KY)
Rep. Mike Clines (KY)
Sen. Donald Douglas (KY)
Rep. Vanessa Grossl (KY)
Sen. Franklin Foil (LA)
Del. Mike Rogers (MD)
Rep. Robert Foley (ME)
Rep. Joe Aragona (MI)
Rep. John Fitzgerald (MI)
Rep. Kristian Grant (MI)
Rep. Greg VanWoerkom (MI)
Sen. Walter Michel (MS)
Rep. Jennifer Balkcom (NC)
Sen. Bill Gannon (NH)
Rep. Meredith Craig (OH)
Rep. Forrest Bennett (OK)
Sen. Hanna Gallo (RI)
Rep. Alex Finkleman (RI)
Sen. Matt LaMountain (RI)
Rep. Joe Solomon (RI)
Del. Irene Shin (VA)
Rep. Calvin Callahan (WI)
Rep. Barbara Dittrich (WI)
Sen. Mike Azinger (WV)
Sen. Cale Case (WY)

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. Lana Theis (MI) and seconded by Asm. Erik Dilan (NY), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Sen. Mary Felzkowski (WI) and seconded by Del. Walter Hall (WV), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's November 22, 2024 and March 14, 2025 meetings.

INTRODUCTION AND DISCUSSION OF NCOIL PRIOR AUTHORIZATION REFORM MODEL ACT

Rep. Pollock stated that we'll start today with the introduction and discussion of the NCOIL Prior Authorization Reform Model Law. As a reminder, at our meeting in San Antonio, we heard a presentation on the prior authorization reform landscape, and now we have Model language to discuss which is based on legislation recently passed in Mississippi. You can view the model on the website and app and in your binders on page 20. We won't be taking any action on this today - just starting our discussions. Before we can go any further, I'll turn things over to the sponsor of the model, Sen. Walter Michel (MS).

Sen. Michel stated that at the NCOIL summer meeting in 2021, I heard an update on the Texas Gold Card prior authorization law. In the first month of the 2022 session, I was approached by a group of physicians who were disappointed that prior authorizations were taking so long. So, we had multiple hearings and received input from many and passed prior authorization legislation in the 2023 session. One of the attorneys who drafted the bill is here with us today, Sam Martin. At that time, he was an attorney with the Mississippi Senate. Now he's here today representing the Mississippi Hospital Association. I'm proud that he's with us today. I'm offering this legislation as a starting point and I look forward to our discussions today as this model evolves.

Melissa Horn, Director of State Legislative Affairs at The Arthritis Foundation, thanked the Committee for the opportunity to speak and stated that I am very excited to see model language on this and your consideration and discussion on it. It's a very important topic, and certainly one that is close to the arthritis community. Currently, there's over 54 million Americans that are living with doctor-diagnosed arthritis, and that doesn't just include adults, that includes kids. And there are over 100 different types of arthritis. So, whenever you're thinking about chronic disease, obviously the name itself explains it, chronic. Our patient communities have to go through a lot of navigation of the health system. And one of the biggest barriers that they have reported back to us has been

around utilization management. Now it's just important to note, I am the State Legislative Affairs Director for the Arthritis Foundation, I cover all 50 states, and we're very excited to work with all of you back home in the districts on this issue because I know sometimes it can be a state-specific solution. But there are principles that kind of travel from state to state that are pretty consistent whenever it comes to making sure it's less burdensome for the patient. So, I'll go ahead and just share some information that we've collected whenever it comes to barriers to care. We like to really emphasize that any legislation be focused on the patient. So, a patient-centered ideal model of care is kind of the terminology that we use as we work around the nation to emphasize the patient perspective, especially from a chronic condition like arthritis. We actually launched a whole multi-year project called our ideal model of care, and I put some links on there and shared it, and I know it's in the presentation materials too. But we did survey over 3,500 of our patients, who have reported their experiences with utilization management, navigating health insurance coverage. And, of the issues that they reported back to us, prior authorization was the top barrier. It was the top two, which tied in directly also with step therapy or that fail-first protocol that is often required before you get to the medication that was prescribed by your provider.

So we collect a lot of information from our patient community and also surveyed in 2023. Both of these are recent reports of the last two years here where a lot of our patients reported back to us that they had to go through prior authorization, at least every plan year, if not more frequently, for the medications that they take to treat their arthritis, which, again, is not ever going away. This is something that they will live with for the rest of their lives, especially if they started as a toddler or had juvenile arthritis. Most patients had to wait quite a bit of time for their appeal – 31% of patients actually reported that they had to wait over seven business days for a response from the insurer. So, this is quite a big hurdle to overcome, especially whenever it comes to arthritis. It takes months to years to even diagnose arthritis, much less get control and manage it. Pain is a big barrier for those living with arthritis, and it is actually the leading cause of disability nationwide and in every state. So, whenever it comes to the cost, I just want to make sure that the committee and everyone knows the real costs that are associated with healthcare in general is not just related to the system and the price of medications, but of course the cost to our economy and the well-being of individuals who are trying to work and live and play, especially for our kids that are diagnosed with these diseases. So again, navigating these appeal processes can be overly burdensome, resulting in multiple points of contact. We're trying to again collect that information on how much time it actually takes one of our patients to navigate a prior authorization process.

So, I'll switch over to some more of the results here. Whenever there is an unsuccessful prior authorization appeal, patients are forced to switch medications. Those medications might not work as well or carry a whole host of other side effects. I myself am a three-time cancer survivor. I've been on this journey as a patient for more than half my life starting as a young adult in high school. So I know what it is to have to navigate health care systems across state lines and to continue to fight for medications for diseases that aren't going away. Again, all of these diseases are chronic. So, when it comes to navigating appeals, if you are constantly going back to an insurer or if you switch plans and have to repeat that process, it's really difficult for the patient who is already

struggling to go through a chronic condition like cancer or arthritis or Alzheimer's or something else that might impact their livelihood and life. And if you're switching medications, those side effects can be pretty dangerous. They can land you in the hospital. Pain management is a big side effect for our patient community, and we certainly don't want to get into a situation where we're adding to an already epidemic level of opioid use. We want to make sure that patients are ahead of it whenever it comes to their symptom management, but also that they're able to afford the medications that they're prescribed, especially if they switch to a different kind. So, paying out of pocket is a high barrier for them, but again, any of these interruptions in care, if they are delayed, they could end up in the hospital. The disease could progress whenever it comes to joint swelling and inflammation, it impacts mobility. So, it impacts literally everything from waking up in the morning to going to work, to getting your kids ready for school, every aspect of life for our patient community. And we don't want them to miss work and have to be on disability or not participate in the things that they want to do in life. In fact, our whole motto is we want to empower our patient communities to not be disabled and to be able to say yes to more things in their life.

There is a lot of great information here. We are a part of a national coalition called the State Access to Innovative Medicines Coalition (SAIM), and this really brings providers, patient organizations, pharmaceutical companies all to the table to talk about what are the key elements that we would like to see in prior authorization. Again, patient-centered, prioritizing continuity of care. So again, patients living with chronic disease, it's a life-long thing. Ensuring timely access and administrative efficiency whenever it comes to the process, especially as patients are switching plans. It can be really confusing and cumbersome to navigate that. But also, what are the processes for appeals and exemptions? If they're in an emergency situation, what do they have to go through? But one last point I just want to emphasize whenever it comes to patients that are navigating chronic conditions, this is a lifelong thing. And as much as it is a great goal to have to eradicate or cure diseases, most people are living with chronic disease. So, navigating that and navigating prior authorization, other utilization management protocols, while I understand it's necessary, it doesn't have to be that burdensome. Again, I mentioned I'm a cancer survivor. For being a thyroid cancer patient, I don't have a thyroid. So, I have to take a medication every day for the rest of my life to navigate that and stay out of the hospital and stay healthy enough to work and again do everything that I want to do in life as a young person. It's not growing back so why do I have to keep repeating the prior authorization process whenever you don't grow back organs? These kind of conditions and exemptions are the things that we're talking about whenever we're looking at legislation. So, I just urge the committee again to take note of that and really think about the patient experience. Again, arthritis patients and any patient that is living with a chronic disease often are navigating more than one as well. So, it's not like they're just dealing with this for one drug or one service or if they have a prosthetic, one limb. They are dealing with this for all of their conditions and all of their care. So, I just want to applaud again the effort of this committee and NCOIL overall, especially from the state of Mississippi, to really navigating this and putting a model forward because it's so important and it's such a great start. But really reduce the burden on the patient. Make sure the response times and the appeals processes are very clear. Try not to wait too long for the patients.

Terry Cunningham, Senior Director of Administrative Simplification Policy at the American Hospital Association (AHA), stated that I really appreciate the opportunity to talk about what I believe to be extremely important and meaningful model legislation before this committee. What I want to do today is to go over kind of the general overview of prior authorization and why it's a necessary space for reform. I'll talk about the overall legislative and regulatory landscape with particular focus on some of the stuff at the federal level. I'll dive specifically into the proposed model before you, highlighting some of the fantastic things included therein. I'll also talk about some opportunities for potentially improving some areas where we might want to go further or tweak some of the language. So, the current problem with prior authorization is really, there's a lot of kind of ways you can categorize it, but I like to categorize it in two-fold. There's one, the patient impact, and I'm not about to say I can sit here and give you as good of an overview as Ms. Horn just did. But two ways in which it's a problem is, it's often a disruption or delay in a patient's care. And then it often can lead to potentially inappropriate denials of care. Care that should have been approved that prior authorization leads to a denial. And so both of those present unique and problematic issues for patients.

The second area is with the administrative hassles that are caused by the specific protocol of health insurers. The way in which prior authorizations are submitted today are often unique to each individual health insurer and its often ways that are not efficient like fax machines or phone calls. And then there's also a lack of transparency related to what information is required to seek a prior authorization, when a prior authorization is required and what the criteria that the plan intends to use to determine whether or not it is an approval of a prior authorization or a denial. When I talk about delays and disruptions in care, one thing I noted is that Kaiser Family Foundation came out with a survey a couple of years ago where 16% of all insured adults, that's not commercially insured, just all insured adults, reported a problem accessing needed care as a result of prior authorization within the previous 12 months. So, this is a significant chunk of all Americans that are dealing with their care. And why is that a particular problem with prior authorization? Well, it often leads to a direct impact on the health outcomes of patients. I'm sure the American Medical Association (AMA) will speak on this more so I won't go into too much detail, but the AMA came out with a survey recently where they surveyed physicians, and 93% of those physicians' reported delays in care as a result of prior authorization for their patients. Perhaps more alarmingly, 82% reported that, at least sometimes or frequently, patients are abandoning treatment as a result of prior authorization. So, not only is their care delayed, but they're just not receiving the necessary care, which can lead to a whole host of subsequent issues both for the patient as well as for the healthcare system on the whole. And then 29% of clinicians reported serious adverse events related to a patient waiting for a prior authorization result. And as a result, what happened to them - his includes things such as death or hospitalization or other things.

The other thing I wanted to point out is a U.S. Senate report that came out last year specifically focusing on prior authorization in the post-acute care space, and this is when a patient is done with their acute care and they're seeking to be transferred to something

such as a skilled nursing facility or a long-term care hospital. The report noted exponentially higher denial rates within prior authorizations and overturned rates of subsequent denials. And so, ways in which prior authorization seems to be used to potentially delay access to care, and frequently it's being used to deny only to have subsequently overturned access to these treatments, which leaves a patient in an acute care bed or unable to start the appropriate next stage of their rehabilitative process. I talked earlier about the denials of appropriate care, and I'll just point out two Health and Human Services (HHS) Office of the Inspector General reports, which these were looking largely at Medicare Advantage spaces, but the large players in the Medicare Advantage space are also the large players in the commercial and state spaces that would be affected by this bill. The 2022 HHS report found that 13% of prior authorizations and 18% of claims were denied despite them actually meeting the medical necessity requirements of the program and being consistent with nationally accepted care guidelines.

And so, this is a large chunk of patients who went through the prior authorization process or went through only to be denied despite that care actually being appropriate. And so only a small proportion of those folks actually went through the appellate program. And so instead it was prior authorizations leading to patients receiving not what their clinicians believe was the most appropriate level of care for them. And another aspect that probably is even more alarming when you consider the first report is the 2018 HHS Office Inspector General report found that 75% of all prior authorizations that are appealed are overturned. Unfortunately, it's like 1% of prior authorizations that end up getting appealed and that's partially because you might not have the time for your patient to be waiting to forego a long appeals process. It might be in their best interest to let's do an alternative treatment at this time because it's certainly not ideal for me to go through this long exhaustive prior authorization appeals process. It's time to move on to the next stage of care. So, the other thing I talked about up front was the administrative hassles that physicians are dealing with and there's a number of ways in which this occurs but one is knowing whether or not prior authorization is required for a particular service. Oftentimes this is something that you'll see in a provider bulletin that an insurer releases or something they're going to post on a website and it's not clear up front if at the time of treatment unless you've gone through those bulletins, does this treatment require a prior authorization? And if so, to the second bullet here, what do I need to do in order to achieve a prior authorization approval? What information do I need to collect from this patient and send along to the health insurer so that they can agree that this is in fact an appropriate treatment for my patient? And the third thing that clinicians are frequently dealing with is, how should I send this information? Each plan has a different way of requiring it. They could require you to send it by fax. They could require you to call them. They can require you to use a specific transaction called the X12278 transaction, or there can be a portal online, each one with a different way of doing it, and each one with a very specific process that you need to be aware of as you're trying to achieve your patient access to appropriate treatment.

So quickly, I want to go over the current legislative and regulatory framework of where things stand now. I want to note that last year, the Interoperability and Prior Authorization Rule was finalized by the Centers for Medicare & Medicaid Services (CMS) and this

established things for all Medicare Advantage plans as well as Medicaid plans, Medicaid managed care plans, Children's Health Insurance Program (CHIP) plans, as well as plans sold on the Federal Exchange. They created a standard way in which plans have to offer prior authorization. So, it's relaying exactly how much, relaying specifically to a physician within their electronic health record (EHR) whether or not something requires prior authorization and what information needs to be pulled so that they can submit a prior authorization request. It also created shorter time frames, requires plans to report on specific metrics related as to how their prior authorization programs are working, including things such as how long in which an average prior authorization takes and things such as that. It also required plans to include specific and detailed reasoning if they're going to deny prior authorization, which provides people with better ability to appeal in an efficient manner. There was also some movement in the CMS Medicare Advantage space focused on medical necessity criteria. They required specific transparency requiring plans to specifically post a list of what requires prior authorization as well as making sure that those medical necessity criteria were both transparent and clinically valid and based on nationally accepted care guidelines. They also addressed some reviewer credentials making sure that physicians with an appropriate level of expertise were the ones denying prior authorizations on the plan side.

Moving to this model which I want to start off by saying this is fantastic – if it was to pass exactly as it's written now we would be very happy with it because it addresses things such as the following: it requires disclosure of prior authorization requirements. So, this would require that a clinician knows if something is subject to prior authorization up front. There would be transparency as to what medical necessity criteria needs to be used when you're, what do you need to satisfy? What are the rules in order to achieve prior authorization approvals? Those criteria need to be evidence-based, nationally recognized, and flexible for a specific patient's individual medical circumstances. And it requires a 60-day notice if a particular form of treatment is going to require prior authorization when it didn't previously. Really, this makes sure that the physicians know when they're providing care what they need to do to ensure that their patient can access necessary treatment. They also sped up time restrictions to seven days. This speeds it up to seven days for a standard prior authorization and 48 hours days for urgent requests, that’s extremely important. Specifically, just making sure that this does not prolong care. It requires the denial specifics which I just talked about. Some of the specific restrictions for the plan grants prior authorization, they need to honor it - they can't deny care later that was previously approved as medically necessary. It also has some provisions related to continuity of care. And the last thing I'll focus on which is so important is enforcement. Enforcement in this space is so important because just having the rules on the books without any teeth can lead to them not being adhered to. And in order for this to truly make sure that plans are utilizing it and going to actually make the meaningful changes necessary to impact patient care it’s important to have enforcement. I think this model does a great job on that.

Again, as it stands this model is great - if there are things that I would recommend potentially tweaking, the model requires the plan to have an electronic standard for all physicians that are submitting prior authorization to use the same electronic standard. However, it allows each plan to have their own specific way of doing it and it can be

portal based. And what that can lead to for a physician is I've got 15 different insurers I am working with and I'm going to have to still navigate 15 different online portals. I'm going to have to log into each one to extract information for my EHR and upload them to their specific portal. And so, while that's a much better system than using fax machines I think because of some of the requirements that plans are going to be able to be required to adhere to there are federal requirements that the same form is used across plans. There's the National Council for Prescription Drug Programs (NCPDP) for prescription drugs and the Da Vinci standard for the Medicare Advantage program that I talked about earlier. I think moving to that instead of requiring each plan to devise their own way in which they're doing it will standardize and make sure it's more efficient. I mentioned post-acute care earlier and I think rather than have a specific carve out for post-acute care and as to how to addresses prior authorizations, I think one way to make sure that the problems with post-acute care access to care would be satisfied is for this model to classify all post-acute care authorizations as urgent. You don't want a patient waiting, they're already ready when this prior authorization is being submitted, they're ready to transition to the next stage of care, you don't want them waiting seven full days to find out whether they're approved, and then subsequently having appeals processes. It's better to make that a quicker process so you don't have patients waiting in an acute care bed to figure out if they can go to the next stage of treatment.

Reporting requirements in this model are extremely important because we want to make sure we can track how plans are doing it. However, it's based on aggregate data instead of service specific data, and the reason I found that to be potentially problematic is, if you're trying to figure out is a plan denying too many prior authorizations, are there too many being upheld on appeal, that might almost encourage more prior authorizations so that you can have more readily approved prior authorizations on the front end so that your aggregate number looks better as opposed to if you've got a high denial rate on specific services. And so, in order to make sure you classify the problem areas, I think it's good to have some form of service specific data reporting. Regarding reviewer credentials, I think the language on making sure that appropriately trained physicians are reviewing appeals is important. But I think that should be moved forward to all denials, not just appeals. And that's kind of a compromise. You're not necessarily requiring all prior authorizations to be reviewed by that physician, but if you are going to issue a denial it has to be reviewed by an appropriately trained clinician reviewer. My key takeaway is this is an area ripe for reform and I want to stress the plans are already required to follow most of these provisions because of the Medicare Advantage requirements, so health insurers can do this. This model is fantastic and the AHA stands ready if there's any desire to work on any language or anything related to this model.

Sam Martin thanked the Committee for the opportunity to speak and stated that I'm currently an attorney and lobbyist in Mississippi and I previously served as staff attorney for the Mississippi Senate Insurance Committee. I just want to give a brief overview of the Mississippi bill as it really came through the process of a lot of compromise along the way. It was a four-year ordeal of really figuring out what would work in our state amongst all stakeholders. We started in 2022 with the prior authorization bill that also included gold card legislation. That bill died pretty early in the session and ultimately, we decided to take the gold card legislation out of the bill when we introduced it in 2023. The bill in

2023 ultimately passed more or less unanimously, ultimately to be vetoed by the Governor. Some of the Governor's concerns really were traced to the fact of some of the timelines and essentially a lot of those timelines what we did was we basically doubled what they were. So, for urgent circumstances we required a 24 hour turnaround and so as a compromise we changed it to 48 hours. In non-urgent circumstances, we had it at a two-day turnaround, and we changed that to seven days. And perhaps most importantly, we previously had the Department of Health overseeing the whole administrative process. And the Governor particularly did not like that because he thought that the Department of Health, since it provides care at county health departments in the state, could potentially have conflicts of interest. So we changed that to the Department of Insurance, which we feel actually made the bill a lot stronger because the Department of Insurance already has oversight over many health plans and has the ability to audit those health plans and ultimately punish them if they do not comply with the bill. Once we passed that bill in 2024, we had the thought that if the Governor were to veto it, we could come back and override it or pass another bill that took into account any sort of his considerations. I think you all can appreciate that over a four-year process, this bill took many different curves and ultimately a lot of compromise occurred along the way. We got it done, and I'm proud that Mississippi was able to do that.

Emily Carroll, Senior Legislative Attorney at the AMA, thanked the Committee for the opportunity to speak and stated that it was such a pleasure to speak to you all in November when we started talking about this issue, and we're thrilled to see this model being offered. Thank you to Sen. Michel for offering it and all the work that's been done in Mississippi to address this important issue. I know when I was here in November, I spoke a bit about our prior authorization statistics and annual survey that we do of physicians, and I won't go too deep into those statistics again or that information. But I do want to let you know that we reissued our annual report in February and the numbers didn't look much better. Prior authorization is still an incredible burden on patients and physicians in the healthcare system. On this slide, I'll just want to highlight again that box in red, 29% of physicians report that prior authorization has led to a serious adverse event for a patient in their care. So, I really would argue that the time is right for reforming this process and protecting patients.

On the next page I'll just again highlight the burden this places on physician practices. Certainly, in the face of an existing physician shortage we're asking physicians to complete 39 prior authorizations per week, that's per physician not per practice, and that adds up to about 13 hours each week completing prior authorization, so a whole workday. And practices are hiring staff just to do this alone, talk about burnout for an individual who is required to argue with insurance companies all day long on behalf of sick patients. And then we know the impact this is having on employees and their employers – 58% of physicians report that patients in the workforce are being impacted, their job performance is being impacted by prior authorization and the delays and denials that come with that. And then finally, just generally there is a waste in our healthcare system as we squeeze the balloon on one end by not allowing access to medically necessary care, we're inflating it on the other end. So, we're seeing tons of use of unnecessary medical services, medical care, like hospitalization, emergency room visits, unnecessary appointments with your physicians as a result of this prior

authorization process. So, 88% of physicians reported that prior authorization leads to higher overall utilization of healthcare. As you all know, so many states in this room have already started to address the issue of prior authorization and we're just so grateful for the momentum that's been building in the states on this issue. I think there were over 100 bills this year introduced that addressed prior authorization, some big massive reform bills, and some very targeted bills that are a result of perhaps a patient situation in a state or a legislator experiencing the process. But we continue to see that momentum and we know you all are working so hard to do that.

Over the last year there were about 12 prior authorization laws enacted in the states, and over the last several years we've seen about 20 states enact really broad comprehensive bills that really try and address this problem. And we see those states come back and try to add on. Kentucky's a great example as you passed wonderful legislation over the years and then you continue to come back and improve the process and address issues that come up and we're grateful for that work. So, going to the model, we think this is a fantastic start. It addresses so many of the critical problems that we see with prior authorization, including the transparency and integrity of the clinical criteria. If you're starting with bad clinical criteria on the plan side, all this other stuff doesn't really matter because if we're not addressing medical and necessary care using evidence based standards then we're not going to get the right care at the right time. And physicians and patients need to know what that criteria is. So we much appreciate that transparency that's offered in this model. The notice of new requirements, that's a big thing. When it feels like these prior authorizations to physicians and patients are constantly changing, especially in the drug space, as rebates and other things are negotiated over time, it's really important to give notice as these new requirements come up so you don't find out when you get to the pharmacy counter that prior authorization was required and you lose a patient to treatment abandonment or whatever else happens.

The data and metric reporting, it's great to have that information both available to the patient who is looking at plans that might be appropriate or not for them based on their medical conditions, but also as states continue to come back to the issue of prior authorization, that data is so important to consider new meaningful reforms for their states. So we love both that plans are required under this model to publicly report that information, but also that that information and that those metrics are going into the Department of Insurance, so that regulators can be looking and studying the impact of prior authorization on patients. Regarding the prohibition on retroactive denials, oftentimes we hear prior authorization is not a guarantee of payment or coverage. We think that it probably should be. If you're going to go through the process of getting a prior authorization and determining that care is medically necessary, we don't want that later cost shifting onto the patient or physician as a result of a denial when you've counted on that prior authorization for approval. So, we were glad to see that in this model. There's also several continuity of care provisions that we thought were just fantastic. That grace period for patients when they move from one plan to another and not having to start over with the prior authorization right away. Giving the patient that 90 days to navigate the new plan and get coverage for that care really will prevent

disruptions in care and the loss of function or negative impact on patient outcomes that comes with those delays.

And then preventing disruptions when there's a change in coverage criteria on a patient who may be stable on a medication or service and ensuring that those changes that are going on in the administrative side of the plan are not impacting the health outcomes of patients. And then finally, the enforcement provisions in this model are great - we continue to see in the states when some of these laws pass that enforcement may lack a bit whether that's because it's unclear for the physician and the patient what kind of coverage they have, is it state regulated or not? Where do they go to report problems? I think the enforcement provisions in this model are excellent, especially allowing the physician to have the ability to talk to the regulator and to report problems, that's not something we see in every state. If I were to nitpick, there were a couple of things that I would suggest changing. We just heard from Mr. Martin that they originally started with tighter time frames on response times. We know that longer delays impact patient outcomes. So, 93% of physicians report care delays, and 82% report treatment abandonment, and 29% report those adverse events that we talked about. And there's a lot of data out there that looks at the harm associated with these delays. Another one I put up here is an American Society of Clinical Oncology (ASCO) survey that said those treatment delays cause things like disease progression and death of patients. So it's really important that those response times from the plans are tight.

We would recommend 24 hours for urgent and 48 hours for non-urgent care. We think that's really doable. I'll note that the Part D standard is 24 hours for urgent and 72 for non-urgent. So, these standards exist at the federal level. And then we have several states that have been able to enact legislation that puts 24-hours for urgent care - Vermont, Kentucky, New Mexico are some of those. And then we have a bunch of others that do less than the seven days - California, Illinois, Iowa, Wyoming, so these timeframes are existing in another states and we would urge some edits to the model to reflect those. The length of the prior authorization is another area I would mention. When you have a chronic condition, those chronic conditions don't go away but why are we asking this to return to their physicians, experience the delays that are associated with prior authorization again and again? I really would recommend reflecting what's at Medicare Advantage plans now as a result of the new rules that were mentioned that the prior authorization should be approved for as long as needed for the treatment so that we're not asking patients to return and we're not wasting resources as folks go back and forth from their doctor's office to get those prior authorizations. Several states have enacted legislation around reducing those repeat prior authorizations, including Vermont, Minnesota, the District of Columbia and Colorado most recently. And then finally, the qualifications of the reviewer at the initial level. We appreciate putting some requirements around who's reviewing denials at the appeals level, but so few prior authorizations actually get to those appeal levels. Our survey says that about 75% of physicians say denials are increasing in the last five years, but only one in five say that they always appeal and some of those reasons can be a perceived outcome that they're going to lose on appeal since there may be a lack of resources and they don't have the staff time or ability to put all those prior authorizations through the appeals process, or

because the patient needs the care right now, so they look for a less desirable alternative as they need to address the patient's situation immediately.

A Kaiser Family Foundation (KFF) study said that only 11.7% of Medicare Advantage prior authorization denials were appealed, but of those, 81.7% were overturned. So, when you do appeal, it shows the decisions were usually wrong the first time on those appeals, but unfortunately so few folks are getting to that appeal level. So, we need to make sure that the decisions are being made correctly at the initial review level. And so we would really recommend that the reviewer at that level, if they're recommending a denial, that it be reviewed by a licensed physician in your state of the same specialty and with experience treating that condition. This language is reflected in new Medicare Advantage rules and we have a bunch of states that are adopting language around there including Arkansas, D.C., Kentucky, Oregon, Pennsylvania, Rhode Island, Tennessee, Washington, and Wyoming. So, it's a really important provision as we need to make sure we're getting prior authorization decisions right the first time. I would just like to say the AMA is here to offer any help and would love to see this model adopted by NCOIL and we're happy to offer any resources.

Miranda Motter, Senior VP of State Affairs and Policy at America's Health Insurance Plans (AHIP), thanked the Committee for the opportunity to speak and stated that AHIP is the national trade association that represents the health plan community, over 120 health plan members providing access to health care through health insurance to 205 million Americans all across this country and residents and constituents sitting in each one of your states. Certainly, our member plans offer a wide variety of coverage in the individual market, in the employer market, in the Medicare market, in the Medicaid market so we're partnering with your states on the ground and certainly for many of you through state employee plans and self-insured coverage. I am really pleased to be able to be here with my provider partners to really talk about this important issue. I know at various points in time we have been sitting together and really talking about how to improve prior authorization. So, what I'd like to do is just spend a couple of minutes talking about why prior authorization is used, who uses prior authorization, how it is used, and certainly talk to the improvements to prior authorization. Again, I know many of you know that in 2018 we all sat together and looked at what those improvements can be and talked about those. And then I'll just quickly end with a couple of comments on areas in the model and we certainly look forward to further discussions over the course of the year with all of you on this important topic.

So let me just quickly start with what is prior authorization. Prior authorization provides a vital check and balance to ensure that patients receive safe and evidence-based care and to reduce low value and inappropriate services so that ultimately coverage for those patients and for the individuals that offer that coverage to patients, mainly through employers in your communities, is as affordable as possible. We all know that doctors provide important care and life-saving treatments, but we also know that we have been impacted by low value care. Low value care is that kind of care that has little or no clinical benefit and where the risk of the harm for that care really outweighs the benefit. And low-value care has a significant impact on our health care system, and, more importantly, it impacts patients. The U.S. spends more on health care than any other

country and many experts agree that up to 25% of care that is provided is wasteful at best and harmful at worst. And in addition to low-value care and how it impacts our country's health care system, low-value care exposes patients to harm and imposes additional out-of-pocket costs to that care that they are receiving that may not be appropriate. And it certainly impacts their quality of life as 87% of doctors have reported negative impacts from low-value care. So, 87% of doctors themselves have reported negative impacts. They have also reported that at least 15% to 30% of medical care is unnecessary. The other thing that I always like to talk about is that medical knowledge doubles every 73 days, and to keep up with the pace of those changes, primary care providers would have to practice at least 27 hours a day. So this is why this discussion is so important. It is important that health plans, doctors, hospitals, are all working together to reduce that low-value care and protect patients from unnecessary and potentially harmful costs in care. And going to who uses prior authorization, it's really important to remember that private and public markets and purchasers utilize prior authorization - employers, employers in your community in the fully insured market, in the self-insured market, state employee plans.

Many of you receive your own health care coverage through your state employee plan that may be self-insured, and it utilizes prior authorization. Medicaid plans through the programs that they are trying to initiate, making sure that value and the care that state taxpayers are paying for is high value and is outcome-driven, they impose prior authorizations. Regarding how health plans use prior authorization, health plans use prior authorization selectively, focusing on clinical areas that are prone to extreme variation in cost or misuse that can harm patients or saddle them with unexpected or costly medical bills. So let me spend a quick moment on selective use, because this is really important. Prior authorization is selectively used, targeting low-value, unsafe, inappropriate care and not consistent with evidence-based clinical guidelines and where there is wide variation in that practice. And a recent survey of AHIP members commercial plans, the kind of coverage that we're talking about through this model, reported that the majority of commercial claims are not subjected to prior authorization. So, for an average commercial plan approximately 96% of pharmacy claims are not subjected to prior authorization so that means only 4% are. For an average commercial plan, approximately 93% of medical claims are not subjected to prior authorization - only 7% are. As I point out on this slide and what the data shows I would also just note that as you're looking through all of our statistics, it's really important to make sure that the statistics follow the markets and what this model is addressing. And I would just note a couple of the statistics that Mr. Cunningham mentioned are related to Medicare Advantage and it’s not that those aren't good to look at, but I would encourage you all as you see the links and the bullets, to make sure that you're going to the statistics and understanding what kind of patient is actually impacted. Because we’re wanting to make sure everyone understands that this model looks at the fully insured market, the Medicaid market, which all of you have an instrumental impact in making decisions on because you're making financial decisions and care decisions, and then again, your own state employee plans.

Let's talk a quick second about improvements. As I said, at least three of our organizations sat at a table back in 2018 and made a strong commitment as

organizations. One, really committing to the fact that we all recognize that prior authorization is burdensome for all involved, for providers, for patients, for health plans. But in that consensus statement, we all agreed, quite frankly, that prior authorization was important because of the variation in the kinds of care that is happening today. Health plans have worked hard to improve the process both for providers and patients and taking action to make sure that we're all working towards this shared goal. The efforts really include waiving or reducing prior authorizations for providers with a demonstrated track record and practicing evidence-based care through gold carding programs. I know that we've heard references to gold carding legislation that may be pending. Gold carding programs are really important when there is an ability to make sure that that provider has a high track record of evidence-based care where it's a contracted provider so there's a relationship and there's an ability to make sure and review that providers practice on an ongoing basis. Again, making sure that the patient is at the center of that. The other thing I would note is that gold carding programs work and are really important when they are part of a value-based relationship. So where that provider is actually at risk for the kind of care that they're getting from a financial and an outcome based perspective, those really work. In instances where they're not, it can be really challenging. Also streamlining prior authorization, plans have been doing that for certain chronic conditions to promote continuity of care. As you can imagine, that is extremely important for continuity of care. I would say that perhaps the most impactful approach to streamline prior authorization is to invest and promote electronic prior authorization. The commitment that we all sat here in 2018 and made was electronic prior authorization (EPA). And EPA has shown to simplify prior authorization requests to shorten decision times and to lower administrative burdens on providers and plans alike. And we know this.

I won't go into a lot of details, but after that consensus statement, health plans really worked and put together what was called a fast track, a technology portal, and we worked with providers and really went into their offices and said, okay, we're building the electronic system. You use that electronic system and let's see what happens. And really what we found, the providers themselves said that it was quicker to decision, quicker to patient care, less burden from phone calls and faxes. And this one is really important and I know I noted this back in November when I spoke, but there is a significant potential reduction for that time. We know from our data that today at least 60% of prior authorizations for medical services are still submitted in a manual way and similarly 40% of prior authorizations for prescription drugs are submitted in a manual way. We also know, and I know Ms. Caroll said this in November that her own members report that their main mode of submission is by phone. And I say it again because it’s really important and many of your states have recognized how important that this is and some of the legislation that Ms. Caroll talked about and others talked require that not only plans build an electronic system, but that actually the providers are using it. Because if we're building a system that's not being used, we're not all really working towards reducing the administrative burden, ultimately for the patient, ultimately getting that care quicker to the patient and reducing the time for providers. We know that at least nine states plus D.C. have passed this two-way legislation that requires health plans to accept it and providers to actually use it. And in some states where there are turnaround times included in that legislation, they actually require the provider to use it to avail

themselves of the quicker turnaround times, which makes a lot of sense. If you're going to have a quicker turnaround time, you should be submitting it electronically.

I'll end by saying thank you and I did want to quickly highlight a couple of the things relative to the model and I look forward to the opportunity to continue to talk about this. I would say first, I think it's really important given that the model applies to your state employee plans, your Medicaid programs, and employees, to really sit down and talk to them about how they use prior authorization. I think it's also instructive to listen to your self-insured employees. I know that the AHA is self-insured and knowing how they use prior authorization for their own employees I think is really important to know from a safety and a cost perspective. The other thing I would say is I appreciate in the model the recognition that electronic prior authorization is important, both for plans and providers, so that provision is in there. And it recommends that for providers to avail themselves of the quicker turnaround times, they have to use that system. And again, we just ask around turnaround times for more discussion. Certainly, we've talked about a lot of turnaround times in terms of consistency and uniformity for providers and that will be important. And then for continuity of care, we look forward to that conversation as we move forward.

Rep. Jim Dunnigan (UT), NCOIL Secretary, asked Ms. Motter about the data from HHS on Medicare Advantage and whether that's applicable and has a high correlation to the other commercial plans. Ms. Motter stated that it's really good to look at that data and understand what the data is saying. I think ultimately from a Medicare Advantage perspective, Medicare is driving better care, it is driving better costs, and Medicare Advantage individuals like their plans. And so I think it's important to look at all statistics, but I also think it's important to make sure as you're thinking about the markets that the model would govern that you're actually talking to the purchasers and the stakeholders that would be impacted. Rep. Dunnigan stated and regarding electronic requests, I think that makes a lot of sense. If somebody wants to get a quick turnaround time, it should be submitted electronically. It speeds it up all the way around. My final question is, one of the criteria is patient flexible criteria. Can you do that? Can you have a quick turnaround and still meet patient flexible criteria? Ms. Motter stated what I would say is certainly today health plans have to adhere to turnaround times and almost all plans are accredited by national accreditation standards. I'm not quite sure what patient flexible criteria is. Ultimately at the end of the day, you want the patients in your districts to be getting evidence-based clinical, safe care and I think that's probably an area we should continue to talk about.

Rep. Dunnigan asked if patient flexible criteria is defined in the model? Ms. Motter and Mr. Cunningham stated that they don't believe it is. Rep. Dunnigan stated that it would seem to be very important to have that defined if it's in the model. Mr. Cunningham stated it sounds like something we need to include in there. It generally means if you have a general set of medical necessity for a patient, it might say that this patient does not meet this particular level of treatment because there's a different drug they should be taking. But if that individual patient is allergic to that specific drug, they might otherwise need to qualify for it so I think what they want to make sure is that a bright-line set of rules doesn't lead to a denial that might be specific to that patient. Rep. Dunnigan

questioned who determines those guidelines and stated that it seems that they should be defined.

Rep. Tom Oliverson, M.D. (TX), NCOIL Immediate Past President, stated that I want to thank Sen. Michel for bringing this model forward. I do think prior authorizations are important. They lower the cost of health care. The data that I've seen is about 30% of the time for any medication, if you put a prior authorization on it, it will reduce the number of requests for that. So, it is an important cost-containment strategy and I think I like the fact that we're reforming it rather than getting rid of it because I think our costs would be much higher. I also hope everybody remembers that prior authorizations, by definition, involve decisions about medical necessity. That is and always will be the practice of medicine. It can't be anything else. And so, it's important as we contemplate this model that we keep in mind that the practice of medicine should be accountable. And people who are practicing medicine should have sufficient expertise and specialty, and they should be accountable to the state that passes the law. Because that is the mechanism by which we regulate the practice of medicine, nationally speaking, is that for each state that a person's practicing medicine and making decisions in, that state needs to be able to regulate that provider's behavior in case they grossly fall below the standard of care and need to be held accountable. So I just want to offer that up. I think it's really important that we keep in mind that prior authorizations are the practice of medicine.

Rep. Pollock stated that I know there are a lot of questions on this issue but we do have to keep on time. I encourage you to e-mail NCOIL staff, myself, or Sen. Michel with any questions because obviously this is truly a big deal for all of our states. And we want this to continue today but due to time, we're going to get one more question and then we've got to move on. In terms of process for this Model, I would like to continue the conversation at our summer meeting Chicago and then make any changes to make the model as good as it can be. And then come November, I hope we get the model over the finish line so we can take it back to our states.

Sen. Lana Theis (MI) stated that having been on the wrong end of a prior authorization, I certainly understand the issues that are being brought forward. However, I have one general question for all of you who have presented. Do your companies provide self-insurance, and do they use prior authorization for your insurance? Mr. Cunningham stated that I believe there is prior authorization on some of the insurance that is offered. And again, I think the key thing here is we're trying to reform prior authorization, not do away with it. And I think making sure that it is administered in a way that is not disruptive to patient care is important because yes, it does achieve cost reduction and that is an important thing. But if it's being administered in a problematic way, you're kind of stuck either way. And so I think what the power of this model could be is allowing prior authorization to still serve the purpose that we see, cutting unnecessary spending for particular services, as Rep. Oliverson said, but having it done in a way that doesn't lead to detrimental patient outcomes. You're kind of caught in a no-win situation, and that's where this model could really fix this. Ms. Carroll stated I absolutely agree. We do use prior authorization. But we use the term a lot, right-sizing prior authorization. We think it's overused generally, but our goal is not to get rid of it. We want to bring it back to

what it originally was meant to do, which is target high costs and new treatments on the market and not used for things like generics and other every day tools.

DISCUSSION ON RESOLUTION REGARDING AUDIOLOGY SERVICES, HEARING INSTRUMENT SPECIALISTS SERVICES, AND CLASSIFICATION OF NON-OVER THE COUNTER HEARING AIDS AS PRESCRIPTION DEVICES

Next on the agenda is an introduction and discussion on a resolution on issues regarding hearing aid classification. At our fall meeting in San Antonio, my friend and colleague, Rep. Deanna Frazier-Gordon (KY), who couldn't make it here today, raised this issue for potential discussion and now we have this draft resolution before you, which I'm proud to sponsor alongside her. You can view the resolution on the app and website in your binders on page 34. This deals with changing state law in light of a recent regulatory change from the U.S. Food and Drug Administration (FDA) regarding classifications of both over-the-counter and non-over-the-counter hearing aids. 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.

Julian Roberts, President & CEO of the American Association of Payers, Administrators, and Networks (AAPAN), thanked the Committee for the opportunity to speak and stated that this is something that we somewhat see as a technical fix that is needed due to passage of regulations by the FDA. It is an access to care issue from a payer and patient perspective, and this has been addressed to some degree in about 22 states, either legislatively or regulatory-wise. And from an issue basis, it's something that not only audiologists and hearing aid instrument specialists deal with but plans and other organizations are jointly working together to pass this in the various states. So we're very excited that NCOIL is looking into this resolution. In August of 2022, the FDA established a new category of over-the-counter hearing aids, while classifying all non-over-the-counter hearing aids as prescription medical devices. This change, which took effect in October of 2022, means that traditional hearing aids, and those are hearing aids that are more common for those that have medium to more severe hearing loss, can now only be obtained with a prescription or order from a state-licensed practitioner. This policy shift was intended to improve safety and oversight, but it has created confusion. The FDA does not have the authority over who is licensed to prescribe or order hearing aids. That power rests with the states. The FDA's own guidance makes it clear that it was never their intent to disrupt access to hearing aids dispensing by state licensed audiologists and hearing instrument specialists.

In fact, the FDA explicitly stated that the same professionals who recommended, selected, fitted, and dispensed hearing aids before the new rule should continue to do so now. However, many state laws and regulations have not yet been updated to reflect this intent. As a result, there is uncertainty about whether hearing instrument specialists, who have long played a crucial role in recommending, fitting, and dispensing hearing aids, are still authorized to provide these essential services for prescription drug hearing aids. This uncertainty threatens to limit access to care, especially for those in underserved or rural communities where hearing instruments specialists are often the primary provider of hearing health services. If we do not act, we risk creating

unnecessary barriers for patients, undermining insurance coverage and reimbursement policies, and disrupting a system that has worked efficiently and effectively for decades. So, I urge your support for this resolution to make it clear that licensed hearing instrument specialists, along with audiologists, have the authority to order hearing aids. This action will ensure continuity of care for patients who rely on trusted hearing instrument specialists, prevent disruption in insurance coverage and reimbursements, align state laws with FDA guidance and long-standing practice, and protect access to hearing care for those who need it, especially vulnerable populations.

Rep. Pollock thanked Mr. Roberts for this comments and stated that we'll continue this discussion at our summer meeting.

CONTINUED DISCUSSION AND POTENTIAL CONSIDERATION OF NCOIL IMPROVING AFFORDABILITY FOR PATIENTS MODEL ACT

Rep. Pollock stated that next on our agenda is continued discussion and consideration of the NCOIL Improving Affordability for Patients Model Act. You can view the model on the website and app in your binders on page 37. We've been discussing this issue since last year's spring meeting and I do think we're at a point where the model can be considered. Of course, if during our discussion today it becomes clear that we need more time to get it right, we can always pause things but I do think the model is very strong as is. Before we go any further I'll turn things over to the sponsor of the model, Rep. Oliverson.

Rep. Oliverson stated that I want to begin by saying how proud I am to be able to carry on this work that was actually started by past NCOIL president Rep. Deborah Ferguson, DDS before she left the Arkansas legislature. We appreciate her leadership very much on this issue and I'm honored to be able to pick it up and carry it. This model is really focused on one area of facility fees charged by a facility and that is situations where facility fees are charged when a patient is seeing a physician in an office that happens to be owned by a facility. And I have to tell you, as a physician, I have some pretty strong feelings on this. I see this as a recent issue that has come up only as a result of vertical consolidation. I grew up in a healthcare world where there was no such thing as a facility fee charged on an evaluation & management (E&M) code, and I think that most physicians probably feel that way unless they happen to be employed by a hospital that can levy these fees. And I see it as being particularly harmful. I will tell you that this is the e-mail I get more often than not from constituents. They took their loved one to go see the doctor themselves, and they got a fee for the doctor, which they were expecting, and then lo and behold, they got a completely separate bill from a facility, which they were not expecting. And from a physician standpoint, the reality is that we all understand and know as doctors when we sign contracts with insurance plans that what you bill for when you charge for an E&M code type visit, the overhead cost of that visit is baked into the fee you get as part of your professional component. So, this relatively recent phenomenon is aggravating for patients, it's doubling or in some cases tripling the cost of health care for folks who are simply seeking to get medical advice and continue management of chronic disease. I do think that this model provides sufficient prohibitions

while at the same time balances the need for certain exceptions and provides transparency. I am strongly supportive of this and it's my hope that we adopt this today.

Randi Chapman, Managing Director of State Affairs at the Blue Cross Blue Shield Association (BCBSA), thanked the Committee for the opportunity to speak and stated that the model effectively addresses the trend that we've been seeing with higher costs in hospital outpatient departments in those settings. Having certain limitations on certain facility fees and requiring unique provider identifiers distinct from a facility's main campus and other off-campus facilities are very important steps to chip away at the higher health costs for patients. As we all know, health care costs are astronomical, and we are all trying to work together to do what we can to ensure that patients are able to access the care they need in the most affordable way possible. We at BCBSA want to thank NCOIL and this committee and Rep. Oliverson for his leadership in this area as well as former member Rep. Ferguson for her leadership in this area. And as always, we stand ready to partner with you all and help out in any way we can.

Eric Waskowicz, Senior Policy Manager at United States of Care, thanked the Committee for the opportunity to speak and stated that we're an organization that ensures everyone has access to affordable health care. We just want to express our strong support for this Model. It very much aligns with our work on the issue and legislation passed into law in 18 states. In addition to this model here, we also encourage the committee, where possible, to consider establishing other protections for patients, including some sort of analysis to understand the impacts of facility fees on people's access to care, as has been done in Colorado and Maine. And also, when you're thinking about how to identify where facility fees occur, we found that it's actually kind of difficult to make that connection sometimes and we encourage the committee to consider language that would create some sort of mechanism by linking affiliated providers and systems by requiring some sort of identifier. And looking at the future as this committee considers further ways to lower health care costs, we urge you to consider site-neutral policies that would allow for fair billing practices to make sure that no matter where someone accesses care, the care is the same regardless of the site of service. I want to thank Rep. Oliverson for his leadership on this model and just want to appreciate the opportunity to speak and support this bill here today.

Rep. Brenda Carter (MI) thanked Rep. Oliverson for sponsoring the model and stated that it’s sorely needed.

Hearing no further questions or comments, upon a Motion made by Rep. Carter and seconded by Sen. Mark Johnson (AR), the Committee voted without objection by way of a voice vote to adopt the Model.

CONSIDERATION OF RE-ADOPTION OF MODEL LAWS

Rep. Pollock stated that next on our agenda is a consideration of re-adoption of model laws. Per NCOIL bylaws, all model laws must be re-adopted every five years or else they sunset. The models up for re-adoption are on the app and website and appear in your binders starting on page 48. The models are the Transparency in Dental Benefits

Contracting Model Act and the Short-Term Limited Duration Interest Model Act. We'll handle these separately as there are different processes with each model. Starting with the dental benefits model, Sen. Justin Boyd (AR), and Vice Chair of this committee ,is sponsoring some proposed amendments to the model and Asm. Jarett Gandolfo (NY) is co-sponsoring the amendments as well. We won't be taking any action on the amendments today. For now, the amendments have been offered by the sponsors for the committee's consideration to discuss throughout the year. Before we go any further, I'll recognize Asm. Gandolfo for some brief remarks.

Asm. Gandolfo stated that I will be brief and just say I think these amendments will go a long way in improving the dental care experience for patients, and that's what a lot of us are here to seek to do as the patients are our constituents as well. And I think it is prudent for NCOIL to always look for ways to improve our models. But with that said, I would hope and I would ask for after we hear from our speakers today that the model be readopted until our next meeting to give us ample time to discuss the proposed amendments.

Chad Olson, Senior Director of Gov't Affairs at the American Dental Association (ADA) thanked the Committee for the opportunity to speak and stated that I'm here to provide introductory comments on the proposed amendments to the model. These amendments represent important progress toward improvement in dental insurance for patients and providers. So, there are three basic things that the amendments accomplish. First is tightening up language in the model to reduce confusion. For example, in the current version of the model there are various terms used for dental insurance coverage including "dental plan" or "benefits." The amended language simplifies this to "dental benefit plan." Second is improving the model language based on real-life patient and provider experience. I have an example - the current model is not specific about how long a dentist may opt to not receive a virtual credit card as payment. What we have found is some dental plans react by only honoring that choice once or for a certain time period, and then revert back to paying with a virtual credit card. The amended language would make the choice permanent unless the dentist proactively wants to receive a virtual credit card as payment. Third is the amendments incorporate into the model two additional issues that fall under the umbrella of transparency in dental contracting. These are, first, a time limit on retroactive denial - basically the ability of a dental plan to claw back claims they have paid. And second, the ability of a patient to choose to have an out-of-network dentist be paid directly by a dental plan. That's otherwise known as assignment of benefits. And I know Rep. Pollock, you recently were sponsoring legislation like this successfully in Kentucky. The model language is much like what was passed in Kentucky. These simple and reasonable reforms are critically important protections for patients and providers, reducing financial barriers to seeking and receiving care. There's an old adage, "if it ain't broke, don't fix it." I have no doubt that the opposing witnesses up here with me today plan on emphasizing that point but NCOIL's model laws should not be viewed as immutable objects. Instead, the model laws should be nimble and responsive to changing landscapes and new data and the reauthorization process for the model acts is exactly the time to make considerations like those in the proposed amendments. I would like to emphasize how important these reforms are for patients and providers. Laws based on the model continue to improve

the dental plan benefit experience, eliminating some of the confusion in what is often a difficult process and empowering choices to help maximize the value of the dental plan policies. Improving the language, as these amendments will do, will only amplify this effect. I would like to thank Sen. Boyd and Asm. Gandolfo for sponsoring these needed amendments and I'm happy to answer questions.

Bianca Balale, Director of Gov't Relations at the National Association of Dental Plans (NADP), thanked the Committee for the opportunity to speak and stated that NADP's members represent more than 200 million Americans with all different types of coverage and I appreciate the opportunity today to comment on the amendments that Mr. Olson laid out. First and foremost I certainly want to acknowledge the hard work of this group in adopting this model in the first place. The original model represents very strong public policy and that's demonstrated by the broad adoption we've seen across the country with 11 states implementing the virtual credit card provisions and 15 adopting the network leasing provisions. The current set of the proposed amendments that are before us now introduce major new concepts to the readoption process. They are extremely impactful and complex and need further consideration. We believe these changes go far beyond the scope of a typical readoption process and as I mentioned do require additional conversation. Currently we're actively gathering feedback from our members at this stage and need additional time to discuss the scope and impact which we would appreciate this model being renewed until the next meeting to allow us that time. We want to ensure that we understand the intent behind the changes because the intent is critical in ensuring we're responding appropriately. And we want to ensure the process reviews all possible consequences of the amendments that are being proposed. As I mentioned we are still reviewing these amendments, but upon initial review from a very high level, the shift from a opt-out to an opt-in in the leasing and virtual credit cards provisions would result in a significant increase in burden on both plans and providers. A change that would remove electronic communications also would cause severe inefficiencies that may raise costs both on plans and providers. And we also believe that the payment parity for in-network and out-of-network providers undermines the values and integrity of the network structure. And finally, the shorter timeframes to recover overpayments and erroneous payments, particularly the inability to recover payments from our network providers, which is included in these amendments, raises severe fairness concerns. So respectfully, we would like to have a robust conversation about the policy rationale for these amendments and we would like to ensure we have the time needed to review them and finally, limit the scope of the readoption to the current provisions of the Model Act. New or substantial revisions should be considered through a thorough and separate process to ensure that it's properly vetted.

Owen Urech, Senior Policy Advisor with America's Health Insurance Plans (AHIP) thanked the Committee for the opportunity to speak and stated that I want to briefly echo NADP's comments. We support renewal of the model as it is currently written and would have some concerns about the impact of the substantial policy changes, not only to the existing sections that would be majorly reworked by the proposed amendments, but the additional language that included which are separate and significant policy issues that warrant their own discussion and process. We look forward to continuing to work with the committee on the readoption of the model.

Jill Rickard, Regional VP of State Relations with the American Council of Life Insurers (ACLI), thanked the Committee for the opportunity to speak and stated that life insurers do also write dental coverage and so many of our members are in this space as well. ACLI agrees that the proposed amendments are substantive and inappropriate for a model readoption. Some of them were actually considered and rejected when the initial model was proposed and drafted. They would have the potential to significantly disrupt the way that the dental marketplace works currently and potentially harm consumers by raising costs and decreasing access to dental insurance. Along with NADP and AHIP, we'd like to understand the rationale behind some of the changes and discuss the negative impacts on consumers and the market, especially to help ensure that out-of-pocket costs for consumers do not rise at this age when medical debt is at an all-time high and consumers are looking for options to reduce health care costs. We look forward to further discussions on this.

Hearing no questions or comments, Rep. Pollock stated that I will entertain a motion to readopt the model until our next meeting in July rather than for the full five years. Upon a Motion made by Rep. Bill Sutton (KS) and seconded by Asm. Gandolfo, the Committee voted without objection by way of a voice vote to readopt the Model until the committee's July meeting.

Rep. Pollock stated next, we'll consider the Short Term Limited Duration Insurance Model Act for re-adoption. This model represents a rare instance of an NCOIL model not seeing any traction in our states. Based on staff's research and comments from some stakeholders the model hasn't been adopted in any states. In light of that and also because of the turmoil that surrounds this issue at the federal level I think it might be best to let this model sunset. There's ongoing litigation right now as well on this issue and then there is expected federal action as well from the new administration. Letting the model sunset of course doesn't preclude us from discussing the issue again and perhaps even developing another model, but for now, letting it sunset seems to be the best path forward. Of course, I'm open to hearing otherwise.

Hearing no comments about the Model, the Committee then voted without objection by way of a voice vote to let the model sunset.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Carter and seconded by Rep. Oliverson, the Committee adjourned at 1:00 p.m.

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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. ***A revised version will be distributed in advance of the Committee's July 18 meeting.*

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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.

616 Fifth Avenue, Suite 106
Belmar, NJ 07719
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 discussed and potentially considered during the Health Insurance & Long-Term Care Issues Committee on July 18, 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.

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

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.

Re-adopted by NCOIL Health Insurance & Long Term Care Issues Committee on April 25, 2025 and NCOIL Executive Committee on April 27, 2025 until NCOIL Summer Meeting in July while proposed amendments are discussed.

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

To be discussed during the Health Insurance & Long Term Care Issues Committee meeting on July 18, 2025.

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 change~~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 a~~A~~dvises 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~~E~~. 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.

Texas HB 3708 will be referenced during the agenda topic "Presentation on Hospital Charity Care and Medical Debt":
https://capitol.texas.gov/tlodocs/89R/billtext/pdf/HB03708I.pdf#navpanes=0

ARTICLES OF ORGANIZATION & BYLAWS REVISIONS COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
ARTICLES OF ORGANIZATION & BYLAWS REVISION COMMITTEE
INTERIM COMMITTEE MEETING – NOVEMBER 1, 2024
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Articles of Organization & Bylaws Revision Committee held an interim meeting via Zoom on Friday, November 1, 2024 at 11:00 A.M. (EST)

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

Other members of the Committee present were:

Rep. Brenda Carter (MI)
Rep. Brian Lampton (OH)

Also in attendance were:

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

QUORUM

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 waive the quorum requirement.

DISCUSSION AND CONSIDERATION OF PROPOSED AMENDMENT TO NCOIL ARTICLES OF ORGANIZATION

Sen. Michel thanked everyone for joining and stated that we're here today to discuss and consider a very minor amendment to the NCOIL Articles of Organization. The amendment deals with conferring the title of "Honorary Member" on certain individuals.

The amendment was distributed beforehand and is also on the website. I'll turn things over to Will Melofchik, NCOIL General Counsel, who can quickly go through the reasoning behind the proposed amendment.

Mr. Melofchik stated that the proposed amendment is to Section III.D. of the Articles of the Organization. The reasoning behind the proposed amendment is that typically, those recognized as an "Honorary Member" are past NCOIL Presidents. However, at the upcoming meeting in San Antonio there are some member legislators that leadership would like to recognize as an Honorary Member as they will be departing the legislature at the end of the year but they have not been NCOIL President.

These are legislators that have been involved at NCOIL for several years and have shown a strong dedication to the organization. An in-person event attendance threshold requirement has been included so that the Honorary Member status still remains something that is rare and we think that's an important safeguard. This is very minor but we thought it was nonetheless important to make sure the proper procedures were followed.

Hearing no questions or comments, Mr. Melofchik concluded.

Hearing no questions or comments on the proposed amendment or on any other matters, upon a motion made by Rep. Carter and seconded by Rep. Lampton, the Committee voted without objection by way of a voice vote to adopt the amendment.

Sen. Michel thanked everyone and stated that the amendment will be presented to the Executive Committee in San Antonio for final ratification.

ADJOURNMENT

Hearing no further business, upon a Motion made by Rep. Carter and seconded by Rep. Lampton, the Committee adjourned at 11:15 a.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
ARTICLES OF ORGANIZATION
AND
BYLAWS

ARTICLES OF ORGANIZATION

PREAMBLE

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

I. NAME

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

II. PURPOSE

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

III. MEMBERSHIP

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

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

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

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

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

IV. MEETINGS/VOTING

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

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

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

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

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

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

D. Voting by proxies shall not be permitted.

V. OFFICERS/EXECUTIVE COMMITTEE

A. The officers of NCOIL shall consist of the following five (5) officers: a President, Vice President, Secretary, Treasurer, and the Immediate Past President. No person shall be elected as an officer of NCOIL who is not a member of the Executive Committee. Effective with the officer election in November of 2025, in order for each officer to advance through the chairs, (s)he shall attend, within the past 12 months, at least two (2) of the prior three (3) NCOIL National Meetings, one (1) of the other NCOIL events (D.C. Educational Fly-in or Corporate & Institutional Partners (CIP) Planning Meeting), and one of the prior three (3) National Association of Insurance Commissioners (NAIC) National Meetings. If, for good cause shown, the President excuses an incumbent officer from one of the above requirements, she or he may replace one of the attendance requirements above with attendance at another of the above meetings or events.

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

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

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

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

F. Persons elected as officers or members of the Executive Committee must be representatives of Contributing States in good standing at the time of their election. The office of an officer or of an Executive Committee member shall be

vacant if the member state of which such person is a Legislator ceases to be a Contributing State in good standing, or if the person shall no longer serve in the Legislature.

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

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

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

VI. DUTIES OF OFFICERS AND THE EXECUTIVE COMMITTEE

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

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

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

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

E. The Executive Committee shall have charge of the management of NCOIL and the direction of its activities. The President shall fill vacancies in the offices of Committee Chairs between annual meetings. The Executive Committee may appoint any individual or organization to function, at its discretion, as Chief Executive Officer or Executive Director. Pursuant to these duties, the Officers, in

consultation with appropriate Committee Chairs as needed, shall have, between meetings of NCOIL, the ability to make temporary decisions on behalf of NCOIL pending Executive Committee approval.

VII. AMENDMENTS

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

VIII. REASONABLE DEPARTURE FROM ARTICLES OF ORGANIZATION

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

BYLAWS

I. QUORUM

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

II. VOTING

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

B. Written Consent in Lieu of Meeting:

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

Committee. Each decision consented to in writing may be in counterparts, which together shall be deemed to constitute one decision.

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

III. COMMITTEES

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

B. Standing Committees of NCOIL shall be:

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

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

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

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

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

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

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

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

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

10. A Nominating Committee, consisting of all NCOIL past presidents, the current NCOIL president, the current NCOIL officers seeking to advance through the chairs, and current standing committee chairs with one year or more of service as a standing committee chair that shall interview potential officers for the upcoming year, report nominations for officers to the annual meeting of NCOIL, and reconvene when there becomes a vacancy among the officers in order to nominate a replacement. A Nominating Committee member seeking to be a candidate for an officer shall recuse herself or himself from Nominating Committee participation; if said candidate is a current officer seeking to advance through the chairs, then recusal is warranted only if she or he has an opponent for the position.

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

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

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

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

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

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

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

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

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

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

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

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

IV. FINANCES

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

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

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

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

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

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

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

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

V. RULES OF PROCEDURE

A. Each model act adopted by NCOIL shall be reviewed by the Committee of original reference every five (5) years. The respective Committee shall vote to readopt the model act for an additional five (5) years, readopt the model act for an interim period to allow for additional study or drafting, amend and readopt the model act, or allow the model act to "sunset." Readopted models shall be sent to the Executive Committee for final adoption. <u>However, by way of a two-thirds vote, a model act may be reviewed by the Committee of original reference before the scheduled five (5) year timeline to determine if the model act should sunset early or if the model act should continue on its five (5) year timeline. A two-thirds vote shall be required to both review the model act before the scheduled five (5) year timeline, and to sunset the model act early. Any vote other than one that achieves the two-thirds majority results in the model act continuing on its five (5) year timeline.</u>

B. The NCOIL committees shall review previously adopted NCOIL model laws in order to provide an appropriate sunset schedule. Such documents shall be reviewed in the following manner: Spring Meeting shall be Life Insurance & Financial Planning Committee and the Health and Long-Term Care Issues Committee. Summer Meeting shall be Workers' Compensation Insurance Committee and Property-Casualty Insurance Committee. The Annual Meeting shall be the Joint State-Federal Relations and International Insurance Issues

Committee, Financial Services & Multi-Lines Issues Committee, and Executive Committee. Model laws shall sunset every five (5) years within the Committee. Committees shall have the authority to extend the model laws from meeting to meeting.

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

VI. AMENDMENTS

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

VII. REASONABLE DEPARTURE FROM BYLAWS

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

ARTICLES OF ORGANIZATION/BYLAWS AMENDMENTS

Adopted 4th Annual Meeting, San Francisco, November 28, 1972;
Amended 10th Annual Meeting, Detroit, November 14, 1978;
Amended 11th Annual Meeting, Charleston, November 14, 1979;
Amended 12th Annual Meeting, San Antonio, November 22, 1980;
Amended 16th Annual Meeting, Little Rock, November 17, 1984;
Amended 17th Annual Meeting, Phoenix, November 24, 1985;
Amended 18th Annual Meeting, Nashville, November 16, 1986;
Amended 19th Annual Meeting, Palm Springs, November 18, 1987;
Amended 23rd Annual Meeting, Scottsdale, November 20, 1991;
Amended 24th Annual Meeting, Charleston, November 18, 1992;
Amended 26th Annual Meeting, New York City, November 13, 1994;
Amended 27th Annual Meeting, San Francisco, November 11, 1995;
Amended 28th Annual Meeting, Austin, Texas, November 20, 1996;
Amended 30th Annual Meeting, San Diego, California, November 21, 1998;
Amended 31st Annual Meeting, Orlando, Florida, November 19, 1999;
Amended Spring Meeting, San Francisco, California, February 25, 2000;
Amended 32nd Annual Meeting, New Orleans, Louisiana, November 16, 2000;

Amended Summer Meeting, Williamsburg, Virginia, July 11, 2003;
Amended Summer Meeting, Chicago, Illinois, July 16, 2004;
Amended Annual Meeting, San Diego, California, November 19, 2005;
Amended Summer Meeting, Boston, Massachusetts, July 21, 2006;
Amended Annual Meeting, Napa Valley, California, November 10, 2006;
Amended Summer Meeting, Seattle, Washington, July 21, 2007;
Amended Annual Meeting, Las Vegas, Nevada, November 17, 2007;
Amended Spring Meeting, Washington, DC, March 1, 2008;
Amended Summer Meeting, New York, New York, July 11, 2008;
Amended Annual Meeting, Duck Key, Florida, November 20, 2008;
Amended Spring Meeting, Isle of Palms, South Carolina, March 7, 2010;
Amended Summer Meeting, Newport, Rhode Island, July 17, 2011;
Amended Annual Meeting, Santa Fe, New Mexico, November 20, 2011;
Amended Summer Meeting, Philadelphia, Pennsylvania, July 14, 2013;
Amended Annual Meeting, Nashville, Tennessee, November 24, 2013;
Amended Summer Meeting, Boston, Massachusetts, July 13, 2014;
Amended Annual Meeting, San Francisco, California, November 20, 2014;;
Amended Spring Meeting, Charleston, South Carolina, March 1, 2015;
Amended Summer Meeting, Portland, Oregon, July 14, 2016;
Amended Annual Meeting, Phoenix, Arizona, November 19, 2017;
Amended Annual Meeting, Oklahoma City, Oklahoma, December 8, 2018.
Amended Spring Meeting, Nashville, Tennessee, March 17, 2019
Amended via Conference Call Meeting of Executive Committee, July 1, 2020
Amended Annual Meeting, Scottsdale, Arizona, November 20, 2021
Amended Annual Meeting, New Orleans, Louisiana, November 19, 2022
Amended Annual Meeting, Columbus, Ohio, November 18, 2023
Amended Summer Meeting, Costa Mesa, California, July 20, 2024
Amended Annual Meeting, San Antonio, Texas, November 24, 2024

PROPERTY & CASUALTY INSURANCE COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
PROPERTY & CASUALTY INSURANCE COMMITTEE
2025 NCOIL SPRING MEETING – CHARLESTON, SOUTH CAROLINA
APRIL 26, 2025 --- DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Property & Casualty Insurance Committee met at The Francis Marion Hotel in Charleston, South Carolina on Saturday, April 26, 2025 at 10:30 a.m.

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

Other members of the Committee present were:

Rep. Rita Mayfield (IL)
Rep. Peggy Mayfield (IN)
Sen. Jason Howell (KY)
Rep. Derek Lewis (KY)
Rep. Mike Meredith (KY)
Sen. Julie Raque-Adams (KY)
Rep. Edmond Jordan (LA)
Rep. David LeBeouf (MA)
Rep. Brenda Carter (MI)
Rep. Mike McFall (MI)
Sen. Lana Theis (MI)
Sen. Michael Webber (MI)
Sen. Jeff Howe (MN)
Sen. Paul Utke (MN)
Sen. Walter Michel (MS)
Asm. Erik Dilan (NY)
Asm. Jarett Gandolfo (NY)
Asw. Pam Hunter (NY)
Rep. Brian Lampton (OH)
Rep. Carl Anderson (SC)
Rep. Dennis Powers (TN)
Rep. Tom Oliverson, M.D. (TX)
Sen. Mary Felzkowski (WI)
Del. Walter Hall (WV)

Other legislators present were:

Sen. Jesse Bjorkman (AK)
Rep. Justin Wilmeth (AZ)
Rep. Eddie Lumsden (GA)
Rep. Brett Barker (IA)
Rep. Elizabeth Wilson (IA)
Sen. Steve McClure (IL)
Sen. Julie Morrison (IL)
Rep. Adrielle Camuel (KY)
Rep. Mike Clines (KY)
Sen. Donald Douglas (KY)
Sen. Rick Girdler (KY)
Rep. Erika Hancock (KY)
Del. Mike Rogers (MD)
Rep. Robert Foley (ME)
Rep. Joe Aragona (MI)
Rep. John Fitzgerald (MI)
Rep. Mike Harris (MI)
Rep. Sarah Lightner (MI)
Rep. Jennifer Balkcom (NC)
Sen. Bill Gannon (NH)
Rep. Ellyn Hefner (OK)
Rep. Perry Warren (PA)
Rep. Alex Finkleman (RI)
Sen. Hanna Gallo (RI)
Sen. Matt LaMountain (RI)
Rep. Joe Solomon (RI)
Rep. Barbara Dittrich (WI)
Sen. Mike Azinger (WV)
Sen. Cale Case (WY)

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 Rep. Rita Mayfield (IL) and seconded by Sen. Walter Michel (MS), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Sen. Mary Felzkowski (WI) and seconded by Rep. Peggy Mayfield (IN), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's November 24, 2024 and February 14, 2025 meetings.

PRESENTATION ON FLORIDA'S PROPERTY INSURANCE MARKET REFORMS

The Honorable Michael Yaworsky, Florida Insurance Commissioner, thanked the Committee for the opportunity to speak and stated that I have been the commissioner since about the second month of 2023 and have overseen the marketplace in its recovery phase from several years of a downward trend and near crisis. He stated that today he would speak about Florida's tort reform and some other reforms that Florida enacted at the peak of the crisis in 2022 and in the first part of 2023 to address the near collapse of the Florida marketplace. He gave a quick overview of Florida's property insurance market in the admitted space. Florida has about $3.8 trillion in total insured value. On the property side, Florida has 7.57 million residential property policies in force as of last month. Florida operates with a corporation called Citizens that is its insurer of last resort. Florida has approved 1.3 million policies for takeout out of Citizens. Citizens property insurance has substantially depopulated in the past two years moving toward more sustainable space and at this point, the 30-day average for requests for homeowners property insurance rate increases stands at 0.5% in Florida. What led to the particular crisis in Florida and the near collapse of its marketplace in 2022 was primarily driven by four factors. Inflation was a key factor. The total insured value of Florida's property insurance market went up between 38% and 50% between 2020 and 2023. What we approve as state regulators in our system is the cost of the rate involved in insurance. The rate is setting the price per brick of insurance you need to rebuild your home. It is not setting a price around the number of bricks you need to rebuild your home. And so, when you have more value in that space and more cost in that space for labor or materials to replace the total insured value of your home, you're naturally going to need more bricks and your cost is going to go up in that space and that's an unregulated area.

The second key factor in the Florida market crisis is litigation. In 2019, Florida accounted for about 8% of all property claims in the U.S. and 76% of litigated property claims in the U.S. And then after about a decade of no storm activity, Florida had a series of storms beginning in 2017 that impacted the state with Hurricane Irma, all the way through to the most recent events we had, which were Debbie, Milton, and Helene. The third factor is the cost of reinsurance increased dramatically during that period. To give one example that's substantial in the pre-reform and post-reform eras, we saw rates of the cost of reinsurance for our insurers operating in the state go from about a 50% to 60% increase in the cost of reinsurance pre-reform to today about a 1% decrease last year post-reform. And we expect pretty good news coming out of this year. We gather data on a sophisticated level on what reinsurance is looking like year over year. We're in phase two of that and we're looking towards a moderate reduction in the cost of reinsurance again in the state of Florida. Finally, one of the things that led to a calamity is if all of these events had occurred in a one-off scenario in Florida, it would have been sustainable. It was really all four of these factors kind of ringing each other's bells and exacerbating each other that led to an unsustainable situation in in Florida. A number of things were enacted legislatively with the help of the leadership of the Speaker of the House, the Senate President, the Insurance Commissioner, and of the Governor. They enacted a series of reforms aimed at stabilizing our property market and building in some long-term sustainability into it. I won't highlight all of them individually but I would be happy to talk separately about them. There were a couple of key factors that influenced Florida, especially the social inflation factors such as litigation. Florida had a relatively unique law on the books - a one-way attorney fee statute. It had been on the books in Florida since reconstruction and it effectively said: if your insurer offers you $1 for your claim and you do not refuse that and you hire an attorney during the course of that discussion, as the attorney is billing for that service, if the end settlement is $1 more than $1, so $2, then all of the attorney fees were automatically paid for by the insurer as well. When we discuss attorney fees it is not a situation where a corporate entity is paying for those fees. Those fees go right into the rate next year and are incorporated into that leading to a higher loss adjustment expenses (LAE) form that winds up costing all consumers more. So, it's really a cost transfer from one policyholder to all policyholders.

Senate Bill 7052 was one of the first bills I worked on when I became commissioner - the Insurer Accountability Bill which said we can't just take away a concept that you can regulate through litigation. If you're going to pull that back and put some hamstrings on that, you've got to make sure that the state itself can step in that role and regulate this space appropriately and protect consumers. Part of that package was a number of new laws to ensure accountability in the space and make sure insurers were moving in the right direction. It gave the office several million dollars and more resources and added staff to the market conduct section for insurer accountability. Looking at the outcomes post-reform, the first one is the underwriting income and net income for our market over the past several years. The golden age of property insurance in Florida was in 2011 to 2014, where everything was just firing well. Companies were making a profit. There was income coming into the state. And then in 2016 and 2017, we started to see the opposite take place. Tremendous losses began to build and that correlates very well with our history that we have developed on the propensity for litigation in the state. Again, it

wasn't the only factor, but it was a major factor. The state of Florida went from a tort heavy space in 2011 and 2012 when there were about 26,000 lawsuits a year in the property space, accelerating to the end of 2022 to over 100,000 lawsuits a year and that cost was all ultimately passed on to the consumer. When this kind of loss continues, you wind up in a situation with rate making where you simply cannot raise rates high enough or quickly enough to accommodate any increased losses.

Now you see post-reform going into 2022 and 2023 good solid profits are returning to our companies. Insurance is, in my view, not a space where you're meant to make massive profits. It's a moderate long-term strategy. Now we have healthy returns on profits that are coming in and we'll continue to monitor that to ensure that profits aren't in an excessive space. As I mentioned earlier Citizens is our state's insurer of last resort. Florida and Louisiana are unique in that we have an actual insurer, a corporation, that is owned by the state. The view that the state has taken is that Citizens should be an entity that is designed to provide comprehensive coverage to individuals who cannot find coverage elsewhere on a relatively affordable basis. It's designed to be able to have the capacity to rapidly grow when the market gets into a distress point and then rapidly shrink through legislation when the market conditions are improving. To give an example, when Hurricane Irma struck, Citizens had about $9.2 billion on hand in additional surplus and capacity to be able to grow rapidly as that market deteriorated. Today, post-reform, although the population needing an insurer of last resort has shrunk, it still sits at about $5 billion in surplus. It's beginning to grow very rapidly to put away cash and surplus for another rainy day down the road. So far we've seen a pretty substantial depopulation over the past couple of years. We're down to about 800,000 policies from our peak of 1.3 million. We expect to continue to depopulate throughout the year. As for the litigation trend within Florida, we monitor a number of different systems and data points to determine the litigation frequency. This is our service of process database that we use to determine what's going on in that space. We see the litigation peak that took place in 2021 and 2022 and then we see a decrease that is beginning. We're now at a point where we still have a ton of litigation, but the numbers are at pre-crisis levels and hopefully continuing its decline. And then what we're seeing in the rate section, the approved average personal residential approved rates, excluding Citizens which can distort the numbers if you include it, we see kind of that peak and valley, but a general downward trend. In December of 2022, the average increase approved rate was plus 21%. As of March of 2025, the average rate increase request was plus 2.82%.

While we focused heavily on property insurance, one area that also impacted cost was bad faith reform that was having a negative impact on the price consumers paid for insurance in the auto space. We see a corresponding decrease within the average rate request that’s taken place post-reform versus pre-reform. In January 2023 the average was 14.47% requested rate increase and last month the average rate request was a decrease of 0.52%. At the moment we see that continued trend although some of those global issues exceed the ability of a state insurance regulator and may have adverse impacts on rates. A noteworthy additional statistic that makes it difficult to capture the true cost of litigation is that while defense containment costs are included in the rate automatically in a specific category, the opposing side plaintiff's fees are not always captured in the same way. It's more of a general category. But here we see the defense

containment costs for defending against litigation has reduced dramatically. And once again all litigation costs end up being passed on to the consumer through the rate-making process, so any time we see a reduction, we're ultimately able to reduce the rate and the experience, and that is done in an appropriate, actuarially sound way. So, as time goes on, the overall impact of litigation will decrease what consumers are paying as a whole and continue to drive prices down.

Sen. Bill Gannon (NH) asked with the property values plummeting, is that helping out a lot or is it just a coastal phenomenon? Cmsr. Yaworsky responded that property value in itself would not necessarily dictate what you're paying on the total insured value of a property. They can generally correlate with each other, but the total insured value of a home is not necessarily just your Zillow estimate, for example. It is truly the cost to replace that home or whatever the coverage is on that home. It's the cost it would take to put that consumer back in the same shoes they would have been.

Sen. Rick Girdler (KY) stated that in Kentucky, we got a lot of business from Florida when it did personal injury protection (PIP) reform and the business Kentucky got is not good. They want to do away with PIP in Kentucky. So, we're getting your lawyers and your chiropractors to come to Kentucky. What did you do specifically with PIP reform? Cmsr. Yaworsky stated that PIP is a regularly contentious issue among the legislature with often different elements of the trial bar and various actors. There's some elements of the trial bar that want it repealed. Some elements are comfortable. What we did do was Senate Bill 19 in 2012 that enacted cost containment measures around PIP that really set a standard. I think there were 19 reforms, but the biggest one was probably pending the cost of the service provided to Medicaid as part of the Medicaid fee schedule, to create some containment measures around that. PIP is an interesting system. Unfortunately, a great deal of waste, fraud, and abuse takes place in that PIP structure. However, it is containing that cost at $10,000, so a known quantity that can be actuarially indicated over time as to what the cost is going to be. Vigorous debate takes place about getting rid of PIP every year. The challenge is if you do remove that cost containment measure, that $10,000, how do you then prevent it from moving into other spaces without those cost containment measures? So, it’s a very tricky and delicate balance that we're trying to strike there with the affordability of insurance for those who can generally afford insurance the least, but then also ensuring that consumers have adequate coverage on the road. And it’s a tricky, difficult space for us to be in.

Rep. Alex Finkelman (RI) asked if there's any correlation in both the underwriting profit and the depopulation of Citizens from people just not buying wind coverage? Cmsr. Yaworsky asked in that case, you'd say they don't have a mortgage and they're choosing not to? Rep. Finkelman replied yes. Cmsr. Yaworsky stated that they do see anecdotal information that indicates that there is some of that. However, when they look at the marketplace as a whole, and certainly Florida continues to grow, but we've seen, even during the crisis years, Citizens grow. At the same time overall, Florida saw the number of policies in force in the state of Florida continue to grow as well. They don’t believe it is a systemic challenge that exists but there are certainly people who decided to go without coverage - they didn't have a mortgage, they’re retired, and their house was in a tragic storm where it received significant damage. There's definitely stories like that out there

we do hear about it. We don't see it as a systemic challenge at this point but it's certainly possible.

PRESENTATION ON LEGISLATIVE DEVELOPMENTS IN THE TITLE INSURANCE MARKETPLACE

Elizabeth Blosser, VP of Gov't Affairs at the American Land Title Association (ALTA), thanked the Committee for the opportunity to speak and stated that deed fraud is actually a pretty broad term that refers to a variety of types of crimes but the commonality is that you have a perpetrator who is seeking financial gain through some sort of crime that involves real estate. Generally, that includes recording false, fraudulent, or forged documents in local land records. With people having record amounts of equity in their homes, real estate has become a high value target for criminals. ALTA is seeing a significant uptick in deed fraud over the last couple of years. One popular instance was the attempt to steal Graceland last year. While that was unsuccessful it really did highlight these types of crimes and the fact that they can happen to anyone. It doesn't matter if it's Graceland, the house down the street or the place you call home - there is a risk. The type of fraud we are seeing most commonly in the marketplace over the last about 18 months is what we call seller impersonation fraud. This is where a criminal impersonates a legitimate property owner and attempts to sell the property that they do not own and abscond with the cash.

These criminals are really sophisticated criminals. They tend to know what types of property to target. Generally, they go after non-owner occupied properties like vacant lots, rental properties, and vacation homes so that nobody notices that the place is up for sale. They generally list below market value and are looking for a really quick sale. We did a survey of title insurance professionals and we found that in 2023, 28% of title companies had experienced at least one attempt at seller impersonation fraud. In April of last year, 19% of title companies had seen at least one attempt at seller impersonation fraud. If you look at those numbers, over half of those had seen multiple attempts. Certainly this is a trend that is growing. Fortunately, title companies are catching a lot of this fraud before closing, but towards the end of last year a bulletin from the secret service indicated that the seller impersonation fraud scheme had changed to include fake title companies. So, the criminals were like, "Oh let's all use the xyz title company", which is not a legitimate title company. And that is certainly very bad news for consumers. If there's not a legitimate title company involved then there is no title insurance coverage. For reference we have seen fraud claims increase. They have more than doubled just over the course of the last two years. They tend to be pretty expensive claims. If a consumer hasn't been working with a legitimate title company, that's very concerning. The average cost for a fraud or forgery claim is about $143,000. We have been working with law enforcement on this issue and we encourage our members to report any sort of real estate related crimes to the Federal Bureau of Investigation (FBI), to state Attorneys General and of course local law enforcement. Just a couple of days ago the FBI released their 2024 numbers, which showed an increase in real estate-related crimes. But you can see for the five-year period ending in 2023, there was $1.3 billion lost in real estate-related crimes. The FBI says these numbers are low. Certainly, there is a still a stigma around reporting these types of crimes. FBI agents

have told me that they think that these numbers could be as low as a 10% representative sample of what's actually happening out in the marketplace. I do want to recognize the good work of a lot of state Attorneys General on this issue. There are dedicated staff that run sting operations with title companies and have been successful in really pushing back in states like Arizona where you have a lot of vacation properties and you see more of this this type of crime occurring.

There are two victims of seller impersonation fraud. The first is the unsuspecting buyer and the second would be the legitimate property owner. So, how does title insurance come into play? So, for the unsuspecting buyer if they have any sort of owners title insurance policy, they will be covered because there was fraud or forgery within the closing process. Title insurance is kind of a unique line of insurance in that it covers things that occurred in the past that happened prior to closing or at closing. But about 15 years ago the industry did put out the homeowner's policy which is an enhanced policy compared to the traditional owner's policy. And one of the unique features of that policy is that it does cover forgery that occurs in the future. If a homeowner has chosen that policy and they are a victim of seller impersonation fraud as the legitimate property owner, then they will have coverage which includes coverage of their legal costs which is going to be the most expensive thing for the legitimate property owner. One of the things that's super important is just making sure consumers are aware of this. It's like every other type of fraud that that people are trying to do a lot of education around. I do want to commend the Texas Dep't of Insurance for putting out this consumer alert on seller impersonation fraud, I think replicating this to consumers anywhere is incredibly beneficial. ALTA has had a national work group going for the last year and a half to help come up with legislative solutions to address deed fraud that includes other trade associations within the real estate space, the notary associations, county recorders and consumer groups like AARP.

One of the pieces of suggested legislative text that we've put forward that has been well received requires counties to let property owners know when a document pertaining to their property has been recorded in the land records. Legislation mandating that all counties provide that service has passed in Utah, Florida and Arizona. This is not an expensive thing generally for counties to do. This is a feature that typically is included with land record management systems. So, in many counties, it's a case of just turning it on. So, even in states where this has not been mandated for every county, many counties offer this for free. And we always encourage every consumer to make sure that they have registered for these free notifications through their County Recorder's office. So, given that we are at NCOIL I did want to talk a little bit about what might be some legislative solutions that a state insurance committee might look at. These are some thoughts that I prepared for this meeting. They're not legislative solutions that we've discussed elsewhere but we're certainly happy to talk with NCOIL or any legislators or regulators further about them.

One idea might be a requirement for notification of the ALTA homeowners policy. Where the homeowners policy is available, it's usually chosen by about 42% of consumers. It's usually several hundred dollars more than a traditional owner's policy, which can be a savings for consumers over other products that purport to protect your title and can cost

hundreds of dollars per year versus a few hundred dollars as a one-time fee. So, that sort of notification might be helpful for consumers. Additionally, you'll note that the homeowners policy is not available everywhere around the country. My understanding is at the time the homeowners policy came out, there were questions in several states about how it would comply with monoline issues. So, that might be another thing where legislators could work with regulators to figure out if there's maybe an exception that can be made for things like forgery coverage. And another idea would be creating a task force in conjunction with the department of insurance and really looking at what can help locally to address this issue based on what's happening in your individual marketplaces. This has been a difficult topic to address because the criminal activity changes pretty rapidly. Anytime you put something in place the criminals adjust. And again, I would emphasize these are very sophisticated criminal organizations that are siphoning billions of dollars away from the American real estate market. So it doesn't make sense to upend an established real estate law to deal with the crime de jour but there are lots of things that can be done to be helpful and certainly we want to be a resource for that and help in any way possible.

Rep. Bennett stated that Oklahoma has taken up legislation related to this. One question that I have is about registering for notices. Do you see a world in which that is automatic for homeowners - an opt-out as opposed to an opt-in? This seems like a pretty pervasive issue and it feels unfair that it would be on the homeowner to sort of go out of their way to get that. Ms. Blosser stated that's a good question and one we've discussed. I sit on the board of directors for the Property Records Industry Association, which is an association of county recorders, land record management systems, and others that are associated with the land record system. We've tried to figure out how you can do that in a cost-effective way, how counties can have days where they sign people up. Generally, in order to keep these costs low, you get notifications by text or email. But there has been a push to say maybe counties need to mail out to the most recent tax records to the address on file every time. And it needs to be mandatory for every transaction, not just for people who have signed up for the system. So, it's really looking at the cost for that.

Rep. Peggy Mayfield (IN) stated I had a bill in Indiana this year to address title deed fraud and I'm almost glad that it didn't get the hearing because now it has developed in a way that I can really hone in on some other issues because it changes so quickly. So, right now we have the notification that something has happened. Someone has presented a document. Do you have thoughts about the possibility of that two-factor authentication or notifying them before someone is presenting a document and I need your approval before we move forward? Do you have some thoughts on that approach to prevent it rather than just notify somebody that this has been done and if it wasn't you, you need to act? Ms. Blosser replied there are really two things you have to think about: how do you quickly address it once it's happened, and then the prevention side. One of the things that we've worked with the National Notary Association on is legislation that would make it explicit in state law that notaries can ask for multi-factor authentication so that you're getting it at that point, especially for in-person notarizations where you're maybe just looking at an ID and it's hard to tell a fake. There's really great fake IDs out there. I think that's good. I think any sort of ID proofing measures can be helpful. The

question really is, how do you make sure that you're not holding up the process where documents are getting recorded in a timely fashion. There are a couple of pilot programs. There's been one in a county in Florida kind of looking at how you do that and some other counties around the country about doing identity verification. I like the idea of trusted submitters, so you have to be a licensed professional in the state to potentially submit otherwise you need to be showing ID and going through some sort of identification process. So, lots to think about in this space, and again, I go back to how difficult it is, because you don't want to upend established real estate law, but certainly things need to be done to combat this criminal activity.

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

Rep. David LeBoeuf (MA) stated that the Model can be found on page 87 in your binders or on the website or app. I want to thank everyone that's been engaged in this process and the discussion. Since the last meeting. Rep. Brian Lampton (OH) and I have taken some feedback and we've worked to incorporate these suggestions in our Model. And I just want to make it clear that we've been consistent this entire time on making sure that we're not prohibiting the practice of using aerial imagery. We just want to make sure that it's done in a way that both protects the consumers and also provides a good standard for the industry. Some quick notes on the changes that have been made - we did remove the requirement to disclose the specific risk scoring system criteria. We recognize that there are some challenges there and didn't want to cross that line about disclosing intellectual property information and then also when it comes to the non-renewals we did recognize that we don't want to compel insurance companies to be mandated to renew policies, recognizing the market, but we did say if they cure the defect that's where the process to renew is. But if they do want to not renew for any other matters unrelated to the defects or conditions that have been cured, that's where that amendment came in. And I do also want to point out that recently because of a lot of local news things, and I'm sure many of you have had constituent cases around this, there have been many states that have opted to do bulletins from their insurance departments relative to this. That's what's actually happened previously in my state of Massachusetts but it relied predominantly on case law. And I recognize there always has to be a balance between legislation and regulatory innovation of the agencies but because this problem is continuing to evolve and it has come to the level that we're getting these matters, I feel very strongly that we do need to have some legislative guardrails along this, and this is why I put the Model forth.

Rep. Lampton stated that I agree with Rep. LeBeouf and I'm glad that NCOIL is taking this on. I also would like to point out I've submitted an amendment there on page 90. It's an amendment that the Ohio insurance industry used on a bill that I'm carrying in the Ohio House having to do more with the use of drones and trespassing. So basically this amendment would have notification requirements for insurers that are utilizing drones, and allow them to utilize the drones for things like underwriting and claims if they've established permission of the property owner. A lot of times, especially in the claims process, I've had some discussions with industry folks about the use of drones, and it speeds up the claims process by, in some cases, hours and in others, days. The

amendment isn't specifically related to the original Model's intent, but I think it is somewhat related in that we want the customers, our policyholders, to know that the use of drones is here and that the industry is asking permission to use them in those examples that I mentioned. Technologies continue to change. In the old days, when an insurance company wanted to do an inspection, they'd have to drive to you at the residence, knock on the door, or walk around taking pictures. Well, now they can sit on the street and launch their drone and fly around, accomplishing the same thing, but saving quite a bit of time. So, that's essentially the purpose of the amendment - to obtain permission from policyholders for the use of the drones.

Amy Bach, Executive Director of United Policyholders, thanked the Committee for the opportunity to speak and stated that I had an opportunity to visit with Rep. LeBoeuf early on in this process, and I think for all of you, no matter where your district is, the property and casualty insurance market is not the way it has been in the past, and a lot of your constituents are probably getting non-renewed. Some of you may have gotten non-renewed yourselves, so you're all aware that we are in the process of trying to find some solutions to the new normal, which is that insurers are now using technology that had not been available to them in the past, including aerial images, to decide who they're going to take and who they're going to put in the discard pile. So, this concept is really an effort to try to establish some guardrails so that we're not trying to say insurers cannot use this technology. Clearly, we want claims to get processed faster, and if that's helping, great. We don't want people's privacy to be violated, but clearly Google Earth has been surveying our homes from the air for many years, and I think the federal privacy laws, as I understand it, do prevent the images from having an identifiable human, and the technology already accounts for that by blurring. I really do appreciate being here, my organization is three and a half decades old. Some of you may not have heard of us. We've been very active at the National Association of Insurance Commissioners (NAIC), and I want to thank NCOIL for really bringing us into the fold here because a lot of important work is getting done here and we appreciate the opportunity to contribute to it. I have been an insurance consumer advocate since I got out of college. This issue has been very hot in the media. I know you all have been feeling it. This was an article that ran in Bloomberg last week about more states looking at legislation. Other articles here on the slides are from last year when the issue really broke in the media.

But this is still something very important. We support the model. I think Rep. LeBoeuf has taken some amendments to address industry concerns and, in a perfect world, we would have liked to keep the specific underwriting reference in there because the whole idea of this proposal, in my opinion, is to try to give the homeowner the information that will help them. So, the model as it's drafted even if you took out the specifics of the underwriting rules that they ran afoul of, you still want the property owner to know what the problem is from the insurance company's perspective and give them a chance to fix it. So we want to make sure the photos are reasonably current. you have that in the model. It gives them the benefit of that information that the insurance company is gathering by their ability to use this technology. What we like about the model is that it gives them a chance to make those improvements that will make it less likely their property will be damaged in a severe weather event. It appropriately rewards the property owner who takes action to reduce risk and that's the key. It provides an

essential incentive for people to invest time and money to risk reduction property improvements, which we know is challenging. The amendment gives insurers that flexibility to non-renew for a business reason unrelated to what the aerial images reveal. So, in closing, I just want to say, and this is just for you all, you can go to our website. We do handouts. We do them in collaboration with insurance departments. We have one with Alabama where we are in the business of trying to help people get through this availability and affordability crisis by engaging in risk reduction. We know it's one of the only strategies we have to try to help people stay insured. So, in a perfect world, I would have said don't put that change into number four because we really do need the consumer to have a carrot. If I do these things, if I fix what doesn't seem to be broke, but you say it is broke, then I will get renewed. That's what people need. But I would encourage you to keep this model moving. I would really hope there wouldn't be further amendments. I think it's very fair as you've got it now, and it balances consumer and industry interests very well.

David Buono, Deputy Insurance Cmsr. at the Pennsylvania Dep't of Insurance thanked the committee for the opportunity to speak and stated that Pennsylvania is one of those states that put out a bulletin notice in relation to aerial imagery and homeowners insurance. So, some may wonder what sparked us to feel the need to do a bulletin notice. We were receiving complaints from Pennsylvanians that were frustrated saying that my roof doesn't have any damage or my company didn't give me the opportunity to fix it. As a regulator, we had to try to figure out what is the best step forward in relation to the situation. So, one option that I have is market conduct, but that really felt like taking a sledgehammer to a gnat. And then we started thinking, have we really talked to folks about the expectations that the regulator has? So, that is where we decided to do the bulletin notice. We wanted to make sure to advise insurers of the department's concerns in relation to the use of the technology when you evaluate the roof. And we wanted to make sure that we clarified the importance of providing the residents the opportunity to challenge aerial results or correctly confirm roof deficiencies before they are canceled or non-renewed. And those were really the focus of the complaints that we received. What I want to do right now is show you a couple of pictures that kind of made us think through what was happening. This home is a home that received a non-renewal cancellation notice for the roof needing to be replaced. From the pictures, and I am not saying anything is wrong with how the pictures were taken or what the pictures were taken of, but when you're looking at that, you don't necessarily know what you're seeing.

This was another home that also had received a non-renewal cancellation notice. Once again, it's hard to tell if that's a tree shadow or a power line. So, we felt that one important thing to follow when non-renewing or canceling a policy is to ensure that the insurance company provides a specific reason as to why they are canceling, because this is kind of hard to judge. The focus of our bulletin notice, first and foremost is we do not seek to restrict the use of aerial imagery. We can absolutely see the benefit of the technology, and the last thing that we want to do is slow down technology but we want to make sure that folks are thinking about the ripples that can occur as you're rolling out the new technology. We also wanted to make sure that in the absence of unequivocal material damage shown, it would be prudent for the insurer to conduct a physical inspection to validate the damage. I spoke to a carrier at one point that said, "we'll send

a letter and have the consumer send us pictures." If you send that to my 73-year-old dad, he will absolutely climb on the roof and take pictures. So, we wanted to say, "we get what you're saying there, and we understand that you want to maybe put that in the hands of the consumer, but if you want to use the technology, let's make sure that you may own the physical review a little bit closer". We also wanted to make sure that the insurers are providing the notice of cancellation and refusal. We did have some instances where folks just did not receive it. The cancellation is what they got. Now, that could have been just a situation where a company was confused in relation to the regulations or it could have been how it was being handled across the country, but we wanted to make sure to set that stage.

And we wanted to make sure that the insurers are providing the consumers the opportunity to identify and stress the importance that maybe the roof didn't need to be replaced. As a matter of fact, in one of the sets of pictures that I had shown, they actually hired a roofer at their own cost to go up on the roof to be told that there was nothing wrong with their roof, and they had received that non-renewal cancellation notice. And that's an expense for a consumer that shouldn't necessarily fall on their shoulders. So, what has the bulletin done for us? The first thing that we did do was we ground set what we would be looking at, because how fair is it for us to come down on someone without letting them know how we're reviewing it, what we're reviewing, and giving them the rules that we would be looking by? We reminded the insurers of the obligations under the Unfair Claims Settlements Practices Act. We didn't want folks being non-renewed that shouldn't be but we also want to make sure to strike the balance that if there are some roofs that need to be repaired or replaced then the consumer needs to act accordingly and get that done. Now since the bulletin announcement we've seen a significant decrease in complaints. We still need more time to better understand the impact because we released that in the summer. As you get into the fall and winter, a lot of times insurance companies are reasonable with saying we don't expect you to go up on the roof right now when it's January and snowing to get that fixed. So, we're still trying to learn and understand. We try to have an open door in relation to any communication with new technology, because we want to make sure that it's successful. We want to make sure that the companies are put in a position to do well, and we don't want Pennsylvanians negatively impacted because of decisions that were perhaps premature or lacking the information to support the decision to non-renew or cancel.

On behalf of Nearmap, Jenna Deneault thanked the Committee for the opportunity to speak and stated that Nearmap is the company that actually collects the aerial imagery, processes it, and uses artificial intelligence (AI) to provide information to insurance companies that's then used in the context of, for example, this model act. Nearmap is an aerial technology company. We have customers that include insurance companies - a total of 200 insurance companies are our customers. We surveyed the U.S. collecting aerial imagery. Our surveys collect images for 87% of the U.S. population. We design camera systems that are then put on manned aircraft so someone is actually flying the plane and they zigzag their way across the U.S. collecting aerial imagery. Then Nearmap itself processes that imagery. They've developed multiple AI products so, depending on the customers' needs, that aerial imagery is fed into an AI system, which then provides information on a new pool, a new trampoline, tree overhang, or roof conditions that might

have deteriorated. Insurance companies can make decisions based on that information. Nearmap basically controls every step in the process from image collection to the final outputs that are provided to the insurance companies. For our discussion here today, there are two points that I'd like to raise with all of you. They have to do with the resolution of the aerial images that would be provided to the insured as part of a non-renewal notice and the recency of the aerial images so that they're actually useful to the insured in understanding why there is a non-renewal notice.

Here I have proposed a potential amendment to the Model Act for discussion purposes. And what this would do is, it would require basically an image that isn't blurry where the insured could actually see what's going on with the roof and better understand what the issue is so that they can ideally address it, and continue being covered under whatever policy they have. So 7.5 centimeters GSD – which stands for ground sample distance - means that within an image for every pixel, it covers 7.5 centimeters. This is detailed enough where you can see roof deterioration, you can see tree overhang, you don't have the shadow issues, or you can tell, to Mr. Buono's point, whether something's a shadow or whether it's an actual physical tree. So, it gives you that level of detail but it's not giving you the level of detail where you have personal identifiable information and you can say “there's my neighbor in that picture” or “there's my dog.” You wouldn't be able to make those distinctions. Here I have a comparison of 7.5 centimeter resolution with 15 to 20 centimeter resolution and you can see there is a difference. If you're sending a non-renewal notice to an insured and you're giving them a blurry picture, it's not going to bring peace of mind that I think the Model Act intends to give and it's not going to necessarily give them clarity on why their roof appears to be deteriorated in the aerial image and was detected by AI as having deteriorated to a point where a non-renewal notice is appropriate. And these images are collected by an airplane that's flying at around 13,000 or 16,000 feet so there isn't the invasive aspect of where you have a drone circling your home, or you have someone climbing up on your roof to inspect it. Sos there's efficiency in terms of collecting the information by the insurance company and there's a less invasive process for the insured. The second point that I'd like to raise is the 12-month recency of the aerial images. There's been some discussion as to whether that should be expanded to 24 months. We believe that 12 months is the appropriate period because a lot can change with a roof in two years because of wear and tear or because of natural events. So, we would propose the amendment to the Model Act with respect to resolution so that the images are more informative for the insured person receiving the notice and then on the recency point, we agree with the Model Act as it is.

Paul Martin, VP of State Affairs at the National Ass’n of Mutual Insurance Companies (NAMIC), thanked the Committee for the opportunity to speak and stated that as a general rule, I think the NAMIC membership would say that the bulletin route is the preferred route. There are about five or six states already who have issued bulletins clarifying on how best to use aerial imaging. It seems to be working for regulators and consumers when it's done that way. It's working for the industry. Having said that, the amended version of this draft bill is a marked improvement. We are working on some suggested amendments of our own, some of which are just technical changes. Others deal with not necessarily prohibiting the use or prohibiting giving the pictures to the

consumer, but rather refining how you create that process by which the policyholder can get the pictures. Also, it's not simply enough to cure the defect, but the defects need to be cured correctly so that it's not me on my roof doing the repair and saying repair is done. It should be someone who actually knows what they are doing. So we're not opposed to the bill per se. There are some things that need to be changed. They are technical in nature, but I think we're probably getting closer to where we need to be than where we were at the onset. And we also are supportive of Rep. Lampton's amendment.

Hilary Segura, Dep't VP & Counsel of State Gov't Relations at the American Property Casualty Insurance Ass'n (APCIA), thanked the Committee for the opportunity to speak and stated I know I've spoken on this in the past and I for purposes of brevity I would echo some of the comments that Mr. Martin has made regarding the use of the bulletins and that does seem to have been working well. The amended version of this model has seen positive developments but I do agree that there needs to be some further clarifications within the bill. Aerial imagery is simply a different medium for obtaining underwriting information. It allows insurance companies to evaluate properties in a safer and more efficient way. It's not really different information, it's just a new way that we are getting the information. There are existing laws and regulations in every state that provide consumer protections. We do have some concerns that some of the language that remains in this model is overly burdensome for implementation purposes. It's incredibly important to allow insurers to make appropriate business decisions within their underwriting guidelines. I won't go into a list of some of the granular suggestions that we do have to make that will provide some further clarifications and I'll provide that to the NCOIL members. But I will echo the concerns regarding making sure that we clarify that the cure corrections are done correctly. Right now the amended language reads that you have to require an offer of a renewal policy after it's cured and we definitely need to make sure that something is cured. Curing can be a matter of opinion and the proof submitted may not meet requirements or expectations of both parties. The process of the cure, the curing itself, needs to be clarified to set standards so there's expectations that both the insurer and the insured understand going into the process.

Wes Bissett, Senior Counsel of Gov't Affairs at the Independent Insurance Agents and Brokers of America (IIABA), thanked the Committee for the opportunity to speak and stated that from our perspective, we strongly support the model. We appreciate Rep. LeBoeuf and Rep. Lampton bringing it to the table. I very much agree with and associate myself with the comments that Ms. Bach made earlier. This is a great technology, but one of the things that we are finding in the agent community is that we are hearing increasingly from agents who are finding that the images that are used are not always perfect. There are oftentimes faulty conclusions that result from that. So, we think this is a very important model. There is a gap in regulation right now. I know there's been some suggestion that state law imposes requirements of this nature already. That's not the case. We need a statutory framework, especially since states are beginning to consider this issue and take it up. Having interstate consistency would be important. We strongly support this. I don't know what the amendments are that the insurer community might be contemplating, but we would urge you not to unduly weaken this model. It's pretty good as is, and we encourage you to adopt it as soon as possible so that states can take it up in 2026.

Rep. Tom Oliverson, M.D. (TX), NCOIL Immediate Past President, stated that to me, as I've listened to all this, I just think that the main issue here is privacy and consent. And I think just like a life insurance policy, if somebody was going to access your protected health information in order to be able to determine if they were going to cover you or if they were going to continue your policy, or what they were going to charge you, you can consent to that or not consent to that, but you should know upfront that we may fly a drone over your house at any time. I just think that's part of the way to solve this, to make sure people are informed and they understand and they have to sign a document that says, I know that part of this policy is that they may fly over my house at any time or get aerial images and I may not even be aware of it. I just think that people should know that that's part of the deal and then at that point they can say, “Well, I don't want to work with this insurance company” or, ”I'm fine with that.”

Sen. Lana Theis (MI) stated I have a couple of comments, one of them being that you mentioned the resolution of at least 7.5 centimeters. The term “at least” 7.5 does not prohibit you from doing a higher resolution. So, while you're saying facial characteristics are not recognizable at that distance, something more absolutely would be. And so, I wanted to mention to our committee members that the language that is recommended does not negate that as a possibility, even though it was discussed as such. And then I guess I take umbrage with the commentary of the caution around the cure. My house was built in 1937. My husband used to repair nuclear submarines and he has repaired so much around the house and he's really good at it. And just because he's not a professional at that doesn't mean he doesn't do a really good job. So, I would also caution us to make sure that language doesn't prohibit people taking care of their own homes and doing it well.

Rep. Mike McFall (MI) stated to piggyback off of earlier comments around consent, those photos also have their neighbors' houses in it, and they weren't blurred out, and they did not consent to those photos being taken. So, I don't know if there's a way that we can also make sure that their privacy is taken into account, because the focus, obviously, is on the main house, but everybody else's property was included in those photos as well.

Rep. LeBoeuf thanked everyone for this discussion. As we move forward, I do want to caution on a couple of things. When we look at the bulletin versus legislation angle, I think all of us have been in situations where there has been a great regulator that has done phenomenal work in their agency and then as soon as they leave, all that work is gone. So having some type of legislative guardrail is great. The second thing I want to say is about the over-specificity. Just to give you a short anecdote, I am currently fighting a budget amendment because there's a statute in Massachusetts that says every registry of deeds has to put their documents on microfilm, and there's a national microfilm shortage. So, if you're over-specific with the technology, as technology advances the statute will have to be amended constantly. So it’s important to allow the regulators to implement the regulations that are necessary and provide the legislative structure so that if things changes we have something in place.

CONTINUED DISCUSSION AND POTENTIAL CONSIDERATION OF NCOIL RENTAL HOME MARKETPLACE GUARANTEES MODEL ACT

Rep. Bennett stated that the last item on the agenda is the discussion and potential consideration of the Rental Home Marketplace Guarantees Model Act. We have the potential to vote on this at the end of this conversation, and I know that Rep. Lampton, the sponsor, has put a lot of work into this since the San Antonio meeting this past November, and a lot of interested parties have been engaged in getting closer together on this so I look forward to hearing from everyone before we take potential action.

Rep. Lampton stated that you can view the clean version of the Model in your binders at page 92, and then again on 97 with the redlined version. Both versions also appear on the website and the app. We've had a lot of feedback and received a lot of interest on this Model from interested parties and committee members. The model has been significantly changed since the last version. Most notably, it's been limited to being applicable to only the rental home marketplace. As I mentioned at the beginning of the discussion, I've always been receptive to making changes to the model to make sure we get things right. As you can see from the latest version, there's been significant changes to ensure that concerns have been addressed. In fact, it might be one of the most changed models in recent NCOIL history. But it's important that we've collaborated and made these changes as discussions have continued. I also note that the original version of the Model has already been enacted into law in Arkansas. So, this important public policy has already been passed in that state. I want to especially thank all the interested parties who have been working on this to get to quite a bit of compromise. I think this model is ready for consideration and I would encourage the committee to support the model today.

Ms. Segura stated that I agree with Rep. Lampton that there has been a lot of back and forth on this as we have been working on language on this Model, and I appreciate Airbnb's efforts as we have worked on the amendment before you today. What I will say is we have moved the model to a much better place from where it originally started. The language in the amendment continues to narrow the focus to property damages that occurred to the property owner. It removes the damages, and perhaps the guarantee from the renter side, which was something we've been very concerned about all along, about the conflict inherent in that with the NAIC and NCOIL travel insurance models. We appreciate all of the work that Airbnb has done with us on this to get it to this place. I know we did hear from the regulatory community yesterday that they had some concerns. I don't know whether or not our agreed language alleviates their concerns, and I think that's up to this body whether or not you all think this is sound public policy.

Matt Overturf, Ass't VP of State Affairs at NAMIC, thanked the Committee for the opportunity to speak and stated that I just want to begin by thanking Rep. Bennett and Rep. Lampton for your patience as we've worked through this issue over the past several months. The version before us today is an improvement. However, we continue to maintain that the model is not necessary and I'll give you two primary reasons why. The first being that there's not been a demonstrated market failure that creates a gap in coverage that warrants this model. And the second is establishing a precedent of model

law offering products that transfer risk outside of the insurance regulatory framework. To that last point, we would encourage this committee or NCOIL, the body at large, outside of the model law discussion, to have future conversations on what we've been calling the "insurance/not insurance/gig economy issue," in an effort to potentially establish policy principles for issues such as this that are likely to come in the future.

Brad Nail of Converge Public Strategies, representing Airbnb, thanked the Committee for the opportunity to speak and stated I'm here with Byron Wobeter, Associate General Counsel for Airbnb, and we'll both be available for questions that you might have. Thank you to Rep. Lampton and Rep. Bennett for working hard on this and thank you also to our fellow stakeholders here who have engaged, and we've worked toward agreeable language. For those of you who were here either at the summer meeting in July or at the annual meeting in November, this issue was discussed at length there. And since that November meeting, a couple of things have happened of note. First, as Rep. Lampton referred to, the prior version of this model was filed in Arkansas by Sen. Justin Boyd (AR), Vice Chair of the NCOIL Health Insurance & Long Term Care Issues Committee, who unfortunately couldn't be at the meeting today. That was the broader version of this bill and it passed the Senate there 33-0. It passed the House 97-0, and has been signed by the Governor, so it is the law in Arkansas today. So, it has been thoroughly vetted by committees and a legislature. The second thing that happened is the stakeholders in the insurance industry had come forward in November and expressed their concerns mostly around the breadth of the model and a desire to narrow the scope. And so, we've engaged in extensive discussions along with the sponsor, and the version that you would be considering today is substantially narrowed. And there are really three main areas where it has been narrowed. First, it only applies now to the rental home marketplace instead of applying to any online marketplace. Secondly, it's important that anyone offering this guarantee be able to demonstrate their ability to have the financial wherewithal to satisfy it. And in the prior iteration of this model, there were three options for them to be able to do so. They could back it with an insurance policy, or they could have a certain amount of cash on hand, or they could have a certain market cap with their company. We've removed two of those, and now it has to be backed by an insurance policy. So, there is insurance involved in this now. And then thirdly, the most recent changes that were suggested by APCIA, as Ms. Segura described, were to narrow it to only applying to the owner or the controller of the property instead of the person who's going to be renting it. So, we think that this is an important model to provide clarity and consistency in the law and to provide direction for your regulators. We've discussed this for a year and we feel that this has been fully vetted and is ready to pass. And now that we have the insurer input into the model, we feel it's well positioned so we would ask for your favorable vote.

Sen. Walter Michel (MS) thanked Rep. Lampton for the work he has put into this as sponsor and I know that this committee has addressed this issue many times in our previous meetings and as a member of this committee, I've had multiple discussions with the various groups on this. I want to thank you all for getting together and for all the time and effort you've spent on working on a model that you are happy with, and I appreciate your efforts.

Asm. Jarett Gandolfo (NY) stated that I'd like to hear a little more about the coverage gap that we're addressing here. What exactly is happening for property owners in the marketplace that current insurance policies are not addressing properly? Mr. Nail stated that I think it's fair to say most homeowners' policies may not provide coverage during short-term rental. What Airbnb does, what they do currently, and what this would recognize, is that if you are the owner or the controller of the property and you would like to list it on Airbnb, the person who rents that from you is contractually obligated to pay you for any damage that occurs to the property. If they fail to satisfy that, if they fail to step up and pay you, Airbnb wants to be positioned to say to you as the owner, we'll pay for that damage and then we'll decide whether to keep going after the renter to pay that. And that's really the crux of this. There have been a couple of states where the regulators have questioned the arrangement, and that's why there are about half the states where there is an exemption in the statute that we think applies to this. There are about half the states where there's probably some case law. But in almost all the cases, that predates really the economy that we're talking about. And so, it would be beneficial to have the clarity in the statute and something that directly addresses the arrangement that we're involved in.

Asm. Gandolfo stated that I'm looking at the definition of "provider" and it includes "any affiliate or representative." What's the reason for that language? Mr. Wobeter stated that comes from other language within statutes and it could be a subsidiary of that company that actually provides it but it still has to be the company and if you go to the definition of "rental home marketplace", it still has to be a company that their primary business is not this. The primary business has to be something else like the rental home marketplace. Asm. Gandolfo further stated, in terms of regulatory authority, what oversight would a Department of Insurance have over this guarantee, because in the model it says the guarantee itself is not an insurance product? Mr. Wobeter responded section 7 of the model has enforcement provisions and the way that is drafted is sort of broad right now, but that would be drafted in a state-specific way in a state bill, so that that's one thing. And then section 8 of the model sets forth the authority for the commissioner to promulgate regulations that are in line with the model, and we think those pieces are important so that it has the appropriate authority. Mr. Nail added that Rep. Lampton has expressed that in his state he believes that this might be better suited under the purview of the Attorney General rather than the Insurance Commissioner, and that's a decision that we think would probably be on a state-by-state basis.

Sen. Mary Felzkowski (WI) stated that as a legislator, when we become elected, we do it to solve issues for our constituents and to really take on and provide solutions. And I come from an area of Wisconsin that's heavily invested in tourism, and I am also an insurance agent. And I have to agree with NAMIC on this one. I have not had one host come to me and say, "I can't obtain insurance on my Airbnb, whether it's commercially because I have numerous ones or maybe it's because I have a summer home up north and I'm going to rent it out part-time to be able to help afford it." The insurance industry has stepped up and done an amazing job to provide coverage for those people and I'm greatly concerned with this model because I don't think that it's putting forth a product that is allowing our hosts to replace or to even provide a product. Because if I have a homeowner's policy and I'm renting it out as an Airbnb, you're not replacing that

insurance product. If that home burns down while it's renting, you're not going to rebuild that home. You're putting a band-aid product out there in the form of a non-insurance product. There's no disclosure around what you're charging the host for that and I actually had a representative try to tell me last night, “it's free, we're not charging you.” There is no free. You're baking these costs in, driving up the cost to the consumer, not being transparent on it, not allowing the host to opt out. I still have to buy and purchase a comprehensive product to insure that property. I wasn't at the NCOIL-NAIC Dialogue yesterday, but there were concerns around claim payment, filing of claims, and actual payment on this. So, whom are we passing this model for? Are we passing this model for the renters? Are we solving an issue for them? I don't think so. Are we solving an issue for the hosts? No, because those hosts still have to buy a comprehensive policy to fully insure and cover the home that they are renting. We are passing this for Airbnb and VRBO. And kudos, it's a great business model and you may pay out some claims. You may do some good with it but let's have an honest conversation about what we're doing.

Mr. Nail stated Sen. Felzkowski and I have talked about this, and I understand her perspective on it. Airbnb, despite the assertions to the contrary, does not even charge anyone for this. This is just a component of their overall costs, and it's necessary to provide the host, the property owner, with peace of mind that when something does happen, that Airbnb or the other rental marketplace will be there to back them up. That's really what we're seeking here, and what we're in need of is sort of the regulatory certainty to continue doing this, because it is a benefit to the hosts and to the guests. Mr. Wobeter stated I would just add that we feel that the consumer protections already in the model are comprehensive and adequate and the regulators will be able to regulate as well. And as Mr. Nail mentioned, this will be backed by an insurance policy, and so that reimbursement insurance policy will be required. Mr. Nail stated and just one more point - we have had numerous discussions with insurance departments in several states, and while there are a couple of states that have expressed concerns, the vast majority of them, when we have met with them and set forth what we're doing today, have told us that yes, they agree that it's appropriate, and that they have no problem with it. So, I don't want there to be a perspective that there's concern about this across the board from the insurance departments.

Rep. Edmond Jordan (LA), NCOIL Treasurer, stated I wasn't going to comment but I think it's fair to give a different perspective. I do think that this solves an issue for hosts. As many of you know, I'm from Louisiana, and while I don't represent New Orleans directly, it is, of course, obviously in Louisiana, but I also represent Baton Rouge. If you've ever been to New Orleans or if you've been to a Louisiana State University (LSU) football game, you know that there's a lot of partying that goes on, and sometimes with that comes destruction. And so, while this isn't an issue that has necessarily come before our insurance committee, I also serve on the commerce committee, and it is an issue that's come before that committee several times. And I will tell you I've heard from several hosts who have said that during the partying scene, either in Baton Rouge or New Orleans, destruction has happened to their properties. And a lot of these claims are relatively minor claims, but still, they want to be able to recover from that and feel like they can be made whole. So, from that perspective, I certainly don't have a problem with the model. From a consumer perspective, if somebody has caused destruction, I think

that there should be some restitution. But if they're relatively minor claims, I would hope that Airbnb or VRBO or whoever it was wouldn't necessarily go and try to penalize somebody for taking 10 towels, but short of that I certainly don't have a problem with this because I do think it solves an issue for the host. And I've heard from those hosts directly and some of those are my constituents.

Rep. Bennett stated that we have discussed this issue for over a year and it seems to me that at this point the remaining issues are sort of philosophical differences about what is insurance, and I know that you all have worked together a lot on this here and you will continue to work together on this at the state level. But at this point I would like to entertain a motion first to adopt the amendments to the Model[1]. Upon a Motion made by Rep. Lampton and seconded by Rep. Jordan, the Committee voted by way of a voice vote to adopt the amendments to the Model.

Then, upon a Motion made by Sen. Paul Utke (MN), NCOIL Vice President, and seconded by Rep. Jordan, the Committee adopted the Model as amended by way of a 12-6 roll call vote[2].

Rep. Oliverson stated that we haven't had a Model go to a roll call vote in quite a while, so I'm going to make a recommendation that we revisit this Model more frequently rather than the standard five years from adoption just to kind of keep an eye on it and see if it's being adopted anywhere. Rep. Bennett stated that it would be good to have a conversation about that during tomorrow's Executive Committee meeting.

ANY OTHER BUSINESS

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[1] Section 2. Definitions

B. "Rental home marketplace" means a person that meets each of the following criteria:

(1) Provides an online application, software, website, system or other medium through which a ~~service~~ property is advertised or is offered to the public as available in this state and that connects platform users to enable them to share property ~~or perform services for other platform users through the same online platform~~.

(2) Provides, directly or indirectly, or maintains an online platform ~~for services~~ by performing any of the following:

(a) Transmitting or otherwise communicating the offer or acceptance of a transaction between two platform users.

(b) Owning or operating the electronic infrastructure or technology that brings two or more platform users together.

(3) If engaged in the offering of rental home marketplace guarantees, does so only in a manner that is ancillary to the conduct of its primary legitimate business or activity.

(4) Is not a local or state governmental entity.

C. "Rental home marketplace guarantee" means a contract or agreement issued in connection with a rental home marketplace, whether or not for a separate consideration, to reimburse a user sharing property ~~platform user~~ for any damages for which ~~another platform user~~ the renter is responsible under the rental home marketplace's terms of service, with or without additional provision for incidental payment of indemnity.

[2] Some legislators who were present at the beginning of the Committee's meeting had left the room by the time of the vote.

Mr. Martin stated that the number one issue NAMIC is working on across the country in state legislatures deals with the issue of utility immunity, particularly with regards to wildfires. There are about 12 states that have entertained these bills. Either they're currently pending or have been considered. The bills all have a different variation, but they go something like this - if a utility company has a wildfire mitigation program and they comply with it to some degree, they are immune from all damages they create, no matter how much property they destroy or lives they take or pets they kill or livestock that is destroyed in these cases. We're not asking for a model law from NCOIL, but we do suggest that at your meeting in the summer that you have a general discussion panel to discuss these issues because we think we're going to see this in other states in 2026. We just want you to be aware of all the issues. It's not that we're necessarily opposed to creating an articulated standard of care for utility companies. That makes perfect sense to us. But when you start to give immunity, you're starting to see some very unique relationships and unity between insurance companies, trial lawyers, firefighters, lumber companies, ranchers, and farmers. We think this organization needs to be fully aware of what's going on so you can make informed decisions back in your states[3].

Sen. Jesse Bjorkman (AK) stated that this is a huge issue in Alaska, and I want everyone to be aware, even my utility pushes for immunity. Immunity doesn't keep the forest and people's communities from burning down. Someone has to be responsible to clear the right-of-way and keep trees from falling on the power lines. Everybody wants it to not be their fault. I don't care whose fault it is if my entire town gets burned down because we don't maintain our infrastructure. Everyone wants to say, “Oh I don't want to be responsible.” Guess what? We're all responsible. And so, I'm involved in a member-owned co-op where that cost would fall on all of my constituents and all of my voters if the utility were responsible. But we all need to be responsible for clearing the right-of-ways and making sure that trees don't fall on lines. I think a more elegant solution for private property is to say, “Hey, as a utility we're going to go remove trees that we think can impact our facility.” If the private property owner says no, then they need to sign a document that says, “I realize I have a risk and now and I assume that liability for the risk of trees falling on lines.” Absolving people of responsibility for large-scale forest fires is not a solution that keeps anybody's community from burning up. It's a big deal. My community's been in danger multiple times. Someone has to be responsible.

Rep. Bennett stated that I look forward to that conversation this summer and I couldn't agree with you more, and Sen. Bjorkman, we’ll invite you to be part of those discussions.

ADJOURNMENT

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

[3] Mr. Martin submitted a witness slip in support of NCOIL further discussing the issue of utility immunity and wildfires.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
PROPERTY & CASUALTY INSURANCE COMMITTEE
INTERIM COMMITTEE MEETING – JUNE 9, 2025
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Property & Casualty Insurance Committee held an interim meeting via Zoom on Monday, June 9, 2025 at 12:00 P.M. (EST)

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

Other members of the Committee present were:

Sen. Larry Walker (GA)
Rep. Rita Mayfield (IL)
Rep. Matt Lehman (IN)
Rep. Peggy Mayfield (IN)
Rep. Mike Clines (KY)
Sen. Donald Douglas (KY)
Rep. Mike Meredith (KY)
Rep. Edmond Jordan (LA)
Rep. David LeBeouf (MA)
Rep. Brenda Carter (MI)
Asm. Jake Blumencranz (NY)
Rep. Brian Lampton (OH)
Sen. George Lang (OH)
Rep. Jim Dunnigan (UT)
Del. Walter Hall (WV)

Other legislators present were:

Rep. Sandra Scott (GA)
Rep. Jim Gooch (KY)

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. Larry Walker (GA), Vice Chair of the Committee, and seconded by Del. Walter Hall (WV), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

CONTINUED DISCUSSION ON NCOIL MODEL ACT REGARDING INSURERS' USSE OF AERIAL IMAGES

Rep. Bennett thanked everyone for joining the meeting and stated that the purpose of this meeting is to conduct some business before we meet in person in Chicago. Let's

start with the Model Act Regarding Insurers' Use of Aerial Images. I know that we've had a lot of conversations about this, and a lot of people have weighed in. So, as we move forward, I and sponsors are hopeful that the model will be ready for a vote when we get to Chicago. But if the model needs more work and folks are still at the table and want to work things out, we'll focus on gaining consensus and having a vote in November. So, before I turn it over to the sponsors, I want to point out that a significant amount of amendments to the Model were submitted by the National Association of Mutual Insurance Companies (NAMIC) and the American Property Casualty Insurance Association (APCIA) last week, and they were distributed and posted on our website. A response to those proposed amendments by United Policyholders were also distributed over the weekend, and you can view those on the website. I'll now turn things over to the sponsors, Rep. David LaBeouf (MA) and Rep. Brian Lampton (OH).

Rep. LeBeouf thanked everyone for their continued feedback and engagement with the model. I thought we had a really great conversation in Charleston and Rep. Lampton and I really appreciated the thoughtful comments that were brought forward. One of the items that we discussed that was brought up by Nearmap was the appropriate size of photos to make sure that they're accurate. I definitely think that's something to consider. However, I don't believe it should be over specified in statute just because of the fact that technology does change. I do believe there should be some type of drafting note to indicate that that should be examined. Another item raised by insurers was the standard for the repair of work that's done to cure and making sure that the homeowner is proving that the repairs were made and also that they're in compliance with certain standards. That's another great issue to work on. I do want to touch on the additional amendments that we received last week from NAMIC and APCIA. I still have to further review them and discuss them with staff but when I look at them initially, I definitely feel that they take the model in a different direction than what was the intention of our proposal, one that doesn't meet the needs of consumers that brought this about. But I am definitely looking forward to having the discussion and hearing from everyone.

Rep. Lampton stated that I'd like to thank NAMIC and APCIA for their input. I have only had a limited opportunity to review those proposed amendments since I am still in session and battling over a budget that's due soon. I also agree with not specifying photo sizes in statute. Rep. LeBeouf is correct that we don't want to be too specific because technology changes. I think we'll be able to put something together and hopefully be ready for Chicago. I also submitted an amendment to the Model in advance of our Spring Meeting but it was a bit off the beaten path of this Model, because it had to do with privacy issues and both I and Rep. LeBeouf agree that this isn't the Model for that to be addressed so we're just going to let that sit at this point. I hope to continue our great conversations with everyone and come up with something that we can all be satisfied with to move forward with in Chicago.

Joel Laucher, Program Specialist at United Policyholders, thanked the Committee for the opportunity to comment and stated that we do want to emphasize that as insurers adopt new technologies that assist them in underwriting risk and establishing rate differentials, such as using aerial imagery, it's important that consumer protections keep pace to ensure that fairness, objectivity, and a reasonable level of transparency remain in the

process. And we believe at United Policyholders that this Model provides consumers with these important protections. But the edits to this Model offered by the insurance industry representatives would actually undermine the protections. I think we all understand that the current property marketplace is a challenging one for industry and consumers alike. As insurers tighten their underwriting restrictions, consumers cross their fingers in hope that the notice they have received in the mail from their insurer is a renewal offer. A notice of non-renewal for a homeowners' policy can lead to a very expensive residual or secondary insurance market. So, it's critically important in today's market that insurers get it right when they determine a non-renewal is warranted and that they rescind that non-renewal if the basis of the non-renewal is determined to be inaccurate or resolved. The consumer may only have 30, 45, or 60 days to resolve the issue before the expiration date, depending on the state of residence. Accordingly, the notice of non-renewal must provide the consumer clear, timely, and potentially actionable information, and a reasonable opportunity to resolve an underwriting concern, if possible, or to protest the accuracy of that information, if warranted. This is the least that we should expect of this process. The Model, as written, would provide these protections. The industry edits would only serve to complicate the process and impose delays that would run out the clock on the consumer. So, United Policyholders urges you to approve the Model as currently written.

Paul Martin, VP of State Affairs at NAMIC stated that I agree that the market is challenging. I'm not going to rehash our proposed amendments and I appreciate the work of our friends at APCIA to help us to come up with some industry-agreed-upon amendments to this. I do want to share just why this is so relevant. Gallagher Re recently issued a report and stated that through the first quarter of this year, insured losses for severe storms topped $11 billion. That is the third costliest first quarter for severe storms in U.S. history. For the period from January to April 2025, it was the fifth costliest year for severe storms, ranking only behind 2023, 2011, 2024, and 2020. So, put it another way, four of the five costliest Januarys through April for severe insured losses have occurred since 2020. So aerial imaging is a really important tool to allow us to pay claims quickly, as well as to balance the need to match rate to risk. What we're trying to do here is match the need for consumers to have a clearly defined process with the needs of insurers who are putting tremendous sums of capital at risk in the face of these record losses. What these edits from the industry do is clarify what constitutes a renewal. They improve the verbiage to use industry-specific terms. For example, it changes "property owner" to "named insured" for clarity purposes. It requires insurers to provide information about how policyholders can go about requesting copies of the images at issue, it requires these images to be sufficiently clear and accurate for purposes of whatever the insurance company is using them for, and it reconciles the period of cure with the existing law pertaining to non-renewals. I think it is important to remember that even with our edits, a named insured still has access to the photographs. When a policy is being non-renewed, they still have access to a process to cure and can provide documentation on how they completed that repair work that is necessary, and it still allows policyholders to report errors in images. So, we think with our amendments, it strikes the right balance between what the consumers need and the insurance companies need who are dealing with these losses and putting tremendous amounts of capital at work for the industry.

Hilary Segura, Dep't VP & Counsel of State' Gov't Relations at APCIA, thanked the Committee for the opportunity to speak and stated that I appreciate the sponsors taking a look at our amendments and I appreciate the comments from United Policyholders. APCIA has been working with NAMIC to work on industry amendments. One thing that wasn't in our amendments that I do want to mention before I get into some of the specifics is, it does seem that this is geared more towards homeowners. Even in United Policyholders' comments, that seems to be where the focus is. I would recommend that we make it clear that this isn't geared towards commercial policies, that this is more of a homeowners issue. I just wanted to bring that to the forefront. To address some of the comments that United Policyholders had regarding our amendments such as the date stamped photo requirement. That's going to require integration between the photo application and the compliance system that generates non-renewal notices. The articulation of what steps the property owner can take to reverse the insurer's decision would convert a semi-automated process into a very manual process, which eliminates any efficiencies to be gained from using aerial images in the first place. To include date-stamped copies of images relied upon for a decision would be operationally challenging and expensive. Proactively sharing photos that show the specific conditions could add significant IT and programming efforts, which ends up increasing costs to all insureds. Currently, the images are provided upon request. Also, providing specific steps that the property owner may take to bring a risk into underwriting compliance would be extremely challenging and expensive. Carriers don't want to be in the position of advising policyholders on repairs or remediation. When we're taking a look at the timeframe, images which provide clarity and accuracy, regardless of age, should be the standards for their use in assisting insurers with their decisions. The preference is for this to be changed to 24 months in order to capture all the cases. For example, some rural areas have less frequent refresh of images.

When we're taking a look at the kind of information that's provided, every insurance company already has an underwriting department and processes to allow consideration for new information. Aerial imagery does not create a need for a separate process or a separate appeal process. This is already currently one in existence. Also, I know United Policyholders had suggested that if our amendments were accepted, they would urge the model to be scrapped. We would also support scrapping the model, as it would place different requirements on insurers that use aerial imagery, compared to carriers that do not utilize the technology. One of the reasons admitted insurers are unable to timely adjust their rates is due to delays in obtaining rate approvals from insurance departments. Insurers need to charge an appropriate rate for the exposure. Most states have existing non-renewal notice and timeliness regulations, and the use of aerial imagery should not somehow bypass those existing laws. A proposed cure period that could be longer or shorter than the notice period is problematic. It limits insurers' underwriting freedoms and would be clumsy to administer. Otherwise, providing policyholders with some time to repair to address a stated issue is acceptable. However, the insurer and the policyholder need to understand that the work needs to meet certain standards that the insurer sets. This is more important than even a fixed time period. 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 underwriting guidelines, and curing something noted may be a matter of opinion, and proof submitted may not meet requirements or expectations. Additionally, requiring renewal suggests a shift of the decision-making to the insured rather than the insurer, and that puts the insurers in a very difficult position.

Wes Bissett, Senior Counsel of Gov't Affairs at the Independent Insurance Agents and Brokers of America (IIABA), thanked the Committee for the opportunity to speak and stated that IIABA strongly supports this Model. It's timely. It's necessary. It addresses the regulatory gap that exists today. I hear from agents all the time, including one this morning, about problems arising with the use of aerial images. In this one case that I heard from the agent this morning, his client had been told that there was an issue with his property. The insurer took it upon himself to resolve the issue, and the insurer told him after that, "we're still not renewing you." So, this is a real-world problem that's been covered extensively by the media. Regulators are beginning to act, and there's a need for a uniform statutory approach to it. I'm going to spend most of my time talking about the proposed amendments that you received from a segment of industry and I should be clear, it's not an all P&C industry approach. The agent community certainly doesn't agree with those amendments. I know P&C consumers don't agree with those amendments and frankly, we were disappointed to see them. We heard in Charleston and San Antonio that there might be technical amendments proposed, but there's nothing technical about the amendments that you received from APCIA and NAMIC.

And some of the amendments cannot be classified other than as poison pill amendments. And Ms. Segura just said that if you scrap the model, that would be okay and I think that's part of the objective here is to either water this model down to the point where it has no effect or meaning or to encourage you to scrap it altogether. So, we would urge you for the most part to disregard those amendments and I'm going to go through some of the real-world effects that those amendments would have, if incorporated. Those amendments would limit the scope of this proposal considerably. So, they would only apply in the case of a non-renewal. So, if an insurer were using aerial images to add roof exclusions or dramatically change and limit and reduce the coverage under a policy, the terms of this model would not apply. They also would recommend that you only apply this model to the narrow case of if an aerial image is used as the sole reason for a non-renewal, which would make it easy for a carrier to evade the requirements of the model proposal. Section 4(A) currently would require insurers to identify the specific conditions that they've seen in the images and the reason for their action. They would just eliminate that requirement altogether. That Section also requires that images be shared proactively and they would flip that and say, "if you're a consumer and you want to see the images, you have to request them." And on one hand, that might seem reasonable, but they're trying to have their cake and eat it too. Their amendments try to narrow the period of time the consumers have to actually implement fixes on the back end. And here at the front end, they're trying to introduce hoops and hurdles that consumers have to jump through that make it harder for you to get that information in the first place. You can't have it both ways. If you're going to have a request requirement, they need a more extended ability to make those fixes. The industry standard when it comes to photos, we heard about this at the last hearing, is 12

months. The insurer trades proposed to double that window to 24 months, and you'd have the use of images that are much more stale.

Section 4(D) of the model, as currently crafted, would ensure that consumers have a period of at least 60 days to address and cure problems that carriers have identified. I think most people would say that's a pretty small window of time. You just heard about a problem that a carrier has. They say you no longer meet underwriting and rating guidelines, and you have 60 days to find a contractor, get the work done, submit it back to the carrier, it's a very narrow window. Some would even say you need more than 60 days. The carrier response is to try to limit that and for some reason tie it to the notice provision, which is just an effort to narrow the period of time that people have to act because there are states that only have a 30-day non-renewal disclosure period, which is, just as an aside, far too short anyway. It should be 60 at a bare minimum, but they're trying to narrow the period of time that consumers have to act. And perhaps most troubling are the proposed revisions to Section 4(E) - that currently says that if you're a property owner, you fix the problem cited by the carrier and you do it within that period of time that's designated in this model, you get renewed. And they do away with that requirement almost altogether. They don't strike through it. They craft it in a way to kind of hide the ball a little bit. They say that if you've done all that work as a customer, you may get an offer of renewal from the carrier, which obviously equally means you may not get an offer of renewal from that same carrier. So, it becomes an empty requirement altogether. If you're a consumer, you might spend thousands of dollars fixing the problems that the insurer cited, but get non-renewed at the end of the day anyway. We think that most of these amendments should be disregarded. If there are clarifications or true technical amendments that need to be made, we are happy to be part of that conversation. We do think there are some things that could be clarified, but most of these revisions that have been proposed and shared with you today are really just poison pill amendments that would dramatically undermine what I think the intention of the sponsors and the concerns of the agent and consumer community are today.

Sen. Walker stated that I'm an independent insurance agent, and this is a real problem in Georgia, particularly with non-renewals of homeowners and using various means to determine that by the carriers. I think they're just wanting to reduce their overall exposure in Georgia, and they're using this aerial imagery as a reason to do that. I drafted some legislation in Georgia this past session and decided it would be wise to wait on the model coming out of NCOIL, which I hope will get passed at the summer meeting. But my thoughts for Georgia are to make it fixed-wing aircraft only, and to make it be automatically sent to the insured if there's any kind of adverse underwriting decision remotely based on the aerial imagery. It's got to be time stamped - within six months was my thinking, not 12, but I could probably live with 12. But I don't want my consumers and my constituents to have a bunch of drones flying around their neighborhood not knowing what it is. So, I'm okay with using drones after a claim to inspect a roof where the homeowner knows that's what they're doing. I generally agree with the comments made by Mr. Bissett. I just want to put that on the record and let the industry know. Also, we've changed our non-renewal statute on homeowners this past session from 30 days to 60 days, and I would recommend all the states look at doing that. In this market in

particular, and with the U.S. mail the way it is, I would suggest everybody go to a 60-day non-renewable minimum on homeowners.

Rep. Bennett asked Sen. Walker if he could extrapolate a bit on the fixed wing requirement and stated that I come from a state where I think a lot of drones in the sky equals target practice for some and I wonder if that was a consideration for you or what motivated the fixed wing only requirement. Sen. Walker stated that the technology is certainly there. I think most carriers are using fixed wing anyway to do this. It's so invasive, I think, with a drone. And we've got statutes already on the books in Georgia regarding privacy and the use of drones over a private residence. And if carriers were to try to do that it might be in conflict with what we've already done. But I just think there's a lot of paranoia and conspiracy theories and legitimate privacy concerns with drones. And I don't think we need the industry using drones to do aerial imagery for underwriting. Now, again, if it's in response to a particular claim and it's limited to a particular property and the property owner is aware that they're going to do that instead of climbing up on the roof, I'm very favorable to that and I think that's a good use of that technology.

Rep. Matt Lehman (IN) stated that I like the Model as currently drafted and I think when you look at what my history at NCOIL has been, these models come out based on what we're seeing in the marketplace and this model is basically a result of what carriers began to do with aerial photography of roofs. They began to non-renew. They gave no way of correcting. Those were hard, fast non-renewals. It just shifted to, “we have to do something about this. That's not good public policy.” So as legislators, we're there to make good public policy. I think the model as drafted is good public policy. I do think there's some technical things we can tweak but I want to address a couple of things that have been said. Mr. Martin brought up the amount of losses. I'm not going to argue that. I think we have absolutely seen some of the worst storm damage we've had in years. But we've also had two and a half years of double-digit rate increases so premiums are going up as well. So, the losses may be increasing, but what are those loss ratios? We've seen a lot of our carriers for the first time begin to hit below 100% combined. So I think you're seeing bigger claims, but you're also seeing more premium coming in as well so we've got to be aware of that. On the personal versus commercial issue, I want to be a little cautious here because I think I want to go look at our underwriting transparency model from a couple of years ago and we're kind of going down the same path. That Model said, “we're going to shift it to the consumers. If consumers want to know they can ask.” We went to a little less information than what we were wanting at that time and it’s very similar to what I'm seeing here. But also, we left commercial out because they're not doing any of that. Well, now they are and we're seeing a lot more commercial technology algorithms used in underwriting. And so, I think it’s not going to be long before they begin to use aerial imagery in commercial properties so I'm not real excited about immediately cutting off that commercial path.

And then I'll say this. I think the reality of this is, from the timing of being able to cure, etc. - in this market we're in right now, if you're going to non-renew me because of my roof, I probably don't have another market, period. Like Sen. Walker said, I'm in the business as well, I don't have a carrier that will take me. My option is the Fair Access to Insurance Requirements (FAIR) plan. So, I'm going to go and triple my premium to have

probably less coverage than what I was leaving, even if I make the commitment to fix. In Indiana I called my contractor and I said, “How long until I can put a new roof on?” He said: “90 days until I can get to you.” What's the balance here? If I make that commitment, whether it's a down payment on that or something else, why is it that I have to go to the FAIR plan before I can go back into the market? That's not good public policy in my opinion. So, again, I think the way that the draft is now, it’s fair. I'm okay with a couple of technical tweaks, and I'll second what Sen. Walker said about the notice of non-renewal period. I think in Indiana, we got ours pushed back to 45 days. It should have been 60, but I think there needs to be some standard in that as well.

Shannon Haar, Deputy General Counsel at Nearmap thanked the Committee for the opportunity to speak and stated I just wanted to share a few points from the Nearmap perspective. We presented at the last meeting in April and I just wanted to reemphasize the points we made, one being with regard to recency. We align with the 12 months as proposed. In fact, as I'm sure many, if not all of us are aware, California is actually looking at a six-month recency requirement, and we're in line to support that as well. So, we affirmatively support sticking with the 12 months and not extending any longer than that. I also want to address questions around our suggestion of adding a 7.5 centimeter resolution requirement. The reason for that is there is a marked difference between, even going to 15 centimeters to 7.5 centimeters. So, it's not necessarily the size, it's about the resolution and the usability of the data that you can obtain from that resolution. Again, we had noted this in our prior presentation, so I just wanted to re-share it and make sure everyone was clear on the reason behind it, and that is it just makes the image more usable. It's fairer when making the assessment to be able to see whether or not there is an issue because when you have that sharper resolution you are able to more quickly and accurately identify what the status of the property is and the underlying characteristics that you may take into consideration when determining if you're going to renew or issue the policy to begin with.

Rep. Bennett thanked everyone for their comments and stated obviously there are further conversations to be had on this and I anticipate between now and the summer meeting that the sponsors will be fielding a lot of conversations from folks. So, with that, I’ll turn things over to the sponsors for closing remarks.

Rep. LeBeouf thanked everyone for the contributions to the conversation. I definitely share the sentiment of many of my colleagues on this committee around moving forward with technical amendments. I think substantively, the Model is in a good space. While I don't want to speak for my colleague, Rep. Lampton, I'm sure we're on a similar page that this should be moved forward in Chicago. I do just want to make a quick clarification comment around the image resolution. I think we're in agreement, Rep. Lampton and I, around a drafting note to indicate a minimum in clarity and size. The hesitation about putting it in statute is what happens if you put something in a statute and the technology changes. As an aside, I'm dealing with a bill to remove the word microfilm from a statute because there's a microfilm shortage and our registry of deeds in Massachusetts are required to put every document on microfilm. And because that word is in the statute, the secretary of state won't allow other types of duplication processes. So, that's why I'm

cautious on that. But I think giving guidance for the implementation of the model is definitely within our scope and that's where the drafting notes come in.

Rep. Lampton stated that he had a question for NAMIC and APCIA and that is we know carriers are using the fixed wing aerial images for a multitude of things. For example, in my agency, one of my carriers was using it to identify swimming pools and if we look at the homeowner policy, and we discover that we did not put that liability charge on that policy, yet the image shows that there is a swimming pool, we need to add that surcharge. My question is regarding the images that are purchased or used by the carrier - what percentage of those will then result in a non-renewal in part or in whole due to that? Mr. Martin stated that he did not know the answer. It's going to vary from company to company for a host of reasons. What I will promise to do for you is to visit with our membership and see if we can come up with some number. Ms. Segura stated that I would say the same - I do not have an answer, but I'm happy to see if there are numbers out there that we can provide.

Rep. Bennett stated that I appreciate this whole conversation and this is evidence that the sponsors are willing to listen and that industry is willing to contribute. So between now and Chicago please reach out to the sponsors so that we can move forward with this if it looks like everyone can come to an agreement.

OPPORTUNITY FOR COMMENT/DISCUSSION ON MODEL LAWS SCHEUDLED FOR RE-ADOPTION BY THE COMMITTEE AT UPCOMING SUMMER MEETING IN JULY

Rep. Bennett stated that I'll now move to comments and discussions on the model laws that are scheduled for readoption by this committee at the meeting in July. Those are: the Storm Chaser Consumer Protection Act, the Model Act Regarding Medicaid Interception of Insurance Payments, the Model Act to Regulate Insurance Requirements for Transportation Network Companies (TNCs), and Transportation Network Drivers, and the Model Act Regarding the Use of Credit Information in Personal Insurance. As a reminder, the NCOIL bylaws state that all Models are scheduled to be considered for readoption every five years and if a model is not readopted, it sunsets. So, that is the landscape of the conversation that we're having right now, and I want to point out that there will not be votes on these readoptions today. This is just an opportunity for us to have comments made and discussions in advance of this meeting in Chicago in July.

a.) Storm Chaser Consumer Protection Act (Originally Adopted 7/19/15; Readopted 9/26/20)

Eric DeCampos, Senior Director of Strategy, Policy & Government Affairs at the National Insurance Crime Bureau (NICB) stated that this Model has provided significant guardrails and consumer protection against storm chasers, where bad actors seek to defraud consumers and insurers alike following catastrophic events through fraudulent activities in connection with an insurance claim. But with a decade having passed since that initial adoption, bad actors and schemes that they commit have evolved over time to continue to threaten consumers and insurers. The model initially focused on predatory roofers, and when I say predatory roofers, of course, I'm only referring to the few bad

apples in the otherwise good bunch. And these folks have often been associated with storm chasing. But NICB over the years has seen new, questionable actors emerge across the country from tree removal companies, mold remediators, and debris removal companies, as well as other entities who offer goods and services related to the repair or remediation of a property in connection with an insurance claim, only to turn around and contribute to questionable and outright fraudulent claims. So, ahead of the readoption of the model, NICB will be holding a formal presentation on this issue in greater detail at the summer meeting in Chicago. And we're also currently working with Sen. Walker on some potential amendments to the model to help address these evolving trends and these new bad actors that are emerging and threatening consumers. We look forward to working with stakeholders and we're having some robust conversations right now. We look forward to continuing those discussions to perfect these proposed amendments, which will be shared soon.

Ethan Wilson stated thanked Mr. DeCampos for his comments and for being a good partner on this and stated that on behalf of the Associated Builders and Contractors (ABC), we will be continuing to take a look at some of this. We had a really good call with Mr. DeCampos to figure out where exactly NICB is coming from on this and it makes a ton of sense. And on behalf of ABC, we may have some comments moving into Chicago. We're still running some traps with our members and some of our chapters in the States. So I just want to get on the record that ABC looks forward to working on this with NCOIL moving forward and making it better.

b.) Model Act to Regulate Insurance Requirements for Transportation Network Companies and Transportation Network Drivers (Originally Adopted 7/19/15; Readopted 9/26/20)

On behalf of Uber, Brad Nail stated that It has been 10 years since the model was adopted. It has been adopted in most states in whole and at least in some form in really every state, even those that made some modifications to it. So, I think by any measure, it has been one of the most successful models that NCOIL has promulgated. Now, over the course of a decade, what was then a nascent industry has now matured, and there have been a couple of components of the statutes that have required revision, and we have made those revisions in a handful of the states so far, really over the last two to three years. And we think that those revisions are worth the committee's time and consideration in relation to readoption in order to keep the model current. I know that the summer meeting agenda is pretty full so we're hoping that there's a possibility of a short-term readoption of the model and then scheduling a full discussion of some potential revisions to the model when the time allows for that. And we, of course, will keep in mind that this model was the product of a lot of work between the TNCs and the property and casualty insurers so we would work with the insurers and work with the committee on any revisions that would be under consideration by the committee.

On behalf of Lyft, Derek Wooley stated that I just want to reiterate some comments made by Mr. Nail. Having worked on this model with this body, NCOIL did a fantastic job of bringing all the participants together. I think that not everybody was happy at the time and that led to a good model that was adopted nearly everywhere. And I think it is

prudent to go ahead and readopt the model and look at modernizing it and I'll definitely be working closely with Mr. Nail and the insurers and the committee to make sure that we get something that everyone can live with.

Rep. Bennett thanked everyone and stated I want to reiterate for anybody who is new to NCOIL, the way that this is going to work is in July when we vote on these models, it will be either to re-adopt for five years, sunset, or we can adopt them on a meeting to meeting basis as we are working on them if we feel that there's need for more conversation. So I just want everybody who's engaged on any of these issues to know that it's not going to be a make it or break it decision in July.

c.) Model Act Regarding Medicaid Interception of Insurance Payments (Originally Adopted 11/23/14; Amended Version Adopted 3/1/15; Readopted 9/26/20)

No comments were offered on this Model by legislators or interested parties.

d.) Model Act Regarding Use of Credit Information in Personal Insurance (Originally Adopted 11/22/02; Readopted 11/19/05; Amended 7/12/09; Readopted 11/15/15; Readopted 9/26/20)

Rep. Lehman stated that I want to bring some issues regarding this Model forward and we can have this discussion in Chicago. As we have seen with a handful of carriers with all the technology they have, they have something like 99 tiers they put people in. We had someone recently who had no credit whatsoever and they were put in the 99th tier and their premium went up quite significantly. When we reached out to the carrier, they said “that's our neutral tier.” I think we need to have maybe a small discussion when we readopt this model to see if we are clear in our statutes of how do you treat someone with no credit? Because the advice from the carrier was they should probably get a credit card and then create some credit so they get a better tier. That's not proper advice in my opinion so I think we need to have that discussion.

ANY OTHER BUSINESS

Rep. Lehman stated that I know recently there have been some discussions about possibly opening up the Travel Insurance model regarding some technical issues. I think that's an issue I’d like to bring up in Chicago and that could be something we could take care of in a matter of minutes.

ADJOURNMENT

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

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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~~June 17, 2025. To be discussed and potentially considered during the ~~interim~~ meeting of the Property & Casualty Insurance Committee on ~~October 7, 2024~~ ~~April 26~~July 19, 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, including the specific standards that any repairs must adhere to. 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]. An insurer shall have the right to assess the work used to correct defects to ensure they have been corrected in a manner that meets the standards originally communicated by the insurer in subsection (a).

(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.

Drafting note: As part of legislative efforts related to insurers' use of drones, states may wish to also address how such use interacts with state laws governing trespass.

Section 5. Rules

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

Drafting note: As part of the rules adopted to effectuate the provisions of this Act, States may wish to include rules that set forth the minimum and maximum sizes of the photos referenced in Section 4(a).

Section 6. Effective Date

This Act shall take effect xxxxxx.

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CHIEF EXECUTIVE OFFICER: Thomas B. Considine

NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

Model Act to Regulate Insurance Requirements for Transportation Network Companies and Transportation Network Drivers

***Adopted by the NCOIL Executive Committee on July 19, 2015. Sponsored by Rep. Michael Stinziano (OH); Re-adopted by the Property & Casualty Insurance Committee on September 24, 2020 and the Executive Committee on September 26, 2020.**

***To be considered for re-adoption by the Property & Casualty Insurance Committee on July 19, 2025.**

A. Definitions

1. "Personal Vehicle" means a vehicle that is:

    a. used by a TNC driver to provide a prearranged ride;

    b. owned, leased or otherwise authorized for use by the Transportation Network Company Driver; and

    c. not a taxicab, limousine, or other hire vehicle

2. “Digital Network” means any online-enabled application, software, website or system offered or utilized by a Transportation Network Company that enables the prearrangement of rides with Transportation Network Company Drivers.

3. “Transportation Network Company" means a corporation, partnership, sole proprietorship, or other entity that is licensed pursuant to this [Chapter/Title] and operating in [STATE] that uses a Digital Network to connect Transportation Network Company Riders to Transportation Network Company Drivers who provide Prearranged Rides. A Transportation Network Company shall not be deemed to control, direct or manage the Personal Vehicles or Transportation Network Company Drivers that connect to its Digital Network, except where agreed to by written contract.

4. “Transportation Network Company (TNC) Driver" or "driver" means an individual who:

a. receives connections to potential riders and related services from a Transportation Network Company in exchange for payment of a fee to the Transportation Network Company; and

b. uses a Personal Vehicle to offer or provide a Prearranged Ride to TNC riders upon connection through a Digital Network controlled by a Transportation Network Company and in exchange for compensation or payment of a fee

5. "Transportation Network Company (TNC) Rider" or "rider" means an individual or persons who use a Transportation Network Company’s Digital Network to connect with a Transportation Network Driver who provides Prearranged Rides to the rider in the driver's Personal Vehicle between points chosen by the rider.

6. “Prearranged Ride" means the provision of transportation by a TNC driver to a TNC rider:

a. beginning when a TNC driver accepts a TNC rider’s request for a ride through a digital network controlled by a Transportation Network Company;

b. continuing while the TNC driver transports the requesting TNC rider; and

c. ending when the last requesting TNC rider departs from the Personal Vehicle

7. The term “prearranged ride” does not include transportation provided through any of the following [CITE DEFINITION IN STATE LAW OR MOTOR CARRIER ACT]:

a. shared expense carpool or vanpool arrangements

b. use of a taxicab, limousine, or other hire vehicle

c. a regional transportation

B. Transportation Network Companies

1. A transportation network company may not operate without a permit issued under [CITE DEFINTITION IN STATE LAW]. 69 a. A permit is valid for one (1) year after the date of issuance.

2. A TNC or a TNC driver is not:

a. a common carrier;

b. a contract carrier; or

c. a motor carrier

3. The department shall issue a permit to a TNC that satisfies the following requirements:

a. establishes a zero tolerance policy for drug and alcohol

b. requires compliance with applicable vehicle requirements

c. adopts nondiscrimination and accessibility policies

d. establishes record maintenance guidelines

4. Before a TNC allows an individual to act as a TNC driver on the TNC's digital network, the TNC shall:

a. require the individual to submit to the TNC an application that includes:

i. the individual's name, address, and age;

ii. the individual's driver's license;

iii. the registration for the personal vehicle that the individual will use to provide prearranged rides;

iv. proof of financial responsibility for the personal vehicle described in 4(a)(iii) above of a type and in the amounts required by the TNC; and

v. any other information required by the TNC;

b. with respect to the individual, conduct, or contract with a third party to conduct:

i. a local and national criminal background check; and

ii. a search of the national sex offender registry; and

iii. obtain a copy of the individual's driving record maintained under [CITE DEFINITION IN STATE LAW]

c. A TNC may not knowingly allow to act as a TNC driver on the TNC's digital network an individual:

i. who has received judgments for:

(1) more than three (3) moving traffic violations in the preceding three (3) years; or

(2) at least one (1) violation involving reckless driving or driving on a suspended or revoked license in the preceding three (3) years; or

ii. who has been convicted in the preceding seven (7) years of a:

(1) felony; or

(2) misdemeanor involving:

(a) resisting law enforcement;

(b) dishonesty;

(c) injury to a person;

(d) operating while intoxicated;

(e) operating a vehicle in a manner that endangers a person;

(f) operating a vehicle with a suspended or revoked license; or

(g) damage to the property of another person; or

iii. who is a match in the state or national sex offender registry;

iv. who is unable to provide information required under subsection (b)

5. A TNC shall establish and enforce a zero tolerance policy for drug and alcohol use by TNC drivers during any period when a TNC driver is engaged in, or is logged into the TNC's digital network but is not engaged in, a prearranged ride. The policy must include provisions for:

a. investigations of alleged policy violations; and

b. suspensions of TNC drivers under investigation

6. A TNC must require that a personal vehicle used to provide prearranged rides must comply with all applicable laws and regulations concerning vehicle equipment.

C. Financial Responsibility of Transportation Network Companies

On or before [MONTH, DAY, YEAR] and thereafter, a Transportation Network Company Driver or Transportation Network Company on the driver's behalf shall maintain primary automobile insurance that:

1. Recognizes that the driver is a Transportation Network Company Driver or otherwise uses a vehicle to transport riders for compensation and covers the driver:

a. while the driver is logged on to the Transportation Network Company's Digital Network; or

b. while the driver is engaged in a Prearranged Ride

2. The following automobile insurance requirements shall apply while a participating Transportation Network Company Driver is logged on to the Transportation Network Company's Digital Network and is available to receive transportation requests but is not engaged in a Prearranged Ride:

a. Primary automobile liability insurance in the amount of at least $50,000 for death and bodily injury per person, $100,000 for death and bodily injury per incident, and $25,000 for property damage.

[Drafting note: Reference by statute all other state mandated coverages for motor vehicles by state financial responsibility law, UM/UIM, Med Pay, NF and/or PIP.]

b. The coverage requirements of this subsection 2 may be satisfied by any of the following:

i. automobile insurance maintained by the Transportation Network Company Driver; or

ii. automobile insurance maintained by the Transportation Network Company; or

iii. any combination of subparagraphs (i) and (ii).

3. The following automobile insurance requirements shall apply while a Transportation Network Company Driver is engaged in a Prearranged Ride:

a. Primary automobile liability insurance that provides at least $1,000,000 for death, bodily injury and property damage;

[Drafting note: Reference by statute all other state mandated coverages for limousines, e.g., UM/ UIM, Med Pay, NF and/or PIP.]

b. The coverage requirements of this subsection 3 may be satisfied by any of the following:

i. automobile insurance maintained by the Transportation Network Company Driver; or

ii. automobile insurance maintained by the Transportation Network Company; or

iii. any combination of subparagraphs (i) and (ii)

4. If insurance maintained by driver in subsections 2 or 3 has lapsed or does not provide the required coverage, insurance maintained by a Transportation Network Company shall provide the coverage required by Section C beginning with the first dollar of a claim and have the duty to defend such claim.

5. Coverage under an automobile insurance policy maintained by the Transportation Network Company shall not be dependent on a personal automobile insurer first denying a claim nor shall a personal automobile insurance policy be required to first deny a claim.

6. Insurance required by this Section C may be placed with an insurer licensed under [CITE STATUTE], or with a surplus lines insurer eligible under [CITE STATUTE] that has a credit rating of no less than “A-“ from A.M. Best or “A” from Demotech or similar rating from another rating agency recognized by the department of insurance.

7. Insurance satisfying the requirements of this Section C shall be deemed to satisfy the financial responsibility requirement for a motor vehicle under [STATE FINANCIAL RESPONSIBILITY STATUTE].

8. A Transportation Network Company Driver shall carry proof of coverage satisfying sections C.2 and C.3 with him or her at all times during his or her use of a vehicle in connection with a Transportation Network Company’s Digital Network. In the event of an accident, a Transportation Network Company Driver shall provide this insurance coverage information to the directly interested parties, automobile insurers and investigating police officers, upon request pursuant to [INSERT ELECTRONIC ID CARD LAW OR CREATE SUCH LAW]. Upon such request, a Transportation Network Company Driver shall also disclose to directly interested parties, automobile insurers, and investigating

police officers, whether he or she was logged on to the Transportation Network Company's Digital Network or on a Prearranged Ride at the time of an accident.

D. Disclosures

1. The Transportation Network Company shall disclose in writing to Transportation Network Company Drivers the following before they are allowed to accept a request for a Prearranged Ride on the Transportation Network Company's Digital Network:

a. the insurance coverage, including the types of coverage and the limits for each coverage, that the Transportation Network Company provides while the Transportation Network Company Driver uses a Personal Vehicle in connection with a Transportation Network Company's Digital Network; and

b. that the Transportation Network Company Driver's own automobile insurance policy might not provide any coverage while the driver is logged on to the Transportation Network Company's Digital Network and is available to receive transportation requests or is engaged in a Prearranged Ride, depending on its terms.

[Drafting note: A state should consider appropriate lienholder language to coordinate with the state's existing law.]

E. Automobile Insurance Provisions

1. Insurers that write automobile insurance in [INSERT STATE] may exclude any and all coverage afforded under the policy issued to an owner or operator of a Personal Vehicle for any loss or injury that occurs while a Driver is logged on to a Transportation Network Company's Digital Network or while a Driver provides a Prearranged Ride. This right to exclude all coverage may apply to any coverage included in an automobile insurance policy including, but not limited to:

a. liability coverage for bodily injury and property damage;

b. personal injury protection coverage as defined in [CITE STATUTE];

c. uninsured and underinsured motorist coverage;

d. medical payments coverage;

e. comprehensive physical damage coverage; and

f. collision physical damage coverage

Such exclusions shall apply notwithstanding any requirement under [STATE FINANCIAL RESPONSIBILITY STATUTE]. Nothing in this section implies or requires that a personal automobile insurance policy provide coverage while the driver is logged on to the Transportation Network Company's Digital Network, while the driver is engaged in a Prearranged Ride or while the driver otherwise uses a vehicle to transport riders for compensation.

Nothing in this Article shall be construed as to require an insurer to use any particular policy language or reference to this section in order to exclude any and all coverage for any loss or injury that occurs while a driver is logged on to a Transportation Network Company's Digital Network or while a Driver provides a Prearranged Ride.

Nothing shall be deemed to preclude an insurer from providing primary or excess coverage for the Transportation Network Company Driver's vehicle, if it so chose to do so by contract or endorsement.

2. Automobile insurers that exclude the coverage described in Section C shall have no duty to defend or indemnify any claim expressly excluded thereunder. Nothing in this Article shall be deemed to invalidate or limit an exclusion contained in a policy including any policy in use or approved for use in [STATE] prior to the enactment of this Article that excludes coverage for vehicles used to carry persons or property for a charge or available for hire by the public.

An automobile insurer that defends or indemnifies a claim against a driver that is excluded under the terms of its policy, shall have a right of contribution against other insurers that provide automobile insurance to the same driver in satisfaction of the coverage requirements of Section C at the time of loss.

3. In a claims coverage investigation, Transportation Network Companies shall immediately provide upon request by directly involved parties or any insurer of the Transportation Network Company Driver if applicable, the precise times that a Transportation Network Company Driver logged on and off of the Transportation Network Company's Digital Network in the twelve-hour period immediately preceding and in the twelve-hour period immediately following the accident. Insurers potentially providing coverage as set forth in Section C shall disclose upon request by any other such insurer involved in the particular claim, the applicable coverages, exclusions and limits provided under any automobile insurance maintained in order to satisfy the requirements of Section C.

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NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

MODEL ACT REGARDING USE OF CREDIT INFORMATION IN PERSONAL INSURANCE

Readopted by the Property-Casualty Insurance and Executive Committees on November 15, 2015. Originally adopted by the Property-Casualty Insurance and Executive Committees on November 22, 2002; readopted by the Committees, respectively, on November 17, 2005, and on November 19, 2005; amended on July 12, 2009, to expand on extraordinary life circumstances provisions; readopted by the Committees, respectively, on September 24, 2020 and September 26, 2020.

****To be considered for re-adoption by the Property & Casualty Insurance Committee on July 19, 2025.***

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Section 1. Short Title

This Act may be called the Model Act Regarding Use of Credit Information in Personal Insurance

Section 2. Purpose

The purpose of this Act is to regulate the use of credit information for personal insurance, so that consumers are afforded certain protections with respect to the use of such information.

Section 3. Scope

This Act applies to personal insurance and not to commercial insurance. For purposes of this Act, “personal insurance” means private passenger automobile, homeowners, motorcycle, mobile- homeowners and non-commercial dwelling fire insurance policies [and boat, personal watercraft, snowmobile and recreational vehicle polices]. Such policies must be individually underwritten for personal, family or household use. No other type of insurance shall be included as personal insurance for the purpose of this Act.

Section 4. Definitions

For the purposes of this Act, these defined words have the following meaning:

A. Adverse Action—A denial or cancellation of, an increase in any charge for, or a reduction or other adverse or unfavorable change in the terms of coverage or amount of, any insurance, existing or applied for, in connection with the underwriting of personal insurance.

B. Affiliate—Any company that controls, is controlled by, or is under common control with another company.

C. Applicant—An individual who has applied to be covered by a personal insurance policy with an insurer.

D. Consumer—An insured whose credit information is used or whose insurance score is calculated in the underwriting or rating of a personal insurance policy or an applicant for such a policy.

E. Consumer Reporting Agency—Any person which, for monetary fees, dues, or on a cooperative nonprofit basis, regularly engages in whole or in part in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties.

F. Credit Information—Any credit-related information derived from a credit report, found on a credit report itself, or provided on an application for personal insurance. Information that is not credit-related shall not be considered "credit information," regardless of whether it is contained in a credit report or in an application, or is used to calculate an insurance score.

G. Credit Report—Any written, oral, or other communication of information by a consumer reporting agency bearing on a consumer’s credit worthiness, credit

standing or credit capacity which is used or expected to be used or collected in whole or in part for the purpose of serving as a factor to determine personal insurance premiums, eligibility for coverage, or tier placement.

H. Insurance Score—A number or rating that is derived from an algorithm, computer application, model, or other process that is based in whole or in part on credit information for the purposes of predicting the future insurance loss exposure of an individual applicant or insured.

Section 5. Use of Credit Information

An insurer authorized to do business in [insert State] that uses credit information to underwrite or rate risks, shall not:

A. Use an insurance score that is calculated using income, gender, address, zip code, ethnic group, religion, marital status, or nationality of the consumer as a factor.

B. Deny, cancel or non-renew a policy of personal insurance solely on the basis of credit information, without consideration of any other applicable underwriting factor independent of credit information and not expressly prohibited by Section 5(A).

Drafting Note: This subsection prohibits an insurer from refusing to insure an applicant, insured, or other individual seeking insurance coverage because the person's insurance score fails to meet or exceed a minimum numeric threshold, unless one or more other applicable underwriting factors independent of credit information are considered.

C. Base an insured's renewal rates for personal insurance solely upon credit information, without consideration of any other applicable factor independent of credit information.

D. Take an adverse action against a consumer solely because he or she does not have a credit card account, without consideration of any other applicable factor independent of credit information.

E. Consider an absence of credit information or an inability to calculate an insurance score in underwriting or rating personal insurance, unless the insurer does one of the following:

1. Treats the consumer as otherwise approved by the Insurance Commissioner/ Supervisor/Director, if the insurer presents information that such an absence or inability relates to the risk for the insurer.

2. Treats the consumer as if the applicant or insured had neutral credit information, as defined by the insurer.

3. Excludes the use of credit information as a factor and use only other underwriting criteria.

F. Take an adverse action against a consumer based on credit information, unless an insurer obtains and uses a credit report issued or an insurance score calculated within 90 days from the date the policy is first written or renewal is issued.

G. Use credit information unless not later than every 36 months following the last time that the insurer obtained current credit information for the insured, the insurer recalculates the insurance score or obtains an updated credit report. Regardless of the requirements of this subsection:

1. At annual renewal, upon the request of a consumer or the consumer's agent, the insurer shall re-underwrite and re-rate the policy based upon a current credit report or insurance score. An insurer need not recalculate the insurance score or obtain the updated credit report of a consumer more frequently than once in a twelve-month period.

2. The insurer shall have the discretion to obtain current credit information upon any Renewal before the 36 months, if consistent with its underwriting guidelines.

3. No insurer need obtain current credit information for an insured, despite the Requirements of subsection (G)(1), if one of the following applies:

(a) The insurer is treating the consumer as otherwise approved by the Commissioner.

(b) The insured is in the most favorably-priced tier of the insurer, within a group of affiliated insurers. However, the insurer shall have the discretion to order such report, if consistent with its underwriting guidelines.

(c) Credit was not used for underwriting or rating such insured when the policy was initially written. However, the insurer shall have the discretion to use credit for underwriting or rating such insured upon renewal, if consistent with its underwriting guidelines.

(d) The insurer re-evaluates the insured beginning no later than 36 months after inception and thereafter based upon other underwriting or rating factors, excluding credit information.

H. Use the following as a negative factor in any insurance scoring methodology or in reviewing credit information for the purpose of underwriting or rating a policy of personal insurance:

1. Credit inquiries not initiated by the consumer or inquiries requested by the consumer for his or her own credit information.

2. Inquiries relating to insurance coverage, if so identified on a consumer's credit report.

3. Collection accounts with a medical industry code, if so identified on the consumer's credit report.

4. Multiple lender inquiries, if coded by the consumer reporting agency on the consumer's credit report as being from the home mortgage industry and made within 30 days of one another, unless only one inquiry is considered.

5. Multiple lender inquiries, if coded by the consumer reporting agency on the consumer's credit report as being from the automobile lending industry and made within 30 days of one another, unless only one inquiry is considered.

Section 6. Extraordinary Life Circumstances

A. Notwithstanding any other law or regulation, an insurer that uses credit information shall, on written request from an applicant for insurance coverage or an insured, provide reasonable exceptions to the insurer's rates, rating classifications, company or tier placement, or underwriting rules or guidelines for a consumer who has experienced and whose credit information has been directly influenced by any of the following events:

1. Catastrophic event, as declared by the federal or state government

2. Serious illness or injury, or serious illness or injury to an immediate family member

3. Death of a spouse, child, or parent

4. Divorce or involuntary interruption of legally-owed alimony or support payments

5. Identity theft

6. Temporary loss of employment for a period of 3 months or more, if it results from involuntary termination

7. Military deployment overseas

8. Other events, as determined by the insurer

B. If an applicant or insured submits a request for an exception as set forth in Section 6(A), an insurer may, in its sole discretion, but is not mandated to:

1. Require the consumer to provide reasonable written and independently verifiable documentation of the event.

2. Require the consumer to demonstrate that the event had direct and meaningful impact on the consumer's credit information.

3. Require such request be made no more than 60 days from the date of the application for insurance or the policy renewal.

4. Grant an exception despite the consumer not providing the initial request for an exception in writing.

5. Grant an exception where the consumer asks for consideration of repeated events or the insurer has considered this event previously.

C. An insurer is not out of compliance with any law or rule relating to underwriting, rating, or rate filing as a result of granting an exception under this section. Nothing in this section shall be construed to provide a consumer or other insured with a cause of action that does not exist in the absence of this section.

D. The insurer shall provide notice to consumers that reasonable exceptions are available and information about how the consumer may inquire further.

E. Within 30 days of the insurer's receipt of sufficient documentation of an event described in Section 6(A), the insurer shall inform the consumer of the outcome of their request for a reasonable exception. Such communication shall be in writing or provided to an applicant in the same medium as the request.

Section 7. Dispute Resolution and Error Correction

If it is determined through the dispute resolution process set forth in the federal Fair Credit Reporting Act, 15 USC 1681i(a)(5), that the credit information of a current insured was incorrect or incomplete and if the insurer receives notice of such determination from either the consumer reporting agency or from the insured, the insurer shall re-underwrite and re-rate the consumer within 30 days of receiving the notice. After re-underwriting or re-rating the insured, the insurer shall make any adjustments necessary, consistent with its underwriting and rating guidelines. If an insurer determines that the insured has overpaid premium, the insurer shall refund to the insured the amount of overpayment calculated back to the shorter of either the last 12 months of coverage or the actual policy period.

Section 8. Initial Notification

A. If an insurer writing personal insurance uses credit information in underwriting or rating a consumer, the insurer or its agent shall disclose, either on the insurance application or at the time the insurance application is taken, that it may obtain credit information in connection with such application. Such disclosure shall be either written or provided to an applicant in the same medium as the application for insurance. The insurer need not provide the disclosure statement required under this section to any insured on a renewal policy, if such consumer has previously been provided a disclosure statement.

B. Use of the following example disclosure statement constitutes compliance with this section: “In connection with this application for insurance, we may review your credit report or obtain or use a credit-based insurance score based on the information contained in that credit report. We may use a third party in connection with the development of your insurance score.”

Section 9. Adverse Action Notification

If an insurer takes an adverse action based upon credit information, the insurer must meet the notice requirements of both (A) and (B) of this subsection. Such insurer shall:

A. Provide notification to the consumer that an adverse action has been taken, in accordance with the requirements of the federal Fair Credit Reporting Act, 15 USC 1681m(a).

B. Provide notification to the consumer explaining the reason for the adverse action. The reasons must be provided in sufficiently clear and specific language so that a person can identify the basis for the insurer’s decision to take an adverse action. Such notification shall include a description of up to four factors that were the primary influences of the adverse action. The use of generalized terms such as “poor credit history,” “poor credit rating,” or “poor insurance score” do not meet the explanation requirements of this subsection. Standardized credit explanations provided by consumer reporting agencies or other third party vendors are deemed to comply with this section.

Section 10. Filing

A. Insurers that use insurance scores to underwrite and rate risks must file their scoring models (or other scoring processes) with the Department of Insurance. A third party may file scoring models on behalf of insurers. A filing that includes insurance scoring may include loss experience justifying the use of credit information.

B. Any filing relating to credit information is considered trade secret under [cite to the appropriate state law].

Section 11. Indemnification

An insurer shall indemnify, defend, and hold agents harmless from and against all liability, fees, and costs arising out of or relating to the actions, errors, or omissions of [an agent / a producer] who obtains or uses credit information and/or insurance scores for an insurer, provided the [agent / producer] follows the instructions of or procedures established by the insurer and complies with any applicable law or regulation. Nothing in this section shall be construed to provide a consumer or other insured with a cause of action that does not exist in the absence of this section.

Section 12. Sale of Policy Term Information by Consumer Reporting Agency

A. No consumer reporting agency shall provide or sell data or lists that include any information that in whole or in part was submitted in conjunction with an insurance inquiry about a consumer's credit information or a request for a credit report or insurance score. Such information includes, but is not limited to, the expiration dates of an insurance policy or any other information that may identify time periods during which a consumer's insurance may expire and the terms and conditions of the consumer's insurance coverage.

B. The restrictions provided in subsection (A) of this section do not apply to data or lists the consumer reporting agency supplies to the insurance [agent / producer] from whom information was received, the insurer on whose behalf such [agent / producer] acted, or such insurer's affiliates or holding companies.

C. Nothing in this section shall be construed to restrict any insurer from being able to obtain a claims history report or a motor vehicle report.

Section 13. Severability

If any section, paragraph, sentence, clause, phrase, or any part of this Act passed is declared invalid due to an interpretation of or a future change in the federal Fair Credit Reporting Act, the remaining sections, paragraphs, sentences, clauses, phrases, or parts thereof shall be in no manner affected thereby but shall remain in full force and effect.

Section 14. Effective Date

This Act shall take effect on [insert date], applying to personal insurance policies either written to be effective or renewed on or after 9 months from the effective date of the bill.

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SUMMARY: NCOIL STORM CHASER MODEL LEGISLATION

Table of Contents
Details the 13 sections of the model bill.

Section 1. Title
Currently, (State) Storm Chaser Consumer Protection Act.

Section 2. Purpose
The purpose of the Act is to protect Consumers from unscrupulous Contractor practices.

Section 3. Definitions
Creates a definition for Consumer, Contract, Contractor, and Person. Contractor includes a definition for roofing-related services, to include a subcontractor and other roofing related services and exempts a Person who meets three specific criteria.

Section 4. Written Contract Required
Determines the minimum requirements for a written Contract between the Contractor and the Consumer. Such requirements include the Contractor's contact and registration information; disclosure of the type of Contractors performing the work; the Consumer's right to pay by credit card; an itemized description of the services and costs; a separate document with a "Notice of Cancellation" statement that states the Consumer can cancel for any reason; and a right to cancel statement.

Section 5. Consumer Right to Rescind
The Consumer has the right to rescind a Contract, within three business days, for any reason, including if he or she has received a written notification from the insurer that all or any part of the claim is not covered under the insurance policy. The section also defines the procedures for a Consumer to send a cancellation notice and requires the Consumer to retain a copy of the cancellation notice.

Section 6. Consumer Right to Return of Deposit after Cancellation
Within ten days after a roofing Contract has been cancelled, the Contractor shall return deposits made by the Consumer. The section also entitles the Contractor to the reasonable value of any emergency services he or she performed.

Section 7. Registration Required

A Contractor shall not undertake any services without being registered as a Contractor with the state's appropriate accrediting body. The section requires a written application and proof of insurance to register as a Contractor. The section gives the state the right to deny or revoke a registration or refuse to issue a registration certificate if a licensee or applicant has met certain criteria, including failure to pay taxes and fraudulent misrepresentation.

Section 8. Insurance Required
Requires the Contractor to have and maintain workers' compensation insurance, liability insurance, bodily injury insurance, property damage insurance, and surety and performance bonds. The section allows the accrediting body to determine the specific insurance amounts.

Section 9. Penalties
Penalties can be applied to a Contractor who violates the Act or Contract terms. The section also authorizes the accrediting body to consider the seriousness of the violation, the impact of the violation on the complainant, any mitigating factors on the part of the Contractor, and the Contractor's history of previous violations before issuing any penalties or revoking a registration.

Section 10. Prohibitions
Prohibits a Contractor from certain activities, including asking for a deposit of more than one half of the Contract price, and operating without a license.

Section 11. Exemptions
Exempts a residential or farm property owner who performs roofing services on their own property without the assistance of a Contractor; any authorized employee of the federal, state or local government performing a roofing service upon a government property; and any Person who furnishes material that is not incorporated into or attached to the roof.

Section 12. Enforcement
Authorizes the appropriate state body to enforce the provisions of the Act.

Section 13. Effective Date
Provides an effective date.

Section 14. Severability
Provides a severability clause to ensure that if one part of the Act is deemed invalid, the remainder of the Act remains in force.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

Storm Chaser Consumer Protection Act

Adopted by the NCOIL Executive Committee on July 19, 2015. Sponsored by Sen. Jason Rapert (AR) and Rep. Rich Golick (GA); Readopted by the Property & Casualty Insurance Committee on September 24, 2020 and the Executive Committee on September 26, 2020.

To be considered for re-adoption by the Property & Casualty Insurance Committee on July 19, 2025

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Section 1. Title

This Act shall be known and cited as the [State] Storm Chaser Consumer Protection Act.

Section 2. Purpose

The purpose of this Act is to establish minimum standards for roofing contracts and to promote fair and honest practices in the roofing services business.

Section 3. Definitions

For purposes of this Act:

A. “Consumer” includes any individual who seeks the service of a “Contractor” as defined in this Act.

B. “Contract” includes the entire cost of the construction undertaking, including labor, materials, rentals, all direct and indirect project expenses, and the parties involved in the agreement.

C. “Contractor” means a Person, including, but not limited to, a Person that is a nonresident roofing contractor, independent contractor, day laborer, or subcontractor engaged in the business of roofing, gutter, downspout or siding services for a fee or who offers to engage in or solicits roofing-related services, including construction, installation, renovation, repair, maintenance, alteration, or waterproofing. The term shall not include a person engaged in the demolition of a structure or the cleanup of construction waste and debris that contains roofing material, nor a person providing roofing services to a residential building of more than four units, nor a person engaged in building a new home or housing development.

D. “Person” includes any individual, partnership, corporation, business, trust, or other legal entity.

E. The words including, includes, and include are deemed to be followed by the words without limitation.

Section 4. Written Contract Required

A. Any agreement with a Contractor in an amount over [Enter Dollar Amount] shall be in writing and shall include the following documentation and information:

(1) The complete agreement between the Consumer and the Contractor, with a clear description of any other documents which are or shall be incorporated into the agreement.

(2) The Contractor’s full legal name, business names, principal address, phone number, email, and the registration number.

(3) The name of the Contractor’s insurer, the type of insurance coverage as required by Section 8, and the insurance policy limits obtained by the Contractor.

(4) An itemized description of the work to be done, any emergency services to be completed, and the materials to be used in the performance of the Contract.

(5) The total itemized amount agreed to be paid for the work to be performed under the Contract, including all change orders and work orders.

(6) A description of who will be performing the work, such as a subcontractor, independent contractor, day laborer, and/or others meeting the Contractor definition in Section 3.

(7) An approximation of the cost expected to be borne by the Consumer.

(8) A provision allowing payment to be made by cash, check, or credit card, at the Consumer's discretion.

(9) The signatures of all Persons party to the Contract.

(10) Contain in immediate proximity to the space reserved for the signature of the buyer in bold-face type of a minimum size of ten points, a statement in substantially the following form:

"You may cancel this Contract at any time within three business days of entering into this Contract with your Contractor. You may also cancel the Contract with your Contractor within three business days of being notified that your insurer has denied all or any part of your claim or loss under the insurance policy. See attached notice of cancellation form for an explanation of this right."

(11) Contain a fully completed form in duplicate, captioned "NOTICE OF CANCELLATION," which shall be attached to the Contract but easily detachable, and which shall contain, in boldface type of a minimum size of ten points, the following statement:

"NOTICE OF CANCELLATION

You may cancel this Contract at any time within three business days of entering into the Contract with your Contractor. You may also cancel the Contract with your Contractor within three business days of being notified that your insurer has denied all or any part of your claim or loss under the insurance policy. You may cancel the Contract by mailing or delivering a signed and dated copy of this cancellation notice or any other written notice to (name of Contractor) at (address of Contractor's place of business) at any time within three business days of receiving such notice from your insurer. You may also send a cancellation notice through email. If you cancel, any payments made by you under the Contract will be returned to you within ten business days following receipt by the Contractor of your cancellation notice, and any security interest arising out of the transaction will be canceled. You shall retain a copy of the notice of cancellation that is transmitted to the Contractor.

I HEREBY CANCEL THIS TRANSACTION

_____
(Date) _____
(Consumer's Signature)"

B. At the time of signing, the Consumer shall be furnished with a copy of the Contract signed by both the Contractor and the Consumer. No work shall begin prior to the signing of the Contract and transmittal to the Consumer of a copy of the Contract.

Section 5. Consumer Right to Rescind

A Consumer has the right to rescind the Contract within three business days after he or she signs a Contract. A Consumer who has entered into a written Contract with a Contractor to provide goods or services to be paid from the proceeds of a property or casualty insurance policy may also cancel the Contract at any time prior to midnight of the third business day after he or she has received written notification from the insurer, including electronic notification, that all or any part of the claim is not covered under the insurance policy. Cancellation shall be evidenced by the Consumer giving written notice of cancellation to the Contractor at the physical address or email stated in the Contract. Notice of cancellation, if given by mail, shall be effective upon deposit into the United States mail, postage prepaid, and properly addressed to the Contractor. Notice of cancellation need not take a particular form and shall be sufficient if it indicates, by any form of written expression, the intention of the Consumer not to be bound by the Contract. The Consumer shall retain a copy of the cancellation notice.

Section 6. Consumer Right to Return of Deposit after Cancellation

Within ten days after a Contract has been cancelled, the Contractor shall tender to the Consumer or possessor of the residential real estate any payments, partial payments, or deposits made by the Consumer and any note or other evidence of indebtedness. If, however, the Contractor has performed any services which were both acknowledged by the Consumer in writing and reflected in the original itemized estimate, the Contractor shall be entitled to the reasonable value of such services.

Section 7. Registration Required

A. No person shall undertake, offer to undertake, or agree to perform Contractor services unless registered with and approved by the [Enter Accrediting Body] as a Contractor.

B. Any Contractor who does not possesses a certificate of registration from the [Enter Accrediting Body] as of [Enter Enactment Date], shall be entitled to complete any preexisting Contracts he or she has entered. However, a Contractor shall be required to register prior to bidding or entering into any Contracts within thirty days following [Enter Enactment Date].

C. In order to be registered as a Contractor, an applicant must make an application to the [Enter Accrediting Body]. The application shall set forth information that includes the following:

(1) The applicant's name, home address, business address, phone number, email address, website address, and social security number.

(2) The names and addresses of any and all affiliates, subsidiaries, partners, or trustees of the applicant including, in the case of corporate entities, the names and addresses of any and all officers, directors, and principal shareholders.

(3) A statement whether the applicant has ever been previously registered in the state as a Contractor, under what other names he or she was previously registered, whether there have been previous judgments or arbitration awards against him or her, and whether his or her registration has ever been suspended or revoked.

D. If requested, the applicant shall furnish the [Enter Accrediting Body] proof of insurance, as described in Section 8 of this Act.

E. The [Enter Accrediting Body] may fix fees, in an amount not to exceed [appropriate dollar amount], in a manner established by its rules for the registration fees and, if appropriate, renewal fees for Contractors. After consideration of administrative expenses, any fees collected under this section shall be used to enforce this Act.

F. The [Enter the Accrediting Body] may deny, restrict, suspend, revoke the registration of a Contractor, or refuse to register an applicant if he or she:

(1) Employs the use of fraud, deceit, or misrepresentation in obtaining or attempting to obtain a registration or the renewal of a registration ;

(2) Practices or attempts to practice roofing services by fraudulent misrepresentation;

(3) Commits an act of gross malpractice or incompetence, as determined by [Enter Accrediting Body];

(4) Has been convicted of or pled guilty or no contest to a crime that indicates that the person is unfit or incompetent to practice as a Contractor, or that indicates that the person has deceived or defrauded the public;

(5) Has been declared incompetent by a court of competent jurisdiction;

(6) Has willfully violated any provision in this Act or any rules adopted by [Enter Accrediting Body];

(7) Has had a Contractor registration suspended in another state;

(8) Fails to maintain insurance pursuant to Section 8 of this Act; or

(9) Fails or refuses to pay any taxes due in this State.

G. The [Enter Accrediting Body] has the authority to accelerate registration for any Contractor that is registered and in good standing in another state with similar registration standards. The [Enter Accrediting Body] has the authority to issue a certificate of registration that will contain information deemed appropriate by the [Enter Accrediting Body]. Said certificate will be valid for [Enter appropriate term] from the date of its issuance and may be renewed upon approval of the [Enter Accrediting Body]. The certificate will not be transferable.

Section 8. Insurance Required

A. A Contractor shall obtain and maintain in full force and effect during the operation of the roofing business all of the following types of insurance:

(1) Workers' compensation insurance in the amount of [Enter Appropriate State Amount];

(2) Public liability insurance in the amount of [Insert the State Requirement];

(3) Bodily injury in the amount of [Insert the State Requirement];

(4) Property damage in the amount of [Insert the State Requirement]; and

(5) A Surety and Performance Bond is the amount of [Insert Appropriate State Amount].

Section 9. Penalties

A. If the [Enter Accrediting Body] determines that any registrant is liable for violation of any of the provisions contained in this Act, the [Enter Accrediting Body] may suspend the registrant's certificate of registration for such period of time as shall be determined by the [Enter Accrediting Body], revoke the registrant's certificate of registration, or reprimand the registrant.

B. The [Enter Accrediting Body] may assess an administrative penalty not to exceed [Enter state penalty] of the total Contract price, whichever is greater, payable within 30 days of their order, for each violation of any of the provisions of this Act, committed by the Contractor who is registered or who is required to be registered, plus any administrative costs incurred by the [Enter Accrediting Body].

C. In determining whether to impose an administrative penalty, the [Enter Accrediting Body] shall consider the seriousness of the violation, the impact of the violation on the complainant, any mitigating factors on the part of the Contractor, and any previous violations by the Contractor.

D. If any provision of this Act is violated, the Consumer has the right to rescind the agreement with the Contractor. However, the Consumer will be responsible for paying the Contractor for any work that was performed prior to the cancellation and acknowledged by the Consumer in writing, as specified in Section 4 of this Act.

[Drafting note: A state may want to consult with its attorney general's office to determine if a criminal penalty is necessary for inclusion in this Act or if an adjustment in the criminal penalty section of the current code is needed.]

Section 10. Prohibitions

A. A Contractor shall not advertise, promise to pay, or rebate any portion of any insurance deductible as an inducement to the sale of goods or services. As used in this Section, a promise to pay or rebate includes granting any allowance or offering any discount against the fees to be charged or paying the Consumer or any Person directly or indirectly associated with the property any form of compensation.

B. A Contractor shall not require a deposit of more than one half (1/2) of the Contract price.

C. A Contractor shall not mandate that a particular form of payment be made in order to start roofing services.

D. A Contractor shall not induce the sale of any goods or services by:

(1) Offering or providing any upgraded work, material, or product;

(2) Granting any allowance or offering any discount against the fees to be charged; or

(3) Paying the Consumer, or any other person directly or indirectly associated with the property, any form of compensation, gift, prize, bonus, coupon, credit, referral fee, trade-in or trade-in payment, advertising, or other fee or payment.

E. A Contractor shall not operate without a certificate of registration issued by the [Enter Accrediting Body].

F. A Contractor shall not abandon or fail to perform, without justification, any ongoing Contract or project, or deviate from or disregard plans or specifications in any material respect without the consent of the Consumer.

G. A Contractor shall not fail to credit the Consumer for any payment the Consumer has made to the Contractor in connection with the Contract.

H. A Contractor shall not make any material misrepresentation in the procurement of a Contract or make any false promise likely to influence, persuade, or induce the procurement of a Contract.

I. A Contractor shall not violate the building code of the state or municipality.

J. A Contractor shall not fail to notify the [Enter Accrediting Body] within 30 business days of any change of trade name or address, or conducting a business in any name other than the one in which the Contractor is registered.

K. A Contractor shall not fail to pay for materials or services rendered in connection with his operating as a Contractor where he or she has received sufficient funds as payment for the particular construction work, project, or operation for which the services or materials were rendered or purchased.

L. A Contractor shall not perform the reporting, adjusting, or negotiating of a claim on behalf of the Consumer and shall not receive compensation for the referral to any entity that reports, adjusts or negotiates a claim on behalf of a Consumer.

M. A Contractor shall not fail to possess any insurance required as defined by state and federal law.

Section 11. Exemptions

The following persons are exempt from the requirements of this Act.

A. Residential or farm property owners who, without the assistance of a Contractor registered under this Act, physically perform or have employees who perform roofing, siding, gutter, or downspout services on the dwelling or on another structure located on the residential or farm property.

B. Any authorized employee or representative of the United States government, this state, or any county, municipality, or other political subdivision of this state performing a roofing service upon government property.

C. Any Person who furnishes any fabricated or finished product, material, or article of merchandise that is not incorporated into or attached to real property by the Person so as to become affixed to the property.

Section 12. Enforcement

A. The provisions of this Act shall be enforced by the [Enter the Accrediting Body].

B. The [Enter the Accrediting Body] should have sufficient funding to properly enforce the provisions of this Act.

Section 13. Effective Date

A. This Act shall take effect on [Enter Effective Date].

Section 14. Severability.

A. The provisions of this Act are severable. If any part of this Act is declared invalid or unconstitutional, that declaration shall not affect the parts that remain.

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NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

Model Act Regarding Medicaid Interception of Insurance Payments

Model adopted by the NCOIL Executive Committee on November 23, 2014, and amended on March 1, 2015. Sponsored by Rep. Brian Kennedy, RI; Readopted by the Property & Casualty Insurance Committee on September 24, 2020 and the Executive Committee on September 26, 2020.

To be considered for re-adoption by the Property & Casualty Insurance Committee on July 19, 2025.

Table of Contents

Section 1 Short Title

This Act may be called the *Model Act Regarding Medicaid Interception of Insurance Payments.*

Section 2 Purpose

In accordance with state law and applicable administrative rules, when applying for Medicaid, an applicant (beneficiary) automatically assigns his or her rights to the (NAME OF STATE AGENCY) to any payments under applicable insurance coverage. The purpose of this Act is to regulate the recovery of monies paid by (NAME OF STATE AGENCY).

Section 3 Scope

This Act applies to no-fault, personal injury protection, medical payments coverage and third party payments for bodily injury from insurers and self-funded primary plans (plan). Claims excluded from interception include liability policies that do not pay for bodily injury, claims for property damage or loss of use of property, claims made against accident and health policies whether expense incurred or indemnity and all workers' compensation claims.

Section 4 Application

A. Nothing in these sections shall limit the (NAME OF STATE AGENCY) from recovery of any other monies allowed, to the extent of the distribution, in accordance with all state and federal laws.

B. Any action to pursue any recovery of monies paid by (NAME OF STATE AGENCY) shall be commenced within two years after the date of the accident or event causing the injury asserted by the beneficiary. Nothing herein shall lengthen any time limitations set forth in any plan or insurance policy.

Section 5 Definitions

A. Claimant--either an insured under a policy of insurance or a third party to an insurance policy requesting benefits orally or in writing in excess of two thousand dollars, $2,000.00, for injuries received as a result of an accident or loss. Claimant includes a person's legal representative, family members or any other individual acting on their behalf.

B. Insurer--any insurance company licensed to do business in (Name of State), excluding those that do not issue coverages within the scope of the act in section 3.

C. Medicaid Beneficiary--an individual who has received (Name of State) Medicaid Medical Benefits in excess of two thousand dollars, $2,000.00, as a result of an accident or loss.

D. Plan--any entity that is self insured for its legal responsibility without the benefit of primary insurance, through the use of a self-insured retention. This includes but is not limited to any entity that is directing the handling of its claims through a third party or as a result of a policy buy back, cost sharing agreement or coverage in place agreement.

Section 6 Match Process

A. For the purposes of this section, the matching process is limited to a beneficiary or estate making a bodily injury or wrongful death claim against a plan or under an insurance policy.

B. Claims excluded from interception include liability policies that do not pay for bodily injury, claims for property damage or loss of use of property, claims made against accident and health policies whether expense incurred or indemnity and all workers compensation claims. A payment made to fund a structured settlement annuity and payments pursuant to a structured settlement annuity are excluded from interception if established after twenty-four (24) months from date of loss.

C. At any time prior to making a total payment of two thousand dollars ($2000.00) or more on behalf of or to a claimant, on a claim under a plan or contract of insurance, every plan or insurer issuing automobile or policies of liability insurance, shall exchange information with the (NAME OF STATE AGENCY) by the means set forth in this Act.

D. In order to facilitate compliance with this Act, (NAME OF STATE AGENCY) shall develop and operate a data match system after consultation with one or more insurers and plans, using automated data exchanges to the maximum extent feasible, to compare claimant information held by insurers and plans with the (NAME OF STATE AGENCY) database of beneficiaries.

E. In order to comply with the requirements of this section, an insurer or plan shall provide the (NAME OF STATE AGENCY) with the following information about the individual or estate determined by the (NAME OF STATE AGENCY) to be a beneficiary:

a. Name,
b. Address

They may provide the following optional data:

d. Date of Birth
e. Last Four Digits of a Social Security Number

F. An insurer or plan may provide such information by:

a. Authorizing an insurance claim data collection organization, to which the insurer or plan subscribes and to which the insurer or plan submits the required claim data on at least a weekly basis, to:

1. Receive or access a data file from the (NAME OF STATE AGENCY) and conduct a data match of all individuals who have a claim with the insurer or plan and who are Medicaid Beneficiaries and submit the required data for each such resulting data match to (NAME OF STATE AGENCY AND/OR THEIR AUTHORIZED VENDOR); or

2. Submit a data file to the (NAME OF STATE AGENCY) which contains the required data for each claim being maintained by the insurer or plan for the (NAME OF STATE AGENCY) to conduct a data match;

b. Providing the required data for each claim being maintained by the insurer or plan directly to the (NAME OF STATE AGENCY)in an electronic medium; or

c. Receiving or accessing a data file from the (NAME OF STATE AGENCY) and conducting a data match of individuals who have a claim with the insurer or plan and who are Medicaid beneficiaries and submit the required data for each such resulting data match to (NAME OF STATE AGENCY);

G. Upon receiving notice of a match as set forth in this section, the (NAME OF STATE AGENCY) shall send the insurer or plan a notice of lien pursuant to (CITATION OF STATE LAW)

H. Any insurer or plan that can show that they have made a good faith effort to comply shall be deemed to have complied unless (NAME OF STATE AGENCY) proves an intentional failure to comply by demonstrating a pattern and practice of non-compliance. A single instance will not be sufficient proof.

Section 7 Payment Process

The insurer or plan shall withhold the lesser of the amount of the claim payment or the full amount as set forth in the notice of lien and shall remit that amount to the (NAME OF STATE AGENCY) as provided by (CITATION OF STATE LAW), subject to conditions as stated below.

A. The lien shall encumber the right of the claimant to payment under the policy or plan, and the insurer or plan shall disburse to the claimant only that portion of the payment, if any, after the lien has been satisfied.

B. The lien shall be inferior to any lien or claim for attorney fees.

C. Should the beneficiary and/or their representative believe that the payment of the lien exceeds the extent of the distribution, in accordance with all state and federal laws, and notifies the insurer or plan that they intend to file an administrative appeal the insurer or plan may issue a check made payable to the beneficiary, their representative and (Name of State Agency).

D. The insurer or plan, may notify the (Name of State Agency) of its intent to issue a payment as a single check made payable to; the beneficiary, any representative, any other lienholders and the (Name of State Agency).

E. If the lien is received after the insurer or plan has issued the payment the insurer or plan will notify the (Name of State Agency) of the following information: Date of Payment, Amount of Payment, Payees(s) and Address of recipient. In no case shall the insurer or plan be obligated to make any further payments.

Section 8 Data Confidentiality

A. The information obtained by the (NAME OF STATE AGENCY) pursuant to the provisions of this section shall be used only to aid in recovery of Medicaid payments.

B. An insurer or plan, and its directors, agents or employees, and any insurance claim data collection organization and its agents and employees authorized by an insurer or plan to act on its behalf, shall keep this information safe and private in accordance with applicable state law.

Section 9 Notice

(NAME OF STATE AGENCY) shall provide written notice to the claimant and his/her attorney if represented which shall include the date, name, social security number, case number, and amount of the payment being withheld to reimburse the state, reason for the payment and opportunity to request a hearing.

Section 10 Request for Hearing

Any beneficiary aggrieved by any action taken under these procedures may within thirty (30) days of the date of the notice to the claimant request a hearing from the (NAME OF STATE AGENCY). Any payments made by an insurer or plan pursuant to this chapter shall be made to the (NAME OF STATE AGENCY), unless there is request for hearing within thirty (30) days of the notice, or within ten (10) business days of a decision after hearing and in accordance with the decision of any hearing that takes place.

Section 11 Immunity

A. An insurer or plan, and its directors, agents or employees, and any insurance claim data collection organization and its agents and employees authorized by an insurer or plan to act on its behalf, which provides or attempts to provide data under this section are immune from any civil liability under any law to any person or entity for any alleged or actual damages that occur as a result of providing or attempting to provide data under this section. This act does not create any other obligations upon insurers or plan.

B. An insurer or plan, and its directors, agents or employees, and any insurance claim data collection organization and its agents and employees authorized by an insurer or plan to act on its behalf, under this section are immune from any civil liability under any law to any person or entity for any alleged or actual damages that occur as a result of making a lien payment to a state agency as demanded by the state.

C. Any person against whom any action is brought who is found to be immune from liability under this section, shall be entitled to recover reasonable attorney’s fees and costs from the person or party who brought the action. This section does not abrogate or modify in any way any common law or statutory privilege or immunity heretofore enjoyed by any person.

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NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

Travel Insurance Model Act

Originally adopted by the NCOIL Property-Casualty Insurance Committee on November 16, 2012, and Executive Committee on November 18, 2012. ***Sponsored by Rep. Robert Damron (KY)***
Updated version adopted by the NCOIL Property-Casualty Committee and Executive Committee on March 5, 2017. Updated version amended by the NCOIL Property and Casualty Committee on July 14, 2017 and approved by the NCOIL Executive Committee on July 15, 2017. Readopted on July 16, 2022. ***Amendments sponsored by Rep. Matt Lehman (IN)***

****Proposed amendments sponsored by Rep. Matt Lehman (IN) and are to be discussed and potentially considered during the Property & Casualty Insurance Committee's meeting on July 19, 2025.***

> **Drafting Note:** This Travel Insurance Model Act is intended to be enacted as a standalone chapter of the insurance code with appropriate cross references to seamlessly incorporate provisions such as licensing and premium tax into the adopting state's existing statutory structure. Alternatively, sections such as the licensing and premium tax provisions that may fit into other sections of an adopting state's statutory structure could be pulled from the Model and incorporated into the sections of the adopting state's insurance code that address those topics.

Section 1. Short Title

This Act shall be known as the "Travel Insurance Model Act."

Section 2. Scope and Purposes

A. The purpose of this Act is to promote the public welfare by creating a comprehensive legal framework within which Travel Insurance may be sold in this state through the establishment of clear regulatory obligations for those involved in the development and distribution of Travel Insurance, preserving the unique aspects of Travel Protection Plans, and protecting and benefiting consumers by encouraging fair and effective competition within the market.

B. The requirements of this Act shall apply to Travel Insurance, whether or not provided as part of a Travel Protection Plan, where policies and certificates are delivered or issued for delivery in this state. It shall not be applicable to Cancellation Fee Waivers and Travel Assistance Services, except as expressly provided herein.

Section 3. Definitions

As used in this Act:

“Aggregator Site” means a website that provides access to information regarding insurance products from more than one insurer, including product and insurer information, for use in comparison shopping.

“Blanket Travel Insurance” means Travel Insurance issued to any Eligible Group providing coverage for specified circumstances and specific classes of persons defined in the policy and issued to a policyholder and not by specifically naming the persons covered, by certificate or otherwise, although a statement of the coverage provided may be given, or required by policy to be given, to eligible persons.

“Cancellation Fee Waiver” means a contractual agreement between a supplier of travel arrangements or travel services and its customer to waive some or all of the non-refundable cancellation fee or penalty provisions of the underlying travel contract between the supplier and customer. A Cancellation Fee Waiver is not insurance.

"Commissioner" means the commissioner of insurance of this state.

> **Drafting Note:** Insert the title of the state’s chief insurance regulatory official wherever the term "Commissioner" appears.

“Eligible Group” means any of the following:

a. Any entity engaged in the business of providing travel or travel services, including but not limited to: tour operators, lodging providers, vacation property owners, hotels and resorts, travel clubs, property managers, cultural exchange programs, and common carriers of passengers, including but not limited to airlines, cruise lines, railroads, steamship companies, and public bus carriers;

b. Any college, school, or other institution of learning covering students, teachers or employees defined by reference to specified hazards incident to activities or operations of the institution of learning;

c. Any employer covering any group of employees, contractors, dependents or guests, defined by reference to specified hazards incident to activities or operations of the employer;

d. Any sports team, camp, or sponsor thereof covering participants, members, campers, employees, officials, supervisors, or volunteers;

e. Any religious, charitable, recreational, educational, or civic organization or branch thereof covering any group of members, participants, or volunteers defined by reference to specified hazards incident to any activity or activities or operations sponsored or supervised by or on the premises of such organization or branch;

f. Any financial institution or financial institution vendor, or parent holding company, trustee, or agent of or designated by one or more financial institution or financial institution vendor, under which accountholders, credit card holders, debtors, guarantors, or purchasers are insured;

g. Any incorporated or unincorporated association, including labor unions, having a common interest, constitution and bylaws, and organized and maintained in good faith for purposes other than obtaining insurance for members or participants of such association;

h. Any trust or the trustees of a fund established, created or maintained for the benefit of members or customers of one or more associations meeting the above requirements;

i. Any entertainment production company covering any group of participants, volunteers, audience members, contestants, or workers;

j. Any newspaper or other publisher covering its journalists and carriers;

k. Any volunteer fire department or any first aid, civil defense or other such volunteer group, or agency having jurisdiction thereof, covering all or any group of the members, participants or volunteers of such fire department or first aid, civil defense or other group; or

l. Any other group where the Commissioner has determined that the members are engaged in a common enterprise, or have an economic, educational, or social affinity or relationship, and that issuance of the policy would not be contrary to the best interests of the public.

"Group Travel Insurance" means Travel Insurance issued to any Eligible Group.

“Limited Lines Travel Insurance Producer” means a (i) licensed managing general agent or third party administrator, (ii) licensed insurance producer, including a limited lines producer, or (iii) Travel Administrator.

“Offer and disseminate” means providing general information, including a description of the coverage and price, as well as processing the application, collecting premiums, and performing other non-licensable activities permitted by the state.

“Travel Administrator” means a person who directly or indirectly underwrites, collects charges, collateral or premiums from, or adjusts or settles claims on residents of this state, in connection with Travel Insurance, except that a person shall not be considered a Travel Administrator if that person’s only actions that would otherwise cause it to be considered a Travel Administrator are among the following:

a. a person working for a Travel Administrator to the extent that the person’s activities are subject to the supervision and control of the Travel Administrator;

b. an insurance producer selling insurance or engaged in administrative and claims related activities within the scope of the producer’s license;

c. a Travel Retailer offering and disseminating Travel Insurance and registered under the license of a Limited Lines Travel Insurance Producer in accordance with this Act;

d. an individual adjusting or settling claims in the normal course of that individual’s practice or employment as an attorney at law and who does not collect charges or premiums in connection with insurance coverage; or

e. a business entity that is affiliated with a licensed insurer while acting as a Travel Administrator for the direct and assumed insurance business of an affiliated insurer.

“Travel Assistance Services” means non-insurance services that may be distributed by Limited Lines Travel Insurance Producers or other entities, and for which there is no indemnification for the Travel Protection Plan customer based on a fortuitous event, nor any transfer or shifting of risk that would constitute the business of insurance. Travel Assistance Services include, but are not limited to: security advisories; destination information; vaccination and immunization information services; travel reservation services; entertainment; activity and event planning; translation assistance; emergency messaging; international legal and medical referrals; medical case monitoring; coordination of transportation arrangements; emergency cash transfer assistance; medical

prescription replacement assistance; passport and travel document replacement assistance; lost luggage assistance; concierge services; and any other service that is furnished in connection with planned travel that is not related to the adjudication of a Travel Insurance claim, unless otherwise approved by the Commissioner in a Travel Insurance filing. Travel Assistance Services are not insurance and not related to insurance.

"Travel Insurance" means insurance coverage for personal risks incident to planned travel, including but not limited to:

1. interruption or cancellation of trip or event;
2. loss of baggage or personal effects;
3. damages to accommodations or rental vehicles; or
4. sickness, accident, disability or death occurring during travel.

Travel insurance does not include major medical plans, which provide comprehensive medical protection for travelers with trips lasting six (6) months or longer, including for example, those working overseas as an ex-patriot or military personnel being deployed, or any other product that requires a specific insurance producer license.

"Travel Protection Plans" means plans that provide one or more of the following: Travel Insurance, Travel Assistance Services, and Cancellation Fee Waivers.

"Travel Retailer" means a business entity that makes, arranges or offers travel services and may offer and disseminate travel insurance as a service to its customers on behalf of and under the direction of a Limited Lines Travel Insurance Producer.

Drafting Note: States that have recently adopted Travel Insurance producer licensing and registration laws or regulations may refer to the applicable definitions adopted therein rather than restating them in this section.

Section 4. Licensing and Registration

A. The Commissioner may issue to an individual or business entity that has filed with the Commissioner an application for such limited license in a form and manner prescribed by the Commissioner, a Limited Lines Travel Insurance Producer License, which authorizes the Limited Lines Travel Insurance Producer to sell, solicit or negotiate Travel Insurance through a licensed insurer.

B. A Travel Retailer may offer and disseminate Travel Insurance under a Limited Lines Travel Insurance Producer business entity ("licensed business entity") license only if the following conditions are met:

1. The Limited Lines Travel Insurance Producer or Travel Retailer provides to purchasers of travel insurance:

a. A description of the material terms or the actual material terms of the insurance coverage;

b. A description of the process for filing a claim;

c. A description of the review or cancellation process for the travel insurance policy; and

d. The identity and contact information of the insurer and Limited Lines Travel Insurance Producer.

2. At the time of licensure, the Limited Lines Travel Insurance Producer shall establish and maintain a register on a form prescribed by the [insert commissioner] of each Travel Retailer that offers Travel Insurance on the Limited Lines Travel Insurance Producer's behalf. The register shall be maintained and updated by the limited lines travel insurance producer and shall include the name, address, and contact information of the Travel Retailer and an officer or person who directs or controls the Travel Retailer's operations, and the Travel Retailer's Federal Tax Identification Number. The Limited Lines Travel Insurance Producer shall submit such register to the state insurance department upon reasonable request. The Limited Lines Travel Insurance Producer shall also certify that the Travel Retailer registered complies with 18 USC 1033.

3. The Limited Lines Travel Insurance Producer has designated one of its employees who is a licensed individual producer as the person (a "Designated Responsible Producer" or "DRP") responsible for the Limited Lines Travel Insurance Producer's compliance with the travel insurance laws, rules and regulations of the state.

4. The DRP, president, secretary, treasurer, and any other officer or person who directs or controls the Limited Lines Travel Insurance Producer's insurance operations comply with the fingerprinting requirements applicable to insurance producers in the resident state of the Limited Lines Travel Insurance Producer.

5. The Limited Lines Travel Insurance Producer has paid all applicable insurance producer licensing fees as set forth in applicable state law.

6. The Limited Lines Travel Insurance Producer requires each employee and authorized representative of the Travel Retailer whose duties include offering and

disseminating Travel Insurance to receive a program of instruction or training, which may be subject to review by the commissioner. The training material shall, at a minimum, contain instructions on the types of insurance offered, ethical sales practices, and required disclosures to prospective customers.

7. Limited Lines Travel Insurance Producers, and those registered under their licenses, are exempt from the examination requirements under *[cite applicable state code section]*, and the pre-licensing and continuing education requirements of *[cite applicable state code section]*.

C. Any Travel Retailer offering or disseminating travel insurance shall make available to prospective purchasers brochures or other written materials that:

1. Provide the identity and contact information of the insurer and the Limited Lines Travel Insurance Producer;

2. Explain that the purchase of travel insurance is not required in order to purchase any other product or service from the Travel Retailer; and

3. Explain that an unlicensed Travel Retailer is permitted to provide general information about the insurance offered by the Travel Retailer, including a description of the coverage and price, but is not qualified or authorized to answer technical questions about the terms and conditions of the insurance offered by the Travel Retailer or to evaluate the adequacy of the customer's existing insurance coverage;

D. A Travel Retailer's employee or authorized representative, who is not licensed as an insurance producer may not:

1. Evaluate or interpret the technical terms, benefits, and conditions of the offered travel insurance coverage;

2. Evaluate or provide advice concerning a prospective purchaser's existing insurance coverage; or

3. Hold himself or itself out as a licensed insurer, licensed producer, or insurance expert.

E. Notwithstanding any other provision in law, a Travel Retailer whose insurance-related activities, and those of its employees and authorized representatives, are limited to offering and disseminating Travel Insurance on behalf of and under the direction of a Limited Lines Travel Insurance Producer meeting the conditions stated in this Act, is authorized to do so and receive related compensation, upon registration by the Limited

Lines Travel Insurance Producer as described in Sub-section (B)(2) above.

F. Responsibility**:** As the insurer designee, the Limited Lines Travel Insurance Producer is responsible for the acts of the Travel Retailer and shall use reasonable means to ensure compliance by the Travel Retailer with this Act.

Drafting Note: States that have already implemented a licensing and registration law or regulation consistent with the NCOIL Limited Lines Travel Insurance Model Act and NAIC Uniform Licensing Standard 34 (Limited Lines Travel Insurance Standard) may choose to cross-reference that law or regulation instead of using the language set forth in this Section. States that have not yet implemented such a law or regulation with respect to Travel Insurance may choose to incorporate this Section under their existing producer licensing laws.

Section 5. Premium Tax

A. A travel insurer shall pay premium tax, as provided in [cross-reference to the state's existing premium tax provision] on Travel Insurance Premiums paid by any of the following:

1. an individual policyholder who is a resident of this state;
2. a certificate-holder who is a resident of this state who elects coverage under a Group Travel Insurance policy; or
3. an Eligible Group policyholder that is resident in, or has its principal place of business in, this state that purchases a Blanket Travel Insurance policy.

B. An insurer shall obtain and maintain documentation necessary to determine the state to which premium tax should be reported based on information provided by the policyholder or certificate-holder, as applicable.

Section 6. Competitive Market

A. A competitive market is presumed to exist for Travel Insurance unless the Commissioner, after hearing, determines that a reasonable degree of competition does not exist in the market and the Commissioner issues a ruling to that effect. Such ruling shall expire no later than one year after issue unless the Commissioner renews the ruling after hearing and a finding as to the continued lack of a reasonable degree of competition.

B. In determining whether a reasonable degree of competition exists, the Commissioner shall consider relevant tests of workable competition pertaining to market structure, market performance, and market conduct, and the practical opportunities available to consumers in the market to acquire pricing and other consumer information and to

compare and obtain insurance from competing insurers. The tests for determining whether a competitive market exists shall include one or all of the following:

1. The size and number of firms actively engaged in the market;
2. Market shares and changes in market shares of firms;
3. Ease of entry and exit from a given market;
4. Underwriting restrictions;
5. Whether profitability for companies generally in the market segment is unreasonably high;
6. The availability of consumer information concerning the product and sales outlets or other sales mechanisms; and
7. Efforts of insurers to provide consumer information.

C. The determination of competition involves the interaction of the various tests and the weight given to specific tests depends upon the particular situation and pattern of test results.

Drafting Note: States that have existing competitive market provisions in statute may choose to cross-reference those provisions instead of using the language in this section.

Section 7. Forms and Rates

A. Notwithstanding any other provision of the [insurance code], Travel Insurance shall be classified and filed for purposes of rates and forms under an inland marine line of insurance~~.~~, provided, however, that travel insurance that provides coverage for sickness, accident, disability or death occurring during travel, either exclusively, or in conjunction with related coverages of emergency evacuation or repatriation of remains, may be filed under either an accident and health line of insurance or an inland marine line of insurance.

Drafting Note: For consistency, states may wish to update their statutory definition of inland marine to include travel insurance as defined in this Act.

B. All Travel Insurance policies, certificates of insurance, endorsements, riders and rates delivered, issued for delivery, or charged in this state shall be filed with the Commissioner before being used. No policy, certificate of insurance, or endorsement shall be issued until the expiration of thirty (30) days after it has been filed, unless the Commissioner shall have given prior written approval.

Drafting note: This subsection is for those states that have form and/or rate filing requirements.

C. Eligibility and underwriting standards for Travel Insurance may be developed and provided based on Travel Protection Plans designed for individual or identified marketing or distribution channels, provided those standards also meet the state's underwriting standards for inland marine, and the Travel Insurance offered as part of the Travel Protection Plan may be offered as individual Travel Insurance, Group Travel Insurance, or Blanket Travel Insurance.

D. Rates filed subject to this Section shall be made in accordance with the following provisions:

1. Rates shall not be excessive, inadequate or unfairly discriminatory.

a. Excessive rates.

i. A rate in a competitive market is not excessive.
ii. A rate in a noncompetitive market is excessive if it is likely to produce a profit that is unreasonably high for the insurance provided or if expenses are unreasonably high in relation to services rendered.

b. Inadequate Rates. A rate is not inadequate unless such rate is clearly insufficient to sustain projected losses, expenses and special assessments in the class of business to which it applies and the use of such rate has or, if continued, will have the effect of substantially lessening competition or the tendency to create monopoly in any market.

c. Unfairly Discriminatory Rates. Unfair discrimination exists if, after allowing for practical limitations, price differentials fail to reflect equitably the differences in expected losses and expenses. A rate is not unfairly discriminatory if it is averaged broadly among persons insured under single insurance plans, whether offered on an individual, Group, or Blanket Travel Insurance policy.

2. In determining whether rates comply with the excessiveness standard upon a finding of a noncompetitive market under subparagraph 1(a)(ii), the inadequacy standards under subparagraph 1(b), or the unfair discrimination standard under subparagraph 1(c), the following criteria shall apply:

a. Due consideration shall be given to past and prospective loss experience within and outside this state; to the conflagration and catastrophe hazards; to a reasonable margin for profit and contingencies; to dividends, savings, or unabsorbed premium

deposits allowed or returned by insurers to their policyholders, members or subscribers; to past and prospective expenses both countrywide and those specifically applicable to this state; and to provisions for special assessments and to all other relevant factors within and outside the state.

b. Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for risks in accordance with rating plans that establish standards for measuring variations in hazards or expense provisions, or both. Such standards may measure any differences among risks that can be demonstrated to have a probable effect upon losses or expenses. No risk classification, however, may be based upon race, creed, national origin or the religion of the insured.

c. The expense provisions included in the rates to be used by an insurer shall reflect the operating methods of the insurer and its anticipated expenses.

d. The rates may contain provision for contingencies and an allowance permitting a reasonable profit. In determining the reasonableness of the profit, consideration shall be given to all investment income attributable to the line of insurance.

Drafting Note: States that have form and rate requirements may choose to cross-reference their existing rate making provisions instead of using the language in this section.

Section 8. Travel Protection Plans

Travel Protection Plans may be offered for one price in this state if:

A. There is no finding by the Commissioner, pursuant to Section 6 [or cross-reference to the state's other competitive market provisions], that the Travel Insurance market in the state is non-competitive or that the Travel Protection Plan restricts competition by either significantly decreasing output or efficiency in the market or that a travel insurer or Travel Retailer is exerting sufficient market power in providing Travel Insurance or Travel Protection Plans such that competition is adversely impacted or that the Travel Protection Plan would exact burdensome terms that would not exist in a competitive market;

B. The Travel Insurance, Travel Assistance Services and Cancellation Fee Waivers are clearly delineated in the Travel Protection Plan's fulfillment materials. The

fulfillment materials shall include the Travel Insurance disclosures required under state law and the contact information for persons providing Travel Assistance Services and Cancellation Fee Waivers, as applicable; and

C. The Travel Protection Plan clearly discloses to the consumer at or prior to the time of purchase and fulfillment that it includes Travel Insurance, Travel Assistance Services and Cancellation Fee Waivers, as applicable, and provides an opportunity for the consumer to obtain additional information regarding the features and pricing of each.

Section 9. Sales Practices

A. All persons offering Travel Insurance to residents of this state are subject to the Unfair Trade Practices Act at [*insert reference to state UTPA law*], except as otherwise provided in this Section. In the event of a conflict between this Act and other provisions of the [insurance code] regarding the sale and marketing of Travel Insurance and Travel Protection Plans, the provisions of this Act shall control.

B. Illusory Travel Insurance. Offering or selling a Travel Insurance policy that could never result in payment of any claims for any insured under the policy is an unfair trade practice under [*insert reference to state UTPA law*].

C. Marketing.

1. All documents provided to consumers prior to the purchase of Travel Insurance, including but not limited to sales materials, advertising materials, and marketing materials, shall be consistent with all Travel Insurance policy documents, including but not limited to, forms, endorsements, policies, rate filings and certificates of insurance.

2. Travel Insurance policies or certificates that contain pre-existing condition exclusions must clearly disclose the exclusion in the coverage's fulfillment materials.

3. Policyholders or certificate holders shall have a minimum of ten (10) days from the later of the date of purchase of a Travel Protection Plan or the delivery of the Travel Protection Plan's fulfillment materials to review and cancel the policy or certificate for a full refund of the Travel Protection Plan price, unless the insured has either started the covered trip or has filed a claim under the Travel Insurance coverage. For the purposes of this section, sending documentation confirming the purchase and providing the Travel Protection Plan's coverage and assistance details, as applicable, to

4. The company shall disclose in the policy fulfillment and documentation whether the Travel Insurance is primary or secondary to other applicable coverage.

5. Where Travel Insurance is marketed directly to a consumer through an insurer's website or by others through an Aggregator Site, it shall not be an unfair trade practice or other violation of law where an accurate summary or short description of coverage is provided on the web page, so long as the consumer has access to the full provisions of the policy through electronic means.

D. Opt out. Unless otherwise permitted by state or federal law, no person offering Travel Insurance or Travel Protection Plans on an individual or Group basis may do so using negative option or opt-out, which would require a consumer to take an affirmative action to deselect coverage such as unchecking a box on an electronic form when they purchase a trip.

E. It shall not be an unfair trade practice to include Blanket Travel Insurance coverage with the purchase of a trip, provided the coverage is not marketed as free.

Section 10. Travel Administrators

A. Notwithstanding any other provisions of the [insurance code], no person shall act or represent itself as a Travel Administrator in this state unless that person:

1. is a licensed producer for property insurance in this state with an inland marine line of authority;

2. holds a valid managing general agent (MGA) license in this state; or

3. holds a valid third -party administrator (TPA) license in this state.

B. A Travel Administrator and its employees are exempt from the licensing requirements of [reference to adjuster licensing act].

Section 11. Registration

A Travel Retailer whose insurance-related activities, and those of its employees, are limited to offering and disseminating Travel Insurance on behalf of and under the direction of a Limited Lines Travel Insurance Producer meeting the conditions stated in this Act, is authorized to do so and receive related compensation, upon registration by the Limited Lines Travel Insurance Producer as described in Section (B)(2) above.

Section 12. Policy

Travel insurance may be provided under an individual policy or under a group or master policy.

Section 13. Enforcement

A. The Commissioner may conduct investigations or examinations of travel insurers, Limited Lines Travel Insurance Producers, Travel Retailers, and Travel Administrators to enforce the provisions of this Act to protect resident Travel Insurance consumers.

B. The Commissioner may take action, following notice and a hearing, necessary or appropriate to enforce the provisions of this Act, Commissioner's orders, and state statutes to protect consumers of Travel Insurance in this state, pursuant to Section [*insert reference to state notice/hearings/court actions law*].

> **Drafting Note:** It is recommended that states review the enforcement procedures in their insurance laws and administrative procedure laws and ensure that enforcement authority under this Section is designated to the proper official(s).

Section 14. Regulations

The Commissioner may promulgate regulations to implement the provisions of this Act.

Section 15. Effective Date

This Act shall take effect 90 days after enactment.

EXECUTIVE COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
EXECUTIVE COMMITTEE
2025 NCOIL SPRING MEETING – CHARLESTON, SC
APRIL 27, 2025
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Executive Committee met at the Francis Marion Hotel in Charleston, SC on Sunday April 27, 2025 at 10:30 AM (EST).

NCOIL President, Assemblywoman Pamela Hunter (NY), Chair of the Committee, presided.

Other members of the committee present:

Rep. Peggy Mayfield (IN)
Rep. Bill Sutton (KS)
Rep. Mike Meredith (KY)
Rep. David LeBoeuf (MA)
Sen. Lana Theis (MI)
Sen. Michael Webber (MI)
Sen. Paul Utke (MN)
Sen. Walter Michel (MS)
Asm. Jarret Gandolfo (NY)
Rep. Brian Lampton (OH)
Rep. Ellyn Hefner (OK)
Sen. Mary Felzkowski (WI)
Del. Walter Hall (WV)

Other legislators present were:

Sen. Jeff Howe (MN)
Sen. Cale Case (WY)

Also in attendance were:

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

QUORUM

Upon a motion made by Rep. Michael Meredith (KY), and seconded by Asm. Jarett Gandolfo (NY), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a motion made by Sen. Lana Theis (MI) and seconded by Rep. Brian Lampton (OH) the Committee voted without objection by way of a voice vote to approve the minutes of the Committee's November 24, 2024 meeting in San Antonio, TX.

FUTURE MEETING LOCATIONS

Asw. Hunter stated that looking ahead to the rest of 2025, the Summer Meeting will be in Chicago, IL from July 16th-19th and the Annual Meeting will be in Atlanta, GA from November 12th – 15th. The Annual Meeting will also start with the 4th Annual NCOIL Open Insurance Legislators Foundation (ILF) Scholarship Golf Outing which has been integral to the financial strength of the ILF Scholarship Fund.

ADMINISTRATION

Will Melofchik, NCOIL CEO, stated that this was the highest attended NCOIL National Meeting ever and we ended up with 408 total registrants including 85 legislators from 32 states and of that number there were 23 first time attendee legislators from 16 states. Additionally, 8 Insurance Commissioners participated with 14 total insurance departments represented.

Mr. Melofchik gave the 2025 unaudited financials through March 31st showing revenue of $595,244.34 and expenses of $287,035.39 for an excess of $308,205.95.

CONSENT CALENDAR

Asw. Hunter 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 Improving Affordability for Patients Model Act, re-adopted until the Summer Meeting the NCOIL Transparency in Dental Benefits Contracting Model Act, and had the NCOIL Short Term Limited Duration Insurance Model Act sunset.

• The Life Insurance & Financial Planning Committee adopted a Resolution in Favor of Encouraging a Redesign and the Use of Lifetime Income Investment Solutions in Defined Contribution Plans.

• The P&C Insurance Committee adopted the NCOIL Rental Home Marketplace Guarantees Model Act (as amended) and the NCOIL Motor Vehicle Glass Model Act.

Asw. Hunter asked if any Committee member wanted anything removed from the consent calendar or had any questions.

Sen. Paul Utke (MN), NCOIL Vice President, asked if the organization should consider expediting the Model Act review process for the NCOIL Rental Home Marketplace Guarantees Model Act since it was a close vote that passed via roll call.

Mr. Melofchik stated that there was some discussion during the Property & Casualty Insurance Committee Meeting around expediting the process for review of that Model

outside of the typical 5 year readoption timeline. That would require the NCOIL bylaws to be amended so it is something that this Committee could recommend the Articles of Organization & Bylaws Revision Committee take up. That Committee could then amend the bylaws to say that in certain circumstances Model Laws can be reviewed before the typical 5 year timeline. Asw. Hunter then asked if Models can be reviewed faster than the 5 year timeline currently in place.

Mr. Melofchik stated that Models can be amended at any time before the 5 year timeline, but this would be different in terms of amending the bylaws to allow a Model to sunset ahead of its 5 year scheduled review.

Sen. Walter Michel (MS), Chair of the NCOIL Articles of Organization & Bylaws Revision Committee stated that he would be happy to have the Committee discuss the issue at its next meeting in Chicago this summer.

Sen. Cale Case (WY) said we shouldn't be locked into the 5 year review process and that timeline should be able to get waived in certain circumstances for Models that may not have broad support.

Rep. David LeBoeuf (MA) stated that it's a good idea to look at the flexibility of the review process especially since technology is rapidly advancing.

Asw. Hunter asked if the bylaws change has to be for a specific Model or could the amending language be broad enough to cover any Model. Mr. Melofchik said that a change of this nature would be broad enough to cover any Model.

Sen. Mary Felzkowski (WI) stated that flexibility is never bad. This is especially true when you have things like Artificial Intelligence coming at us so fast, so having the ability to review Models sooner rather than later is necessary.

Asw. Hunter asked that Sen. Michel and staff conduct a review of the bylaws and have his Committee discuss making an amendment broad enough to cover all Model laws and report on that in July.

Rep. Bill Sutton (KS) said a suggestion is to have the full policy committee vote to review a Model ahead of its scheduled timeline instead of having one legislator reopen the issue. Asw. Hunter said that any amendment of this nature would follow the Committee structure or perhaps involve having the Model's sponsor raise the Model for review.

Upon a motion made by Rep. LeBoeuf and seconded by Sen. Theis, the Committee voted to adopt the consent calendar without objection by way of a voice vote.

NEW EXECUTIVE COMMITTEE MEMBERS

Asw. Hunter asked if anyone would like to make any nominations to the Executive Committee. Sen. Michel stated he would like to nominate Del. Walter Hall (WV).

Upon a motion made by Rep. Peggy Mayfield (IN) and seconded by Rep. Ellyn Hefner (OK), the Committee voted without objection by way of a voice vote to add Del. Hall to the Executive Committee.

OTHER SESSIONS

Asw. Hunter stated that the Institutes Griffith Foundation held a great Legislator Luncheon & Breakfast. Professor Hal Weston from Georgia State University gave a presentation about the McCarran Ferguson Act as this year is the Act's 80th anniversary, and Dr. Lars Powell of the University of Alabama gave an interesting presentation about resilience initiatives and their role in the insurance marketplace. Asw. Hunter noted the importance of state resiliency initiatives and encouraged further discussion on the issue both at NCOIL and in State Legislatures.

Asw. Further stated that there were two great General Sessions including part 1 of our 2 part series on Prescription Drug Affordability Boards, and a session titled "AI in Insurance – What is the Impact of Losing the Human Element?"

We also had a great lineup of Featured Speakers. South Carolina Lieutenant Governor Pamela Evette welcomed us to South Carolina at the Welcome Reception on Thursday. In an NCOIL first, a sitting U.S. Cabinet Member, HHS Secretary Robert F. Kennedy Jr., spoke at the Welcome Breakfast to announce a new state-federal partnership aimed at treating sickle cell disease. Additionally, South Carolina Attorney General Alan Wilson spoke at the Keynote Luncheon about leadership and his service to the state of SC.

Last but not least, we held our Strengths, Weaknesses, Opportunities, and Threats (SWOT) Exercise. Thank you to everyone that participated. I think it was very positive that the organization underwent that exercise and we're going to discuss everything internally to see what next steps we can take to incorporate some of the feedback.

Mr. Melofchik stated that staff will compile the responses from the SWOT exercise and consult with the Officers about what changes should be implemented. Certain items won't require Executive Committee approval such as the variety of meals provided at meetings. Other things that may require bylaws changes will be discussed at future Executive Committee meetings.

Rep. Sutton said that the state recruitment initiative raised during the SWOT exercise was a great suggestion and it would be good to see that implemented. Mr. Melofchik said that it seemed like there was unanimous agreement on that suggestion and staff is going to get to work on that.

ADJOURNMENT

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