30 DAY MATERIALS AND GENERAL SCHEDULE
NCOIL SPRING MEETING
APRIL 16 - 19, 2026

As of March 18, 2026, and Subject to Change

The Hyatt Regency Louisville
Louisville, Kentucky

NCOIL SPRING MEETING
Louisville, Kentucky
April 16 - 19, 2026
SCHEDULE

Note: There will be a room (Churchill Downs 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.

THURSDAY, APRIL 16TH

NCOIL CIP President's Policy Roundtable ***Open to President's Roundtable and Speaker's Roundtable CIP Members Only***	2:30 p.m.	-	4:30 p.m.
Welcome Reception	6:00 p.m.	-	7:00 p.m.

FRIDAY, APRIL 17TH

Registration *Exhibits Open: 8:00 a.m. – 5:00 p.m.*	7:00 a.m.	-	5:00 p.m.
Welcome Breakfast	8:00 a.m.	-	9:30 a.m.
First Time Attendee Legislator & Staff Meeting	9:30 a.m.	-	9:45 a.m.
Networking Break	9:30 a.m.	-	9:45 a.m.
Workers' Compensation Insurance Committee	9:45 a.m.	-	11:00 a.m.
Health Insurance & Long Term Care Issues Committee	11:00 a.m.	-	12:45 p.m.
The Institutes Griffith Foundation Legislator Luncheon The Guaranty System: A Primer Part 1 – The Property & Casualty Safety Net ***Open to Public Policymakers and Staff Only***	12:45 p.m.	-	1:45 p.m.

NCOIL – NAIC Dialogue	1:45 p.m.	-	3:00 p.m.
General Session Developments in Rural Health Improvement Policies and the Rural Health Transformation Program	3:00 p.m.	-	4:30 p.m.
Networking Break	4:30 p.m.	-	4:45 p.m.
Life Insurance & Financial Planning Committee	4:45 p.m.	-	6:00 p.m.
Adjournment	6:00 p.m.		
CIP Member & Sponsor Reception ***Open to Public Policymakers, CIP Members, and Spring Meeting Sponsors***	6:30 p.m.	-	7:30 p.m.

SATURDAY, APRIL 18th

Registration *Exhibits Open: 8:00 a.m. – 5:00 p.m.*	8:00 a.m.	-	3:00 p.m.
Property & Casualty Insurance Committee	9:00 a.m.	-	10:45 a.m.
Networking Break	10:45 a.m.	-	11:00 a.m.
General Session Network Leasing in Healthcare – What Policymakers Need to Know	11:00 a.m.	-	12:30 p.m.
Luncheon with Featured Speaker	12:30 p.m.	-	2:00 p.m.
Joint State-Federal Relations & International Insurance Issues Committee	2:00 p.m.	-	3:30 p.m.
Adjournment	3:30 p.m.		
Special Thunder Over Louisville Reception Muhammad Ali Center (0.5 Miles from Hotel) ***Open to All Attendees***	4:00 p.m.	-	10:30 p.m.

SUNDAY, APRIL 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 Guaranty System: A Primer Part 2: The Life & Health Safety Net ***Open to Public Policymakers and Staff Only***	8:00 a.m.	-	9:00 a.m.
Financial Services & Multi-Lines Issues Committee	9:00 a.m.	-	10:45 a.m.
Executive Committee	10:45 a.m.	-	11:15 a.m.
Adjournment	11:15 a.m.		

******Please note all speakers listed are scheduled to speak as of March 18, 2026. There will be modifications between now and the start of the Meeting.******

******Note: There will be a room [Churchill Downs 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******

Thursday, April 16, 2026

NCOIL CIP President's Policy Roundtable
Thursday, April 16, 2026
2:30 p.m. – 4:30 p.m.
*****Open to President's Roundtable and Speaker's Roundtable Corporate & Institutional Partners (CIP) Members Only*****

Welcome Reception
Thursday, April 16, 2026
6:00 p.m. – 7:00 p.m.

Friday, April 17, 2026

Welcome Breakfast
Friday, April 17, 2026
8:00 a.m. – 9:30 a.m.

1.) **The Hon. Sharon Clark – Kentucky Insurance Commissioner**
    -Welcome to Louisville
2.) **Will Melofchik**
    -Introductory Comments from NCOIL CEO
3.) **Sen. Paul Utke (MN)**
    a.) President's Welcome
    b.) New Member Welcome and Introduction

4.) Any Other Business
5.) Adjournment

First Time Attendee Legislator & Staff Meeting
Friday, April 17, 2026
9:30 a.m. – 9:45 a.m.

Networking Break
Friday, April 17, 2026
9:30 a.m. – 9:45 a.m.

Workers' Compensation Insurance Committee
Friday, April 17, 2026
9:45 a.m. – 11:00 a.m.

Chair: Rep. Brian Lampton (OH)
Vice Chair: Rep. Mark Tedford (OK)

1.) Call to Order/Roll Call/Approval of November 13, 2025 Committee Meeting Minutes
2.) Evaluating the Ohio Workers' Compensation System
Stephanie McCloud – Administrator & CEO – Ohio Bureau of Work Comp
3.) Presentation on Innovations in Treatments for Mental Injuries
Gretchen Shaub, Director of Gov't Affairs – Definium Therapeutics
4.) Presentation on Trends and Developments in the Kentucky Work Comp Marketplace
The Hon. Scott Wilhoit – Kentucky Cmsr. of Dep't of Work Comp Claims
5.) Any Other Business
6.) Adjournment

Health Insurance & Long Term Care Issues Committee
Friday, April 17, 2026
11:00 a.m. – 12:45 p.m.

Chair: Rep. Michael Sarge Pollock (KY)
Vice Chair: Sen. Mary Felzkowski (WI)

1.) Call to Order/Roll Call/Approval of November 13, 2025 Cmte. Meeting Minutes
2.) Introduction and Discussion on NCOIL Model Act Ensuring Access to Eye Care Services and Materials for Patients Through Transparent and Fair Business Practices by Vision Benefit Plans
Rep. Deanna Gordon (KY) – Sponsor

3.) Continued Discussion on NCOIL Charity Care and Medical Debt Reform Model Act

Rep. Tom Oliverson, M.D. (TX) – Sponsor

Joe Burchfield, National Director, State Policy – Ascension

Lucy Culp, VP of State Gov't Affairs – Blood Cancer United

4.) Discussion and Potential Consideration of NCOIL Resolution in Support of Public Policy Improving Maternal Health

Rep. Greg Scott (PA) – Sponsor

Sarah Duggan Goldstein, DrPH, MPH, Managing Director, Legislative and Regulatory Policy, Health Equity Policy - Blue Cross Blue Shield Association

5.) Discussion and Consideration of Re-adoption of Model Laws

a.) NCOIL Telemedicine Authorization and Reimbursement Model Act – Adopted 11/20/21

American Specialty Health (ASH) Representative

b.) NCOIL Model Act Regarding Air Ambulance Patient Protections – Adopted 11/20/21

c.) NCOIL Accumulator Adjustment Program Model Act – Adopted 11/20/21

d.) NCOIL Employer-Sponsored Group Disability Income Protection Model Act – Adopted 11/20/16

6.) Any Other Business

7.) Adjournment

The Institutes Griffith Foundation Legislator Luncheon
Friday, April 17, 2026
The Guaranty System: A Primer
Part 1 – The Property & Casualty Safety Net
12:45 p.m. – 1:45 p.m.
*****Open to Public Policymakers and Staff Only*****

Evan Eastman, PhD, Associate Professor, Florida State University Herbert Wertheim College of Business

Roger Schmelzer, President and CEO, National Conference of Insurance Guaranty Funds (NCIGF)

NCOIL – NAIC Dialogue
Friday, April 17, 2026
1:45 p.m. – 3:00 p.m.

Co-Chair: Rep. Edmond Jordan (LA) – NCOIL Vice President
Co-Chair: Sen. Walter Michel (MS)

1.) Call to Order/Roll Call/Approval of November 14, 2025 Cmte. Mtg. Minutes
2.) Recap of NAIC Spring Meeting and Discussion on NAIC 2026 Priorities
3.) Discussion on Artificial Intelligence (AI) Matters
    a.) NAIC AI Systems Evaluation Tool
    b.) Federal Developments
4.) Discussion on Insurance Affordability and Availability Issues
5.) Update on NAIC Property & Casualty Insurance Market Intelligence Data Call
6.) Update on Renewal of Terrorism Risk Insurance Act (TRIA)
7.) Any Other Business
8.) Adjournment

General Session
Friday, April 17, 2026
Developments in Rural Health Improvement Policies and the Rural Health Transformation Program
3:00 p.m. – 4:30 p.m.

Moderator: Del. Walter Hall (WV)

Sara Hohman
Dir. of Gov't Affairs
Nat'l Ass'n of Rural Health Clinics

The Hon. Kristin Roers
ND Majority Caucus Leader
Member – ND Rural Health Transformation Cmte.

Amber Sprengard
VP of Gov't Affairs & External Relations
Health Carousel

Terry Cunningham
Senior Director, Administrative Simplification Policy
American Hospital Association

Zil Joyce Dixon Romero
Senior State Gov't Affairs Manager
National Rural Health Association

Networking Break
Sponsored by Aflac
Friday, April 17, 2026
4:30 p.m. – 4:45 p.m.

Life Insurance & Financial Planning Committee
Friday, April 17, 2026
4:45 p.m. – 6:00 p.m.

Chair: Rep. David LeBoeuf (MA)
Vice Chair: Sen. Justin Boyd (AR)

1.) Call to Order/Roll Call/Approval of November 13, 2025 and February 23, 2026 Cmte. Meeting Minutes
2.) Consideration of NCOIL Model Act Regarding Life Insurers' Use of Genetic Information
Rep. Brenda Carter (MI), NCOIL Secretary – Sponsor
3.) Presentation – The Common Thread: What's Woven Into the Most Successful State Retirement Plans
Surya P. Kolluri - Head of TIAA Institute
4.) Presentation on Retirement Security and Gig Workers
Claire Wolkoff, MAAA, FSA – American Academy of Actuaries
5.) Consideration of Re-adoption of Model Laws
a.) NCOIL Beneficiaries' Bill of Rights – Adopted 11/21/10
b.) NCOIL Life Insurance Consumer Disclosure Model Act – Adopted 11/21/10
c.) NCOIL Long Term Care Tax Credit Model Act – Adopted 7/10/98
6.) Any Other Business
7.) Adjournment

CIP Member & Sponsor Reception
Friday, April 17, 2026
6:30 p.m. – 7:30 p.m.
*****Open to Public Policymakers, CIP Members, and Spring Meeting Sponsors*****

Saturday, April 18, 2026

Property & Casualty Insurance Committee
Saturday, April 18, 2026
9:00 a.m. – 10:45 a.m.

Chair: Sen. Lana Theis (MI)
Vice Chair: Del. Walter Hall (WV)

1.) Call to Order/Roll Call/Approval of November 15, 2025 Cmte. Minutes
2.) Presentation on Developments in the Parametric Insurance Marketplace
Dan Rabinowitz, Esq., Partner – Herbert, Smith, Freehills, Kramer LLPs

3.) Update on Potential NCOIL Model Act Regarding Insurers' Use of Aerial Images
4.) Continued Discussion and Potential Consideration of Proposed Amendments to the NCOIL Transportation Network Company (TNC) Model Act

Sen. Walter Michel (MS) – Sponsor of Proposed Amendments

5.) Presentation on Paths to Affordability and Availability in Homeowners Insurance

Fox Parker, Director, Center for Capital Markets Competitiveness - U.S. Chamber of Commerce

Bob Passmore – VP of Personal Lines Dep't – American Property Casualty Insurance Association (APCIA)

National Association of Mutual Insurance Companies (NAMIC) Representative

6.) Any Other Business
7.) Adjournment

Networking Break
Saturday, April 18, 2026
10:45 a.m. – 11:00 a.m.

General Session
Network Leasing in Healthcare – What Policymakers Need to Know
Saturday, April 18, 2026
11:00 a.m. – 12:30 p.m.

Moderator: Rep. Michael Sarge Pollock (KY)

Kathy Larkin
Sr. Manager of Regulatory Oversight & Compliance
DenteMax

Emily Carroll
Senior Legislative Attorney
American Medical Association (AMA)

Dr. Mark Vitale
Dentist
American Dental Ass'n (ADA)

Luncheon with Featured Speaker
Saturday, April 18, 2026
12:30 p.m. – 2:00 p.m.

Scott Jennings
CNN Contributor & Former Presidential Advisor

Joint State-Federal Relations & International Insurance Issues Committee
Saturday, April 18, 2026
2:00 p.m. – 3:30 p.m.

Chair: Asm. Erik Dilan (NY)
Vice Chair: Rep. Mike Meredith (KY)

1.) Call to Order/Roll Call/Approval of November 14, 2025 and March 12, 2026 Cmte Meeting Minutes
2.) Discussion on 340B Drug Pricing Program
Bill Smith, Senior Fellow and Director of Life Sciences Initiative – Pioneer Institute
Bharath Krishnamurthy, Sr. Associate Director, Health Analytics & Public Policy – American Hospital Ass'n (AHA)
3.) Continued Discussion and Potential Consideration of NCOIL Individual Coverage Health Reimbursement Arrangements (ICHRA) Model Act
Rep. Meredith Craig (OH) – Sponsor
4.) Presentation on Data from the No Surprises Act Balance Billing Independent Dispute Resolution Program
Kennah Watts, Research Fellow, Center on Health Insurance Reforms, McCourt School of Public Policy – Georgetown University
5.) Any Other Business
6.) Adjournment

Special Thunder Over Louisville Reception
Muhammad Ali Center (0.5 Miles from Hotel)
4:00 p.m. – 10:30 p.m. (Fireworks at 9:30 p.m.)
*****Open to All Attendees*****

Sunday, April 19, 2026

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

The Institutes Griffith Foundation Legislator Breakfast
The Guaranty System: A Primer
Part 2: The Life & Health Safety Net
Sunday, April 19, 2026
8:00 a.m. – 9:00 a.m.

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

Evan Eastman, PhD, Associate Professor, Florida State University, Herbert Wertheim College of Business

Jana Lee Pruitt, Executive Director, Kentucky Life and Health Insurance Guaranty Association

Financial Services & Multi-Lines Issues Committee
Sunday, April 19, 2026
9:00 a.m. – 10:45 a.m.

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

1.) Call to Order/Roll Call/Approval of November 14, 2025 Committee Meeting Minutes
2.) Continued Discussion and Potential Consideration of Resolution Affirming U.S. State-Based Regulation of Artificial Intelligence in Insurance Consistent with the McCarran-Ferguson Act
    Asm. Erik Dilan (NY) – Sponsor
3.) Presentation on Artificial Intelligence in Healthcare Accreditation Program
    Dr. Shawn Griffin, MD, President and CEO - URAC
4.) Presentation on Wyoming's First-in-the-Nation Cryptocurrency Framework
    Debra Brookes, Chief Risk and Compliance Officer – Wyoming Stable Token Commission
5.) Risk Retention Groups 101
    Joe Deems, Executive Director – National Risk Retention Ass'n (NRRA)
    National Association of Mutual Insurance Companies (NAMIC) Representative
6.) Any Other Business
7.) Adjournment

Executive Committee
Sunday, April 19, 2026
10:45 a.m. – 11:15 a.m.

Chair: Sen. Paul Utke (MN) – NCOIL President
Vice Chair: Rep. Edmond Jordan (LA) – NCOIL Vice President

1.) Call to Order/Roll Call/Approval of November 15, 2025 Committee Meeting Minutes
2.) Future Meeting Locations
3.) Administration
    a.) Meeting Report
    b.) Receipt of Financials

4.) Consent Calendar – Committee Reports Including Resolutions and Model Laws Adopted/Re-adopted Therein
5.) Other Sessions
    a.) The Institutes Griffith Foundation Legislator Sessions
    b.) General Sessions
    c.) Featured Speakers
6.) Any Other Business
7.) Adjournment

WORKERS' COMPENSATION INSURANCE COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
WORKERS' COMPENSATION INSURANCE COMMITTEE
2025 NCOIL ANNUAL MEETING – ATLANTA, GEORGIA
NOVEMBER 13, 2025
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Workers' Compensation Insurance Committee met at the Whitley Hotel in Atlanta, Georgia on Thursday, November 13, 2025 at 2:15 p.m.

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

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Sen. Larry Walker (GA)
Rep. Matt Lehman (IN)
Rep. Mike Clines (KY)
Del. Mike Rogers (MD)
Sen. Lana Theis (MI)
Sen. Paul Utke (MN)
Sen. Jerry Klein (ND)
Rep. Brian Lampton (OH)
Sen. George Lang (OH)
Rep. Mark Tedford (OK)
Rep. Tom Oliverson, M.D. (TX)
Del. Walter Hall (WV)

Other legislators present were:

Rep. Carolyn Hall (AK)
Rep. Elizabeth Wilson (IA)
Rep. Camille Lilly (IL)
Rep. Daniel Grossberg (KY)
Rep. Shaun Mena (LA)
Rep. Robert Foley (ME)
Sen. Jeff Howe (MN)
Rep. Garland Pierce (NC)
Sen. Jeff Barta (ND)
Sen. Bill Gannon (NH)
Sen. Tim McGough (NH)
Asw. Catalina Cruz (NY)
Sen. Pam Helming (NY)
Rep. Ellyn Hefner (OK)
Rep. Greg Scott (PA)
Rep. Matthew Morgan (TX)
Rep. Trey Wharton (TX)
Rep. Cal Roberts (UT)
Sen. Mary Felzkowski (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 Sen. Justin Boyd (AR) and seconded by Sen. Lana Theis (MI), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Sen. George Lang (OH) and seconded by Del. Mike Rogers (MD), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 18, 2025 meeting.

PRESENTATION FROM THE DISABILITY MANAGEMENT EMPLOYER COALITION (DMEC)

Dina Klimkina, on behalf of DMEC, thanked the Committee for the opportunity to speak and share a little bit about the national landscape of leave and absence management. Before I start, I'd like to share a little bit about DMEC. We're the only national organization that provides education resources and a professional community for those managing employee leave and accommodations as well as return-to-work programs. Our membership spans public and private sector employers, including state agencies and more than 20,000 practitioners across the U.S. and Canada. So, it's a large coalition of employers. If you don't know about DMEC already, we're excited to introduce ourselves because right now paid leave is rapidly evolving and we'd like to be here as a key resource for you and the policymakers in your states. Our offerings include expert guidance on complicated topics such as federal, state, and local leave laws, curated resources such as policy briefs, webinars, and legislative updates. We recently released a white paper on artificial intelligence as well as a policy guide, for example. We also have a community of practice where you can exchange information and share resources among states, as well as special events featuring legal experts and targeted trainings. So, now I'll dive more into the meat of the presentation to really clarify things about leave. Let's talk about the terms "leave" and "time off" since they are very different. Time off refers to planned or unplanned time away from work. These are generally short in duration, being 6 vacation or personal days, whereas in contrast, leave is an approved period of extended absence from work for a specific reason and these can be categorized into two different types, paid and unpaid leave. Paid leave ensures employees receive all or part of their wages during an absence, which can include the items on the left, such as paid medical leave, family leave, paid family and medical leave, and paid sick leave. And then unpaid leave provides job-protected wages, though some benefits such as insurance may still apply. And I'll catch this in the Family and Medical Leave Act (FMLA) which guarantees workers the right to take up to 12 weeks of job-protected, unpaid leave each year, and eligible employees may take up to 26 weeks of leave in a 12-month period.

All that to say, an estimated 40% of U.S. employees are currently not eligible for paid leave or unpaid leave due to employer size, tenure, or employment status. So, this is somebody who's in an organization of less than 15 individuals or maybe has not been with their employer for a year, things like that. And the structure and availability of leave can really influence work stability, employee well-being, employers' ability to attract and retain talent. Research suggests that paid family and medical leave may be associated with higher employment rates for new mothers and family caregivers, improved earnings for new parents, and improved health outcomes, which is relevant to the maternal mortality discussion you had this morning, and lower costs compared to other types of leave programs. To the national landscape, as of 2025, 13 states and the District of Columbia have their own paid family or medical leave systems, and these policies can really vary in specifics, such as statutory duration, benefit amount, and job protection. The vast majority of them offer a maximum of 12 weeks of paid leave, and this is the case in Colorado, Connecticut, Delaware. Starting in 2026, D.C., Maine, Maryland, Massachusetts, Minnesota, New Jersey, New York, Oregon, and Washington. And then 16 states plus D.C. have extended unpaid job-protected leave beyond the 12-week FMLA requirement. D.C. also offers up to 16 weeks of unpaid family leave. Massachusetts allows up to 26 weeks for parental or military leave. And 5 states California, Hawaii, New Jersey, New York, Rhode Island have mandatory statutory disability insurance (SDI). Additionally, about 10

states: Alabama, Arkansas, Florida, Kentucky, New Hampshire, Tennessee, Texas, Virginia, and Vermont have the legal provision to provide benefits via the private insurance market.

So, that was a lot of data that I just threw at you, but really what I want to emphasize is that the landscape of leave policies is complicated and dynamic. There are over 30 different configurations of leave that states can have. For us, we think it's essential that states work together and coordinate and collaborate so that there's a more even distribution and they have to abide by fewer regulations. Now I'd like to highlight some state leave trends that we've seen over the past year. Recent developments really reflect a shift toward broader coverage, improved benefit design, and expanded eligibility criteria. These trends include expansion of paid parental leave, leave for non-traditional events, benefits and wage replacements, and leave eligibility including defining family members. Over the past decade, state legislators have really significantly expanded their focus on paid family leave, and in fact, lawmakers in over 44 states have introduced more than 300 measures related to paid leave, reflecting the growing bipartisan recognition of its importance to workforce participation, economic stability, and employer competitiveness. Alabama, Arkansas, Colorado, Illinois, Iowa, Mississippi, and New Hampshire that I've highlighted on the screen have passed legislation expanding paid or unpaid parental leave this year. For example, Alabama enacted legislation providing paid parental leave for state employees and employees of education agencies, and since the slide was put together, my home state of Kentucky did so as well. Next, states are also implementing leave for non-traditional events, so it's been interesting to watch this expansion. Arkansas, Connecticut, Illinois, Oregon, Rhode Island, and Vermont have enacted or operationalized policy expanding leave for non-traditional events such as blood donation, caregiving, death of a family member or child, mental health, military funeral leave, reproductive health care decisions, safe leave, harassment, and domestic leave. A good example is Connecticut HB 5005, which expanded sick leave to cover bereavement, domestic violence, and caregiving.

Other states have advanced policies related to benefits and wage replacement, so for instance, California, Delaware, Missouri, New Jersey, New York, Rhode Island, and Washington have revised contribution rates, increased benefit caps, and introduced progressive wage replacement to better support low and middle-income workers. And lastly, many states are defining family in new ways. Connecticut, Montana, New Jersey, North Dakota, and Texas have all amended their state laws regarding leave eligibility, and some states have added leave benefits for employees holding public office or those who act as volunteer service providers, while others have expanded the definition of what a family member might be. For example, in Maryland, they expanded leave eligibility to include chosen family which covers non-biological care giving relationships. And then Texas established paid leave of absence for public employees classified as fire protection personnel, and Montana had similar legislation as well. So, what is next? As we look at the landscape of paid leave, there's a few emerging trends. We've been focused on developing a policy framework to help guide states in their efforts around expanding leave or really modifying or making it more suited to their state’s needs. The large trends that we've seen are interstate leave coordination. As I mentioned, the patchwork approach is really robust, and we want to see states collaborating and coordinating with one another. The impacts of artificial intelligence in state leave, how are companies safely and effectively using new technology? Stay at work, return to work, which promotes policies that help employees stay connected to the workplace.

We know that an individual, if they're out for longer than 8 to 12 weeks, their likelihood of returning to work is reduced by 50%. So, we definitely want to make sure that there's policy options to help those people return to their job or to maybe an alternative work arrangement.

And mental health. So many states are strengthening coverage and workplace supports to address growing mental health needs. And this is in rural communities and urban communities and beyond, and ranges from expanding the behavioral health workforce to generally improving access. We have published a policy blueprint which offers practical employer field-tested insights that support collaboration between states, employers, and the broader workforce community. So, we'd like to share a few of our resources. We have a lot of paid leave resources, state and local leave law maps, paid sick leave updates, legislative updates. We have a lot of policy resources, and we are offering everyone here a free policymaker account to the DMEC resources. So, we'd love to talk to you and see how we can best support you. We just want to emphasize that DMEC is a resource, so we are happy to provide free information and technical assistance on anything and everything that we've discussed today. So please reach out. We'd love to support you in your work. Please feel free to contact partners@DMEC.org or contact our CEO, Bryon Bass, or feel free to speak to me, and I'll give you a card. We are looking forward to working with all of you.

Sen. George Lang (OH) asked who's going to pay for all these enhanced programs? Ms. Klimkina stated I believe that the states that are passing legislation have them in their budget. So, for the majority of states that have provided state leave, I think that's in their budget and it's really just providing them to their state employees. Sen. Lang stated so, in those states, it's the taxpayer? Ms. Klimkina responded yes.

Rep. Anderson thanked Ms. Klimkina and stated we really appreciate you being here and providing us with this information. We look forward to working with you and getting everything from you so that we can carry it back and deal with our various states.

CONTINUED DISCUSSION AND CONSIDERATION OF THE NCOIL EXPERIENCE RATING MODIFICATION MODEL ACT

Rep. Anderson stated we will next continue the discussion and consider the NCOIL Experience Rating Modification Model Act sponsored by Rep. Matt Lehman (IN).

Rep. Lehman stated we went into this I think with two goals. One was my concern that the insured who was part of a third party claim would be hit with an experience modification on their workers' comp that then once subrogation was completed it made the insurance company whole, but the insured was never made whole with their additional cost from that experience mod. My initial proposal was to put that into the system itself and have the carriers recalculate, etc. There are a few technicalities on that that could be problematic. I think the solution we came to finally was giving them access as part of the subrogation claim. So, if the carrier is going to subrogate for their loss, they can now include my additional cost as my premium as part of the subrogation. So, I think it gets to our desire to give them a path forward to at least have the chance to access that lost money. The second part of this that was important to me was the bidding. We were seeing some situations where entities would prohibit a bid, even to submit a bid, based on your modification. Well, my modification was based on a third-party claim. I had nothing to do with that. I was being adversely kept out of the process. So, what we did is we said you have to allow them to be a part of the process. You can take into consideration their modification when you award a bid, but you can't prohibit them from participating. So, that has basically stayed the same, and then we tweaked the first part of the Model to talking about the experience modification and recouping their lost premium, and I think through the subrogation process is a good compromise and a good path. So, the way the Model is with those changes, I'm very supportive.

Rep. Anderson thanked Rep. Lehman and stated that as a reminder, this Model was introduced at our Spring Meeting and we had a good further discussion at our Summer Meeting. Since then, as just noted by Rep. Lehman, he has made some changes to the Model in response to feedback, and I think it's in a good place to be voted on at this Meeting.

Paul Martin, Vice President of State Affairs at the National Association of Mutual Insurance Companies (NAMIC) thanked the Committee for the opportunity to speak and stated that Rep. Lehman asked me in Chicago if there was ever a Model that NAMIC would come to the table and say, "it's a great model, it's a perfect model, and you should all vote for it." And I'm going to say that today. It's a great model, it's a perfect model, and you should all vote for it. The changes that Rep. Lehman has accepted are, in fact, the current law in the state of Minnesota and have been the law for over 20 years. We think it strikes a really good balance between the needs of the insurers to pursue subrogation as well as to give the employer the ability to recoup that amount of money that they're having to pay as part of the modification. So, we think this addresses everyone's concerns. It's been tested. It works well in Minnesota. We have no reason to think it won't work well in your states too. Rep. Lehman, thank you for working with us and hearing us out, and we're very appreciative of the opportunity.

Joe Roth, Assistant Vice President of State Govt' Relations at the American Property & Casualty Insurance Association (APCIA), thanked the Committee for the opportunity to speak and stated I agree with Mr. Martin's comments. APCIA is pleased with this new approach and appreciative to Rep. Lehman for his continued work on finding solutions to the problems.

Rep. Mark Tedford (OK) stated it says in Section 3(A) that a party may not prohibit an employer from bidding on a contract solely on the basis of experience rating. So, you're saying this is current law in your state, and I'm curious how that's played out there. Mr. Martin stated I need to go back and look and see if it's worded exactly that way in Minnesota. The language we're talking about in Minnesota is really that language about giving the employer the ability to pursue the e-modification, whatever that delta is. In talking with our members, when I first read that provision, I thought this is problematic. But when we talk to our member companies who write the product, they say that's actually a good piece of the model to have. So, I think it addresses Rep. Lehman's concerns, and our members think that's a good piece of public policy as well.

Hearing no further questions or comments, upon a motion made by Rep. Brian Lampton (OH) and seconded by Rep. Tedford, the Committee voted without objection via a voice vote to adopt the Model. Rep. Anderson thanked everyone and stated that the Model will now be placed on the Executive Committee's agenda for final ratification.

PRESENTATION ON ARTIFICIAL INTELLIGENCE (AI) IN WORKERS' COMPENSATION: AN OVERVIEW OF PROMISES AND CHALLENGES

Sebastian Negrusa, Vice President of Research at the Workers' Compensation Research Institute (WCRI) thanked the Committee for the opportunity to speak and stated that WCRI is an independent research organization focusing on public policy issues that are of interest for the workers' compensation sphere. We provide research and analyses that are objective. We do not make recommendations. We do not take positions, and we benefit from a very diverse membership support, including government agencies, employers, insurers, labor advocates, and so on. Talking about AI, my brief presentation today will be a summary of a study that we published a few months ago at WCRI focused on exactly this topic, AI in workers' compensation. The way we approached this topic was in the form of stakeholder interviews. That was the centerpiece of this study. We had 34 semi-structured interviews with stakeholders

from workers' compensation including regulators, insurers, employers, labor advocates, and attorneys. The crucial questions that we asked were what type of AI are you using? Let's make sure we talk about the same thing. What is the benefit of the new AI tools you are using in your organization? What are the challenges? What are the risks? What are the threats that come with the adoption of new AI tools? And not least, what have been the best practices you already put in place or you follow, and what is the oversight that you have from regulatory bodies? So, starting with the first question, the answer is fairly simple. It's really generative AI. That's what our stakeholders told us. We're talking about tools like ChatGPT that came to the market in November 2022. That doesn't mean that the stakeholders that we talked to did not stop using analytic AI, which would be machine learning, predictive analytics, voice recognition, natural language processing. Those are still in place and being used but they are nothing compared to the large language models, LLMs, that are the basis of tools like ChatGPT. So, you see also what the future might hold. We're not there yet, the genetic AI and artificial general intelligence. We may or may not go there, but my presentation and the study from which this presentation comes from did not deal with those kind of future potential AI applications.

So, the next question, and perhaps one of the most important questions that we addressed in our interviews with our stakeholders was what is the value of these generative AI tools? And we received a lot of very nuanced, very refined, very detailed answers, and assessments and opinions, that we crystallized into these four categories. An optimization of the claims processing, an improvement in the medical treatment that is provided to injured workers - the ultimate beneficiary of the workers' comp systems - a better way to comply with the legal requirements of the workers' compensation systems, and not least, a better way to assess injury risk and prevent injuries at the workplace. So, let's dive a bit deeper into how exactly claims processing has been improved or will continue to be improved with the help of AI. Given that the large language models are very good at systematizing and summarizing structured but especially unstructured data, this was front and center as being one of the benefits and one of the uses of generative AI in the industry. Summarization of mountains of data that sometimes and often accompany workers' compensation claims. Then another way that led to and that can continue to lead to improvements in the processing of claims was through adopting AI in critical points in the workflow and you see here some examples that that have been told that our stakeholders have been telling us have been already applied and will continue to be adopted increasingly going forward.

Also, once systematization of the documentation, if summarization and workflow get to be streamlined, then that frees up some resources and our stakeholders told us that those additional resources have been used to further enhance communication with the injured worker and communications between the insurers and the employers. Not only was that communication enhanced, but communication, according to our stakeholders, was improved with the help of AI tools themselves. You see here some examples that AI tools increased the level of communication with the injured worker, including even language translation, and better summarizations of medical records, medical information, clinical data, and so on. Speaking about improvements in the way medical treatments are being delivered to injured workers, predicting recovery trajectory, that is one very beneficial use of AI that our stakeholders mentioned to us and given that the workers' comp system is not only about delivery of benefits, that, of course, is important, but it's a system that has a lot of regulations, and they vary from state to state. Our stakeholders mentioned to us that they have been using AI to make sure they are compliant with the regulations, and they keep track of various deadlines, notifications, and so on. State regulators mentioned to us that they use AI to better track trends and monitor compliance issues much better than in the past. And not least,

claimant attorneys did bring up to us that AI is a very useful tool for creating legal arguments and researching past cases.

And in terms of preventing and assessing risk and preventing injuries, this is something that employers and insurers in workers' compensation have been working on quite successfully in the last few years through wearable devices that would allow both an employer as well as an insurer, to monitor injury risks in real time. AI is taking everything to the next level. This kind of information is not only providing real-time monitoring but also is analyzed by AI and risks are assessed even better and even in the case of conditional on an injury occurring, the readiness of the return to work for the injured worker is better assessed with the help of AI tools. So, there are a lot of benefits but with benefits come challenges, threats and potential issues and here are a few and they are quite intuitive as everybody is talking about how AI in general can bring a lot of good but a lot of potentially problematic situations as well and they refer in essence to potential biases, discrimination, lack of data protection. You're dealing with a robot, ultimately, and from the perspective of the injured worker, there's a lack of empathy and that can, of course, be a problem for the recovery of the injured worker. And the garbage in, garbage out criterion applies in the case of generative AI as well. These tools are only as good as the input you're providing them with and sometimes even if the input is good, the output can still be bad if the algorithms are not accurate enough, or they're not precise, or good enough. You see here some ways in which the stakeholders we interviewed are dealing already with these kinds of situations, and they follow a number of principles that have already been established back in 2020 by the National Association of Insurance Commissioners (NAIC). What we also heard through our interviews was that some of the organizations that we interviewed already have internal committees making sure that when they adopt AI tools, they abide by these principles of safety, consumer-centric, making sure they don't hurt the injured worker, and so on. And they also have even third-party auditors to make sure that they do comply with these principles.

There's also an emerging body of legislation, and you see here some examples. These are not examples of legislation that applies specifically to AI and workers' compensation. It's regulations and standards and guardrails that apply to the use of AI in insurance in general. You can see that there's a lot of mention about claim denials, making sure they're not just done by a machine. A human always needs to be involved, like in the case of the Senate bill from Florida that's up on the slide. There also has been interest in making sure discrimination is reduced as much as possible. Various safeguards and whistleblower protections, and so on. So, there's a lot of interest and there's, of course, a lot of efforts that are now put into making sure there is proper AI oversight. But given that the evolution of AI tools, generative AI tools, is so fast, it is likely that legislators are going to continue to play catch up with AI-related legislation. So, what our stakeholders suggested to us was that going forward, it will be important to look at litigation cases around the use of AI as those cases might define the contour of AI use in the future. Challenges, of course, will be important to untangle and those challenges include the black box nature of some of these algorithms. It's hard to identify where things go wrong, where biases are generated, where inaccuracies occur, where malfunctions start, and so on. There continues to be a concern with respect to fairness and equity that sometimes these tools do not have, or they do not have it by default. So, this is really a highlight of our findings. There are a lot of beneficial uses of AI in the industry. We're talking about generative AI tools, and they have been already interspersed in all places of claims processing and delivery of medical care to injured workers but there are challenges in adopting AI tools within organizations and those pertain to organization specific challenges, change in management and technical solutions and so on. But there are also a lot of challenges with respect to the fairness of these models and for the legal and regulatory gap that might still exist.

Rep. Lehman stated I serve on our AI task force in Indiana and I kind of ask this of everyone. As more of this is falling to data collection and that kind of thing, I've always said when it becomes front-facing to where it's connecting with the people, should there be some disclosure that the information was AI-generated? Because they did a demonstration where the person was actually having a conversation with a person, and the person was an artificial human being, which doesn't exist. And they asked the question, are you a human being? And she laughed. You would never know without it being disclosed. So, should these things that are going to be used more and more, if they become front-facing to the client or to the patient or whoever in the work comp space, should that be disclosed prior to the information being provided? Mr. Negrusa stated I can speak from the perspective of our study. As an independent research organization, we do not make these kind of recommendations, but what we heard in these interviews was that definitely should be the case, that there should be an awareness and the transparency to the injured worker, to the ultimate beneficiary of the system, that some of these outputs, both in the conversation or in the care that's being delivered or in the communication to the injured worker, should be clarified as being coming from AI or with assistance of AI or without the assistance of AI. So, there's definitely this kind of concern that we perceived when we were conducting these interviews.

DISCUSSION ON DEVELOPMENTS IN THE GEORGIA WORK COMP MARKETPLACE

Ben Vinson, Chairman and Chief Appellate Judge of the Georgia State Board of Workers' Compensation, thanked the Committee for the opportunity to speak and stated that our main office is here in Atlanta, but we have 6 regional offices across the state. I'll give you a little overview of how it works, who we are, what we do, and then I might even talk about a couple of legislative issues. As Rep. Anderson said, I'm the Chairman and Chief Appellate Judge, and I sit on a three-judge panel. You're at the appellate level, so you go to our trial division first. We have 12 trial court judges, four judges that are also in our alternative dispute resolution (ADR) divisions. We have 16 first-level judges. Then we've got three second-level judges. We're all appointed by the Governor to 4 year terms. I was first appointed in 2017, then reappointed in 2021 and made the Chairman that year, and then reappointed this year in May. We not only administer the whole system, we're essentially a state agency and only have 120 employees, but we have this kind of regulatory operational side of our jobs, but then we also have the judicial side, so it's a really a good setup. Our goal is to keep the system stable and balanced in Georgia. We have a really good system, and my job is just to not mess it up, so here's essentially what we do. Every year, we have around 300,000 employers in Georgia, and about 5 million employees. We essentially help the administration of transferring about $1.7 billion dollars a year from the employer insurer side over to the injured worker side so those are kind of the numbers that we're looking at here in Georgia that's what we do so the whole agency is set up to help that process to make it smooth and efficient as when you're an injured worker you need to get medical and then you need to get back to work. We help both sides and we do it equally and we try to be responsive to the employers and employees in Georgia.

A couple of trends that we're seeing lately, we are seeing an increase in settlements and an increase in mediations in all of our cases. Let me back up one second. Every year there's about 110,000 claims that are filed in Georgia. So, every 110,000 claims, we're whittling that down. Most of them are very simple and resolved between the parties, but the ones where there's friction and there's litigation, we are seeing a lot of those go to through mediation and we have our own mediation division. You can also use a private sector mediator, but we're seeing an increase that started about 3 years ago. We saw a spike go up in our settlements and it's corresponding. We're seeing a decrease in our hearings and a decrease in our appeals. We're staffing up on our mediations division. We're staffing up in our settlements division to kind of

react to what's going on in the sector. Every year, we promulgate our fee schedule. We put it out at the beginning of April. So, April 1st, we spend a lot of time working on that to make sure that we've got good doctors and good providers in the system but then we also don't have out-of-control cost. It's a balancing act. We take a lot of input on that every year and focus on it. That's a big part of what we do, kind of the administration side of the job. We also have the ability to promulgate rules and regulations. We have really an ongoing all-year process, but we try to get those rules out on July 1 every year. Real quick, to talk about our rules and medical and other things we do, I want to make sure you understand we have an advisory council in Georgia. It was created about 30 years ago. It was created because of a huge firefight that occurred at the Georgia Capitol between employers and injured workers and labor. It was a major disruption.

There were some leaders at the Capitol at the time who decided that it would be a better approach and a better system if the workers' comp stakeholders could just gather together every year and talk things out and then come back to the Capitol with consensus proposals and try to work out our own problems, basically. So, we are dedicated to doing that. It's about 90 members that are on the advisory council. I appoint them, and there are people that have been there forever and people that are new, and I rotate them out every year. We have seven different committees, so we just met in October and had our big advisory council meeting, but we meet with them and talk to them all year long. I think it's a great tool that we have and helpful to me in my job to help with policy. And then the legal issues that we're looking at. Just talking about that, one of the things that the advisory council does, they really help us vet legislative issues. I'm going to touch on two issues that have emerged recently in the last legislative session. One of them involves Professional Employer Organizations (PEOs), and I know that you have a Model Act on that and I think the issue's probably not new to many of you, but going back several years ago, I actually authored an opinion in a court case and we all held a PEO liable in a case where an injured worker essentially fell through the coverage crack. It was a pretty bad factual situation, and so we used a statutory employer scheme and held a PEO liable, where that PEO was trying to not be liable because of the terms of their agreement.

So, since then, there have been a couple different efforts at the Capitol by the PEOs to allow Georgia law to change so that they would be able to control their liability by contract. Essentially, the advisory council studied it. There's a bill that's pending in the Georgia Senate right now. It's House Bill 250. It passed from the House, went to the Senate. That bill was looked at by my advisory council, and of all the people that are involved in workers' comp, they evaluated it, and they suggested to me there are probably more concerns than benefits with that bill. There's a lot of it that would probably be a good thing no matter what, but there are a couple provisions that really penetrate that premise that you should have full and complete coverage in workers' comp. That's why the system works, is that you don't have people that fall through the coverage crack. Once you have full coverage and everybody knows what you're supposed to do, then the system should work efficiently and properly. I do think there are some systemic concerns, and I know that debate is going to continue as you go into the next legislative session.

And then there's another issue that's emerged that I find interesting and it involves longshoremen. As you may have read, the Georgia Ports Authority has been coming on strong the last several years, going back the last 10 to 20 years. As the port continues to grow, there are more longshoremen that are working on the Georgia coast, and there are more injuries that occur. So, Georgia is currently a concurrent jurisdiction state. An injured longshoreman can file a federal claim and a state claim at the same time and pursue both. Both systems have an offset, so you can't actually get double your temporary total disability (TTD) or double recovery

at the same time. One would be subtracted from the other one. But you can kind of use both systems simultaneously, and very good lawyers know how to do that. And so there is a bill pending in the House and in the Senate, that would move us from concurrent jurisdiction to exclusive federal jurisdiction. So, in that case, an injured longshoreman would only be able to file under the Federal Longshore Act. There are different ways to look at it. It's kind of a debate between the labor side and the employer side. In this case, it's a particular very large employer at the Georgia coast. But we studied it in advisory council and have a pretty good white paper to explain the issue. I think I'm just going to be able to respond to the members of the General Assembly. If they want to know more about it, I'll tell them all that I know and how it works, and then they will be able to make a policy call on that bill. But I think it's very interesting.

Finally, the mod factor discussion you had earlier - we have subrogation in Georgia and it's a consistent issue. We hear about it from the employer insurer side in particular. I've seen studies that show that Georgia is the most draconian state in the nation. It's kind of the toughest to use subrogation to recover once you've paid out on a workers' comp claim. So, there's always interest in Georgia about what can we do, and I have heard some discussions very recently about the mod factor and the experience rating and how you might be able to alter that. So, it's a very tough topic. I'm glad that I was here today to hear that and we are going to continue that discussion. Thank you so much for having me. We have a great system in Georgia. We have great people that work at the State Board, and I look forward to working with the members of the General Assembly going forward.

ADJOURNMENT

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

HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
2025 NCOIL ANNUAL MEETING – ATLANTA, GEORGIA
NOVEMBER 13, 2025
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee met at The Whitley Hotel in Atlanta, Georgia on Thursday, November 13, 2025, at 10:00 a.m.

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

Other members of the Committee present were:

Rep. Camille Lilly (IL)
Rep. Matt Lehman (IN)
Rep. Bill Sutton (KS)
Rep. Chad Aull (KY)
Rep. Edmond Jordan (LA)
Rep. Robert Foley (ME)
Rep. Brenda Carter (MI)
Rep. Kristian Grant (MI)
Rep. Mike McFall (MI)
Sen. Lana Theis (MI)
Sen. Jeff Howe (MN)
Sen. Paul Utke (MN)
Sen. Walter Michel (MS)
Sen. Jerry Klein (ND)
Asm. Erik Dilan (NY)
Asm. Jarett Gandolfo (NY)
Sen. Pam Helming (NY)
Asw. Pam Hunter (NY)
Rep. Meredith Craig (OH)
Rep. Brian Lampton (OH)
Sen. George Lang (OH)
Rep. Ellyn Hefner (OK)
Rep. Carl Anderson (SC)
Rep. Tom Oliverson, M.D. (TX)
Rep. Jim Dunnigan (UT)
Rep. Barbara Dittrich (WI)
Sen. Mary Felzkowski (WI)
Del. Walter Hall (WV)

Other legislators present were:

Rep. Carolyn Hall (AK)
Rep. Naquetta Ricks (CO)
Rep. Elijah Pierick (HI)
Rep. Emil Bergquist (KS)
Rep. Cindy Neighbor (KS)
Rep. Sean Tarwater (KS)
Rep. Mike Clines (KY)
Rep. Mike Meredith (KY)
Rep. Shaun Mena (LA)
Del. Mike Rogers (MD)
Sen. Paul Utke (MN)
Sen. Bill Gannon (NH)
Rep. Garland Pierce (NC)
Rep. Mark Tedford (OK)
Rep. Greg Scott (PA)
Rep. Trey Wharton (TX)

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. Ellyn Hefner (OK), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Barbara Dittrich (WI) and seconded by Rep. Brian Lampton (OH), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 18, 2025 and September 19, 2025 meetings.

PRESENTATION ON POLICY INITIATIVES TO SUPPORT MATERNAL HEALTH

Sarah Duggan Goldstein, DrPH, MPH, Managing Director of Health Equity Policy at Blue Cross Blue Shield Association (BCBSA), thanked the committee for the opportunity to speak and gave a brief introduction on the blue system and our commitment to maternal health, both at the association and across our health plans as well, both in maternal health in reducing disparities, and supporting maternal mortality review committees. BCBSA is the trade association over all 33 independent licensee plans which have their own service areas. It's really the depth and the breadth of the blue system that have really drawn me into the potential impact that you can have on public health and member wellness. Locally, the blue plans are woven into the fabric of the communities that they serve and then nationally, the trade association helps them with their networking programming. This is a very deep footprint. We still cover one in three Americans across every zip code, which is about 114 million members. And from that, we also have very deep networks with our providers in our hospital communities.

Back in 2019-2020, the Blue System made a commitment that was led by BCBSA to reduce disparities in health, specifically in maternal health. The board doubled down on this in November of 2024 to this commitment to reducing disparities in maternal health even more. These three pillars were sort of the framework by which the Blue System was going to approach this, both in approaches to care, so integrating new care models and very robust data and analytics across all lines of business, and of course investing in our local communities, all of this bolstered by our policy and advocacy work at the national and the state level. I'll take a minute here to talk a bit about how the blue system from the plans have really taken this challenge individually. And you can see some of these examples up here. This is not exhaustive. Lots of work has been done by the plans in integrating doulas and midwives into care models which I'm sure everyone here is familiar with. And then down here on the bottom, you'll see some of the system commitments that we at the association made as well, starting with the March of Dimes partnership to improve implicit bias training, and as well as our Health of America reports that really dove into data, both in commercial and Medicaid populations, as well as an FEP doula pilot that has been very successful and is showing great data going forward.

She continued with a brief overview of some of the data stating that this is one of the clinical initiatives that has come out of our network side. You'll see here that rates of hypertensive disorders in pregnancy continue to rise, both in commercial and Medicaid members. This data we actually brought up because one of our programs, the Blue Distinction Centers for Maternity Care, works directly with plans in their service areas to work with hospitals that need a little bit more help in improving their outcome rates. And so you'll see that these have gone up over time and this is important because hypertensive disorders are obviously one of the major risk factors in maternal morbidity and mortality. On the policy and advocacy

side, nationally, we've continued to advocate for good maternal health legislation. This, of course, includes the Preventing Maternal Deaths Act, Healthy Moms and Babies Act, Black Maternal Health Momnibus, which has several parts, about 13 bills inside of that, as well as the Maternal Health Quality Improvement Act. But, of course, the Preventing Maternal Deaths Act is one of the most important here because it's the one that supports the Maternal Mortality Review Committees (MMRC), which is what we're here to talk about today.

If anyone's unaware of what a MMRC is, they are multidisciplinary state or local groups that are the only group that provides a comprehensive review of pregnancy-related deaths, both clinical and non-clinical factors. They're independent groups. It's very important that they are also apolitical in some way and that they really provide these comprehensive recommendations and strategies to improve health for moms. Unfortunately, the data continues to be very poor for maternal mortality, and you don't have to see the numbers on the slide to see on this left-hand graph to see that one thing does not look like the other. These disparities the bars show reach to the sky there are for black women, and then you have all other ethnic groups behind it. So, there's still a lot of work to be done, which is why MMRCs are critical to improving the status quo for what we have right now. State legislation and state legislators are very important here. As I said, these are state federal partnerships, these MMRCs, and so states really play a critical role in supporting the fact that they can enable the dissemination of the recommendations that come out of the MMRCs and support national data reporting which is very important to see because some of these numbers are small, so in order to see the impact of some of this, you need to be able to see everything at a national level. And states can ensure that MMRCs maintain that they're independent and they're multidisciplinary structure.

Dr. Yolanda Lawson, Executive Medical Director of Maternal and Infant Health at Healthcare Services Corporation thanked the Committee for the opportunity to speak and stated that I'll address the role of MMRCs in strengthening maternal health through data, data review and accountability. I never assume that everyone is at the same point when we talk about maternal health. When we talk about maternal death or maternal mortality, that's defined by the World Health Organization as the death of a woman while she's pregnant, or within 42 days of the end of the pregnancy, irrespective of the duration or site of the pregnancy and think about ectopic pregnancies, those types of things. Secondly, versus pregnancy-related death, that's when a birthing person or a pregnant woman dies during pregnancy, or within one year after the end of their pregnancy from health problems related to pregnancy. When we talk about the U.S. in deaths per 100,000, you'll see this here, 23.8. That is the U.S. rate of deaths per 100,000 for all women in the U.S. and you'll look at us compared to other high-income or developed nations. You look at Australia, that number's two. Germany, 3.6. And then you look here, you'll see U.S. white women are at 19.1, U.S. Hispanic women at 18.2, and then U.S. black women at 55.3. This is 2022 data. And so, when I'm talking to audiences, I make it very clear, all women in the U.S. fare worse than other high-income nations and then the work we know we also need to do is dealing with these racial disparities.

In 1987, the pregnancy-related mortality rate was around a little over 7 per 100,000. And then you see this spike here. This is 2021. So, over the last five to six years, there is a maternal health crisis because of this steady, consistent rise, and then we get to 2021, and we hit 32 deaths. Again, remember, seven over here in 1987. And then you begin to look at 2022 and lots of interventions and focus and advocacy around this, and we get down to that 23.8 number. This is a snapshot of 2018 to 2023. And so, again, as I talk about the spike we saw in 2021, of course, likely contributed to the pandemic and you'll see that in 2022 and

2023, the numbers do begin to decrease and we would hope that would be the case. Many of you worked at your state levels putting into place programs and initiatives and such to help. The one thing I remind us of, while we saw the U.S. rate overall decreasing in 2023, we did not see the racial disparities decrease. So, we still have these differences that occur between certain populations. Those are still stark and there's still work to do. I quickly want to address postpartum and the considerations you should take into account. This postpartum phase is critical to all women for childbirth. I practiced OBGYN in Texas for 23 years and people didn't realize that those conditions that are pregnancy related, even after the baby, you can still get preeclampsia. The body just doesn't realize today, I'm no longer pregnant. And 40% of women do not have a follow-up postpartum visit. It's very important as that's how we recognize dangers. And of course, attendance is lower for those women with less resources or access to care, and certainly those on Medicaid. And that lack of follow-up contributes to those disparities that we see, not only the mom's health, but also the baby or the infant. I'm often asked, “what are people dying from?” From day 43 after you have a baby up until one year, the leading cause is going to be cardiovascular disorders, then mental health conditions, and then embolism or blood clots. Those are some of the leading causes.

Oftentimes, people are so focused on labor they're forgetting about postpartum, but about 52% of those deaths occur in postpartum or after one gives birth and about 13% occur to the day of delivery. So, as I just shared with you, the U.S. maternal mortality rates are highest in the developed world. I think if we look at the U.S. broadly, about 80% of those deaths are preventable. I was just presenting in Illinois last week and I think it's 91% are preventable in the state of Illinois. So, we do see some nuances there. Our target for the U.S. is to get this number to less than 15.7 per 100,000 live births and eliminate those racial disparities in outcomes. And again, rural and Medicaid populations, we know that they're disproportionately affected for a number of reasons but the things we want to raise up today are these fragmented data systems. They hinder targeted interventions. And so, to reach the U.S. health goal, we must strengthen standardization of that data and the accountability and that's what's rooted in our MMRCs. So, I'm going to take you to do a little bit of a historic journey around data interventions in the U.S. And so, in 1986, The Centers for Disease Control and Prevention (CDC) began maternal mortality surveillance due to gaps in the data. It was really difficult and very fragmented in the U.S. and the first year reporting was in 1987. And so, I want to make sure you're clear on pregnancy mortality surveillance versus the work of your MMRCs.

Review committees perform detailed work and information on deaths beyond just vital statistics data. The first MMRC in the U.S. was established in Iowa in 1970. They were established in the early 20th century to investigate deaths when rates were the highest on record. In the 1980s, many of them became inactive and that was due to state funding. Many states just didn't make it a funding priority. You now have 49 states, D.C. and New York City, Philadelphia and Puerto Rico, that are legally required to review pregnancy-related deaths. Ten states, D.C. and New York City, require the committee's reports to address racial disparities, and six states and New York City track maternal morbidity data. When we do a deep dive in looking at MMRCs, they're multidisciplinary state-based committees composed of clinical and non-clinical individuals to review each maternal death in detail to determine, number one, the cause of the death, was it preventable, what were the contributing factors, and to make recommendations for action to address it so it doesn't happen again. The data is de-identified and it is standardized and the CDC has a national database. It's called MMRIA, the Maternal Mortality Review Information Application and that's the national system that provides reports on the U.S. maternal mortality trends. It

informs those healthy people targets you heard me mention and also, more importantly, it directs the Health Resources and Services Administration (HRSA) and the CDC funding priorities. Also, these are confidential, and the confidentiality protections also need to stay in place.

The National Vital Statistics System, they use death records for maternal mortality rates and those are deaths that occur within those 42 days in the U.S. And they have legal authority for the registration of these events. And that's all 50 states and two cities, Washington, D.C., and New York City, and then five territories, which include the Virgin Islands, Puerto Rico, the American Samoa, and the Northern Mariana Islands. So that's everyone that participates in the National Vital Statistics. That's how we know how many births occur in this country. Then when you look at the Pregnancy Mortality Surveillance System, that provides national data that tracks trends of pregnancy-related deaths and it uses those death and linked birth records to provide that data, and it does not include any injuries but all 50 states participate. When you look at MMRCs, they review the deaths to determine pregnancy relatedness, that one year I talked about. They identify prevention recommendations and do include injury deaths, and they investigate those deaths during pregnancy, and up to one year after. They use death records, any linked birth records or fetal death records, medical records, social services records, health related social needs screenings, autopsies, and informant interviews. So, they get a lot more in-depth data than what our regular vital statistics and mortality systems would. The data is standardized in how the states collect the data and analyze maternal death data. And so, what it does is creates a centralized, secure, and comparable national data set. It allows for the evidence to shape smart policy and clinical practice recommendations, and also allows better benefit design. Many of you have likely heard this term, “what gets measured gets paid,” or “what gets measured gets improved.” That's what MMRCs do. They inform an intentional investment where the data shows the greatest need. All maternal deaths usually tell a story and MMRCs and the MMRIA system ensure that we learn form each of these deaths going forward.

This here is the CDC Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) at present in the U.S. Texas is the only state not participating in the MMRIA system for that centralized data set. You will see the darker blue states are all participating and funded by the CDC and the lighter blue states are participating but not funded federally. And so why does this matter? Because you heard me state 80% of these deaths in the U.S. are preventable. Rising costs, health disparities, those all signal, at some level, a system-level failure and without MMRCs, we'd lose that structured case-level understanding of why women died during pregnancy. We would know how many women died, maybe, but we wouldn't understand root causes or if those deaths were preventable and then we'd also lose the ability to identify when and where women are most vulnerable during their journey in pregnancy. As you think about 60% of pregnancy-related deaths occur after birth, that means they're outside of the hospital, and then mental health and substance use deaths. Some of the reasons we know this data is because of the work of our MMRCs because those deaths occur up to 6 to 12 months postpartum, so after delivery and those would not be captured with hospital data alone.

This chart outlines what we would lose and why MMRCs matter. So again, we lose data around prevention, the timing and location of these deaths, what are the clinical causes, are they associated with social determinants of health, disparities, what system level failures exist, national comparability, looking at our standardized multi-state data set, and then family and community voices. MMRCs take all of that into account to structure prevention

and interventions. So why do they matter to health insurance companies? They provide us comprehensive cross system data that insurers are unable to access elsewhere. There are limitations on our claims data and in my work, I'm constantly addressing state level data to inform work, interventions and programming. MMRCs review the full continuum of care - clinical notes, hospital records, autopsies and such. I'll give you an example. There's a 32 year old woman, she has been good in her prenatal care with several prenatal visits on the record per her claims data. But the MMRC review shows she had a missed blood pressure follow-up and delayed referral to the cardiology and that's what contributed to her death. It wasn't that she wasn't getting her prenatal care. And so insurers need these insights to develop targeted interventions to the member or with providers, quality improvement incentives, and also enhance our member outreach. MMRCs also provide the context that's needed to understand why high-cost, high-risk events occur and which interventions would prevent them. MMRCs are a feedback loop for quality improvement and also value-based strategy design.

Why do MMRCs matter for you as legislators? I strongly feel they provide and articulate actionable policies and legislative levers that you can use across coverage, care coordination, workforce decisions, non-medical drivers of health, and performance transparency. You'll look at recent legislation passed last year in Illinois. Much of that was from the 2023 Maternal Morbidity and Mortality Report, taking those recommendations, and translated into coverage policies on doulas, lactation consultants, midwives. In Indiana, part of the work of their MMRC really promoted them extending postpartum coverage to 12 months and they had an enhanced focus on substance use and mental health disorders and through the work of the committee, they realized these are issues effecting our communities. And they established a women's health task force. In Texas, the MMRC findings led to Texas extending Medicaid postpartum coverage to 12 months, ensuring that hospitals adopt best practices, adopting those Alliance for Innovation on Maternal Health (AIM) bundles around obstetric emergencies, hemorrhage, and certainly the cardiac conditions. And then thinking about policy alignment with the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS), maternal health measures, and certainly Section 1115 waivers for postpartum coverage. Earlier this year, Arkansas was awarded the Transforming Maternal Health award and was granted a $17 million federal grant to improve maternal health outcomes, certainly with a focus on their Medicaid recipients. I also speak to legislators thinking about the support from other funding resources through the data and the work of your MMRC that help you get awards such as Arkansas received this past year. Regarding the current policy landscape, we've talked about some of the funding instability, and authorizing the Preventing Maternal Deaths Act of 2025 is important along with national coordination through the MMRIA data set. Again, every maternal death tells a story, and MMRCs make sure we hear it and act upon it.

Rep. Brenda Carter (MI) stated that Dr. Lawson said that with black women, their deaths are preventable. Tell me what systemic issues are attributing to the continuing rise of maternal deaths with black women? Dr. Lawson responded I want to clarify 80% of deaths broadly in the U.S. are preventable and the disparities with black women, there are multiple contributors such as access to care, access to health insurance, and racism and discrimination have been cited as causes. And also, again, that higher burden of the social determinants of health.

Rep. Edmond Jordan (LA), NCOIL Treasurer, stated in Louisiana we have, if not the highest, certainly one of the highest maternal death rates in the nation and most of that would be, I think, with African-American women so that's a grave concern for us. In the last

few years we have given them access to doulas and midwives and tried to make some of that more accessible so I'm just wondering is that one way to prevent it or are there other ways that we might be missing? Dr. Lawson stated I spend quite a bit of time doing advocacy work in Louisiana. It is in the right step to think about access to doulas. I've practiced over 20 years and always use doulas in practice but it's not everything because doulas don't offer clinical care. Keeping your hospitals open is important. I live in Dallas and some hospitals have closed maternity wards. Looking at that for your districts is important and thinking how do you support them in the hospital and outside of the hospital in the home with maternal home visitations with someone who can go out and do screenings is important. And also making sure you're supporting your MMRC to understand the social determinants of health issues for your state so you can be intentional. Is it that they don't have transportation and food? Is it housing? You should really dive into the data that they produce for you.

Rep. Ellyn Hefner (OK) stated in Oklahoma we used to have a program that we stopped funding, which was maternal home visits. New Jersey had a statewide program, and this is what I heard in looking to run some legislation to try to get more money into that program in Oklahoma because the minimum of two visits have changed New Jersey's maternal mortality rate from 47th to 28th. So, tell me a little bit about putting more effort towards the state putting money into programs like that and how it helps. Dr. Lawson stated Illinois passed similar legislation to implement maternal home visitation starting next year so we are working on supporting that effort. Some of the work we're doing are training maternal home visitors, training doulas. Also, thinking about who are your partners in the state who can help me first get the workforce in place, we've seen that be a common challenge also. Once the workforce is in place, then thinking about working with your insurance partners to implement payment for that. Because some of my patients with means were able to have these things regardless. It didn't take legislation, but the majority of the population can't afford it. And so, I applaud you. I think that's wonderful and we are here to help and support you through that.

Rep. Hefner stated we talk a lot about about prenatal care and my concern is for those young adolescents and I wish insurance companies would put more money in the education for young females before any of that, because in Oklahoma once they're pregnant, especially if they have some chronic disparity health conditions, it's already too late and babies end up in the Neonatal Intensive Care Unit (NICU). What do you think about that kind of education that the insurance companies can take on helping those young women? Dr. Lawson replied I fully support it. That's probably my soapbox, thinking about how do we make sure all women, even adolescents, enter pregnancy healthier and have the information, education, and resources, and even our listening sessions yield that. They want to get more information and understand. I'm happy to work with you offline and we're investing in some community-based partners who are doing that work for us, not integrating into the school, but integrating with a focus on adolescents.

Sen, George Lang (OH) stated I was really shocked by the spike that you showed in 2021 and at least in Ohio, that correlates to a spike in overall morbidity rates amongst the African-American community as it related to COVID. I'm just curious if the spike you showed was in any way related to COVID? Dr. Lawson replied yes, it was. I was still practicing during COVID and for those who don't know, when you're pregnant, all respiratory viruses are extremely dangerous and require hospitalization. And so, for pregnant women, the rates of pneumonia were high. They were afraid to go to visits and we were seeing people dying at home and so yes, COVID certainly did contribute to the spike. We saw ectopic pregnancies,

delay in care, hemorrhage, sepsis, mental health issues, suicide. All of that burden during the pandemic contributed to that spike that I shared with you.

Rep. Greg Scott (PA) stated I'm a proud member of the Pennsylvania Black Maternal Health Caucus and this is our second term that we've had this. In Pennsylvania, as you highlighted, black women are two times more likely to die from what should be one of the most joyous times of their life. And as a proud father of a 14-week-old, I wanted to acknowledge that you did paint a very stark picture, but there are scientific-backed research ways that we can prevent this. And in Pennsylvania, I'm happy that put $30 million into this. We expanded Medicaid coverage for doulas. We've established maternal care access zones in health deserts. We've required that private insurance cover blood pressure monitors. We've expanded Medicaid coverage for blood pressure monitors. But one of the things that we have not been able to figure out is how do you regulate implicit bias? Where best should we focus our attention? Is it in the training? Is it in the hospitals? I feel like we're coming up short. We're throwing a bunch of daggers at this thing and we're still producing doctors that don't listen to women when they cry out in pain. Can you please shed some light on where you think we can make impact on that? Dr. Lawson stated it should be all of that. There are oaths that we take entering the medical profession so it certainly should be in medical school. It should certainly be in residency and fellowship training and it also should be in hospitals. But I live in a state where it's illegal to perform implicit bias training and so how do we go about this where we think about it broadly and openly? And for me, it's around language. It's all of these things that can contribute to bias and so we should take the opportunity to train and educate and make sure there's awareness at every opportunity we have available. Some states do it through their medical board licensure process. They require bias training to get your licensure. Some hospitals require it to get your privileges at a hospitals so I think you can use all of those levers to advance the work.

INTRODUCTION AND DISCUSSION ON NCOIL CHARITY MEDICAL CARE AND MEDICAL DEBT REFORM MODEL ACT

Rep. Tom Oliverson, M.D. (TX), NCOIL Immediate Past President and sponsor of the Model, stated that the charity care portion of the Model is based on a bill that we ran in Texas. It was essentially an issue that just sort of came to my office's attention, and the concept is pretty straightforward. There are hospitals and hospital systems in each of our states that are granted tax-exempt status in exchange for providing charity care and being willing to reduce the financial burden on patients who cannot afford the health care that they desperately need. And although my state is held out to be sort of the poster child for good things in terms of regulating and making sure that charity care is actually providing charity to patients, what we found in Texas is that we had situations where hospitals were sending people to debt collectors and destroying their credit, and then subsequently writing that off as bad debt and claiming that they did charity by destroying someone financially. We had situations where hospitals were putting drinking fountains in the lobbies of their hospital and claiming that was a community benefit and that should be counted as charity, just miscellaneous things like that.

I believe in tax-exempt status for charitable things. I think that's a great incentive, and I do believe very strongly that hospitals provide incredibly important services to our community. I myself have worked as a hospital-based physician in multiple hospitals, both tax-exempt and for-profit, for the last 20 years, but I will tell you, as a provider, I see no difference in terms of how indigent patients are treated by for-profit hospitals and tax-exempt hospitals at the end of the day, which is alarming considering what the tax-exempt hospitals are getting.

I should be careful to point out that nothing that we're talking about today impacts hospitals that would fall under the disproportionate share definition. So, your rural hospitals, your critical access hospitals are completely unaffected by anything we're discussing today. However, for the big hospitals that are getting the benefit, this simply requires that before they send a patient to a debt collector and destroy them financially, they have to first verify whether or not the patient would have qualified for charity care under their own guidelines that they self-regulate and self-promulgate. It was a very interesting hearing in Texas on this. It's gotten a lot of press as I think everybody's kind of waking up to the idea that we really are giving away something for very little in return, and it's time that we took a little closer look at it.

Jared Walker, Founder of Dollar For, thanked the Committee for the opportunity to speak and stated that Dollar For has a very simple mission - we want to make charity care known, easy, and fair. I started this organization because I watched my own family go through a medical emergency and realized when you have a medical crisis, a lot of times you have a financial crisis. So, I wanted to help people in this situation. I started a crowdfunding platform to help people pay medical bills. I paid hundreds of thousands of dollars in hospital bills for low-income patients, and then I met Eli Rushbanks, General Counsel & Director of Policy at Dollar For, who told me about hospital charity care, and I realized I had spent years of my life paying hospital bills for low-income patients that all would have been eligible for these programs. And I felt like a chump so I thought what is going on here? Hospitals don't do a great job of telling people about charity care. This is not uncommon. Every year, millions of people go on payment plans or declare bankruptcy for bills that they actually do not have to pay. So, I started helping patients access these programs. I started reading through policies and filling out applications. I started faxing applications to hospitals, because that's how they like to receive them. Applications were lost in the mail, I was waiting on hold for hours and being told to schedule an appointment with a financial counselor. I was answering questions about how much money patients have in their retirement funds, how much livestock do they own, if they've raised any money on GoFundMe. I saw how difficult it is to actually get charity care but once I knew how to jump through the hoops, it worked. In a few months, Mr. Rushbanks and I got over $1 million dollars in medical debt to disappear for low-income patients. So, I wanted to get the word out, which unfortunately, led me to TikTok and I made a 60 second video that told people what charity care was, how to access it, how to apply, and it exploded - that video got over 30 million views, and why is that? Because it was new information as no one knows about charity care which is a huge problem. Most patients leave the hospital without any knowledge of these programs and if they do know, it's very difficult to get, and if they do get it, it can take eight months or more.

So, here's how Dollar For is trying to solve this problem. We've built a database of every hospital in the country and all of their eligibility criteria. We can tell patients if they're eligible in a matter of seconds. We took it a step further. We've automated the application process. You can fill it out on your phone, tablet, computer and it will map to your hospital's application. We submit it and advocate on your behalf. We know a lot about charity care. We've read every policy that exists. We know what they say on paper, but we've also submitted over 40,000 financial assistance applications so we know what they look like in action. And we've worked with hospitals and states to make these programs better. We've helped relieve over $120 million in medical debt for patients all across the country. And here's what we know. First, Dollar For should not have to exist. This is crazy as I have to raise money through philanthropy to fund a nonprofit that has to enforce policies that nonprofit hospitals are legally required to have. We should be mad about this. You should

want to put me out of business. Please put me out of business. Only 29% of patients that are eligible for charity care actually get it. This is about as bipartisan as it gets. I think most people agree that you shouldn't lose everything because you get sick. Most people know someone going through this right now. Most of us have contributed to GoFundMe accounts for friends and family members to pay medical bills, and we all hate it. So, for the patient, it goes much further than just a medical bill. Patients can buy better quality food, put money in savings accounts, make their rent on time, continue their education, buy their first home. Medical debt is still the number one cause of bankruptcy in America. It is still the most likely thing to push someone into a cycle of poverty. So, if you care about every day working folks in your communities, I think this is the lowest hanging fruit to help them, and I don't even think it's close.

Mr. Rushbanks thanked the Committee for the opportunity to speak and stated that I'm realizing I should probably let everyone know that when we say charity care and financial assistance, we're talking about the same thing as both terms are used in the industry. Medical debt from hospitals is very widespread, and it wreaks havoc on communities. The quick stats that I pulled are 15% of families in the U.S. currently have past due medical debt. Two-thirds of these families have household incomes below 200% of the federal poverty level and 73% of these people owe at least some of their debt to hospitals, and 28% of these people owe their debt exclusively to hospitals. The fallout from this is that one in four patients skip or delay needed care and 62% of bankruptcies are related to medical debt, and people with medical debt are up to three times more likely to be housing and or food insecure. These medical bills are clogging debt collection dockets. They're affecting patient health and affecting the very foundation of people's lives. Hospital financial assistance is supposed to help these patients. If they're low and middle income, they're supposed to submit an application and have the bill reduced to an amount that they can pay or potentially to zero. The problem is these programs are broken. Patients aren't learning about financial assistance, they don't understand it enough to apply, and they can't navigate the bureaucracy at the hospital on their own, often while sick and recovering. Also, only 29% of these people that are eligible actually receive these benefits. So, we think the solution, which is part of the NCOIL model, is to just screen these people before they have to apply and remove the application process entirely. There's a few states that have already started experimenting with a model like this. Oregon is probably the furthest along. We're still waiting for data to come out from the state to see how this is going statewide but the little bit of data that we do have shows that OHSU, the largest hospital in the state, implemented presumptive screening for every patient that passes through their doors. Before they did that, 12% of their patients received financial assistance. After they did that, 64% of their patients received financial assistance.

The best part about all of this is that if you get financial assistance up to 100% of those eligible, that this isn't going to cost the hospital a significant or a meaningful amount of money. We published a report yesterday where we partnered up with Dr. Naman Shah at the L.A. County Department of Public Health. We looked at MEPS data, which is Medical Expenditure Panel Survey data published by the Agency for Healthcare Research and Quality, and we found that if hospitals gave charity care to every eligible patient under the terms of their own policy, it would have reduced what they collected in net patient revenue by 0.7%. And so, this really isn't surprising when you think about where hospitals get their money. There's three main sources. They're going to get it from private insurance. They're going to get it from some sort of government payer source like Medicaid or Medicare, or it's going to be an out-of-pocket payment made directly from the patient. The out-of-pocket payment portion is exclusively where charity care comes from because it doesn't apply to

insurance or government payments, and that's about 2.5% of revenue for hospitals. So really what we're talking about here is if we were to accept that we could reduce hospital revenue just from patient services, not from any other revenue source that the hospital has, by 0.7%, less than three-quarters of 1%, we could dramatically reduce bankruptcies, wage garnishments, hunger, and homelessness, and we could greatly improve treatment and public health outcomes.

Aaron Wesolowski, VP of Research, Strategy & Policy Communications at the American Hospital Association (AHA) thanked the Committee for the opportunity to speak and stated we want to highlight some of the operational considerations that we hope you take into account as you look at legislation like this and we're lucky to have here as well Van Loskoski, CEO of Stephens County Hospital, a community hospital in Georgia, to talk through the practical process of charity care from his perspective. First, I think it's really important to remember that charity care is one component of community benefits that not-for-profits provide. There are a lot of other components. The big components are charity care and Medicaid shortfall - the losses that hospitals incur treating Medicaid which typically pays below the cost of care. Those two pieces together represent the bulk of the benefits that hospitals provide to low-income patients, whether they're uninsured or whether they're in public assistance programs that reimburse low. And oftentimes hospitals incur losses on those Medicaid patients. What we see when we look at that bigger picture of community benefits of not just charity care but charity care in relation to things like Medicaid shortfall is that they tend to move in tandem so the more Medicaid patients you have oftentimes the fewer uninsured patients you have. The more uninsured patients you have, the fewer Medicaid patients you have. So as one goes up, the other goes down.

From our perspective, it's really important to take a step back and look at the other big components of community benefit. There are a lot of other categories like medical education, research, and subsidized services - services that hospitals incur a loss on even when you include higher commercial rates. And things like trauma care, burn care, and behavioral health in a lot of cases. A lot of different things drive into community benefit but the two primary components are charity care, and Medicaid shortfall. I want to offer that context. The other important piece of context that we want to highlight here is that charity care doesn't just apply to the uninsured. I think a lot of times when folks think of folks who are eligible for charity care they think of people who have no insurance. Increasingly we see people who have some form of insurance also needing charity care and that can be for a variety of reasons. Obviously it can be the financial situation that they're in but in a lot of cases it's the plan benefit design that they're living with. So, whether it's high-deductible health plans or other kind of skinny plans, just having insurance doesn't mean that you don't need assistance when you when you receive a bill. So, increasingly patients with some form of insurance make up a big chunk of the charity care that that hospitals provide. I mentioned that because as you're thinking about the pool of people who are potentially eligible for charity care in the context of this legislation it can be the entire patient population so that's just a really important point to highlight if you're screening potentially eligible people, in a lot of cases that means screening the entire patient population. Another important context around specifically the uninsured is that we've seen in the last few years consistent drops in the number of uninsured. We're about to see really big increases in the number of people who don't have insurance. Some of the impacts of HR1 in terms of folks rolling off of Medicaid and the potential expiration of the enhanced marketplace subsidies in January, it's unclear what's going to happen with those in Congress, but there's a very good chance that those tax credits will expire and the Congressional Budget Office (CBO) has predicted that will result in millions of people rolling off of insurance and becoming uninsured.

Add to that some of the big layoffs that we've seen recently at companies like Amazon and UPS, the trend is towards an increase in the uninsured which is something we haven't seen in a few years. So, that's all important context to think about this in that we will be seeing the need for charity care increase. We're going to be seeing more people coming through the door. Bear that in mind as you think about charity care and any legislation around it. Mr. Loskoski can talk a little bit about this in more detail but with a large pool of potentially eligible people for charity care, both insured and uninsured, the process for screening for eligibility is really important. There are a few different ways that eligibility is assessed, and Mr. Walker and Mr. Rushbanks talked about the tools they provide to people they work with to try to make that process easier, but from a hospital perspective, generally it either looks like a manual process where you ask somebody if they want to apply for charity care, and then there's a manual back and forth of documentation, income information, and employment information. There are automated versions of that as well. There's something that folks refer to as presumptive eligibility, which is a more automated approach and it involves pulling in data so that some of that stuff can happen in the background. That process we think works better than a completely manual process, but the issue with that is there are vendors who sell those services to hospitals and they can be very expensive so it requires a sizable investment to be able to tap into those resources to automate that. Without those resources there isn't an easy way to automate that process to make it less manual.

If this is a universal screening for hospitals that don't have access to those kinds of resources, this manual process can be resource intensive for everybody. Also, I know in the model that you all are considering there's steps of violations if the hospital doesn't meet the requirements of assessing eligibility. It's important to understand what is and isn't a violation in that context. Was an assessment not conducted at all or did something fall through the gaps? If there was manual documentation going back and forth, was there a good faith effort to try to determine eligibility or was assessment not conducted at all? And a manual process opens up a lot of opportunities for gaps like that. We think it's important to make sure that as you're looking at processes like this, that you're helping hospitals have the resources they need to make this process easier. A lot of times that means connecting them to data. There are the third-party vendors that hospitals have to pay for, but you all as legislators have the ability to make state data available. State wage databases or eligibility for public assistance programs, that kind of information would help hospitals conduct eligibility. Moving in the direction of trying to automate this process we think is helpful, and we hope you consider that in terms of making it easier. I just want to end with a few questions to ask as you're thinking through this. Does any policy that you're looking at, first of all, reduce the need for financial assistance, which we think is pretty fundamental. Does it help hospitals in assessing eligibility as opposed to just putting mandates around assessments in place? And does it recognize the natural complexity of determining eligibility and that in a lot of cases, it's a very manual process?

Mr. Loskoski thanked the Committee for the opportunity to speak and stated that just to get a glimpse of where the hospital is, we're about as far northeast in the state as you can get. We're a 96-bed hospital. We have 15 emergency department beds and six operating rooms. We also operate nine ambulatory care centers, two assisted living facilities, and we operate the county emergency medical services (EMS). We provide indigent care and financial assistance in all of our facilities and for all of our services. There are some challenges that we face in our community. If you look at one hospital, then you've seen one hospital. Each hospital is unique and has its own unique challenges, and that's based off the population that you serve. In our particular community, we have a particular problem because there's

no Federally Qualified Health Center (FQHC) in the county. We are the only provider of indigent care in the entire county. We're up in the mountains so there are transportation issues. There are very few sidewalks in the county. There are very few options and decreasing options for low-income housing, especially when you consider our under and uninsured population. We have a transient population and there are some reasons for that that I'll go into in later slides, so it makes the follow-up and continuity of care for our patients extremely difficult. When you have patients that are constantly changing addresses or their cell phone might be disconnected the day after we saw them, it makes continuity of care extremely challenging and has an impact that we see in our emergency department. There are educational barriers. In a rural community like ours, we do see higher rates of illiteracy, and those present challenges when it comes to providing financial assistance to many of our patients. We have a significant and higher-than-state average rate of substance abuse disorders. That also translates into mental health disorders. And we're also seeing the cost of care continue to rise. Our supply costs are increasing. Our utility expenses are increasing. Providing care in general is just getting more expensive. It's the same thing as going to a grocery store. Everything that you're buying now is a little bit more expensive than it was a few years ago. That's the reality of the world we're living in. The majority of uninsured care that we provide in our organization is through our emergency department as 16% of our ER visits are accounted for by uninsured patients. Only 8% of those patients will pick up and complete an application for financial assistance.

I mentioned the coordination of care and how difficult that can become. Our uninsured patients are 15% more likely to return to the emergency department within 30 days than our insured population. There are a lot of reasons for that, but how that translates into cost for our hospital, we are not a wealthy health care system. We are a non-for-profit hospital and $10.3 million in charges over our last 12 months have been billed out to uninsured patients. We have been reimbursed $236,000 of that, just over 2% of what we actually bill out, and $7.9 million of that has already been adjusted off to our indigent care program or to bad debt and 85% of that to our indigent care trust fund and 88% of uninsured patients have made no payment toward their care in our hospital over the last 12 months. It all goes back to what is the priority of the patient. You're in a hospital. You're getting discharged from the hospital. What are your priorities? Well, for a lot of our uninsured patients, it's where's their next meal coming from or where am I going to sleep tonight or how am I going to feed my children? The last thing on their mind is how am I going to pay for that hospital bill that's going to come in a month or so. I'm really worried about what is present of mind today, and that is the fact that it's cold outside and I don't know if I'm going to be able to be warm tonight. There are some other barriers for those that do want to participate in our financial assistance program. Again, I've mentioned only 8% of patients will actually complete an application for financial assistance of those who qualify. We've done everything we can up to deploying a community paramedicine team, a pro bono team of nurses who visit our indigent population at home post-hospital discharge to make sure that they got their medication, that they understand how to use medical equipment that we've given to them, and that they have all of the information they need so that they can apply for financial assistance. Yet still, 92% of the qualified patients won't go through that process. A lot of them we might never hear from again. Again, we go to call them, and that phone has been disconnected. We send them a letter. We deploy people to their home to help them but their address has changed. It makes it nearly impossible for us to effectively screen and help provide that financial assistance to all those who may qualify for that service. So, those are just some of the perspectives that we have from our organization.

Dave Almeida, Senior Director of Gov't Affairs at Blood Cancer United, thanked the Committee for the opportunity to speak and stated that medical debt is a significant issue for us because blood cancers are extraordinarily complex and difficult to treat and expensive to treat. In fact, the average price to treat acute leukemia just in the first year is around $500,000 and about 42% of patients exhaust their entire life savings paying for that treatment. And then what happens? They incur medical debt. We did some extensive polling and I've got some figures but I'll forego those figures and provide you with that polling information. Essentially, what we concluded is that medical debt is a serious issue for blood cancer patients, and it's one that very much affects not only their financial well-being, but also their medical well-being because as a highlight of what we found in that study is that people were making treatment decisions based on medical debt. They were foregoing treatment, they were delaying treatment, or they were not going back to the same provider where they owed money. A big component of where we see a solution is a two-pronged approach, as is reflected in the model. The first is to prevent patients from incurring medical debt in the first place and I'll stop there and say that we believe very strongly that hospitals are essentially the first line of defense when it comes to medical debt. And it's important, as we've heard, for patients to be made aware of the financial assistance programs that are available to them. But to put yourself in the shoes of a patient, just remember that oftentimes they have just been recently diagnosed. They are facing uphill battles as it relates to treatment. Perhaps in an ideal world, they would also consider enrolling in charity care, even as it's presented to them, but we think hospitals should go one step further, which is to actively help those individuals whom they have screened and they have determined are eligible for charity care to help enroll them in that charity care.

We are pleased to see that the model provides this provision. We would recommend, however, reconsideration of the exemption of disproportionate share hospitals (DSH). They are by their very nature serving populations that are most in need of these supports. They are also likely to be a step ahead as they already screened patients' finances to qualify. But, again, we ask them to take one step further, which is not only to screen but also to help enroll. The second component to preventing people from medical debt is to ensure that they are not subjected to the more egregious collections practices, such as the seizure of a primary residence or a vehicle, income through wage garnishment, negative credit reporting, and the imposition of high interest rates on outstanding balances. In the interest of time, I'll focus on credit reporting. We strongly support the section of the model that keeps medical debt off credit reports. As many of you are aware, the Consumer Finance Protection Bureau (CFPB) recently issued an opinion stating that states are preempted from taking this action and not just that the states can't regulate how credit agencies use that information but even going so far as to say that states can't keep providers from reporting that information. The CFPB clearly states it's not a legally binding rule, and many legal scholars do not share this opinion. In fact, 15 states already have laws on the books and we would encourage you to consider keeping this model.

Rep. Bill Sutton (KS) asked Mr. Rushbanks about the reduction of 0.7% revenue if the charity care is issued - is that before or after the collection costs that the hospitals are currently utilizing to collect debt? Mr. Rushbanks stated that number is purely the reduction in revenue. It doesn't consider any potential costs the hospital might have with collection efforts. Rep. Sutton asked if the data generated any information on how much is being spent on those collection efforts? Mr. Rushbanks stated we don't know as I don't think the data would be publicly available. I think a hospital would have to offer that up voluntarily. Rep. Sutton then noted to Mr. Loskoski that the model exempts DSH's so that should help. Mr. Loskoski stated that I do understand that and I'm here to represent all hospitals. I think

it's an important distinction that you make and well noted. There are very few mechanisms to help hospitals that provide indigent care, and DSH augments a little bit of that but I will say you're generally collecting 40% of cost. Rep. Sutton stated absolutely and I would agree that is certainly a distinction so presenting data for DSH's in regards to this model should share that distinction, which means it doesn't particularly apply.

Rep. Carter thanked Rep. Oliverson for sponsoring the model and stated that communities like mine are disproportionately impacted by debt and when people need to have medical services, the last thing they need to think about is how they're going to pay for it and how it's going to impact them in the future. I hear more collaboration between the speakers than I hear opposition, which opens the door for us to work together to come up with a solution to this problem of how hospitals can be made whole without running patients into bankruptcy. And in my community we have a high mortality rate because people can't afford to go to the hospital, and talking about the mountainous area, we have the upper peninsula in Michigan and right now hospitals are closing every day, and if a person is pregnant, they have to go miles to see a doctor. I would love to see how you could work together to put something in the hands of us legislators where we could address this.

Sen. Lang asked Rep. Oliverson about the intent of the model. Is it to prevent hospitals from turning debt over and ruining people's lives, or is the intent to prevent a provider from trying to get charitable status if they do turn it over? So, if a hospital wants to continue to go after bad debt, does that just mean they can do that but they just can't apply for charitable status because a bad debt isn't only a detriment to the consumer, it's also a detriment to the provider, and we all know that they don't eat those costs. There's just a cost shift that takes place.

Sen. Mary Felzkowski (WI) stated I just downloaded 500 990s from our hospitals in Wisconsin and I think every legislator should do that and you would be very surprised once you do. Our hospitals are all nonprofits and on average they do less than 12% charity care and if you think your hospitals are losing money, you're going to be very surprised. Less than 16% of our hospitals have lost money in the last nine years and their net incomes have far exceeded our retail, manufacturing, and construction revenues. And on average, if I pull out our rural and DSH hospitals, 30% of their expenses goes to their top executives. And they're not doing their charity care and when we added up what their tax base would be, it's in the billions of dollars and I kind of find it insulting that the AHA pulls in a DSH hospital to represent them here today of all the hospitals in the U.S. I think this is an amazing model and it's time we do something like this.

Rep. Oliverson noted that DSHs are not the problem here and I represent some community hospitals as well, and actually this data would show that rural hospitals and hospitals that are critical access are way ahead of the curve in terms of actually meeting their obligations as a not-for-profit hospital and providing charity care. And that's why we're not talking about you today because you're already doing a better job in what we think. So, the reality is that the only thing that this model is about is making sure that the tax incentives that your states are already giving to tax-exempt hospitals are actually in exchange for charity care being provided to people who desperately need access to it. Hospitals shouldn't destroy people financially when they can't afford to pay their bills and should actually be providing charity care instead of naming a ballpark after yourself and calling that community interest or putting water fountains in the lobby and calling that community interest or taking out an advertisement in the town gazette or sponsoring a float in the Thanksgiving Day Parade which is free advertising and calling that community interest. We're all aware that we have

entered into a time in which in our country things are less affordable than they used to be, and medical care is no exception to that. And so my question has always been and will continue to be whether or not these supposed costly things that we're asking for that they're already supposed to be doing in exchange for tax benefits meet or exceed the value of these tax incentives, and I know that they're not. And as we work on the model we will need to make a decision about whether we want this model to be applicable generally to any case where somebody has an unmet patient portion, insured or uninsured, that cannot afford to pay their bill or whether we want it to be focused specifically on the uninsured. How broadly applicable do we want it to be? Because in my conversations with the AHA they have stated that the model seems ambiguous on that point. I look forward to working with everybody on this. I think it's a great bipartisan model, and I think it's really going to help our folks back home.

CONSIDERATION OF NCOIL PRIOR AUTHORIZATION REFORM MODEL ACT

Rep. Pollock stated that next on the agenda is consideration of the NCOIL Prior Authorization Reform Model Act. The model was first introduced at the April meeting and it has received substantial feedback from interested parties and legislators. Several amendments to the model have been incorporated throughout the process from a range of interested parties. Both myself and the sponsor of the model, Sen. Walter Michel (MS), believe that the model is now in a strong position for consideration today.

Sen. Michel noted that as Chair the Mississippi Senate Insurance Committee, several years ago I was approached by some medical providers who wanted to address the prior authorization process. They said the process was taking too long and needed reform. We were in the middle of a session and didn't have time to address it with legislation, so we promised we'd have hearings that summer and we wanted to hear both sides of the issue so we talked to health plans as well who also said that the process could use improvements and oftentimes the reason that the prior authorization is not addressed in a timely manner is because the forms were not being filled out correctly or the process was antiquated through faxes and through phone calls. So, in our Mississippi legislation, we set up a web portal and all required data is on the portal and the process is streamlined. We set up categories for emergency medical services, urgent care services and non-urgent services. We set up a review process for denied prior authorization requests. We set up a statistical reporting system to show the results of approvals, denials, appeals, and timetables in the system.

All these items are contained in this model that we have before us today. The model has generated a lot of feedback received throughout the year. We've heard from multiple perspectives on this issue. This latest version of the model reflects feedback we've received. I have participated in many conference calls throughout the year, and if you review the minutes from our September interim committee meeting, you will see that we heard from 10 additional interested parties on this model and if we were to accept additional changes to the model that have been offered, it would veer too far from the law that is the basis for the model. We have three minor changes to the model that are printed before you that I want to present to you today. First, there's an edit made to Section 2 to reinforce that the purpose of the model is to regulate prior authorization[1]. Second, I've added a drafting note to Section 4

[1] The purpose of this Act is to regulate prior authorization by: protecting the health care professional-patient relationship from unreasonable third-party interference; preventing prior authorization programs from hindering the independent medical judgment of a physician or other health care provider; and ~~to~~ ensure~~ing~~ the transparency of a fair and consistent process for health

just to make sure that states need to cross-reference their statutory codes to make sure certain definitions used in the model align with definitions elsewhere in the code[2]. And third, I've added another drafting note to Section 20 to make clear that the rules set forth by the insurance department should include reasonable enforcement provisions for adherence to Section 6, which is the electronic prior authorization process[3]. This all came back from feedback we've received over the last year. This model can be used by states as a tool to use when implementing prior authorization legislation. Individual states are free to modify things like the time provisions, the review process, the statistical supporting systems, and other matters of the model. That being said, I encourage the committee's support in moving this model forward today.

Miranda Motter, Senior VP of State Affairs & Policy at America's Health Insurance Plans (AHIP) thanked the Committee for the opportunity to speak and stated that she appreciated the dialogue and the engagement that has happened over the past year on the model and certainly on this issue in general. My comments this morning are going to focus on three areas. First, the industry's prior authorization initiative. I know that when we were here last meeting, I sat here with the BCBSA and we spent a lot of time talking about the proactive, significant work that the health insurance industry brought forward as it relates to prior authorization. Since that meeting, I wanted to update this group on a couple of things

First, there are now 57 companies that have voluntarily agreed to move forward in this initiative, and what that essentially means is that more than 260 million Americans covered in the commercial space, in the Medicaid space, in the Medicare space will be impacted by this industry initiative. We believe this is significant. This is the industry proactively coming forward to help streamline and reduce provider abrasion, while at the same time making sure that patient care is safe and affordable. Those areas span across six different initiatives and items, and one of the things I wanted to reiterate here is we really believe the most significant initiative is working to address the use of outdated manual systems that we know providers continue to use today. So, since that announcement, the sort of work has been actively underway, the work to gather the data to do industry aggregate reporting. And what I commit to is that we can come back and share that at the end of first quarter next year. The second area is the significant need to move past using outdated manual systems. Over the course of the last year, you've heard me stress the need to move away from those systems. Today, almost 50% of providers are using phone, fax and mail and we strongly appreciate the language that is currently included in the model which requires plans to build but providers to use electronic systems but what I would say is that the model still lacks any real enforcement against providers to actually have to use those electronic systems. While there are significant enforcement measures for plans to build the electronic systems and to do reporting, there is nothing included in the model that will actually move the needle for providers.

We believe that if providers want to avail themselves of the quicker turnaround times in the model, they should have to submit electronically. That should be a common sense solution

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care providers and their patients.

[2] Drafting Note: States may wish to ensure that the definitions in the Model conform with the definitions of these same defined terms elsewhere in a State's statutory code.

[3] Drafting Note: These rules should include reasonable enforcement provisions for adherence to Section 6.

to really making sure providers are moving away from outdated systems. The last thing I would say is we have appreciated the opportunity to engage in this process by providing comments several times but I still think in some areas it is unclear to us why certain language was included while other language was not and one example is the turnaround times for urgent care. Those turnaround times that sit in front of you today are not only a drastic departure from what the Mississippi law is, but it was actually turnaround times that were rejected during that process. They are not aligned with federal law, and our concern is that that will only lead to confusion amongst consumers and providers. Lastly, I commit to you that we will bring that data relative to the industry initiative early next year and I would just ask as you look to make sure that this is the right policy, that you're looking at it from a perspective of patient care and patient affordability and making sure that these are really driving to those issues which we know are incredibly important to the constituents in your communities.

Emily Carroll, Senior Attorney at the American Medical Association (AMA), thanked the Committee for the opportunity to speak and thanked Sen. Michel for bringing this critical issue to the committee and working so hard to advance it and getting it to a place where we believe it will help states establish meaningful reforms to protect patients from the delays and harms that result from prior authorization abuse. This model will also reduce administrative waste by helping to automate the system and reduce the time physicians spend on insurer requirements so they have more time to spend with their patients and on clinical care. I want to note every provision and solution in here has been negotiated and adopted in states across the country so these are tested ideas. While we had some modifications we would have liked to have seen incorporated, we think you ended up with a pretty balanced compromise. If adopted, I know physician groups and other advocates in the states will use this model as a foundation for reform efforts. As such, we urge the committee to adopt the model and we thank you for all your time and letting us be part of the conversation.

Terry Cunningham, Senior Director of Policy at the AHA thanked the Committee for the opportunity to speak and stated that I think the sign of any good piece of legislation is where no party is completely satisfied and that's where you've arrived at a compromise and I think that's what we've got here. You've heard from the AHA several times on this throughout the year and there are some things that we think could be stronger in the model, and AHIP has identified some things that the plans think could be addressed better, and I think that might be a good sign that you have reached an appropriate compromise and we support passing this model as it sits before you.

David Lloyd, Chief Policy Officer at Inseparable thanked the Committee for the opportunity to speak and stated that this Model is a step in the right direction. He urged the committee to support the model and said he looks forward to working with states on implementation to address these important issues.

Randi Chapman, Managing Director of State Affairs at BCBSA thanked the Committee for the opportunity to speak and stated that she echoes the comments made by Ms. Motter. BCBSA is proud to have participated in the industry commitments mentioned by Ms. Motter and we stand by those as well. We are also very concerned about the need for enforcement for providers to participate in the electronic prior authorization process. And we are also very concerned that the model still does not have the needed alignment with some of the federal requirements, particularly those in the Centers for Medicare and Medicaid Services (CMS) Interoperability and Prior Authorization Final Rule.

Sen. Lang asked Ms. Motter about the reporting data that will be available at the end of the first quarter of 2026. He asked what kind of information and data will be included in those reports? Ms. Motter stated there are six areas of this commitment, and each one of the commitments have varying timelines associated with them. One of the first timelines is the commitment to reduce the number of claims that are subjected to prior authorization. The other one relates to standardization of data and standardization of the elements. Those are the kinds of things that will be coming as part of our organization's gathering this data from the plans that have committed voluntarily, and we will bring that as an aggregate report to this committee.

Rep. Jim Dunnigan (UT), NCOIL Secretary, asked Ms. Motter what is the solution to the comments made regarding getting requests by fax and things like that. Ms. Motter stated I think ultimately we want to move away from those systems. And providers should have to use new systems. We know many of your states have passed prior authorization laws and you have required insurers to build those new systems and regardless, we still sit here with a significant number of prior authorizations submitted manually. Generally, what we will hear is that departments of insurance don't necessarily have enforcement authority over providers. You could look at that in different ways if you could have licensing boards do that, but we think at a minimum, to allow the providers to avail themselves of some benefits, we must make sure that they use the new systems. It's common sense to require that if you are going to use the quicker turnaround times, that you have to submit it electronically.

Rep. Oliverson stated I have never met a provider that enjoys using a fax machine to turn in paperwork for prior authorization. This process needs reform. When you are the butt of a joke on an entire South Park episode, as prior authorization has been, it is time for change. I passed gold carding legislation through my committee in Texas reforming prior authorization which was infinitely less favorable to the health insurance companies, and they like it a lot less. And the model is a very measured, balanced, careful approach. I want to applaud Sen. Michel for his work on this because I think it threads the needle very well. I think we need to adopt this. We need to put something down and push back against the status quo. I assure you that if 100% of insurers went to electronic mechanisms for submitting prior authorization tomorrow, there would be an infinite uptake on the part of providers who would be grateful to not have to make phone calls and sit on hold for three hours and submit stuff via snail mail and fax machines. That is not a construct that is favored by anyone on the provider side of this equation. Because it's a delay tactic. I love this model. I hope we adopt it today and I just want to thank Sen. Michel for his thoughtful and careful efforts to listen to all parties in working on this.

Ms. Motter stated it's important to note the 2018 consensus statement of all of our industries coming together voluntarily and saying what needs to be done on this issue. One of the places that we all agreed to was automation and in 2025, we're still sitting here with almost 50% of those submissions being done by fax, mail, or phone. Insurers are building these systems. We are required to do so in many of your states and unless we actually move the needle and require that those be used by providers, I fear that we will be sitting here five years from now having the same conversation. We have to move away from those outdated systems. We have to do that for the patients that we're actually trying to get faster care to. Rep. Oliverson stated I understand that but the number one thing I hear from providers when I go around and I talk to them about issues in insurance is "when are we getting away from the fax machines?" And I agree that we've been talking about this for a long time. It is not up to the providers to get rid of the fax machines and I think they will gladly go for a faster, more seamless approach that provides a more timely decision, but insurers have to

build the system and they will come. I just find it to be almost a red herring kind of issue that we're sitting here talking about, “well, providers aren't going to want to do this.” Of course they're going to want to do this. They've been asking for this for more than a decade.

Rep. Sutton asked about the expedited prior authorization verbiage in the model. I've heard that the 24 hour requirement has been used in other states but not in Mississippi. What states has it been used in, and how did it affect the rejections for prior authorization? Ms. Carroll stated that several states have adopted that 24-hour turnaround time but she did not have the specific list in front of her but she would get that list to Rep. Sutton. It is becoming a more popular provision for sure. I think that it has improved access to care. Plans can do this as about 90% of prior authorizations are approved, so it's just matching up data in a short amount of time. And 24 hours, if you need urgent care, is a lifetime to be waiting on approval from the health plan for that care that your physician has already determined is medically necessary and urgent. It seems to me that 24 hours is a pretty reasonable requirement. Rep. Sutton stated I'm curious as to how the insurers feel about that and also how it has it affected other states. You mentioned 90% are approved, and that's exactly right, but it's the 10% that are actually reducing costs and saving lives and so we don't want to necessarily sweep that 10% under the rug just because it's a small number.

Mr. Cunningham stated regarding the turnaround time, I'll point to the pledge that Ms. Motter talked about earlier in which they're pledging to move the overwhelming majority of their things to real-time authorizations, so much faster than 24 hours. We're talking real-time, and so that involves getting to the standards that need to be built that they're talking about. But again, the notion of what's best for the patients and what insurers are already on the books as trying to move to is real-time prior authorization response so I think 24 hours is a completely reasonable number to move forward with.

Rep. Scott stated that the timeline, especially on the appeals, is incredibly important. I really love Section 10 of the model dealing with personnel that are qualified to review appeals, especially considering in my district we've had three people that have been detrimentally affected by insurers using artificial intelligence (AI) to streamline these processes. So having a human review is incredibly important and I do think that we've got to move as a committee to really focusing on insurers and the use of AI and the data that they use to get it. I'll get into more with the sponsor, but I just want to lift up the fact that AI is taking over a big part of this, and Section 10 of the model covers a lot of my concerns.

Rep. Hefner stated that there are new advances and the barriers that we put in, like before in the panel talking about applications, if anyone's filled out a Medicaid application, it's like a second job. And so, there are new things coming up that have to do with AI, such as an AI agent. It just streamlines a lot of information so people can get through those applications. It took me three weeks to try to get a medication done for my son because someone wasn't answering the phone or I was on, and then they asked for a fax. It's a problem if we want to help save lives, and I'm hoping that we are all open about maybe talking about AI again and how we can put those guardrails on for our vulnerable populations, but not go away from innovation so we can take care of these barriers that are just worthless.

Sen. Lang stated that a recent meeting of the NCOIL Property & Casualty Insurance Committee, we talked about the importance of quality over time and I think most of my colleagues agree that it's important that we have prudence to make sure all considerations are given fair consideration. I appreciate the fact that we've had multiple hearings on this issue but based on new evidence I heard today that there will be some reports coming out in

2026, I am not recommending a no vote but I am recommending that we delay this until we see those reports and we see what actions that the free markets are taking to correct this problem. Because I believe much more in free markets knowing best how to fix a problem than I do in government knowing how to fix a problem.

Sen. Michel stated that if we delayed this any further we would probably get the same results that we had from our September interim meeting and instead of 10 speakers we probably would have 20 or 25 speakers want to comment on the issue. I think we have a balance on the model and states are certainly free to make changes to it that they think are more suitable to their needs and I think we should consider the model today.

Hearing no further questions or comments, upon a Motion made by Sen. Michel and seconded by Asw. Pam Hunter (NY), NCOIL President, the Committee voted by way of a voice vote to adopt the proposed amendments earlier referenced by Sen. Michel with Rep. Pollock determining that the yes votes clearly outnumbered the no votes. Then, upon a Motion made by Rep. Oliverson and seconded by Asw. Hunter, the Committee voted by way of a voice vote to adopt the Model with the amendments with Rep. Pollock determining that the yes votes clearly outnumbered the no votes.

CONTINUED DISCUSSION AND CONSIDERATION OF PROPOSED AMENDMENTS TO NCOIL TRANSPARENCY IN DENTAL BENEFITS CONTRACTING MODEL ACT

Rep. Pollock stated that next on the agenda is consideration of proposed amendments to the NCOIL Transparency in Dental Benefits Contracting Model Act. He reminded the committee that a large set of amendments to this model were introduced earlier this year and the committee voted to readopt the model at our past two meetings on a meeting-to-meeting basis to allow time for further work and discussion on the proposed amendments. Throughout the process, I've worked with the sponsors and interested parties to make clear that since this model is back before the committee on its first readoption review five years after initial adoption, and since the model has been very successful in terms of being adopted by several states, the only amendments being considered today are those related to virtual credit cards. The first review for re-adoption isn't meant to be an opportunity to take the model and go in a different direction, unless the model has become outdated or there is a policy shift in the states that the model should respond to. I do recognize that the network leasing amendments are very important, but those are relevant to the entire health care system, not just to dentists, so that conversation should have more time next year and involve other interested parties. But for today, I understand some states have gone in different directions with the virtual credit card provisions, so I'm happy to have the committee entertain changes if that is the sponsor's intent. Unfortunately, the main sponsor of the amendments, Sen. Justin Boyd (AR), Vice Chair of the Committee, is unable to be here due to a canceled flight, but Asm. Jarett Gandolfo (NY), co-sponsor of the amendments, is here with us.

Asm. Gandolfo thanked everyone for their work and comments on this throughout the year. There's been a lot of conversations over the last about year about this and I've learned a lot about dental insurance from both sides and it's been great and I appreciate all the engagement from the dentists and the dental plans. It's really been an enlightening process. Regarding the virtual credit card amendments, Sen. Boyd and I took into account some of the changes that the dental plans were looking for and the spirit of our amendments focus on shifting from an opt-out approach to an opt-in approach for providers. Six states have gone in this direction, most recently Florida, California and Pennsylvania so we believe that

these amendments are reflective of a trend we are seeing in both red and blue states. I understand there is an alternative approach to the virtual credit card amendments that we might be hearing about today, but Sen. Boyd and I would like to see the model re-adopted with the amendments we have put forward.

Rep. Robert Foley (ME) thanked everyone for their work on this and stated that I'm going to defer to the sponsor on how he'd like to proceed as I know he's worked very hard on these amendments. But I just wanted to make it clear that I am offering an alternative approach to the virtual credit card amendments that was referenced by Asm. Gandolfo. After both approaches are discussed, I'll defer to the path Asm. Gandolfo would like to proceed with, but I'm offering the alternative approach that I think strikes a good balance of making a tweak to the model during the re-adoption process, but not doing something that significantly changes it like shifting from the opt-out to the opt-in approach. And that is the core difference between the approaches to the virtual credit card amendments, the opt-in vs. opt-out change. The approach I'm offering maintains the opt-out approach while the Sen. Boyd and Asm. Gandolfo amendments switch to an opt-in approach.

Chad Olson, Senior Director of State Gov't Affairs at the American Dental Association (ADA) thanked the Committee for the opportunity to speak and stated that there are three reasons to adopt the amendments as proposed by Sen. Boyd and Asm. Gandolfo. It is good policy. It is in line with the legislative trends we're seeing in the states, and it makes a positive change to the 2020 model and keeps it current. First, why is opt-in fee-based payment good policy? If a provider decides to accept a payment with a fee associated with it, that provider should have maximum power of choice. We have found that opt-out isn't providing that, but opt-in will, and here's why. Opt-in supports the basic contracting notion of an offer and acceptance after due consideration. For example, with opt-in, before ever receiving a virtual credit card, dentists would be asked if they would like to receive that kind of payment and, after considering what worked best for their practice, could say yes or no. That's sound policy. Not so with opt-out. The dentist is at the mercy of the carrier sending a virtual credit card, one where the carriers may be receiving a small percentage of what it costs for the dentist to use it, and if the dentist doesn't want the virtual credit card, she has to go through the process of asking to receive money a different way, causing delay, burning staff time and confusion if the carrier is subcontracting to another entity, which may not honor an opt-out sent to the carrier. For small business owners, this is a big deal.

Second, opt-in matches legislative trends we're seeing around the country, and dental plans are already complying with opt-in in many states. Six states - Vermont, Missouri, Maryland, Oregon, Florida, and California have opt-in as law. And according to the 2024 National Association of Dental Plans Enrollment Report, this already represents coverage for 41 million, or 25%, of the 170 million enrolled lives in the U.S. today. Lastly, the amendments represent positive changes that fit the spirit of the model, while keeping it relevant to the experience on the ground between dental carriers and dental offices. In opposing the amendments, the dental plans have used phrases like "drastic" and "180-degree change," and you'll likely hear them again in just a second. But we strongly disagree. The spirit of the model was to ensure that dental plans are transparent in their actions and that providers are empowered to make proper decisions on behalf of their practices and patients. Adjusting to opt-in on fee-based payments fits that spirit perfectly. This is good policy, it's in line with legislative trends, and it's a positive change that fits the spirit of the model. For these reasons, I urge committee members to vote in favor of the amendments.

Bianca Balale, Director of Gov't Relations at the National Association of Dental Plans (NADP), thanked the Committee for the opportunity to speak and acknowledged the thoughtful discussion surrounding this model and the decision to defer consideration of network leasing to allow for a more comprehensive discussion at that time. There is something I want to address before I get into some of my comments, and I will be brief. There was a reference to six states that have adopted an opt-in approach. Just to be clear, for three of those six states, those virtual credit card provisions are related to all health insurers, not specific to dental. We are speaking on a dental-specific model here. The additional states that were referenced, while they have an opt-in provision, they do not align with what is before you today. What is before you today includes an "express acceptance" definition that would require an opt-in physically in writing. So I want to make sure that is clear to the committee as we are further discussing this. But I do want to speak to the opt-out approach. We believe it preserves flexibility for plans and providers and provides both a clear and transparent way to receive payments. The proposal raised by Rep. Foley is aligned with the amendments introduced by Asm. Gandolfo and Sen. Boyd, but does maintain the opt-out structure, which is currently in the model.

So, that would prevent this from being a full rewrite of the model within the re-adoption process. These amendments from Rep. Foley increase transparency, offer additional protections for providers, and ensure the model remains viable for the duration of the re-adoption period. This is in addition to the existing model provisions, which include strong notice requirements and consent provisions. Maintaining the current opt-out structure, which has been adopted in 15 states to date, allows providers to utilize existing credit card terminals to accept payments promptly without increasing administrative burden on their practices. It allows these small dental providers to elect what's best for them. We urge you to renew the model with the amendments offered by Rep. Foley and to maintain that opt-out structure. Shifting to an opt-in approach would rewrite the model, while adopting the amendments proposed by Rep. Foley allows for meaningful targeted improvements within the framework that has proven effective.

Vince Ryan, Regional VP of State Relations at the American Council of Life Insurers (ACLI), thanked the Committee for the opportunity to speak and for the thoughtful discussion and deliberations on this proposal. He continued that the ACLI joins NADP in opposing the overhaul of the model's payment provisions proposed by the ADA, and supports the compromise amendments proposed by Rep. Foley. Virtual credit cards provide security and convenience especially for small offices that may not utilize electronic records and what is being proposed by the ADA would upend the current system and make it harder for providers to access the virtual credit card payment method if they so choose. Finally, the current model already has protections in place around payment methods but these amendments proposed by Rep. Foley would add additional safeguards while allowing providers to retain meaningful control over their payment methods via the right to opt out.

Asw. Hunter commented in support of Sen. Boyd's and Asm. Gandolfo's opt-in amendments. In New York, we had an opt-out situation relative to an insurance issue that caused so much problem and concern with not only policyholders but carriers, and we had to change that. So, I support those amendments and would ask all of my colleagues to do the same.

Rep. Matt Lehman (IN) asked Ms. Balale if I provide a service you're going to pay for and you offer me a virtual credit card and I say no, doesn't that automatically trigger a secondary payment of a different method? Send me a check. Why is there any delay in that? I'm

hearing there's a delay and I don't get paid. Why would an opt out not immediately trigger a secondary payment? And then question two is if that's the only method I'm being offered, is that contractual, or how do you get away with not offering multiple methods of payment, especially to maybe a smaller dentist? Ms. Balale stated under the current NCOIL model, plans are required to offer additional methods of payment. Rep. Lehman stated but it sounds like are there some states that when they adopted this, they didn't adopt that portion or maybe Mr. Olson can provide examples where dentists were not paid immediately when they opted out of the virtual credit card. Mr. Olson stated yes - I'm thinking of an email I received from an Ohio dentist that was trying to opt out of the virtual credit card that was received. Like you said, it's basically, "I don't want to take this form of payment" and then it was another company that was involved in actually issuing the credit card, so in notifying the carrier they weren't able to "opt out" in a timely fashion so there was a delay in the payment, and that's what I was speaking to.

Rep. Lehman stated it perplexes me why that's not simple. The other thing is I've heard from some other entities that are kind of watching this to see if it's going to be changed to an opt-in because they want to come and kind of latch on to that. Then it really starts to concern me that we're opening up a re-adoption of a model that is a significant change and it's going to be utilized by others to kind of use as their model now to go forward. So, I just have some concern with changing it that way. You said six states have adopted this as opt-in so then you can go back to your state and change it to opt-in if it's a problem. But I think this is going a little bit farther than what I think the intention of a re-adoption of a model would be. I would say bring back a separate model that deals with multiple practices for an opt-in or opt-out payment system.

Mr. Olson stated in response to Rep. Lehman's concern, with network leasing there were discussions to withdraw the amendments and have that discussion next year and that was really appropriate. What I would say is that we have a large number of states that have already adopted opt-in, but the backing of NCOIL would have that discussion be, I think, broader. And even in places that have passed into law opt-out, maybe a reconsideration would be appropriate. Because I think what I'm hearing from the dentists that I work with is that it is something that they feel in their offices as small business owners and I think it also speaks to making NCOIL reactive to what's being faced on the ground when these laws are already enacted, and makes it more meaningful in terms of how relevant the model would be. It's a real targeted approach that Asm. Gandolfo and Sen. Boyd are looking at, and I think it's appropriate in the reauthorization process. I know that's my opinion.

Ms. Balale stated I think Rep. Lehman makes a very good point in setting a precedent in the re-adoption process with a lot of eyes on this model and potential interest on how this will go. And as I indicated previously, while we have seen some states adopt opt-in, again, that is not what's before you today. There is an opt-in before you but the language does not mirror what has been adopted in the states that have looked at opt-in. It is far stricter. It requires an in writing election which runs a significant risk of further slowing down the process, causing confusion, delaying payments, as well as potentially putting our plans out of compliance with prompt pay laws in your states as well.

Rep. Scott stated that he supports the amendments put forward by Sen. Boyd and Asm. Gandolfo. I sponsored House Bill 1664 in Pennsylvania, and it started out because I went to the dentist and found out about this issue and how my dentist was forced to receive his payment on a virtual credit card. Mind you, this is not only a consumer protection issue or a small business issue, this is also a patient safety issue as well. With the 5% that his dental

insurance virtual credit card payment was charging, once we passed this bill and absolved that, he was able to hire two more dental hygienists at his office, which then boosts his office. I also just want to point out that ultimately our bill was expanded to other practices. It's important to note that in this healthcare sector, we have a lot of providers, especially specialties, that are being bought by private equity because of the sometimes over regulation or the hardness of just doing the small business aspect and this would help bring more revenue into the provider's office. So, I'm very supportive of this and I think that it's about time. And I think the only other solution would be the insurers absorbing the cost of that fee. If they want to absorb the cost of that fee and not put it on the backs of the business owners that have already negotiated a smaller fee than they would normally charge then I'd be happy to entertain that but until then let's support this.

Ms. Balale stated to clarify the issues on fees, the fees that you are referencing could be associated with the actual use of the card as dental plans do not charge fees for this. Rep. Scott the dentist that's providing the service has already negotiated a fee with the insurer so they're entitled to that fee. If the cleaning's $150 and you negotiated $75, they should be able to get their $75. If you want to charge a fee for that or if they want to get the money off, they shouldn't have to pay a 5% fee for that. Ms. Balale stated they are absolutely reimbursed at that negotiated rate you referenced. Rep. Scott stated yes, but minus the fee. Ms. Balale stated it depends on their payment election.

Rep. Carl Anderson (SC) thanked everyone for their work on this and stated that before traveling to this meeting he received a note from the South Carolina Dental Association supporting the amendments from Sen. Boyd and Asm. Gandolfo. The Ass'n stated that the model has made a big difference for dental patients in South Carolina and the amendments would be another step forward for improving the oral health of South Carolina patients.

Rep. Camille Lilly (IL) asked how the amendments would impact health savings accounts (HSAs)? Mr. Olson stated I think that the plans would have to follow up on the answer to that question. Ms. Balale agreed and stated I'm not aware of any impact at this current moment, but I would definitely want to follow up with you on that.

Rep. Pollock asked Asm. Gandolfo how he would like to proceed. Asm. Gandolfo stated that he wanted to move forward with the Sen. Boyd and Asm. Gandolfo amendments.

Hearing no further questions or comments, upon a Motion made by Asw. Hunter and seconded by Rep. Anderson, the Committee voted by way of a voice vote to adopt the Sen. Boyd and Asm. Gandolfo amendments with Rep. Pollock determining that the yes votes clearly outnumbered the no votes. Then, upon a Motion made by Rep. Anderson and seconded by Asw. Hunter, the Committee voted by way of a voice vote to re-adopt the Model with the amendments with Rep. Pollock determining that the yes votes clearly outnumbered the no votes.

ADJOURNMENT

Hearing no further business, upon a motion made by Asm. Gandolfo and seconded by Sen. Lang the Committee adjourned at 11:45 a.m.

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CHIEF EXECUTIVE OFFICER: Will Melofchik

National Council of Insurance Legislators (NCOIL)

Charity Medical Care and Medical Debt Reform Model Act

Sponsored by Rep. Tom Oliverson, M.D. (TX).

Draft as of March 18, 2026~~October 14, 2025~~. To be ~~introduced and~~ discussed during the Health Insurance & Long Term Care Issues Committee on April 17, 2026~~November 13, 2025~~.

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Section 1. Title

This Act shall be known as the [State] Charity Medical Care and Medical Debt Reform Act.

Section 2. Purpose

The purpose of this Act is to ensure certain hospitals ~~implement~~ adhere to appropriate charity care screening procedures, and to prohibit creditors and debt collectors from reporting to any consumer reporting agency medical debt obtained from lifesaving and emergency care services rendered at certain medical facilities.

Section 3. Definitions

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

(A) "Charity program" means a hospital's or hospital system's financial assistance and charity care program.

(B) "Commission" means the Health and Human Services Commission.

Drafting Note: States may wish to replace Health and Human Services Commission with a different regulatory entity.

(C) "Consumer" means an individual who is a resident of this state.

(D) "Consumer report" has the meaning ascribed to it in 15 U.S.C., Section 1681a(d).

(E)"Consumer reporting agency" means any consumer reporting agency, credit bureau, or similar agency which furnishes a credit report or rating as well as any agency within the meaning ascribed to it in 15 U.S.C., Section 1681a(f).

(F) "Creditor" means one in whose favor an obligation exists, by reason of which he or she is, or may become, entitled to the payment of money.

(G) "Debt collector" means any person who regularly collects, or attempts to collect, consumer debts for another person or institution or uses some name other than its own when collecting its own medical debts.

(H) "Executive commissioner" means the executive commissioner of the commission.

Drafting Note: States may wish to replace "Executive commissioner" with the head of the relevant regulatory entity charged with implementing this Act.

(I) "Hospital" means a nonprofit hospital.

(J~~I~~) "Medical debt" means a debt owed by a consumer to a person whose primary business is providing medical services, products, or devices, or to that person's agent or assignee, for the provision of medical services, products, or devices. Medical debt includes, but is not limited to, debt owed to a(n) [State] medical facility.

(K~~J~~) "Lifesaving and emergency care services" means the necessary medical or surgical care services rendered to treat a potentially life-threatening condition or symptom.

(L~~K~~) "[State] medical facility" includes, but is not limited to, any hospital or related institution licensed pursuant to [*insert citation to relevant state licensing statute*], nursing facilities licensed pursuant to [*insert citation to relevant state licensing statute*], and medical offices operated by or employing physicians, physical therapists, physician assistants, pharmacists, nurses, and home health care providers within this state.

(M) "Presumptive screening process" means the process by which a hospital uses publicly available data and information to estimate a patient's percentage of the federal poverty level for use in applying for charity or financial assistance benefits.

(N) "Reasonable efforts" has the meaning assigned in 26 CFR § 1.501(r)(6).

Section 4. Charity Care Screening

(A) Using the process prescribed by the commission under this section, a ~~non-disproportionate share~~ hospital shall screen all patients for eligibility of the hospital's financial assistance program and charity care policy. A hospital cannot pursue debt collections of any patient account until the hospital verifies the patient is not eligible for the hospital's financial assistance program and charity care policy.

(B) Nothing in this section shall require or obligate a hospital to:

(1) perform a presumptive screening process when billing for elective procedures including but not limited to cosmetic procedures;

(2) provide non-emergent care to a patient who resides outside the hospital's defined community as specified in the hospital's financial assistance policy as required by Internal Revenue Service Code 501(r).

(C~~B~~) The executive commissioner of the Health and Human Services Commission shall adopt by rule the process for screening a patient for eligibility for charity care under Subsection (A). The rule established by the commission shall:

(1) clearly define what constitutes a violation of the process by a hospital;

(2) establish clear timeframes for:

(a) notice of the violation by the commission to the hospital; and

(b) review and approval of the corrective action plan by the commission.

(3) identify any applicable state resources and data sources to which the commission will facilitate hospital queries to expedite and automate the eligibility screening process to the extent possible.

(D~~C~~) The rules and process adopted under Subsection (B) must require a hospital:

(1) before sending a bill to the patient, to conduct ~~the~~ a presumptive screening process and apply any charity care discounts up to 100% of the patient responsibility ~~or full cost coverage~~ for which the patient qualifies on the basis of that screening ~~for~~; and

(2) include on each billing statement notice of:

(a) the availability of financial assistance;

(b) the contact information for the office or department of the hospital that can provide information about obtaining financial assistance; and

(c) the direct Internet address for the financial assistance policy.

(E~~D~~) A patient may apply or re-apply for charity care if the patient was screened for eligibility and ~~was found~~ determined not to be eligible, to demonstrate a change in their financial circumstances during the application period, or to demonstrate that a prior determination was made in error ~~or the patient disagrees with the amount of the charity care discount~~.

(F~~E~~) The inability to establish a patient's eligibility for financial assistance or charity care discounts based on insufficient or inaccurate information supplied by the patient and/or queried from external sources after reasonable efforts to obtain and verify such information shall not constitute a violation of any rule or process adopted under Subsection (C).

(G~~F~~) If a hospital makes an incorrect determination under Subsection (A) based on the information provided by the patient at the time of the determination, the hospital shall:

(1) refund any payment made by the patient in the amount of charity care for which the patient qualified; and

(2) reimburse any other associated reasonable costs, such as legal expenses and fees, incurred by the patient in securing charity care.

(H~~G~~) If the hospital sold debt based on an incorrect determination to a collection agency or authorized a collection agency to collect the debt on behalf of the hospital, the hospital shall notify the collection agency that the debt is invalid.

(I~~H~~) If the commission determines that a hospital fails to comply with this section:

(1) upon the first violation, the commission shall ~~institute~~ require the hospital to design and institute a corrective action plan for the hospital ~~and post it on the commission's website~~ that:

(a) establishes a reasonable time period for the hospital to amend its procedures and train staff on changes where applicable to avoid future violations;

(b) is submitted to the commission for review and approval within xx business days of notice of the first violation; and

(c) is posted on the commission's internet website upon approval.

(2) upon ~~the second~~ any violation after the corrective action plan has been instituted by the hospital:

(a) the commission shall apply an administrative penalty of not less than $xx; and

(b) apply a probationary period of not more than xx days, after which the commission shall confirm that the hospital is in compliance with this section; and

(3) upon ~~the third~~ any violation after completion of the probationary period, the commission shall inform the attorney general of the nature of the non-compliance, who may ~~shall~~ bring an action in the name of this state to revoke the hospital's state tax exemptions.

Section 5. Calculation of Net Patient Revenue

(A) When calculating net patient revenue under [*insert citation to applicable charity care financial statutes]*, a hospital or hospital system shall include all and facilities and practices offering medical services located in this state under the common governance of a single corporate parent, regardless of their radius from that corporate parent.

(B) All facilities described by Subsection (A) must comply with charity care screening requirements found in Section 4.

Section 6. Credit Reporting and Debt Collection for Debt Related to Lifesaving and Emergency Care

(A) Creditors and debt collectors are prohibited from reporting to any consumer reporting agency medical debt obtained from lifesaving and emergency care services rendered at an [State] medical facility.

(B) Consumer reporting agencies are prohibited from including consumer debt obtained from lifesaving and emergency care services rendered at a(n) [State] medical facility on a consumer report.

Section 7. Rules

The [*insert appropriate state agency]* shall adopt rules to effectuate the provisions of this Act.

Section 8. Effective Date

This Act shall take effect [xxxxxxx]

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CHIEF EXECUTIVE OFFICER: Will Melofchik

National Council for Insurance Legislators (NCOIL)

Model Act Ensuring Access to Eye Care Services and Materials for Patients Through Transparent and Fair Business Practices by Vision Benefit Plans

Sponsored by Rep. Deanna Gordon (KY)

Draft as of March 18, 2026. To be introduced and discussed during the Health Insurance & Long Term Issues Committee on April 17, 2026.

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Section 1. Title

This Act shall be known as the [State] Access to Eye Care Services and Materials for Patients Through Transparent and Fair Business Practices by Vision Benefit Plans Act.

Section 2. Definitions

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

A. "Contractual discount" means a percentage reduction from a provider's usual and customary rate for covered services and covered materials required under a participating provider agreement.

B. “Materials” means ophthalmic devices including but not limited to lenses, devices containing lenses, artificial intraocular lenses, ophthalmic frames and other lens mounting apparatus, prisms, lens treatments and coatings, contact lenses, low vision devices, vision therapy devices, and prosthetic devices to correct, relieve, or treat defects or abnormal conditions of the human eye or its adnexa, or any material allowed to be utilized by the [state]’s Board of Optometry and Practice Act.

C. "Covered services" means the professional work performed by an eye care provider for which reimbursement from an insurer, vision benefit manager, or subcontractor is provided to an eye care provider by an enrollee's plan contract, or for which a reimbursement would be available but for the application of the enrollee's contractual plan limitations of deductibles, copayments, or coinsurance, regardless of how the services are listed or described in an enrollee’s benefit plan’s definition of benefits.

D. “Covered materials” means materials for which reimbursement from an insurer, vision benefit manager, or subcontractor is provided to an eye care provider by an enrollee’s plan contract, or for which a reimbursement would be available but for the application of the enrollee’s contractual limitations of deductibles, copayments, or coinsurance, regardless of how the materials are listed or described in an enrollee’s benefit plan’s definition of benefits.

E. “Eye care provider” means a licensed doctor of optometry practicing under the authority of [statutory reference] or a licensed medical or osteopathic doctor practicing under the authority of [statutory reference].

F. *“*Participating eye care provider” means an eye care provider that has entered into a contractual agreement or other business relationship with an insurer, vision benefit manager, third party administrator, or subcontractor to provide covered services or covered materials.

G. “Health benefit plan” means a policy, contract, or agreement offered by an insurer, third party administrator, or subcontractor to an enrollee to pay for, reimburse, discount, or offset health care costs.

H. “Vision benefit plan” means a policy, contract, or agreement offered by an insurer or vision benefit manager to an enrollee to pay for, reimburse, or offset health and vision care costs.

I. “Vision benefit discount plan” means a policy, contract, or agreement offered by an insurer or vision benefit manager to an enrollee that solely provides for a discount for vision care services or materials.

J. “Vision Benefit Manager” means an individual, company, organization, group, or other entity, including but not limited to insurers, third party administrators, and subcontractors, that creates, promotes, sells, provides, advertises or administers, an integrated or stand-alone vision benefit plan, vision benefit discount plan, or other insurance policy or contract which provides vision benefits or discounts to an enrollee pertaining to the provision of covered services or covered materials.

K. “Insurer” means, for the purposes of this [Chapter/Title/etc.] an individual, corporation, partnership, company, organization, group, HMO, captive, risk-retention group, self-insurance group, optometric service and indemnity corporation or other entity, whether organized for profit or not-for-profit, whether foreign or domestic, that conducts business in this state and that offers a vision benefit plan or provides coverage for vision-related services or vision-related materials to enrollees. For avoidance of doubt, an entity is considered an Insurer for purposes of this Act irrespective of:

(i) its corporate form or category of licensure, if applicable, including whether it is otherwise subject to insurance regulations or any other regulations;

(ii) whether it, either directly or indirectly reimburses, indemnifies, pays, or discounts the costs of vision services or vision materials; or

(iii) whether it delegates, assigns, or contracts performance of any function regulated by this Act to an affiliate, subsidiary, contractor, intermediary, or network leasing entity.

L. “Third party administrator” means an individual, company, organization, group, or other entity that provides services including but not limited to administrative, operational, regulatory, human resource, compliance, and claim adjudication services for an insurer, vision benefit manager, individual, company, organization, group, or other entity under a contract or agreement.

M. “Subcontractor” means an individual, company, organization, group or other entity including but not limited to agents, servants, brokers, wholesalers, distributors, indirectly-owned, partially-owned or wholly-owned subsidiaries, and controlled organizations that is contracted by the vision benefit manager to supply services or materials to another vision benefit manager, eye care provider, or enrollee to execute or fulfill the health benefit plan, vision benefit plan, or vision benefit discount plan of a vision benefit manager.

N. “Enrollee” means any individual participating in a health benefit plan, vision benefit plan or vision benefit discount plan that is purchased by an individual or provided to an individual by an Insurer, company, organization, group, employer, government assistance program, or any other entity that purchases or supplies coverage for a health benefit plan, vision care benefit plan or vision benefit discount plan.

O. “Chargeback” means a dollar amount, fee, surcharge, rebate, or item of value that reduces, modifies, or offsets all or part of the patient responsibility, provider reimbursement, allowed amount, or fee schedule for a covered service or covered material.

P. “Fee Schedule” means the document or system that lists the predetermined payment rates or allowed amounts for covered services and/or covered materials and determines how much eye care providers are reimbursed by the insurer or vision benefit manager and how much patients are charged by the insurer, vision benefit manager, or eye care provider.

Q. “Nominal” means, when there is no corresponding reimbursement in the current year’s published Physician Fee Schedule (PFS) released annually by the Centers for Medicare & Medicaid Services (CMS) or in the current year’s published state Medicaid fee schedule, an amount less than the reasonable compensation to the vision care provider rendering the covered service or covered materials, taking into account the provider’s direct and indirect costs, i.e., the actual acquisition costs and actual pro rata overhead costs, and reasonable profit.

R. “De Minimis” means equal to zero or an otherwise negligible amount.

Section 3. Transparency and Disclosure Requirements for Insurers and Vision Benefit Managers

A. An Insurer or Vision Benefit Manager shall disclose the following information publicly on its internet website and with all documents and document packages including but not limited to proposals, responses to requests for proposals, sales documents, enrollment documents, benefit plan documents, purchaser contracts, enrollee contracts, and provider agreements that are presented to purchasers, potential purchasers, enrollees, potential enrollees, participating eye care providers, potential participating providers, and state agencies with jurisdictional, regulatory, or enforcement authority over its business:

1. its legal name and entity type;

2. its legal address and state in which the legal entity is formed or organized;

3. the physical address, mailing address, electronic mail address, and phone number of its operational headquarters;

4. the agencies, departments, committees, commissions, and other bodies that have jurisdictional, regulatory, or enforcement authority over the business;

5. a statement that no jurisdictional, regulatory, or enforcement authority exists over its business, if none exists;

6. the names, physical addresses, mailing addresses, electronic mail addresses, and phone numbers of all parent companies, related holding companies, wholly-owned subsidiary companies, and partially-owned subsidiary companies;

7. All federal and state litigation in which the company is, or has been, a party to in the current year and during the preceding five (5) years.

8. All [state department of insurance] formal complaints against the company in the current year and during the preceding five (5) years by purchasers, enrollees, or eye care providers.

B. All information required to be disclosed by an Insurer or Vision Benefit Manager in subsection (1) shall be conveyed in plain language and typed with a minimum of ten (10) point font size and prominently displayed:

1. on the Insurer's or Vision Benefit Manager's website in a publicly accessible section titled "Required Transparency Information for Patients, Doctors, and Purchasers"; and

2. in a separately created document titled "Required Transparency Information for Patients, Doctors, and Purchasers" that shall be included with all documents and document packages including but not limited to proposals, responses to requests for proposals, benefit plan documents, sales documents, enrollment documents, purchaser contracts, enrollee contracts, and provider agreements.

C. An Insurer or Vision Benefit Manager shall provide notice to each participating eye care provider of any proposed amendments to existing provider agreements, fee schedules, provider handbooks, provider manuals, or related policy documents via electronic mail.

D. A participating eye care provider shall be provided with a minimum of ninety (90) calendar days from the time of distribution to review changes and respond, if necessary, to any proposed amendments from an insurer or vision benefit manager to existing provider agreements, fee schedules, provider handbooks, provider manuals, or related policy documents. Any such proposed amendments proffered by the Insurer or Vision Benefit Manager in violation of the foregoing shall be void and unenforceable as a matter of law.

E. Any proposed amendments to existing provider agreements, fee schedules, provider handbooks, provider manuals, or related policy documents by an Insurer or Vision Benefit Manager delivered to a participating eye care provider shall be:

1. enumerated in a cover letter;

2. marked with highlights or in tracked changes within the applicable agreements and/or documents to clearly display all changes over the previous version(s);

3. structured to include implications of agreeance or non-agreeance by the participating eye care provider.

F. An Insurer or Vision Benefit Manager shall maintain:

1. a phone number to company representatives to receive questions and communications from participating eye care providers at all times during standard business hours;

2. the ability for an eye care provider to leave voice messages at all times; and

3. the ability for an eye care provider to have a live phone discussion with a company representative within (24) hours of an initial phone call or a voice message left with the Insurer or Vision Benefit Manager.

G. An Insurer or Vision Benefit Manager shall maintain a physical mailing address and an electronic mail address to company representatives to receive questions, disputes, and communications from participating eye care providers about all matters, at all times, including but not limited to proposed amendments to existing provider agreements, fee schedules, provider handbooks, provider manuals, and related policy documents, and will publish instructions for mail submission and electronic mail submission of questions, disputes, and communications in a place visible to participating eye care providers including on its website and in any provider agreements, provider handbooks, provider manuals, or related policy documents.

H. An Insurer or Vision Benefit Manager shall acknowledge receipt of an electronic mail message within one (1) hour by use of a return electronic mail message with a communication tracking number, and shall respond to the substantive questions or communications of the electronic mail message within seventy-two (72) hours in writing by use of a return electronic mail message.

I. An Insurer or Vision Benefit Manager shall, at all times, make available to the eye care provider the most up-to-date provider agreements, fee schedules, provider handbooks, provider manuals, and related policy documents via website access.

J. Insurers or Vision Benefit Managers shall not engage in marketing or advertising activities that are misleading or deceptive to the public. Such acts are considered deceptive trade practices and subject to penalty under [state's deceptive trade practice statute].

K. Upon request by a state agency with jurisdictional, regulatory, or enforcement authority over its business, Insurers and Vision Benefit Managers shall submit all information related to a health benefit plan, vision benefit plan, or vision benefit discount plan, including but not limited to proposals, responses to requests for proposals, benefit plan documents, sales documents, enrollment documents, purchaser contracts, enrollee contracts, provider agreements, and marketing and advertising activities for review.

Section 4. Covered and Non-Covered Services and Materials Provisions

A. No agreement or contract between an Insurer or Vision Benefit Manager and an eye care provider may seek to or require that an eye care provider provide services or materials at a fee limited or set by the Insurer or Vision Benefit Manager unless the services or materials are defined and reimbursed as covered services or covered materials under the agreement or contract.

B. All fee schedules in an agreement between an Insurer or Vision Benefit Manager and an eye care provider and all reimbursements paid by an Insurer or Vision Benefit Manager to an eye care provider for all covered services and covered materials shall not be Nominal or De Minimis. There shall be no limitation on the ability of an individual eye care provider or a group of eye care providers who practice under a single Employer Identification Number (EIN) or Tax Identification Number (TIN) to engage in direct negotiations with the Insurer or Vision Benefit Manager regarding reimbursement fee schedules, and ultimately agreeing to a different fee schedule than the fee schedule provided by the Insurer or Vision Benefit Manager to other participating providers or groups.

C. A contract between an Insurer or Vision Benefit Manager and an eye care provider shall include a fee schedule that includes and individually identifies each covered service and covered material and its corresponding allowed amount, reimbursement amount paid to the eye care provider, and any form of a cost-sharing amount paid by the enrollee to the eye care provider.

D. Insurers or Vision Benefit Managers shall not advertise, claim, or represent to purchasers or enrollees that services and materials provided by a participating eye care provider are covered, included, or covered with an additional deductible, copay, or coinsurance, if the Insurer or Vision Benefit Manager does not remit an actual payment to the participating eye care provider as full or partial reimbursement for the service or material.

E. A service or material provided by a participating eye care provider cannot be designated as a covered service or covered material by the Insurer or Vision Benefit Manager in the design of a health benefit plan, vision benefit plan, or vision benefit discount plan if the reimbursement amount to the participating eye care provider is only comprised of an enrollee's payment to the participating eye care provider.

F. Insurers or Vision Benefit Managers shall not condition application to or network participation in a health benefit plan, vision benefit plan, or vision benefit discount plan by an eye care provider based on the eye care provider's usual and customary pricing or discounts on usual and customary pricing for services or materials that are not covered services or not covered materials. Any such contractual language, policies, or procedures set by the Insurer or Vision Benefit Manager in violation of the foregoing shall be void and unenforceable as a matter of law.

G. Insurers or Vision Benefit Managers shall not make conditional a fee schedule proposed or made to an eye care provider of a health benefit plan, vision benefit plan, or vision benefit discount plan for covered services or covered materials based on the eye care provider's usual and customary pricing or discounts on usual and customary pricing for services or materials that are not covered services or not covered materials. Any such contractual language, policies, or procedures set by the Insurer or Vision Benefit Manager in violation of the foregoing shall be void and unenforceable as a matter of law.

H. A contract between an Insurer or Vision Benefit Manager and an eye care provider shall not contain a provision, fee schedule, or reimbursement amount in which the eye care provider, with consideration of any applicable deductibles, copays, coinsurances, discounts, rebates, or chargebacks, to provide covered services or covered materials to an enrollee at a financial loss. Any such contractual language, policies or procedures set by the Insurer or Vision Benefit Manager in violation of the foregoing shall be void and unenforceable as a matter of law.

I. An Insurer or Vision Benefit Manager shall not promote or use in any marketing or advertising for a health benefit plan, vision benefit plan, or vision benefit discount plan that a covered service or covered material is "free" or "no charge" or "complimentary" or any materially similar language to induce a client, group, employer, purchaser, company, enrollee or prospective enrollee to purchase services, materials, supplies, or plans from the Insurer, Vision Benefit Manager, or affiliate of the Insurer or Vision Benefit Manager.

J. Insurers or Vision Benefit Managers shall remit to the participating eye care provider the contracted reimbursement amount from the fee schedule for a covered service or covered material provided to an enrollee if the enrollee is verified to be eligible by the participating eye care provider through customary

verification methods of the Insurer or Vision Benefit Manager to receive the covered service or covered material on the date of service.

K. Insurers or Vision Benefit Managers shall not retroactively reverse a reimbursement or withhold a future reimbursement to a participating eye care provider who relied in good faith on an individual's presented coverage credentials and the customary verification methods of the Insurer or Vision Benefit Manager, if the Vision Benefit Manager later determines that the enrollee was ineligible to receive covered services or covered materials on the date of service.

L. Participating eye care providers are allowed, but not required, to offer an enrollee the opportunity to pay the participating eye care provider directly for covered services and covered materials if such direct payment would be less costly to the enrollee than the total out-of-pocket cost required under the terms of a health benefit plan or vision benefit plan. A provider may not be subject to an audit, removed from participation in the network, or otherwise penalized or discriminated against in any manner for offering an enrollee the opportunity to pay the participating provider directly under the conditions of this provision.

M. Insurers or Vision Benefit Managers shall not, in the course of adjudicating a claim for reimbursement by a participating eye care provider for a covered service or covered material, alter, delete, substitute, or otherwise change any code or modifier submitted by the eye care provider, including by downcoding, bundling or reassigning to a different code, if such change would reduce payment or otherwise adversely affect the provider and/or enrollee. For purposes of this section, "downcoding" means to alter, delete, substitute or assign a code that results in a lower level of service, a lower-valued code, or a reduced reimbursement amount relative of the code(s) submitted by the eye care provider; and "bundling" means to combine, substitute, or treat two or more distinct services, supplied, or materials reported on the same claim or date or service as included within a single code, package, or global service, and denying, reducing, or disallowing separate reimbursement for one or more of these codes.

N. All provisions in this chapter shall apply to all affiliates, parent companies, third party administrators, and subcontractors that are used by an Insurer or Vision Benefit Manager to supply covered services or covered materials to an eye care provider or enrollee and be subject to all applicable penalties as referenced in this [chapter] or [section].

O. An Insurer or Vision Benefit Manager shall not require nor request an eye care provider to opt-in or opt-out of the provisions set forth in this [chapter] or [section].

Section 5: Prohibiting Coercive Tactics by Insurers and Vision Benefit Managers; Providing Reimbursement Parity for Optometrists and Ophthalmologists; Requiring Affiliates to Comply with Statute

A. No agreement between an Insurer or Vision Benefit Manager and an eye care provider shall require that an eye care provider must participate with, be credentialed by, or enter into an agreement with any specific vision benefit plan or vision benefit discount plan as a condition for participation in the health benefit plan provider network of the Insurer or Vision Benefit Manager to provide covered services or covered materials to the enrollees of the health benefit plan.

B. No agreement between an Insurer or Vision Benefit Manager and an eye care provider shall require that an eye care provider must participate with, be credentialed by, or enter into an agreement with any specific health benefit plan as a condition for participation in the vision benefit plan or vision benefit discount plan provider network of the Insurer or Vision Benefit Manager to provide covered services or covered materials to the enrollees of the vision benefit plan or vision benefit discount plan.

C. Any Insurer or Vision Benefit Manager issuing or renewing a health benefit plan, vision benefit plan or vision benefit discount plan which provides benefits for covered services or covered materials rendered by a physician or osteopath duly licensed under [statutory reference] that are within the scope of practice of an optometrist duly licensed under the provisions of [statutory reference] shall provide the same reimbursement for covered services or covered materials to optometrists as allowed for those covered services or covered materials rendered by physicians or osteopaths.

D. An Insurer or Vision Benefit Manager shall apply the same terms and conditions of participation for all eye care providers, irrespective of their educational credentials, i.e., MD, DO, OD, subject to the permitted scope of practice for the licensee under applicable state law.

E. An Insurer or Vision Benefit Manager shall not require an eye care provider to possess, offer, procure, or sell materials or covered materials in their office as a condition of participation in the provider network of health benefit plan, vision benefit plan, or vision benefit discount plan. Any such contractual language, policies or procedures set by the Insurer or Vision Benefit Manager in violation of the foregoing shall be void and unenforceable as a matter of law.

F. If an eye care provider enters into any subcontract agreement with another provider to provide his or her licensed health care services to an enrollee or a covered dependent of an enrollee of a health benefit plan, vision benefit plan, or vision benefit discount plan where the subcontracted provider will seek

reimbursement from the plan or enrollee for the subcontracted services, the subcontract agreement must meet all requirements of this [chapter]or[act].

G. The provisions of this subsection shall also apply to any agreements an Insurer or Vision Benefit Manager enters into with another entity to provide an enrollee with covered services or covered materials.

Section 6. Acceptance as Participating Eye Care Provider

A. An Insurer or Vision Benefit Manager shall not exclude an eye care provider from applying to, or becoming a participating provider in, the network of a health benefit plan, vision benefit plan, or vision benefit discount plan because of:

1. the aggregate number of eye care providers in a state, county, city, zip code, or other geographically defined service area;

2. the time, distance, or appointment availability for an enrollee to access a participating eye care provider;

3. the provider's professional designation, independent practice affiliation, or participation status in other health benefit plans, vision benefit plans, or vision benefit discount plans.

Section 7. Permitting Eye Care Providers to Use any Lab or Supplier

A. No agreement between an Insurer or Vision Benefit Manager and an eye care provider shall restrict or limit, either directly or indirectly, the eye care provider's choice or use of sources and suppliers of covered or uncovered services or materials, including the choice or use of optical laboratories, provided by the eye care provider to an enrollee. Any such contractual language, policies or procedures set by the Insurer or Vision Benefit Manager in violation of the foregoing shall be void and unenforceable as a matter of law.

B. An Insurer or Vision Benefit Manager shall not directly or indirectly apply a chargeback to an enrollee or eye care provider if the chargeback is for a covered product or service for which the insurer or vision benefit manager does not incur the cost to produce, deliver, or provide to the enrollee or eye care provider.

Section 8. A Private Right of Action for Eye Care Providers

Any eye care provider adversely affected by a violation of this subchapter may bring an action in a court of competent jurisdiction for injunctive relief against the Insurer or Vision Benefit Manager and, upon prevailing, in addition to such injunctive relief, shall recover monetary damages, including but not limited to direct, indirect, special and

punitive damages, and penalties, of no more than $10,000 for each violation, plus attorney's fees and costs.

Section 9. Relationship to Other Laws

The requirements of this Act are in addition to, and do not limit, any other requirement applicable to an Insurer under State law. In the event of a conflict between this Act and another provision of State law applicable to Insurers, the provision that affords greater protection to Eye Care Providers or plan enrollees shall control. Notwithstanding any other provision of State law, including any law that purports to be the sole body of law governing the Insurer, an Insurer shall comply with this Act, to the extent not preempted by Federal law.

Section 10. Enforcement

A. The [Commissioner/Department] has jurisdiction to administer and enforce this Act with respect to any Insurer, as such term is defined herein. The [Commissioner/Department] may: (i) bring an action, issue orders, and impose remedies authorized by this Act against any Insurer; (ii) adopt rules to identify activities that constitute the administration, management, or control of vision benefits or materials; and (iii) coordinate enforcement with other State agencies that regulate Insurers under other applicable law. The Attorney General has concurrent enforcement authority for violations constituting unfair or deceptive acts or practices.

B. The Insurance Commissioner shall:

1. Provide a mechanism for aggrieved individuals, whether actively or formerly enrolled with a particular vision care plan, to submit complaints to the Insurance Commissioner for review, investigation, and as appropriate, discipline under applicable law.

2. Enforce the state's insurance laws and this provision using powers granted to the commissioner in the (Name of State) Insurance Code (Code citation);

3. Ensure that Insurers and Vision Benefit Managers comply with the requirement of this act; and

4. Be entitled to seek an injunction against an Insurer or Vision Benefit Manager in a court of competent jurisdiction if the Insurer or Vision Benefit Manager:

i. issues a coverage policy that does not comply with the requirement of this Act, uses fraudulent, coercive or dishonest practices, or

demonstrates incompetence, untrustworthiness, or financial irresponsibility in the conduct of business;

ii. fails to deal equitably with any eye care providers or other persons of facilities which offer services or materials covered within a contract or policy issued pursuant to this Act; or

iii. fails to substantially comply with the insurance laws of this state or violates any regulation, rule, subpoena or order of the Commissioner

C. The Attorney General shall:

1. Enforce the state's laws and this Act's provisions, using powers granted to the Attorney General in the (Name of State) Insurance Code (Code citation) and/or the state's consumer protection statutes; and

2. Be entitled to seek an injunction against an Insurer or Vision Benefit Manager in a court of competent jurisdiction.

3. The penalties and remedies provided in this chapter for violation of this provision: (i) are cumulative, and in addition to any other penalties and remedies available under state law; and (ii) shall not waive, limit, or otherwise affect the applicability of the state's [Unfair Trade Practices Act/Consumer Protection Act/Deceptive Trade Practices Act], or any other law providing for civil or criminal penalties or remedies for unfair, deceptive, or unlawful business practices.

Section 11: Severability Clause

If any provision of this Act or the application thereof to any person or circumstance is held invalid, the remainder of the chapter and the application of such provision to other persons or circumstances shall not be affected thereby.

Section 12: Rules

A. The requirements of this section apply to Insurer or Vision Benefit Manager policies, contracts, addenda and certificates executed, delivered, issued for delivery, continued or renewed in (State).

1. No Insurer or Vision Benefit Manager shall construe re-credentialing as re-contracting with a participating eye care provider. A provider agreement must be a distinctly separate document from any credentialing materials and must be signed by the eye care provider and the Insurer or Vision Benefit Manager.

2. An Insurer or Vision Benefit Manager must include a copy of the current plan provider manual referred to in a provider agreement at the time an

agreement is sent to any provider and prospective provider, as well as any policies referenced in the provider agreement, e.g. dispute resolution policies.

B. This law shall go into effect immediately upon passage and shall apply to all Insurers and Vision Benefit Managers upon the earlier of:

1. the renewal of enrollee's current benefit plan or upon issue of a new benefit plan to any enrollee;

2. the initiation of a new provider agreement with an eye care provider or upon any amendment of an existing provider agreement with an eye care provider; or

3. January 1, 202x.

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CHIEF EXECUTIVE OFFICER: Will Melofchik

National Council of Insurance Legislators (NCOIL)

Resolution in Support of Public Policy Improving Maternal Health

Sponsored by Rep. Greg Scott (PA)

Draft as of March 18, 2026. To be discussed and potentially considered during the meeting of the NCOIL Health Insurance & Long Term Care Issues Committee on April 17, 2026.

WHEREAS, access to and quality of healthcare before pregnancy can affect health outcomes, yet only approximately 16% of mothers receive adequate prenatal care[4], highlighting persistent gaps in access to timely and appropriate services; and

WHEREAS, more than 80% of pregnancy-related deaths are preventable[5]; and

WHEREAS, hypertensive disorders in pregnancy are strongly associated with severe maternal complications, such as heart attack and stroke, and are a leading cause of pregnancy-related deaths in the United States[6]; and

WHEREAS, pregnant women living in rural America face significant barriers to maternity care, with 2.3 million women residing in counties deemed maternity care deserts. Pregnancy-related mortality is higher in rural populations with 37.9 deaths per 100,000 live births, compared to 23.1 per 100,000 live births in metropolitan areas[7]; and

WHEREAS, disparities in maternal health outcomes persist, with pregnancy-related mortality for Black women, Native American, and Alaska Native women being two to three times higher than for White, Hispanic, and Asian Pacific Islander women[8]; and

WHEREAS, the number of U.S. counties with a severe risk for maternal mental health disorders has risen. Maternal mental health is a risk factor associated with poor maternal

[4] Inadequate prenatal care: United States, 2019-2024 | PeriStats | March of Dimes
[5] Preventing Pregnancy-Related Deaths | Maternal Mortality Prevention | CDC
[6] Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion,
CDC; Division of Heart Disease and Stroke Prevention, National Center for Chronic Disease Prevention
and Health Promotion, CDC
[7] Rural Maternal Health
[8] Racial Disparities in Maternal and Infant Health: Current Status and Key Issues | KFF

health outcomes; poverty, social instability, and isolation contribute to this risk in many counties, while insufficient providers and other resource shortages exacerbate risks in others[9]; and

WHEREAS, acting upon reliable and comprehensive maternal health data is necessary to reduce disparities, improve care delivery and improve maternal and infant health outcomes[10]; and

WHEREAS, Maternal Mortality Review Committees (MMRCs) are multidisciplinary state or jurisdiction-level bodies inclusive of clinical and non-clinical experts representing populations disproportionately affected by maternal mortality; and

WHEREAS, MMRCs are uniquely positioned to identify preventable factors which contribute to maternal deaths, as well as recommend evidenced-based structure, policy and process changes which may help prevent future maternal deaths.

WHEREAS, BE IT NOW THEREFORE RESOLVED, that the National Council of Insurance Legislators (NCOIL) urges the 50 state legislatures, health departments, and other state agencies and institutions to make the prevention of maternal morbidity and mortality a high priority by ameliorating factors that lead to adverse outcomes, such as lack of access to appropriate and timely care and inadequate data structures, while improving the health and wellness of all mothers through the following measures:

Strengthening Maternal Mortality Review Committees (MMRCs) Through Legislation That:

• Ensures MMRCs operate as independent bodies comprised of a diverse group of expert participants;
• Supports the dissemination and implementation of MMRC recommendations and ensures MMRC data collection remains centralized;
• Maintains or increases funding for MMRCs via state public health agencies to support sustainability and effectiveness.

Improving Data Collection and Infrastructure

• Develop policies that support the collection of Severe Maternal Morbidity (SMM) data by hospitals and birthing facilities to help identify opportunities for clinical and structural improvements which may improve outcomes and reduce disparities in care;
• Address gaps in state data infrastructure that prevent comprehensive analysis of adverse maternal events by supporting efforts to standardize and centralize data collection;
• Encourage adoption of the Office of Management and Budget's Statistical Policy Directive No. 15 standards for maintaining, collecting, and presenting federal data on race and ethnicity.

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[9] 2025 U.S. Maternal Mental Health Risk and Resources by County - Policy Center for Maternal Mental Health
[10] Maternal Morbidity and Mortality Data and Analysis Initiative

Expanding Access to Maternal Support Services

• Increase investments to expand access to maternity care doula services in Medicaid, including workforce development programs to maintain an adequate number of providers, and ensure hospital policies enable maternity care doulas to serve as part of the care team.

Addressing Maternal Mental Health

• Promote the incorporation of multidisciplinary teams into integrated and collaborative maternal care models to address maternal mental health, including community-based perinatal support workers, obstetric and child health nurses, obstetricians, pediatricians, and family physicians.

Promoting Evidence-Based Clinical Quality Initiatives

• Encourage hospitals to adopt the Alliance for Innovation in Maternal Health (AIM) Hypertension Bundle to improve hypertension management and reduce pregnancy related complications.

WHEREAS, BE IT FINALLY RESOLVED, that a copy of this Resolution shall be sent to xxxxxxxxxxxx.

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National Council of Insurance Legislators (NCOIL)

Accumulator Adjustment Program Model Act

***Sponsored by Sen. Jason Rapert (AR)**
***Rep. Deborah Ferguson (AR); Rep. George Keiser (ND); Asw. Pam Hunter (NY) – Co-Sponsors**
***Adopted by the NCOIL Health Insurance & Long Term Care Issues Committee on November 18, 2021 and the NCOIL Executive Committee on November 20, 2021.**

***To be considered for re-adoption by the NCOIL Health Insurance & Long Term Care Issues Committee on April 17, 2026.**

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Section 1. Title

This Act shall be known and may be cited as the "[State] Accumulator Adjustment Program Act."

Section 2. Legislative Purpose

(A) The legislature finds that cost sharing assistance is indispensable to help many patients with rare, serious, and chronic diseases afford out-of-pocket costs for their essential, often lifesaving, medications.

(B) The legislature further finds that patients need cost sharing assistance because of the high out-of-pocket cost of medications.

(C) The legislature further finds that when patients face unexpected charges during the plan year, they are less likely to adhere to their medication regimen.

(D) The legislature further finds that lack of patient adherence to needed medicines leads to potential negative health consequences for the patients, such as unnecessary emergency room visits, doctors' visits, surgeries, and other interventions.

(E) The legislature further finds that patients are only able to use cost sharing assistance after they have met requirement(s) for coverage of their medication. Requirements for coverage can include the medication's inclusion on the patient's formulary and utilization management protocols, such as prior authorization and step therapy.

(F) The legislature further finds that health insurers and pharmacy benefit managers (PBMs) have implemented programs, such as accumulator adjustment programs, to restrict cost sharing assistance from counting towards a patient's deductible or annual out-of-pocket limit.

(G) The legislature further finds that as a result of an accumulator adjustment program, a patient is required to continue to make payments even if the patient has already hit an out-of-pocket limit when including cost sharing assistance. As such, the cost sharing assistance depletes leaving the patient responsible for paying the full deductible and meeting the annual out-of-pocket limit for a second time. This means accumulator adjustment programs limit the benefit patients receive from copay assistance programs.

(H) The legislature further finds that patients often are not aware of the inclusion of accumulator adjustment programs in their health plan contracts. Patients tend to learn about these types of programs when they attempt to obtain their medication after their cost sharing assistance has run out, whether at the pharmacy, infusion center, or at home through the mail.

(I) Therefore, the legislature declares it a matter of public interest that health insurers and PBMs must count any amount paid by the patient or on behalf of the patient by another person towards a patient's annual out-of-pocket limit and any cost sharing requirement, such as deductibles.

Section 3. Definitions

(A) "Cost sharing" means any copayment, coinsurance, deductible, or annual limitation on cost sharing (including but not limited to a limitation subject to 42 U.S.C. §§ 18022(c) and 300gg-6(b)), required by or on behalf of an enrollee in order to receive a specific health care service, including a prescription drug, covered by a health plan, whether covered under the medical or pharmacy benefit.

(B) "Carrier" OR "Insurer" OR "Issuer" means [cross-reference state insurance statutes and use their existing definitions], and shall include, but not be limited to any health insurance company, nonprofit hospital and medical service corporation, managed care organization, and, to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health benefit plan offered by public and private entities. For the purposes of this section, "insurer" does not include self-insured employer

plans governed by the Employee Retirement Income Security Act of 1974 (ERISA) (Pub.L. 93–406, 88 Stat. 829, as amended).

(C) "Commissioner" means the state insurance commissioner.

(D) "Generic Equivalent":

(i) means a drug that has an identical amount of the same active chemical ingredients in the same dosage form, that meets applicable standards of strength, quality and purity according to the United States Pharmacopeia or other nationally recognized compendium and that, if administered in the same amounts, will provide comparable therapeutic effects.

(ii) does not include a drug that is listed by the United States Food and Drug Administration as having unresolved bioequivalence concerns according to the Administration's most recent publication of approved drug products with therapeutic equivalence evaluations.

(E) "Health Plan" means a policy, contract, certificate, or subscriber agreement entered into, offered, or issued by a health insurance issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services.

(F) "Person" means a natural person, corporation, mutual company, unincorporated association, partnership, joint venture, limited liability company, trust, estate, foundation, nonprofit corporation, unincorporated organization, or government or governmental subdivision or agency.

(G) "Pharmacy Benefit Manager" means any person or business who administers the prescription drug or device program of one or more health plans on behalf of a third party in accordance with a pharmacy benefit program. This term includes any agent or representative of a pharmacy benefit manager hired or contracted by the pharmacy benefit manager to assist in the administering of the drug program and any wholly or partially owned or controlled subsidiary of a pharmacy benefit manager.

Drafting Note: Use existing statutory definitions of "health plan" and "pharmacy benefit manager" when possible.

Drafting Note: If "person" is already in the state's definition, that includes corporation. Otherwise, can remove "by another person."

Section 4. Cost-Sharing Requirements

(A) When calculating an enrollee's overall contribution to any out-of-pocket maximum or any cost-sharing requirement under a health plan, a [CARRIER/INSURER/ISSUER] or pharmacy benefit manager shall include any amounts paid by the enrollee or paid on behalf of the enrollee by another person for a prescription drug that is either:

(1) without a generic equivalent; or

(2) with a generic equivalent where the enrollee has obtained access to the prescription drug through any of the following:

(a) prior authorization

(b) a step therapy protocol

(c) the health care insurer's exceptions and appeals process.

(B) A person that pays any amount on behalf of an enrollee for a covered prescription drug:

(1) must notify the enrollee prior to the acceptance of the financial assistance of the total amount of assistance available and the duration for which it is available; and

(2) may not condition the assistance on enrollment in a specific health plan or type of health plan, to the extent permitted under federal law.

(C) If under federal law, application of subsection (A) would result in Health Savings Account ineligibility under section 223 of the federal Internal Revenue Code, this requirement shall apply only, for Health Savings Account-qualified High Deductible Health Plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under section 223, except for with respect to items or services that are preventive care pursuant to section 223(c)(2)(C) of the federal Internal Revenue Code, in which case the requirements of subsection (A) shall apply regardless of whether the minimum deductible under section 223 has been satisfied.

Section 5. Rules

The commissioner shall promulgate rules necessary to carry out this Act.

Section 6. Enactment

This section shall apply with respect to health plans that are entered into, amended, extended, or renewed on or after January 1, 202##.

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National Council of Insurance Legislators (NCOIL)

Model Act Regarding Air Ambulance Patient Protections

***Sponsored by Del. Steve Westfall (WV)**
***Rep. Thaddeus Jones (IL); Rep. Deanna Frazier (KY); Rep. Tom Oliverson, M.D. (TX) – Co-Sponsors**
***Adopted by the NCOIL Health Insurance & Long Term Care Issues Committee on November 18, 2021 and the NCOIL Executive Committee on November 20, 2021**

***To be considered for re-adoption by the NCOIL Health Insurance & Long Term Care Issues Committee on April 17, 2026.**

AN ACT to amend the insurance law, in relation to private air ambulance services and consumer protections

Section 1. Short Title

This Act may be cited as the Air Ambulance Patient Protection Act.

Section 2. Purpose

This Act is intended to help preserve the long-standing jurisdiction that states have over the regulation of the business of insurance as expressly established by the McCarran-Ferguson Act (15 U.S.C. 1011 et seq., 1945), and to affirm the ability of states to regulate the business of insurance without threat of Federal obstruction.

This Act does so consistent with McCarran-Ferguson Act standards by defining and regulating the particular practice of risk transferring and spreading air ambulance subscription memberships. Legislating protection from consumer harm in these insurance contracts is an appropriate and necessary measure fulfilling the states' responsibility and authority under McCarran-Ferguson to exercise broad regulatory authority over the business of insurance.

Section 3. Section (X) of the insurance law is amended by adding a new subsection (X) to read as follows:

(a) An air ambulance service provider or any affiliated entity who solicits air ambulance membership subscriptions, accepts membership applications, or charges membership fees, is deemed to be engaged in the business of insurance to the extent that it contracts,

promises, guarantees, or in any other way claims to pay, reimburse, or indemnify the copayments, deductibles or other cost-sharing amounts of a patient relating to the air ambulance transport as determined or set by the patient's health insurance provider, health care provider or other third parties or, any post-service payments of costs to third parties relating to the transport.

(b) To the extent that an air ambulance membership subscription falls within the business of insurance described in paragraph (a) of this section, it shall be considered insurance and an insurance product and may be considered secondary insurance coverage or a supplement to any insurance coverage and shall be regulated accordingly by the State Department of Insurance.

Section 4. Air Ambulance Patient Billing Consumer Protections

(a) An entity operating an air ambulance membership program pursuant to Section 3(a) of this Act shall, within one year of enactment of this Act, implement a patient advocacy program, which shall include, at a minimum, the following components:

(1) A dedicated patient hotline number and dedicated patient resource email address to process patient billing and claims, and to address patient questions, complaints and concerns;

(2) A dedicated patient advocacy page on the air medical provider's website that is clearly marked as the "patient portal" or "patient advocacy" page, which is easily navigated to and contains clearly-written and comprehensive resources for patients, including:

(A) A layperson's explanation of what to expect during the claims process,

(B) Frequently asked questions and answers,

(C) Frequently used forms,

(D) Information regarding the air ambulance provider's financial assistance or charity care program, and

(E) Additional resources for patients, including but not limited to contact information for the DOT Consumer Affairs Division, state and federal health and insurance regulatory agencies and departments, and other health consumer informational resources;

(3) Dedicated individuals assigned to review patient complaints and disputes about air ambulance billing and to respond to patients, governmental agencies and any other concerned parties no later than 3 months from the date the complaint is received;

(4) The inclusion of the patient hotline number and email address required by paragraph (1) and patient advocacy webpage address required by paragraph (2) on all patient communication materials, including but not limited to websites, brochures, letters, invoices or billing statements that are sent to or made available to patients;

(5) Mandatory yearly patient advocacy training for all air medical provider personnel who have direct interaction with patients and/or their family members via written, verbal or electronic communications; and

(6) A financial assistance or charity care program to assist patients suffering financial hardship with resolving any unpaid balance owed to the air medical provider.

(b) This provision shall not be enforced in a manner that conflicts with federal law, including the federal preemption of state regulation of air carriers.

Section 5. Consumer disclosures.

(a) An entity selling air ambulance membership products pursuant to Section 3(a) of this Act shall make the following general disclosures in writing in bold type and not less than twelve (12) point font on any advertisement, marketing material, brochure or contract terms and conditions made available to prospective members or the public:

(1) if eligible and covered by Medicaid or Medicaid managed care, the prospective member is already covered with no out of pocket cost liability for air ambulance services; and

(2) if eligible and covered under Medicare and/or a Medicare supplemental plan, the prospective member might already be covered for air ambulance services and should consult with a representative of the Medicare program or a representative of their Medicare Advantage or Medicare Supplemental Plan to determine the level of existing coverage they have for air ambulance and out of pocket costs and whether their plan provider recommends additional supplemental insurance coverage.

Section 6. Severability

If any provision, part or clause of this Act is declared invalid or unconstitutional by a court of competent jurisdiction, such decision shall not affect the validity of the remaining sections or provisions of this article or the article in its entirety.

Section 7. This Act shall take effect one year after enactment.

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CHIEF EXECUTIVE OFFICER: Will Melofchik

National Council of Insurance Legislators (NCOIL

Telemedicine Authorization and Reimbursement Act (TARA)

Sponsored by Asw. Pam Hunter (NY)
Adopted by the NCOIL Health Insurance & Long Term Care Issues Committee on November 18, 2021 and the NCOIL Executive Committee on November 20, 2021.

To be considered for re-adoption by the NCOIL Health Insurance & Long Term Care Issues Committee on April 17, 2026.

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Section 1. Title.

This act shall be known as and may be cited as the Telemedicine Authorization and Reimbursement Act.

Section 2. Purpose

The Legislature hereby finds and declares that:

(A) The advancements and continued development of medical and communications technology have had a profound impact on the practice of medicine and offer opportunities for improving the delivery and accessibility of health care, particularly in the area of telemedicine.

(B) Geography, weather, availability of specialists, transportation, and other factors can create barriers to accessing appropriate health care, including behavioral health care, and one way to provide, ensure, or enhance access to care given these barriers is through the

appropriate use of technology to allow health care consumers access to qualified health care providers.

(C) There is a need in this state to embrace efforts that will encourage health insurers and health care providers to support the use of telemedicine and that will also encourage all state agencies to evaluate and amend their policies and rules to remove any regulatory barriers prohibiting the use of telemedicine services.

(D) The need to access health care services is compounded by the challenges associated with COVID-19, as consumers are experiencing the negative effects the pandemic has on physical, mental, and emotional health that will extend into future years.

(E) Access to telemedicine is vital to ensuring the continuity of physical, mental, and behavioral health care for consumers during the COVID-19 pandemic and responding to any future outbreaks of the virus.

Section 3. Definitions

(A) “Telemedicine” means the delivery of clinical health care services by means of real time audio only telephonic conversation, two-way electronic audio visual communications, including the application of secure video conferencing or store and forward technology to provide or support healthcare delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self management of a patient’s health care while such patient is at an originating site and the health care provider is at a distant site; consistent with applicable federal law and regulations; unless the term is otherwise defined by law with respect to the provision in which it is used.

(B) “Telehealth” means delivering health care services by means of information and communications technologies consisting of telephones, remote patient monitoring devices or other electronic means which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient’s health care while such patient is at the originating site and the health care provider is at the distant site; consistent with applicable federal law and regulations; unless the term is otherwise defined by law with respect to the provision in which it is used.

(C) “Store and forward” transfer means the transmission of a patient’s medical information from an originating site to the provider at the distant site without the patient being present.

(D) “Distant site” means a site at which a health care provider is located while providing health care services by means of telemedicine or telehealth; unless the term is otherwise defined with respect to the provision in which it is used.

(E) “Originating site” means a site at which a patient is located at the time health care services are provided to him or her by means of telemedicine or telehealth, unless the

term is otherwise defined with respect to the provision in which it is used; provided, however, notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties.

Section 4. Coverage of Telemedicine Services

(A) Each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for the cost of such health care services provided through telemedicine services, as provided in this section.

(B) An insurer, corporation, or health maintenance organization shall not exclude a service for coverage solely because the service is provided through telemedicine services and is not provided through in-person consultation or contact between a health care provider and a patient for services appropriately provided through telemedicine services.

(C) An insurer, corporation, or health maintenance organization shall not require a covered person to have a previously established patient-provider relationship with a specific provider in order for the covered person to receive health care services provided through telemedicine services; however, the establishment of a patient-provider relationship shall not occur via an audio-only telephonic conversation.

(D) An insurer, corporation, or health maintenance organization shall reimburse the treating provider or the consulting provider for the diagnosis, consultation, or treatment of the insured delivered through telemedicine services on the same basis that the insurer, corporation, or health maintenance organization is responsible for coverage for the provision of the same service through in-person consultation or contact.

(E) An insurer, corporation, or health maintenance organization may offer a health plan containing a deductible, copayment, or coinsurance requirement for a health care service provided through telemedicine services;, however, such deductible, copayment, or coinsurance shall be combined with the deductible, copayment, or coinsurance applicable to the same services provided through in-person diagnosis, consultation, or treatment.

(F) No insurer, corporation, or health maintenance organization shall impose any annual or lifetime dollar maximum on coverage for telemedicine services other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy, or impose upon any person receiving benefits pursuant to this section any copayment, coinsurance, or deductible amounts, or any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the policy, contract, or plan.

(G) The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, or extended in [State] on and after January 1, 20__, or at any time thereafter when any term of the policy, contract, or plan is changed or any premium adjustment is made.

(H) This section shall not apply to short-term travel, accident-only, limited or specified disease, or individual conversion policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

(I) Nothing shall preclude the insurer, corporation, or health maintenance organization from undertaking utilization review to determine the appropriateness of telemedicine services, provided that such appropriateness is made in the same manner as those determinations are made for the treatment of any other illness, condition, or disorder covered by such policy, contract, or plan. Any such utilization review shall not require prior authorization of emergent telemedicine services.

Section 5. Limited Telemedicine License

An applicant who has an unrestricted license in good standing in another state and maintains an unencumbered certification in a recognized specialty area; or is eligible for such certification and indicates a residence and a practice outside [State] but proposes to practice telemedicine only across state lines on patients within the physical boundaries of [State], shall be issued a license limited to telemedicine by the [State] Medical Board. The holder of such limited license shall be subject to the disciplinary jurisdiction of the [State] Medical board in the same manner as if (s)he held a full license to practice medicine.

Section 6. Network Adequacy and Limitation

(a) An insurer shall not solely use telemedicine or telehealth to satisfy network adequacy requirements with regard to a health care service.

(b) An insurer shall not limit coverage only to services delivered by select third party telemedicine or telehealth organizations.

Section 7. Rules

The [chief State insurance regulator and the chief medical licensing regulator] may adopt rules regulating that are consistent with this Act.

Section 8. Effective Date

This Act shall become effective immediately upon being enacted into law.

Section 9. Severability

If any provision of this Act is held by a court to be invalid, such invalidity shall not affect the remaining provisions of this Act, and to this end the provisions of this Act are hereby declared severable.

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National Council of Insurance Legislators (NCOIL)

Employer-Sponsored Group Disability Income Protection Model Act

Adopted by the NCOIL Health, Long-Term Care & Retirement Issues Committee on November 19, 2016 and the NCOIL Executive Committee on November 20, 2016. Re-adopted by the Health Committee on April 17, 2021 and the Executive Committee on April 18, 2021. Re-adopted on July 17, 2021.
Sponsored by Rep. George Keiser (ND)

To be considered for re-adoption by the NCOIL Health Insurance & Long Term Care Issues Committee on April 17, 2026.

Section 1. Purpose

The legislature finds that this state's residents, government, taxpayers, employers, workers, and their families share a common interest in protecting workers' income against the effect of disabling illness and injury. It is therefore the intent of the Legislature to provide tax incentives to encourage employers to establish group disability income protection plans for their employees and to enroll eligible employees in those plans.

Section 2. Definitions.

A. "Group disability income protection plan" means a group short-term disability policy and/or a group long-term disability policy instituted by an employer to provide income benefits to employee(s) unable to work for an extended period of time due to illness or accident.

B. "Employer" means [reference to applicable definition found in existing state code].

C. "Employee" means [reference to applicable definition found in existing state code].

Section 3. Tax Incentives for Employer Establishment of Disability Income Protection Plan

A. An employer in this state, who establishes a group disability income protection plan after the effective date of this Act, shall be allowed a credit against annual state income tax liability in an amount equal to 25 percent of the costs of establishing and administering a group disability income plan for employees.

B. Amounts paid by an employer to defray disability income protection plan premiums shall not be included in costs when calculating the amount of tax credit allowed.

C. An employer who has established a group disability income protection plan for employees may claim tax credit under this section for no more than three years.

Section 4. Employer Tax Incentives for Employee Enrollment in Disability Income Protection Plan

A. An employer in this state, who establishes a group disability income protection plan for employees after the effective date of this Act, or re-opens an existing plan for new enrollees, shall be allowed a credit against annual state income tax liability in an amount of $100 for each employee newly enrolled in such group disability income plan.

B. For purposes of calculating an employer's tax credit under this Act, only employees enrolled for the entire tax year and employees newly enrolled upon becoming eligible and enrolled through the end of the tax year shall be considered enrolled.

C. Under this Section, an employer may receive a credit against annual state income tax liability of not more than $10,000 for any tax year.

D. Under this Section, an employer may receive a credit against annual state income tax liability for no more than three years.

[Drafting Note: If state financial resources require a more limited tax credit, either Section 3 or Section 4 could be eliminated.]

Section 5. Effective Date

This Act shall become effective on _____.

NCOIL – NAIC DIALOGUE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
NCOIL – NAIC DIALOGUE COMMITTEE
2025 NCOIL ANNUAL MEETING – ATLANTA, GEORGIA
NOVEMBER 14, 2025
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) NCOIL – NAIC Dialogue Committee met at The Whitley Hotel in Atlanta, Georgia on Friday, November 14, 2025 at 10:45 a.m.

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

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Rep. Matthew Gambill (GA)
Rep. Camille Lilly (IL)
Rep. Matt Lehman (IN)
Rep. Michael Sarge Pollock (KY)
Rep. David LeBoeuf (MA)
Rep. Brenda Carter (MI)
Sen. Lana Theis (MI)
Sen. Michael Webber (MI)
Sen. Paul Utke (MN)
Sen. Jerry Klein (ND)
Rep. Tim Barhorst (OH)
Rep. Meredith Craig (OH)
Rep. Greg Scott (PA)
Rep. Tom Oliverson, M.D. (TX)
Rep. Jim Dunnigan (UT)
Del. Walter Hall (WV)

Other legislators present were:

Rep. Carolyn Hall (AK)
Rep. Naquetta Ricks (CO)
Rep. Elizabeth Wilson (IA)
Sen. Larry Walker (GA)
Rep. Cindy Neighbor (KS)
Rep. Sean Tarwater (KS)
Rep. Mike Clines (KY)
Rep. Mike Meredith (KY)
Rep. Shaun Mena (LA)
Del. Mike Rogers (MD)
Rep. Robert Foley (ME)
Rep. Mike McFall (MI)
Sen. Jeff Howe (MN)
Sen. Bill Gannon (NH)
Rep. Julie Miles (NH)
Rep. Tim McGough (NH)
Rep. Garland Pierce (NC)
Sen. Jeff Barta (ND)
Asw. Catalina Cruz (NY)
Sen. George Lang (OH)
Rep. Brian Lorenz (OH)
Rep. Mark Tedford (OK)
Rep. Robert Foley (ME)
Del. Mike Rogers (MD)
Rep. Matt Morgan (TX)
Rep. Trey Wharton (TX)
Rep. Cal Roberts (UT)
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. Tom Oliverson, M.D. (TX), NCOIL Immediate Past President, and seconded by Sen. Lana Theis (MI), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Brenda Carter (MI) and seconded by Rep. Michael Sarge Pollock (KY), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 18, 2025 meeting.

INTRODUCTORY REMARKS

Asw. Pam Hunter (NY) thanked everyone for their engagement and spirit of collaboration between the two organizations. She stated that it is important that we don't lose sight of this partnership we have and our overarching goals of supporting the state-based system of insurance legislation and regulation. She asked everyone in attendance to introduce themselves: Georgia Commissioner John King; Mississippi Commissioner Mike Chaney; Montana Commissioner James Brown; Oklahoma Commissioner Glen Mulready; and Washington Commissioner Patty Kuderer. Cmsr. Mulready echoed Asw. Hunter's comments and stated that the NAIC is grateful for the collaboration and the relationships that we have built and enjoyed in recent years.

UPDATE ON NAIC ACTIVITIES RELATED TO ARTIFICIAL INTELLIGENCE (AI)

Asw. Hunter started the discussion with the NAIC's request for information (RFI) regarding possible development of an AI model law. When we last met, the NAIC was still reviewing all of the comments from the RFI and having initial discussions. Since that time, we understand that the NAIC has had some formal and informal meetings and discussions about what the best path forward would be, and it does seem that there might be a bit of an impasse as to what should be done. I think we're kind of feeling the same way here at NCOIL. I think that we're all kind of struggling to figure out what are we going to do relative to AI. But It's not going away so our respective organizations need to offer guidance for opportunities in terms of legislation and regulation.

Cmsr. King stated we've struggled with the scope of discussions, and the discussions have been all over the place, especially as we focus regionally and really on the impacts of AI. We know the AI tools and machine learning tools are already being quite widely utilized in this market. We want to make sure that we get the NAIC AI bulletin out which shows the proper uses of AI. We are going to be waiting to get more socialization of that bulletin out before there's really any serious movement for really recommending a model law. And we're, of course, very respectful of the role of legislators in this space so we're looking at working together with NCOIL to see how you all react in this space, because we want to be careful that we are not stymieing innovation but we also want to make sure that there's a human being involved in critical decisions, whether to deny a claim or fraud referral. And so we're very sensitive to that and I think that's why we're struggling. And of course, now the federal government wants to engage in this space as well and we're sensitive to that. Personally, I don't want to get ahead of our legislature and so we have a lot of discussions about that here in Georgia and we want to make sure that we're not rushing to failure.

Asw. Hunter stated across the country states are struggling with this and the technology is obviously moving much faster than the work that we're able to produce, either via legislation or by regulatory mechanisms like bulletins and we don't want to fall behind but obviously we want to make sure that we're having protections in place. Cmsr. King stated that as the form filings are getting more complex, we as regulators are having to develop AI tools to examine these forms because they're getting so big and so complex that we couldn't staff quick enough with the talent quality that's required to examine these filings without some assistance that machine learning can provide us. We're very sensitive to that very careful balance, and protection to the consumer is the primary focus but also making sure that we don't stymie innovation in the industry. Cmsr. Mulready stated I think the emphasis from many of the states as far as where to go next has been a pause and push forward with the bulletin that's out there. We've had 24 states that have put out the AI bulletin, and so I think we're looking for more widespread adoption of that bulletin before taking big steps forward.

Asw. Hunter than asked for an update on the NAIC's AI systems evaluation tool. Cmsr. King stated that the evaluation tool basically creates a set of principles that we can use to evaluate the use of AI tools to make sure that they don't cross any thresholds of discrimination or other improper things. We're inviting tech companies to come and deliver presentations to talk about what principles and what governance they have, and try to establish a common view of that. We can become more knowledgeable with these presentations on how the use of AI tools is being implemented.

Asm. Hunter asked if there's any uniformity that can be the baseline for something like that. Cmsr. King stated that's what the bulletin wanted to address. We wanted as regulators to tell companies these are our principles that we want you to be mindful of. As you create this, don't forget these are our principles in this bulletin. And that's why we wanted to push this bulletin out to as many states as possible so at least the industry knows what the examination tool is that we're going to be using to rate the proper use of these tools. Cmsr. Mulready stated I think that's the idea is to standardize that, and also there is an open meeting on November 19th where the new version of the evaluation tool will be unveiled.

Rep. Carter asked what is the status of the evaluation tool. Cmsr. Mulready stated it hasn't been implemented yet and it's optional for all regulators and is a way to have a standardized way to review those AI processes.

Rep. Naquetta Ricks (CO) stated Colorado is the first state to adopt policies to regulate the use of AI in underwriting. We're looking liability issues and there's been a lot of dispute back and forth between big tech and who is going to be responsible. But I think that should be a basis for what we're looking at - to see who to hold accountable if there's discrimination and to ensure that there isn't discrimination. But if it does happen, who do you come after as far as liability? Cmsr. King stated that we license insurance companies so those are the folks that we're going to hold accountable, not tech companies since we don't license tech companies.

Cmsr. Kuderer stated in Washington, we know that some of the insurers are utilizing tech companies in data gathering and if they're acting as a health care benefit manager by processing claims and that sort of thing, we do have the ability to regulate them. So, there is some nuance here when it comes to the tech companies. At my office, we formed an AI advisory board to look at how we can utilize AI systems internally. We're already using some, but we don't want to get into the high-risk systems that the European Union (EU) has banned. But we also want to know how we can use it internally to improve our processes. We also need to know how it's being used in the industry and we don't regulate underwriting in Washington,

but we do regulate the rates and we monitor that. And right now, based on our understanding, it's not being used in the rate setting. It is used in the underwriting piece. We're struggling with that as well, but I'm hoping that our AI Advisory Board will help give us some clear recommendations on how best to improve transparency when it comes to utilization of AI systems in the industry, because our charge is to make sure that it's not being used in a discriminatory way, and right now, I don't know that we have the tools to be able to determine that.

DISCUSSION ON FEDERAL MATTERS IMPACTING INSURANCE MARKET

Asw. Hunter stated that when we last met in July in Chicago, we discussed the recently passed federal reconciliation bill and how there were so many questions relative to Medicaid, the exchanges, and other matters at that time. Here we are in November, a couple days removed from the longest shutdown in history, and we have maybe more questions. So, there's a lot to discuss here, but I'd like to hear your perspective on where you think things stand in states in terms of things like open enrollment and what you and the NAIC are hearing from consumers.

Cmsr. Mulready stated we continue to monitor everything and the NAIC sent several letters this year to Congress encouraging the extension of the tax credits and noting the impact that would have on our states if they expired. They were originally put in place in 2021 and then extended several times and here we are and what I have talked about was some type of a step down or gradual glide path of those as opposed to a hard cliff here come the end of the year. I think most states are estimating that if those are terminated as is, it could be up to 30% disenrollment in those states, and there would be a big ripple effect of that. I did an op-ed back in February and sent a letter to our state leadership talking about the ripple effect of that and everyone knows the premiums will go up for the individuals, but then also you have the uncompensated care that goes out to, at least in our state, an already fragile rural hospital system and so there's a lot engaged with that. I requested earlier this week that the NAIC send one more letter really just with the message that it's never too late to do some sort of extension of those tax credits because what we were hearing was that the open enrollment has already happened so it's too late to do anything for 2026.

We're trying to drive home that message that that idea is not accurate. It's certainly not ideal, it should have been dealt with eight months ago, but it is not too late. And so we will take a vote on Monday for that and hopefully get that out. The U.S. Senate Committee on Finance has scheduled a meeting for next week to discuss alternatives. It's an interesting mix when you talk about the federal exchange versus the state-based exchange. In Oklahoma, we are slowly moving to a state-based exchange to try to give us some more control. In Oklahoma, we've got a little over 300,000 people on the marketplace and in Georgia, they've got about 1.5 million on theirs. But if you're trying to make some decisions based on establishing a state-based exchange and the revenue that comes with that, you have to ask are we going to have two-thirds of the people enroll and two-thirds of that revenue? So, we have sort of slowed down our process.

Asw. Hunter stated when we were at our meeting in July, we talked a little bit about the rate increases that would be forthcoming - what percentages are you seeing and what kind of guidance are you giving carriers? They're going to be coming asking you for rate increases, and it seems like they are asking for significant increases. What can the consumer expect January 1 based on where we are right now?

Cmsr. Mulready stated in Oklahoma, we're seeing a 29% weighted average increase. We're working a lot on education to the consumers about alternative plans like moving from a silver plan to a bronze plan, or even other alternatives off the marketplace or this perspective that having some type of coverage is better than no coverage at all.

Cmsr. King stated that if you ever needed a reason to start a state based exchange, this experience screams for it. It has given us the opportunity to be a lot more flexible and adaptable to be able to get insurance companies to put more options on the table for consumers. The rates had to be published a month ago and on October 1st, we let people go and window shop, not select a plan, but to start looking. And we're averaging about 20% in rate increases but we've been able to now offer more plans in other categories. You're looking at allowing agents to talk to the customer and ask, "okay, you used this much insurance last year so perhaps you are more suited for this plan." And so it gives us the opportunity to really market and not just react to whatever the federal government does. So we're in a lot better spot than we would have been had we stayed on the Affordable Care Act (ACA) exchange because we can control the marketing and we can give options to consumers to keep them in the marketplace, which is my focus and I want to make sure they're not just dropping all insurance and going to emergency rooms to get their health care provided, which is the most expensive, most inefficient way of delivering health care to our nation.

Cmsr. Brown stated in Montana, we're experiencing about a 21% increase. We have three carriers that participate in the federal marketplace, providing insurance to about 66,000 people and that seems lower than the other states, but you have to keep in mind that we're a small state so it is a significant portion of our population. Like Cmsr. Mulready, I also wrote an op-ed this summer urging Congress to extend the enhanced premium tax credits for Two main reasons. One is to provide certainty to our insurance companies, at least through 2026. And then secondly, to keep insurance affordable for many working Montanans. I agree that there should be some kind of glide path if Congress decides not to move forward with the enhanced premium subsidies just to provide some certainty, both to the carriers and to the insureds. The second thing is an aspect that you would be interested in as legislators is there's a cost to our regulatory agency when the federal government engages in political showdowns like this because as the other Commissioners I'm sure would tell you is we've had to engage in about three rate reviews because of what's happening with the federal government doing rates with and without the subsidies. And then of course the litigation that's happening in federal court around the integrity rule has an impact not only on the workload for my staff but also the funding that's provided to my agency by the legislature.

Cmsr. Chaney stated the rate increases vary across the states based upon whether or not you're a state-based exchange or a full federally facilitated marketplace. Ours is 40.9%, and I know Louisiana's is 51% rate increase from Blue Cross Blue Shield on the ACA. So, what you have to look at as a regulator is what are the cost drivers? Why are the rates going up, and what do we do? And those cost drivers are things like pharmacy benefit managers (PBMs), which we don't regulate, and pharmaceutical matters. And you've got to understand that 35% to 40% of your premium is owned by the pharmaceutical companies. It's not the medical profession. And the doctors are now being bought up by the hospital corporations and they control what they want on networks and that's a cost driver also. And it depends on what state you're in but we're looking at putting 66% of the people that are presently in the ACA exchange back into the uninsured market which means that you're going to have 200,000 plus people going into a hospital for uncompensated care and when that happens, the hospitals are going to close the emergency rooms if they can get away with it and you're going to end up with no care at all.

You're going to end up with health care deserts. It's an issue that's got to be addressed different. The systemic risk really involves the risk factor and you've got to address that.

And back to the credits, we can't continue this model forever. Somebody's got to have some skin in the game and you can't continue giving free everything to everybody. Somebody's got to pay for it. So, we've got to have a glide path. I'm probably the only person up here that's going to say you've got to be careful of accepting the tax credits. We're just going back to where we were four years ago and you can get people, if you can educate them, to buy down into the bronze level and it's not good insurance, but it's better than nothing. Or we've got to open up high-risk pools, which most of you, as legislators, have killed. Not Texas and we didn't kill ours, so we've still got the ability but the problem is The Centers for Medicare and Medicaid Services (CMS) will not give you the 1332 waiver that you've got to have to open that up to provide health insurance to the people that really need it. It's a downhill spiral if we don't address it and you know who's going to catch the blunt of it? You are, as a legislator - you're going to be the ones that people are going to look at.

Cmsr. Kuderer stated we have, on average, a 21% increase. Roughly 7% of that is related to the expiration of the enhanced premium tax credits. We're going to see about 80,000 people drop coverage. Most of them will be strong and healthy. We're a prior approval state. When we asked the insurers about what their reasons were for the rate increases, they were pretty unified in four major factors which were: increased utilization which we're going to see if the enhanced premium tax credits expire; consolidation; PBMs; and the uncertainty coming from the federal level. I think we can all agree, no matter what side of the aisle you're on, that the system's not working. It's not working for patients, it's not working for providers, and it's not working for our rural hospitals either. So, there probably is a better way. We did an emergency rule earlier this year, premium alignment, that we hope will reduce that 80,000 number by about 35% if we're lucky. We are a state based exchange and the ACA allowing state-based exchanges and the enhanced premium tax credits reduced our uninsured rate from around 15% to under 5% which has really helped stabilize premiums to some extent in the state. So it depends on your perspective on how you look at the enhanced premium tax credits, but they've been working pretty well in Washington and I've been encouraging our delegation to work very hard to extend them. And we do need to figure out a better way. We're in conversations about 1333 waivers, and we've reached out to other states to talk about how states can work collaboratively to help make sure that folks can access health care because it's a good investment. We don't want people using the emergency rooms to get their health care, and it's good for the economy, too. So, we actually see an economic benefit from investing in those enhanced premium tax credits.

Cmsr. Mulready stated 1333 waivers allow the states to compact together which is what has been referred to. The fear with this is someone goes to the open enrollment and they go to see what's happening with their plan and they see that large increase and they bail out. And now the problem is next week something changes and something's available to them and now we have to educate them to get them to come back in and take a look at that and to actually enroll. I think legislators can really help educate the public if something does change in a positive manner to help them enroll.

Cmsr. Chaney stated I think most of us would be very concerned if these tax credits go back to the insurance companies. They're using it as a profit center. They need to go back to the consumer and that's who we're trying to protect here. And this is going to take a lot of us working together to figure this out.

Rep. Oliverson stated I heard Cmsr. Kuderer say that 7% of the increase is due to the expiring tax credits. Is that standard for all of you? That's lower than I thought it would be. I think we have this impression that the big numbers we hear are all just because of these credits expiring but it sounds to me like the majority of the problem is still utilization and consolidation and the same factors that we've been dealing with for the last 20 years. Have we ever seen a year where we actually saw a decrease? I think we've had some level years. I was just curious if that's your experience across the country.

Cmsr. Brown stated it's 8% in Montana. You identified some of the primary cost drivers. For us in Montana it's provider inflation, double national inflation for what our providers are charging, and then specialty drug coverage are big factors as well.

Cmsr. Chaney stated that the factors that we see depend on what part of the country you're in. A lot of them are pharmaceutical benefits and we have more people demanding that they get a drug that costs $60,000 or $70,000 a year. We've started covering a lot of drugs for heart diseases, and then you've got the GLP-1s. You've got bariatric surgery and you put all of that together and those are cost drivers that drive you up. So, when you try to quantify what portion of this is due to providers and what's due to pharmaceutical and what's due to actual inflation, it's a combination of all of them. But tax credits accumulate and in a poor state, they're extremely high and ours are close to 27%. And so you're affected a lot. And on the political side, if Republicans don't fix it, they're going to lose the midterms. The blue states think they've got it now and they can fix this problem. I predict that we'll get some type of credit. We just hope that it will be a glide path instead of cutting them out.

Sen. George Lang (OH) stated I would like your response to my assertion that the ACA is actuarially designed to increase costs for the exchanges, and here's what I mean by that. We know for a fact if you have an actuarially sound health group, meaning you have 1,000 man-years in that group to do full underwriting, about 30% of the people with full insurance in that plan do not use their insurance policy at all. They're young, they're healthy, they don't even go to the doctor once a year. And insurance is designed so that those young, healthy people are paying into the system to support those old folks like me that are high utilizers of the system. And Pareto's law, the 80-20 rule, is real in insurance, but for insurance, it's even worse. In insurance, 4% to 6% of your people are 60% of your claims. You still have 20% of your people that are 80%, but it's 4% to 6% are driving the cost. And the ACA is designed with no preexisting conditions rules and young people today have no motivation to enter the exchanges. I have a 42-year-old daughter. She is uninsured. She said, "Dad, why should I be insured? As soon as I get sick, they have to take me, and they have to cover me." So, my assertion is the ACA is actuarially designed not to fail, but to drive cost up on the exchanges.

Cmsr. Mulready stated you've just identified the problem with the tax credits going away and the real concern, and with the person I just talked about, is the person in these last two weeks has logged on and seen the increases. They're young, they're healthy, and they're going to say, "I'm out, I'm not going to participate." And so, I think in a bigger picture way, we need to think about how do we engage young, healthy people and keep them in that pool. They are needed in that pool, as you've illustrated. And indeed, pre-existing conditions, they can come on without that. However, it also does have to be during the open enrollment. So that total loophole is somewhat closed. But you've identified the problem of how do we keep young, healthy people in the pool?

Sen. Paul Utke (MN), NCOIL Vice President and Co-Chair of t he Committee, stated that one thing I haven't heard much of was legislative action. And when you come from a state like I do where they love to push the costs onto the insurance companies and others and just this last

year they raised fees of over $1 billion in the last budget on providers and that's going to drive up the costs because they don't absorb those. They've got to pass them on to us. And then the mandated benefits that have been passed the last few years have driven up the cost of per member per month by $30. So we're hearing all the other things that come into making sausage out of this whole thing, but part of it is our legislators and what they're doing in their respective legislative bodies. And I know some of you are a whole lot better off than where I come from, but we are not helping the problem either. So, this gets dumped on the insurance companies' heads, and it's not all their fault.

Cmsr. Chaney stated we would agree with you on that, but our job is not to benefit the insurance companies. Our job is to protect the consumer and be a good regulator. We're not on the policy side. The legislators are. And what we need from legislators is good statutory law without mandates because insurance is based on risk. The premiums are based on risk and if the risks go up, rates are going to go up and premiums are going and consumers demand more service for paying a $500 a month premium and then you want $5,000 a month in benefit, that's not going to happen. That's not a sustainable model. And when you look at adverse selection, which we're going to, that just means that the healthy people are going to get out. The people that are left in the ACA are sick people. And you look at trying to establish a state-based exchange, it's hard to do that today because to make that exchange work, you've got to have some type of income. In Georgia's case there is 1.5% off the top. If you're new in this and you're using the facilitated marketplace to do your state-based exchange, you can't run it at that. The insurance companies are just a pass-through, and you've got to have everybody in the pool or it's not going to work.

Rep. Jim Dunnigan (UT), NCOIL Secretary, stated that intuitively, with all the media talk you'd think that without the subsidies, the piece of the increase would be much greater than what we heard. But as stated, the subsidies were taken back to where they originally were four years ago so it'd be a much higher piece if the subsidies were completely gone but we still have the original subsidies that came out. Regarding giving the money to the consumer, the consumer already has the money. They don't have to use it as an advanced premium tax credit. They can let it sit there. They can pay for whatever product they want, and they can take it on their tax return as an increased refund. But if we're going to give it to the consumer, many consumers are not sophisticated shoppers for health insurance. How are they going to have the mechanism to go and apply that to the policy different than what we have now? Can they use that money for something else such as a television or a trip somewhere? Even with a penalty, they'll do that. Maybe you can't do that. But for 1332 waivers, it sounds like the federal officials are not going to approve those for risk sharing going forward. What about states that are already doing the waivers to do cost sharing? Do you think they'll be renewed or not?

Cmsr. King stated that our conversations with the federal government on our waivers have been pretty positive. They're willing to listen and look at them. They want the states to experiment and innovate and this administration seems to want to give that bandwidth for the states to take more of this and take it away from the federal government so I'm encouraged. We're looking at how we're going to develop our waivers for the renewal, but we've used ours very effectively and it's given us the latitude to be able to innovate and not be responsive to the noise from D.C. and actually take a little bit more control over our destiny.

Cmsr. Mulready stated in our state we don't have a 1332 waiver but we are looking into it. But I will say that the federal administration is encouraging states to be creative and innovative with 1332 waivers and 1333 waivers have been pushed pretty heavily by Peter Nelson, Executive Director of the Center for Consumer Information and Insurance Oversight (CCIIO). So, there's a

lot of creativity and flexibility being pushed out there. And regarding benefit mandates, any mandates that were passed post-essential health benefits were supposed to fall onto the states to pay for that. But that has not been enforced but there is talk that may be coming so that's something that you should be thinking about and sort of probably quantifying too.

Asw. Hunter then discussed developments surrounding the National Flood Insurance Program (NFIP). A result of the government shutdown was that the NFIP lapsed. That meant no new policies could be issued and existing policies couldn't be renewed until Congress reauthorized the program. This is obviously made worse by having this occur during hurricane season. And I suppose to no one's surprise, the NFIP was included in the recently passed spending bill, but it was again reauthorized on a short-term basis. Both of our organizations have long supported long-term reauthorizations of the NFIP to avoid situations like this. Needless to say, this is a terrible situation for everyone involved and we're curious, what has the NAIC been hearing from state insurance departments in terms of consumers reaching out to insurance departments about flood insurance? Has the private flood insurance market responded well to this? And do you think this will now finally motivate Congress to enact a long-term reauthorization of the program?

Cmsr. Mulready stated that we've had these short-term extensions 33 times over the last eight years and we have continued to push for a long-term reauthorization. I chair the Federal Emergency Management Agency (FEMA) advisory group for the NAIC and I had a call with FEMA and they were tasked this year by the President to take a look at all that and there is a report due back in December on that. There was a call in September that I was on with them and they were having a round table meeting at the White House on September 30th. I was not able to attend, but a handful of NAIC representatives were there including NAIC President and North Dakota Commissioner Jon Godfread and our team's focus was on long-term reauthorization of at least 10 years and to encourage private market growth. A number of our states have seen some good growth in the private market of flood insurance, but certainly we would like to see more of that. The issue is if someone moves to the private market for flood insurance and then tries to go back to the NFIP, they're basically penalized for that because they're seen as though that coverage lapsed. But it didn't lapse. They went to private coverage. So, that's a loophole we'd sure like to see get fixed. Mitigation incentives was another focus as well as mapping and modeling and investing in that. And then just more consumer education is always needed with the NFIP. I think in all of our states there is a very low percentage uptake on flood insurance. There is a big question about FEMA funding and I think there's thoughts of things we push down to the states but does that mean responsibility and funding, or does that mean responsibility with less funding? That's an unknown right now. I've had two meetings with our emergency management team trying to plan ahead if funding is cut substantially, what do we do and what do our towns and communities do? And specifically in our case, it's about infrastructure. There is insurance coverage for their buildings and their property and their liability, but what about when a road or bridge gets washed out and there's no federal money coming to replace that?

Rep. Matt Lehman (IN) stated the issue is this is not working, period. Even extending it for 10 years is not going to work. The NFIP is $20 billion in debt and if you remember back in 2017, they were $16 billion in debt and they wiped it clean. So, if you wipe it clean again and start over, where are they going to be 10 years from now? The issue is you've got to get people in a room who say we have to find a long-term solution that does not involve the federal government being dollar one. That does not work. I think after September 11, 2001, the industry came and said “we can't handle another terrorism claim” and what came out of that was the Terrorism Risk Insurance Act (TRIA) and they said we'll absorb a box of this but after that, they've got to take

the risk. Why is that not a model being looking at with flood? The industry can underwrite this if you give them a cap but when you give them a $10 billion exposure, it's going to be very difficult. So you've got to come up with some solutions beyond a long term reauthorization extension. Florida has one of the most aggressive private flood markets, and it's not working. And you talk about people not affording health insurance, they're going to walk away from flood insurance. And now you've created a massive lending crisis as all this is tied together. But I think we as legislators need to get a hold of our Members of Congress and say stop extending something that's a broken system to begin with. It's not working. Cmsr. Mulready stated that he agrees 100% and from my notes from that mid-September meeting, that debt is $26 billion. They also talked about addressing the 5% of policies that have repetitive losses. But to your point, it isn't working and I think TRIA is a good model for them to take a look at.

DISCUSSION ON UPDATES TO RISK BASED CAPITAL (RBC) FRAMEWORK

Asw. Hunter stated that we're aware that the NAIC has undertaken a major overhaul of its RBC framework with the goal of modernizing solvency oversight. It's a big change that will have a significant impact and we're curious what led to the decision to make these changes, what the comments have been like, and what the timeline looks like to finalize your work.

Cmsr. King stated that one of the factors that we started looking at is investment companies and looking at how they're investing in insurance and so that really was the impetus for the NAIC to start looking at how we treat investment. We were traditionally looking at RBC and looking at how money is collateralized to handle risk but when you have Bitcoin and all these other investment vehicles coming in, we have to look again at how we assess the capital to be able to pay claims. And so that's what's caused NAIC to take this up. We have some incredibly talented commissioners and staff looking at how do we see all these investment systems who are now playing a part in insurance and how do we collateralize? How do we account and how do we audit it? Because the hardest part of what we're facing is as state regulators, how do we go into a company to audit what assets they have available to pay claims?

Cmsr. Kuderer stated that I actually sit on the NAIC's RBC task force and I can tell you that based on my understanding, there were some requests from the industry to look at the RBC methodology to determine if it needed to be updated. I think it's good to review formulas over time because things change. That was really kind of the impetus behind it. And there's been two public comment periods. We just finished the second one, and the second one we narrowed down what was being looked at in terms of RBC. The main thing was that they wanted to keep it tied to solvency and not include whether or not this is going to impact new product ideas and things like that. There was a lot of uniformity around that should not be included because of what RBC is all about. But the nine proposed principles emphasize the updates to RBC levels. We've recommended these. This was on the second public comment period. But they needed to be material which is the threshold at which an RBC update could meaningfully impact a regulator's assessment of solvency risk. They have to be objective. They have to be accurate and grounded in statutory accounting and reserving and transparent and reflective of equal capital for equal risk and inclusive of emerging risks and subject to a clear and repeatable process, and prioritized. So, those were the nine principles that were emphasized in the second public comment period. We only got eight comments on those, and I think at this point we're going to be taking it up at our fall meeting to make a decision one way or the other.

DISCUSSION OF NAIC'S AFFORDABILITY AND AVAILABILITY PLAYBOOK

Asw. Hunter then turned the discussion to the NAIC's development of an affordability and availability playbook. The playbook aimed to help state regulators address the growing homeowners insurance crisis. We're all feeling that now. Developing the playbook is a big undertaking as the affordability and availability crisis is complex and as we know there unfortunately isn't one single reform that can be enacted to fix everything. Can you provide us an update in terms of what the development has been like, the proposed timeline for finishing it and if it will be accompanied by any NAIC model legislation or regulation?

Cmsr. Brown stated I sit on the NAIC's property and casualty insurance committee and certainly we have heard today about affordability but the one thing that we haven't touched on is availability. All of us as regulators want to make sure that there's plenty of coverage in the market to make sure consumers are able to get insurance in the first place. The western part of Montana is heavily timbered and we are hearing of insurance companies non-renewing policies because of perceived wildfire risk. The playbook is designed as I think has been explained to assist you as legislators and us as regulators with messaging and addressing affordability challenges. We did release a revised outline for this document in October and we encourage you to take a look at it and there's some good information in there that you can use to communicate with your constituency, and hopefully we'll adopt a finalized version of this when we have all our fall meeting.

ADJOURNMENT

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

LIFE INSURANCE & FINANCIAL PLANNING COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
LIFE INSURANCE & FINANCIAL PLANNING COMMITTEE
2025 NCOIL ANNUAL MEETING – ATLANTA, GEORGIA
NOVEMBER 13, 2025
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Life Insurance & Financial Planning Committee met at the Whitley Hotel in Atlanta, GA on Thursday, November 13, 2025 at 3:45 p.m.

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

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Rep. Matthew Gambill (GA)
Rep. Camille Lilly (IL)
Del. Mike Rogers (MD)
Sen. Walter Michel (MS)
Sen. Jerry Klein (ND)
Sen. Pam Helming (NY)
Rep. Meredith Craig (OH)
Rep. Tim Barhorst (OH)
Sen. George Lang (OH)
Rep. Ellyn Hefner (OK)
Rep. Carl Anderson (SC)
Rep. Tom Oliverson, M.D. (TX)
Sen. Mary Felzkowski (WI)

Other legislators present were:

Rep. Naquetta Ricks (CO)
Rep. Eddie Lumsden (GA)
Rep. Daniel Grossberg (KY)
Rep. Shaun Mena (LA)
Rep. Robert Foley (ME)
Rep, Kristian Grant (MI)
Rep. Paul Utke (MN)
Rep. Bill Gannon (NH)
Asw. Catalina Cruz (NY)
Rep. Garland Pierce (NC)
Rep. Jeff Barta (ND)
Rep. Mark Tedford (OK)
Rep. Matt Morgan (TX)
Rep. Trey Wharton (TX)
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. Matthew Gambill (GA) and seconded by Sen. Pam Helming (NY), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Sen. Helming 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 adopt the minutes of the Committee's July 17, 2025 meeting.

CONTINUED DISCUSSION ON NCOIL MODEL ACT REGARDING LIFE INSURERS' USE OF GENETIC INFORMATION

Rep. Carter stated that we'll begin with a continued discussion on the NCOIL Model Act Regarding Life Insurers' Use of Genetic Information, a Model that I am sponsoring. You can view the model in your binders on page 58, and it's also on the website and on the meeting app. As a reminder, the issue was first raised at the Charleston meeting in April and I introduced the draft model at the Chicago meeting in July. This topic has sparked significant discussion in legislatures across the country, and we had a robust exchange in Chicago. No vote on the model is scheduled today. The goal here is to provide states with thoughtful guidance as they consider this issue in their own legislative processes. The model does not propose an outright prohibition on the use of genetic information by life insurers. Instead, it outlines reasonable standards for the use of that information, modeled after the approach Tennessee enacted a few years ago. She noted that she has made some modifications to the model based on the discussions in Chicago. The changes are generally clarifying in nature.

Professor Anya Prince from the University of Iowa School of Law thanked the Committee for the opportunity to speak and stated that I have been working on genetic discrimination and genetic privacy issues for over 15 years, including having a five-year grant from the National Institutes of Health (NIH) to look at policy options for life, long-term care, and disability insurer use of genetic information. This has been an issue that is perennial with everybody in the genetic information space and really has been a concern since the Human Genome Project first started of people saying, "well, what's going to happen when we create this information out there? How might other actors, especially insurers, use this information?" And as I'm sure you all know, the Genetic Information Non-Discrimination Act, or GINA, was passed in 2008 after 13 years in Congress. And some versions of the bills in Congress included prohibitions on life insurers' use of genetic information. And I've been tracking state laws in this area since, and we have seen really an explosion of state bills around this area. And this really is the highest level of public engagement that I personally have seen in these issues in the 15 years that I've been studying this so I think the time is ripe for action.

I think also it's so important to think about a model law in this space. This is a screenshot of a new website that a colleague and I just recently put out that is really targeted for legislators and patients and providers to help understand the landscape of life insurance and long-term care and disability insurer use of genetic information, as well as law enforcement use, but that's probably not your purview. And so, this is just a screenshot that shows really the patchwork of protections, and they're really hard for genetic counselors who are counseling patients on whether or not to take a genetic test to be able to cohesively say what protections are for both them and their family members living across the country. I've provided you with some written testimony that has some further discussion, especially about notes about the consent section in the model and some suggestions regarding the definition of genetic testing that I think could be expanded in ways that will foresee some of the advances in genetics that have occurred. But for time purposes, I really want to focus in on Section 4A of the model which I think is really the crux of the issue here. So currently as written, this allows for the use of genetic information, and uses the language "based solely on," which my understanding of reading some case law in this area, talking to insurance people, is that this was really an actuarial justification model, saying as long as you have actuarial justification, you can use genetic information. And I would argue that stronger protections are warranted in this space. And so, I'm going to go through just a couple of arguments to back this up, and happy to talk further in Q&A.

One issue that I know has come up in both your April and July meetings is that there's little real-world evidence of adverse selection in the case of bans on use of genetic information. Florida is often brought up as the one state in the U.S. that has barred life insurers from using genetic information and as people at the American Council of Life Insurers (ACLI) have mentioned, five years is not a long enough time necessarily to see the impact but I think if we look abroad, we can see other laws that have been passed. So, one in particular is the UK. They have had a voluntary agreement barring the use of the vast majority of predictive genetic tests. That began in 2001. And so, we have 25 years of policy and what's more, it's been reviewed, and continuously renewed in concert with both the insurance industry there and the government. That signals a stable policy for decades. Admittedly, it is very difficult to model real-world adverse selection as there are challenges to that. Absent actual evidence we have to look at modeling. And when we look at modeling and the impacts of a ban on insurer use of genetic information, one of the things that goes into this is assumptions about insurance purchasing behavior of people following a predictive genetic test. I want to spend a little bit of time talking about what goes into that modeling. And so, there's really been three main actuarial studies that have modeled the impact in this space. One, which was done by McDonald and Yu, said that there would be about a 1% premium increase. That was out of the UK but looked at impacts. Howard et al. looked at this in Canada right before they passed their ban on life insurer use of genetic information and that said that there would be about a 12% premium increase. And a few years later, the U.S. Society of Actuaries said it's somewhere in the middle of about 4% to 8%.

There's a really wide range of potential impacts of policy in this space but what a lot of this modeling comes down to is assumptions about insurance purchasing behavior. Polling from the Society of Actuaries report says if we change assumptions about insurance purchasing behavior, that is, if you get a positive genetic test you'll go out and get a lot of life insurance. If we change assumptions about that, then the impacts of these laws is much lower. And the Howard et al. article that said that there'd be a 12% increase in premiums estimated that 75% of people who got a positive genetic test would go out and get 10 times the amount of life insurance. I do not think that that matches real-world experience because people can't afford 10 times the amount. Life insurers will look at other aspects like family history and current age and medical conditions and so it's definitely not at that 75% and we really need to look at this. There are studies that show that people may purchase more insurance, but as part of a really interdisciplinary group a few years back that included an actuary and an economist and several lawyers, we looked at adverse selection or anti-selection in this space, and our conclusion about these studies was that there's variance in the literature. Overall, the variance in the literature suggests no widespread agreement on the impact of genetic tests on insurance-purchasing behavior and therefore anti-selection, and that any evidence that there is an impact is based on studies with small sample sizes and focused on diseases with high penetrance and few preventive measures. I'm currently part of a large-scale genetic study that has over 10,000 people who've gotten their results returned to them, and we asked questions about insurance-purchasing behavior to those tens of thousands so we're going to start to get high numbers. Unfortunately, the data was not quite ready for public consumption in time for this meeting, but I can tell you it does not match those 75% estimates and indeed, it shows that some people who got a negative genetic test also said that they were going to increase their life insurance premium which would be pretty good for the life insurance industry. So, I think more data can say that the impacts might not be as strong as predicted.

What we do know, however, is that there is real-world evidence of people opting out of genetic testing and research for fear of genetic discrimination and that has a huge public health and clinical significance if people don't feel comfortable getting genetic tests. So as an example, one large-scale genomic study across multiple sites that was funded by the Human Genome

Research Institute at NIH found that 13% of individuals who declined to participate in the study cited discrimination concerns and they did this study because they had quite high rates of people declining participation in this study. The other thing I will say about this version of the model law is I worry that a codification of the status quo that is, that insurers can continue to use genetic information, will not address consumers' concerns and therefore is unlikely to quell future advocacy and legislative action. And if the goal of a model law is to provide that consistency, then if we start to see continued efforts to push for more protection to address people's legitimate concerns, then we're not going to face that consistency. Kenneth Meier, a really prominent insurance scholar, argued that salient issues, those that are characterized by intense conflict of broad scope, allow for political elites and consumer groups to be influential, and the power of the insurance industry is important but weaker in these situations. And another researcher, I believe she's a sociologist in Europe, she did an ethnography of life insurance underwriting and she argued that the rise of genetic technologies has turned private insurers' medical risk selection into a major public issue again and this seems to be the catalyst that has drawn state regulators to intervene into private insurance markets.

And so there's this draw to address these issues from the public that is very different than any other sort of mainstay insurance arguments that you might have. And indeed, just to show that in my tracking, 33% of states that have current actuarial justification laws specific to genetic information in the last four years alone have had subsequent bills introduced with stronger protections. Now those bills haven't necessarily passed because of advocacy on the insurance side, but my point is that if the model is passed as is, I worry that we will continue to have at least a third of the states continuing to try to have stronger protections, which just won't be sufficient. This is language of more of a ban on insurer use, and this was presented in your July meeting by Alex Meixner from the ALS Foundation, and it offers the strongest possible protection, and so I would encourage the committee to look at this. But even absent that, I just gave a presentation about how the evidence of the impact to the insurance industry is mixed, and there's lots of uncertainty in that modeling, although I think it's weaker than it's often presented. But even so, there are additional policy middle grounds that exist that have been brought up but not engaged with necessarily as much such as a monetary cap. I think this is a really sensible policy. It says insurers can look at genetic information, but only for life insurance policies over a certain amount that insulates against that gaming the system and going out and purchasing high levels of insurance after a genetic test. But it also allows people who have genetic predispositions that may or may not ever come to be to get the life insurance that they need and to feel like they're protecting their family into the future.

Vince Ryan, Regional VP of State Gov't Affairs at ACLI thanked the Committee for the opportunity to speak and stated that ACLI supports the model in its current form. ACLI submitted to this committee a comment letter dated October 14th that referenced three points made during the summer meeting where the life insurance industry and patient advocates align and I just wanted to briefly touch on those three points. First, risk is not destiny. We agree that genetic information reflects probabilities, not certainties. That is why life insurers view genetic information as a single factor in a holistic risk assessment that also includes any preventive actions applicants are taking to manage their genetic risks. Second, our industry predates genetic testing. While this is true, it is also true that consumers now have access to far more information about their own health risks than they did a century or even a decade ago. This includes genetic test results, which can influence their decisions to seek coverage. And finally, I wanted to address the effects of the Florida law on the market, because short-term stability can be misleading. And as we have stated many times, life insurance premiums must remain sufficient to cover claims that may not occur for decades. It's unlike health insurance that experiences year-over-year-over-year losses. We're covering a policyholder for 10, 20, 30, 40,

50 years out and when assumptions prove wrong, insurers cannot go back and reprice policies or raise premiums. What may appear in the early years as a thriving market can mask long-term imbalances that only surface decades later when claims begin to emerge. Higher-risk consumers may already be disproportionately purchasing coverage as well. By the time adverse experience is reflected in the market, insurers may have collected inadequate premiums for decades, and new policyholders will likely bear the burden through higher prices.

As Chair of the ACLI's Risk Classification Committee, Dr. Deborah VanDommelen thanked the Committee for the opportunity to speak and stated that she has been a medical director in the life insurance industry for over 15 years and is trained in family medicine and holds degrees in public health as well as genetics. Underwriting is actually a benefit to the majority of consumers by allowing insurers to offer the most coverage to the most people at the lowest price. And that truth does not change when we're talking about genetic information and genetic risk. Understanding the medical risks that can affect life expectancy is necessary for insurers to meet our commitments to those policyholders decades into the future, even though we only have one chance to set pricing. Other types of insurance have the ability as often as annually to change their pricing if they have adverse claims experience. Other types of insurance get that more immediate feedback on whether their pricing is going to be sufficient but it can take 10 to 15 years for us to know, and by that time, it could be too late to change course. And so that's one of our main concerns when it comes to restrictions on genetic information and underwriting. I want to reassure the committee and the consumers that underwriting is not based upon a single piece of information. If we want to have any expectation of predicting mortality in an accurate way, we have to look at it holistically. Therefore, we consider treatments and interventions, regardless of the condition, whether it's an inherited risk or whether it's hypertension, where someone may be taking blood pressure medicines to well manage their blood pressure. And therefore, we take that into consideration and give them that credit.

Privacy is a piece of this model, and I think it offers a lot of protections in the way it outlines. There's also the consent process, which is a standard part of our existing insurance application process. But my main concern is actually on the clinical consent side. There's a lot more concern about misinformation or incorrect information that is being provided in that decision-making process to patients and research participants. And I'm excited to hear about the website that maybe can help pull together some of that information to better educate genetic counselors. ACLI has done outreach with the National Society of Genetic Counselors to try to make sure that they understand what those protections that already exist are for most of their patients. I do want to circle back to a few comments that Prof. Prince made, looking at especially where things have allegedly turned out fine where they've put in restrictions. I want to add some context to that. For instance, if you look at Europe and the UK, one of the main reasons it came up as an issue is that there is, to some extent, a mandate for life insurance. If anyone wants to own a home and get a mortgage in those countries, they have to have life insurance to back up that mortgage. And so that was creating a crisis where there's a mandate to buy it. That's part of the reason why it's worked there and why some of those estimates were so low as far as how much restriction would impact pricing, because there's a mandate. In the U.S., we're not talking about mandating life insurance purchase. It is a purely voluntary product to buy.

As far as Canada, their law changed in 2017, and from the information I've seen since then, their pricing for life insurance has gone up as much as 20%. That can't be all blamed on that change in law as it could be multifactorial but I worry that as pricing increases, the purchases of life insurance decreased. We want to insure as many people as possible and that's why I think this particular model does a wonderful job of trying to balance things. I think you've really weighed the interests of a subset of consumers with the majority of applicants and

policyholders. The current language is a sufficient and reasoned approach to maintaining that balance between risk and pricing, keeping insurance as affordable as possible to the majority of consumers, as well as supporting access to those who are stretching to afford protections for their family with all the other increases in costs that we've heard about this morning in the other discussions. It also ensures a consent process that maintains privacy. So, I think you've pulled together some of the best pieces of the legislation that we've seen across the states.

Sen. Justin Boyd (AR) stated I'm thinking through a scenario of we've got a parent who has colon cancer and tests positive for Lynch syndrome. The parent has two kids. One is positive for Lynch syndrome, genetically, and the other is not. Might it help the one who's not if he or she is able to present that to underwriting? If that's not the right scenario because of some other thing I'm sure there's another genetic test where that would make sense. Dr. Van Dommelen stated I would say that I think you're picking up on a really important piece and an important way that Florida got it wrong, because there are situations exactly the way you describe where the assumption is use of genetic testing and underwriting is always to the harm or the detriment of the applicant, but there are definitely places where it could be to the benefit. And so, it puts insurers in a very difficult position that if we're not allowed to use that information in Florida, are we going to charge someone more in premium than we think it represents their risk? But if we don't do that, we're breaking the law. So, I don't know how different insurance companies are approaching that, but it's a very difficult position to be in.

Prof. Prince stated this goes to my comments in my written testimony about the definition of "genetic information" in this current model. It currently defines genetic information to only include an increased risk of disease. So the law as written, would not cover the scenario that you're talking about and wouldn't change how insurers have to cover protective genetic information because protective genetic information actually isn't in the law. But the other thing I will say is I appreciate that concern. What I am concerned more about in that family member is if the person who is Lynch syndrome positive, that means an asymptomatic risk of colon cancer fails to get that clinical testing. Lynch syndrome means that you can go and get colonoscopies and it's like 100% effective at saving this person's life. And so, if that person is so scared to learn about their genetic risk for fear of insurance discrimination, which we have evidence that happens, that they don't get the genetic test, then that person could pass away and I worry more about that than one person having a slightly elevated premium.

Sen. Boyd stated to clarify, it does increase your risk of female cancers if it happened to be the sister so the colonoscopy would not catch those per se. And then my follow-up question would be, is that not somehow discriminatory that we allow it to be used one way but not the other? This is new to me. I haven't really thought through the ethics of it. Prof. Prince stated Lynch syndrome raises risk of multiple different cancers. That's true of lots of different cancer risks. My understanding, I'm not a doctor, but it's a much lower risk. It's not the primary risk of Lynch syndrome is colon cancer, not endometrial cancer. But is it discriminatory if they can't take into account any genetic information, then you're taking into account family history and your manifested conditions, and so that would be treating everybody the same way.

Rep. Matt Morgan (TX) stated I'm from the P&C world and as that's where I spent most of my career and this sounds like the scenario where they put in the little thing and they can track where you drive and how you drive. You can opt in to do that if you want to try and get lower rates. So, it feels like maybe a model that we try and put out should have something that has the ability for people to opt in should they choose, and the ability to not opt in and leave it as it is now where the information is not necessarily accessible by the life insurance carriers. Prof. Prince stated life insurers are doing this in a way with wellness programs. There are wellness

programs that are starting to introduce genetic testing for preventive conditions, and there are some life insurance companies that are starting to offer this to their current policyholders. And so, this is a way where it's theoretically a win-win for both people, where the policyholders can learn of their genetic risk and therefore lower their future risk if they find out that they have Lynch syndrome or another preventive disease, and the life insurance industry is lowering their risk, too, if people take it up on that. So, that's an example of how that's playing out, but outside of the underwriting space.

Dr. Van Dommelen stated key to her example is that the insurance is already in place. And we would encourage people to make their decision on the need for their family and protection in life insurance, first, and then worry about if there is genetic testing second. That way, there's no way for the two to become intersecting. There's nothing for us as an insurer to do after that policy is in place. They have that policy. That's their policy as long as they want to pay their premium and maintain that policy. The other slightly nuanced piece about the testing is that, yes, some insurers it's a very small number, but some insurers the testing that they're offering is actually looking for cancers in the body. Unfortunately, we only have about four cancers that we have really good screening for, and there are certain genetic tests out there that claim, we're still waiting to see if they can refine it and prove it out, but the genetic testing is actually a blood test to look for up to 60 different cancers that someone might have. So, it's not necessarily looking for a propensity for cancer. It's looking to see if you have existing cancer cells circulating in your blood that can be picked up genetically.

Rep. Morgan stated I agree to disagree in that most people buy term life insurance and not whole life so therefore you're changing that on a fairly regular basis, I would say. So, unless I'm buying it outside of my work which most people I don't think do, that changes on a fairly regular basis and gives the insurer and the consumer ability to negotiate and decide if they want to do genetic testing or not. I appreciate the other points that were raised as far as that goes.

Rep. Carter thanked everyone for their participation and stated she looked forward to discussing the model further at the next meeting where hopefully it will be ready for consideration. If anyone has any questions, please reach out to me or NCOIL staff.

A WORD FROM OUR INSURTECHS

Laura Heeger, Chief Compliance & Privacy Officer at Ethos, thanked the Committee for the opportunity to speak and stated that Ethos is an InsurTech life insurance distribution platform for individual policies. My background is at the carriers. I spent 12 years at MetLife. I was their chief compliance officer for international and U.S. businesses at the end of my career there and then I went to Prudential Financial where I was head of international business compliance and their global ethics officer and head of anti-financial crime. I then went to Ethos. Ethos is currently private and scaling very quickly and it was built just seven years ago to try and drive insurance to mass market. We're talking about direct-to-consumer sales of insurance. Over 60% of our sales are direct-to-consumer. Ethos is a licensed producer because of the direct-to-consumer sales. We're also a third-party administrator (TPA) for some of the carriers that sell through our site and on our site, in as little as 10 minutes, 95% of the people that visit will get approval and a decision at the end and then will be instantly issued an insurance policy. They can download it right then, so it really is changing how insurance is sold and bought.

To show a little bit on how the platform works, we think about it as a three-sided platform. It's available for consumers to come direct to consumer, and we sell that way. We also allow independent agents to bring their consumers through our funnel, and then carriers contract with

us to have their products on our platform. To explain a little bit how the platform works, if you think about if you went to buy a plane ticket on Kayak and you said I wanted to go to Atlanta for NCOIL and Kayak would look through all the different airlines and find you one that matches what you need, that's essentially how our platform works. A customer will come in, we'll do a simple needs analysis, the applications are digitized in the platform, and the customers flow through the application which is dynamic and trees out as they answer questions.

For example, if you are a healthy 40-year-old non-smoking woman and you're coming through the flow and you're looking for term insurance, it's going to be a very short series of application questions. If you're looking for a whole life or an indexed universal life (IUL) product, it's going to be much more complex with more treeing going on. Similarly, if you had underlying health conditions, it would tree out and be reflexive as you went through the process. The other thing to call out about the platform is we haven't simply made a PDF editable. We've really digitized the application experience, and I have some sample screens I can show you, but I just wanted to drive home that this is built for mobile and for desktop because they function differently, and it's really built for digital consumers. To call out a little bit more of what Ethos does, we actually start the whole process when carriers come to us and say we want to sell products through your platform, and we help them design and build products that will be effective in the digital space, because what we need to do is find products that can be explained in a digital manner that customers can understand as they come through.

As I said, we only sell individual products, we don't sell group products, and we act as a TPA for many of the carriers on our platform. We have a bespoke underwriting engine that we've developed but we use the underwriting rules for each carrier for their products as customers are coming through and all of this is interactive. The carriers, however, still pay all the claims. The carriers are responsible if there's any rescission. I was here earlier for the artificial intelligence (AI) discussion and we don't use any AI in our underwriting either. That's the high level of what goes on with the platform. The other thing to call out is the compliance risk management that goes on. The way we fit into the insurance space in terms of distribution is essentially we're onboarding customers for carriers and so we're subsumed into the carrier programs for onboarding. We pick up their anti-money laundering requirements, their sanction screening requirements. We have advanced fraud screening techniques we use in our flow where we can pick things up in real time as customers are going through and we have the same compliance risk management program that I had in place at MetLife and Prudential. It's a highly scalable continuous loop feedback, looking at our first line controls that exist and what we're picking up from those and the feedback that comes back.

Anecdotally, I can tell you, coming from carriers, one of the huge differences in the InsurTech space is the speed at which we can react to the data we're seeing from our controls and from our customers and if there's a customer complaint or if a carrier has a concern. In my first two weeks at Ethos, there was some little bug on the platform and they came to me and said, “how fast should we fix this?” And I still had my carrier hat on, so I was thinking in carrier timelines, and I thought it needs to be fixed reasonably quickly, so in carrier timelines, that would be within the next two quarters as that would be amazingly quick for a technology fix. We need funding, we need a project plan, we need to get it on the IT schedule, it's a big deal. And I said three to five, meaning three to five months in my head, and they said hours or days and they fixed it in two hours, and it was done. Everything happens in sprints. If I say something's priority 0, it happens this week. If it's priority 1, it happens next week, and there's nothing past that. And so, in working with our carriers, we can be incredibly responsive to emerging risks that we might discover through our compliance program and through their compliance program. We have quarterly meetings with compliance teams at special investigative unites (SIUs) where we're

sharing information about what we're seeing in real time. And we have huge amounts of data we can bring to the table to really analyze what could possibly be going on and what we're seeing.

It's been, for me, a real education in you really can go faster in terms of risk management. You really can handle things differently than I always was able to do with the carriers. And it's been, frankly, from a compliance standpoint, kind of freeing to be able to address things differently. The last thing I wanted to do was just show you some screens. I wanted to show you where they kind of come in the digital front door of our website. We do sort of a very basic needs analysis. This would be for a standard term policy as they're coming through - what are your costs, who depends on you, those kinds of things. And then they're going to flow into this very dynamic application and we actually take the application questions that have been approved in every state, and then that's what's flowing through. One of the first questions we're going to ask the consumer is what's your zip code, because we need to know the state. We can determine agent licensing then if there's an independent agent bringing them through, but we can also determine if there's any state-specific requirements.

And that's one thing we've noticed is that when a customer comes through the digital front door, most of the time we can give them a fully digital experience but there's still some state laws that linger that require paper and that requires us to come up with workarounds with our carriers and figure out how to handle things that still require paper in some states. But we're mostly completely digital. They'll get approved, they'll get a coverage explanation, there's a little slider where they can say, what if I got more coverage, what would my premium be, what if I got less coverage, what would my premium be, and they can play around with it. They review their application, they consent to all of that, and then they sign out where they get to review their application again, their beneficiaries, their coverage amount, and you can see on the "congratulations, you're approved screen," where they've gotten this is the carrier that you've been assigned to and the policy you're getting. And as I said, this is all in less than 10 minutes, and that includes all of my compliance controls running in the background of it. So, hopefully, it's been a good experience. The average net promoter score, how often customers are telling friends and family to go to this carrier, in the insurance industry is 14. Ethos' net promoter score is 71. So, we have a much better customer experience of buying insurance coming through our digital platform than in standard insurance sales.

Sen. Boyd stated out of curiosity, do you have a more robust incontestable period when you don't go through the traditional underwriting process? Ms. Heeger replied no, the contestability period's the same, and we use the same underwriting rules. The carriers give us their underwriting rules for their products, and that's what we're pulling through. We just have real-time data. So, for example, if you're going through our application, you're answering questions, and before you begin the application, we've gotten your consent to pull data on all kinds of data, and you've consented to all of that. We'll begin to pull data in real-time as you're answering the application questions, and so we're sort of underwriting in real-time as we're going through and validating what you're saying. If you say something that doesn't match data that we've pulled, we'll ask you about it. Sen. Boyd asked if you have access to medical records or something similar like my pharmacy records. Ms. Heeger replied yes, all of that is flowing in.

UPDATE ON FEDERAL RETIREMENT SECURITY INITIATIVES: SECURE ACT 3.0 ON THE HORIZON?

Andrew Remo, VP of Retirement Security at ACLI thanked the Committee for the opportunity to speak and stated that I'm going to first talk about HR 1, the One Big Beautiful Bill Act. From a

life insurance industry perspective, we were quite pleased with that. The last time that Congress did a big tax bill, which was in 2017, the life insurers really got hit as a pay-for up to the tune of $25 billion, where every other industry got a tax break. The life insurance industry did not. So, frankly, we were paranoid about what was going to happen this go-around, and we were very pleased that we were held harmless. The net result here was no changes to subchapter L provisions, no change to the corporate tax rate, no changes to the corporate, state, and local tax deduction or C-SALT, no increase to the share repurchase excise tax, no negative changes to product tax. And then just in the employer benefits space, there were no changes to the federal income tax incentives for both retirement and health and welfare plans. There was an improvement to the tax law with respect to the paid family and medical leave credit, so Section 45S, or what's called the Fischer Tax Credit. That was extended and made permanent, and it was expanded to permit the credit to be taken for paid leave insurance premiums. So that's a provision that we advocated for, and we were happy to see that included.

One of the provisions that took a lot of observers by surprise in this space was a provision that created a new savings vehicle called the Trump Account, and it also created a contribution pilot program. This is a new tax-preferred savings account for minors. It ultimately was defined as an IRA so you can make cash-only after-tax contributions up to $5,000 per year into these accounts. There's a provision in the law that says employers can contribute up to $2,500 per year and exclude that contribution from the employee's income. And one of the most interesting pieces of this is for every child now that's born starting the beginning of this year through the end of 2028 will get when they open up an account and apply for this, will get a $1,000 government contribution. So, that's an idea that has gone back I think since the 1970s in terms of just contributing seed money for every child and providing a saver stake for every single child in the country and we're going to see that sort of play out. There's a lot of questions in terms of details around this provision but it's an intriguing one. There's also investment restrictions within these accounts and fee caps that could make it less attractive for folks versus other sort of savings vehicles and frankly less attractive for financial service providers to offer these or to promote these in a significant way. But I think the seed money is going to be attractive and they have a year until the further details come out but Treasury is going to be working very hard on standing this program up and providing the rules of the road for financial providers to offer these accounts so that's just something to watch as it develops.

The One Big Beautiful Bill Act also made various 529 plan changes which is a savings vehicle that's been around quite a while but that's been expanded significantly in terms of allowing for new qualified higher education expenses. So, now you can have a 529 and you can pay for additional elementary or secondary, public, private, religious, and homeschool expenses up to $20,000 in tuition. So, that's a broad expansion of what you can use the vehicle for and then you can also use a 529 to pay for certain post-secondary credentialing. So non-college, if you want to get a credential in whatever profession and have a 529, you can use those savings for that. So, that was the major tax changes that happened in our space this year, but what's next? The two major retirement bills that were enacted in the last six years at the federal level, SECURE 1.0, SECURE 2.0, and if you even go back further to the Pension Protection Act in 2006, and a lot of the changes that were in the 2001 tax law that really built the framework and the bones for our current defined contribution system that we have - those laws did a really good job of automating people into the system, providing automatic enrollment features, automatic escalation features, so you can defer more money automatically in a working career.

And even SECURE 2.0 had a provision called auto portability where if you have a smaller dollar balance and you go from employer A to employer B, that money follows you to your next 401k so you can really build up that pot of money for your retirement as opposed to just cashing it out

at job change. I think automation is critical. People tend to act through inertia and so how can we automate the system to drive optimal outcomes I think is critical. The one gap that we have is really automating now the distribution phase or the decumulation phase of retirement, which is really where the life insurance industry plays the critical role with respect to guaranteed lifetime income with respect to annuity products and that's really what we want to focus on for SECURE 3.0 is automating distribution and retirement. And that's really where these proposals come in that we're focused on. Step one is to require employers that have a 401k plan to have a guaranteed lifetime income distribution option available for participants so when they get to that stage in retirement, that's an option available. It's not required now. We also want to update the liquidity rules especially with respect to default investments because now that you automatically enroll people, you need a default investment for people that don't choose another investment that's available and we think guaranteed lifetime income has a role to play there.

I think Wall Street is developing products with guaranteed lifetime income features with annuity wrappers to these default investments and we want the laws to reflect that and that's a part of our proposals. And then some of the smaller items would be to create a new in-service rollover distribution option for folks. So if you're age 50 and you're working in an employer that has a 401K plan and you have a significant amount of savings built up, we want to allow those people to take that out and to purchase an annuity and lock up that guaranteed lifetime income, but also be able to continue to save through the last 10, 15 years of their life to maybe have a more liquid pot of money too. So that was sort of intriguing because age 50 is sort of when you can make catch-up contributions, and you can make really juiced-up contributions right towards the end of your retirement, and that's usually when hopefully you paid off your house, you paid your kids' tuition, and now you're really focused on your own savings for your own end of life so that's sort of where that idea came from. And then finally is an update of what's called the 402F model rollover notice, which is a notice that Treasury is required to give everybody that separates from employment rollover options. It's a very complex form. We're just trying to simplify it and highlight the fact that you can take a rollover and purchase a guaranteed income product like an annuity. So that's sort of what we're working on for SECURE 3.0. Outside of that, I think you're starting to see that retirement policy on the Hill is one of the few policy areas that is bipartisan in large part. And we've seen that process play out in SECURE 1.0 and SECURE 2.0 and the Pension Protection Act as those were overwhelmingly bipartisan bills and we would like to see that again. This Congress has been very partisan and each party wants to their priorities and that gets contentious particularly in the tax arena through reconciliation bills. We want to separate the retirement stuff out from that because that inherently is less stable and tends to get undone and we've seen that play out before.

I don't think SECURE Act 3.0 is really germane for this Congress. I think it's more perhaps the next Congress or at some point in the future but they're starting to work on proposals and this is just sort of a snapshot of the other bipartisan proposals that we see out there. The first line is just to allow for 403b plans to have collective investment trust investments and separate account insurance product investments that all other defined contribution plan vehicles have. That's a pretty wide consensus issue but that's a securities law change so that needs to go through the banking process. So, that's sort of separate from other retirement policy as it's on a separate track but that could be something that gets done this year as part of a broader capital markets financial services package. But the bottom four bills have been introduced in both the House and the Senate on a bipartisan basis and that would form the basis for SECURE 3.0, hopefully along with our annuity proposals that I talked about. The first piece is expanding Employee Retirement Income Security Act of 1974 (ERISA) coverage to age 18 as now, the minimum coverage level is 21, so that sort of modestly increases the pool of people that employers would have to cover if they had an ERISA plan. Another piece is requiring automatic

re-enrollment. So, if you're automatically enrolled and you opt out, you can get automatically re-enrolled, say, within the first three years or up to annually. And then a couple of tweaks to the small employer pension plan startup credit to make it more generous for micro-employers, and that's defined as employers between one and nine employees, to get the full $2,500 for the first three years if you have a 401k plan. And then also to apply the credit to tax exempt employers that don't have traditional employer income tax liability, but to provide an incentive to have a 401k or a 403b plan, but to take that tax credit off on their payroll taxes, since as tax exempt, they don't by definition owe any income tax.

Rep. Tim Barhorst (OH) stated regarding the Trump accounts and the $1,000 at birth, I'm a group benefits consultant and do 401k planning and I've got one of my vendors researching if we can implement the Trump accounts underneath the group annuity contract that is sometimes a 401k or whether it's our open architecture. Is that something that you are involved in, or do you see that as a roadblock they'll hit when they research this or have those rules not been developed yet or is there an opportunity to try to figure that out? Because with new things, the marketplace has to embrace and facilitate and implement it and make it easier to happen. Mr. Remo stated I think that's a huge question. The rules have to come out within the first year but I think there is going to be a real interest for anybody that has a kid that is born now and in the next four years to have access to these accounts and there is an intent with that $2,500 incentive to have employers sort of facilitate this in some way but we really have to get the rules out and then there has to be company interest in offering these and then sort of marketing it through their distribution channels.

Rep. Barhorst stated when the Roth IRA option came up, it took a little longer to get the pickup on it, but it's kind of a normal thing now, and I just was curious if that would be something similar here. Mr. Remo stated any type of major employee benefit changes are very complex, and there are a lot of details that tend to come out. I will say that this is the number one priority probably now for Treasury and there's sort of a limited time on this. There was a provision in SECURE 2.0 called the Saver's Match that would basically translate the Saver's credit into a matching contribution. That doesn't kick in until 2027, but a lot of the same sort of piping questions are there and if you have an account, you can get up to $2,000 if you contribute $400 to an IRA. A lot of those same issues apply to the Trump accounts that now need to be done more quickly so I think there's been some thought that's been given to how to facilitate this through the Saver's match. That law was passed in 2022, and they're just now sort of applying those lessons to the Trump accounts.

Sen. George Lang (OH) stated for the last 30 years, I've had my Series 6, 7, 63, 24, 26, and my life and health licenses and for that entire period of time, the only thing that has been consistent is we have been playing in the defined contribution market. We currently do business in over 500 school districts, multiple 401Ks, multiple 457s, and we play in the alternative retirement plans at colleges and universities as well. I have some concerns about the emphasis on annuities in the retirement phase. As you know, when 403Bs first came out, the only option you had available was an annuity so 100% of all sales were annuities. At that time, they were only fixed annuities. Then they allowed variable annuities. Now they allow a whole plethora of investment options and we don't even allow any of our agents to market annuities in those plans anymore because they tend to have significantly higher fees and you pay the higher fees, you get some benefits, the deferred taxation, but you get that in the qualified plans anyway, so that benefit that you're paying a higher fee for is redundant, and the reality is anybody at retirement, if they choose to, could roll their money easily into an annuity, and annuity contracts tend to be more rigid with less flexibility, or they can design their own annuity plan within the investment options that they currently have available and adjust it for inflation on an annual basis without

the rigidity or inflexibility of an annuity plan. And the last thing I would like to add, if you are an investment advisor, and you are an registered investment advisor or a certified financial planner, or some other fiduciary responsibility, you couldn't even sell an annuity if there was a better option available to your clients. I was really excited about everything you recommended with the exception of the annuity for the distribution phase of the retirement plan and maybe you can help clarify some of your reasons a little better for me.

Mr. Remo stated I represent the ACLI and our members sell annuity products. I view annuities as insurance. It's the only product in the marketplace that guarantees an income stream of payments throughout the rest of your life. None of those other products do that. And so there is a premium to be paid for the guarantee. An annuity is not necessarily an investment product per se. It's more of an insurance product. So, some people value that. Annuities aren't for everybody and I personally would say you should annuitize a portion of your savings or at least purchase a deferred annuity passed a date certain to protect against the longevity risk because that's what these products are designed for. Your concerns are valid about should everybody lock up all of their savings in retirement on a rigid annuity product? I would say no and there should be probably more flexibility there so it's definitely a philosophical conversation. Sen. Lang stated we use a lot of life insurance products in our retirement vehicles that aren't annuities, so I love the life insurance product platforms because they give you so many more options than some of the mutual fund platforms, so I just wanted to throw that out there. Anybody that wants to annuitize today certainly has that option.

ADJOURNMENT

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

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
LIFE INSURANCE & FINANCIAL PLANNING COMMITTEE
INTERIM COMMITTEE MEETING – FEBRUARY 23, 2026
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Life Insurance & Financial Planning Committee held an interim meeting via Zoom on Monday, February 23, 2026, at 12:00 P.M. (EST).

Representative David LeBoeuf of Massachusetts, Chair of the Committee, presided.

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Rep. Camille Lilly (IL)
Rep. Edmond Jordan (LA)
Rep. Brenda Carter (MI)
Sen. Mark Huizenga (MI)
Sen. Lana Theis (MI)
Sen. Michael Webber (MI)
Sen. Walter Michel (MS)
Sen. George Lang (OH)
Rep. Ellyn Hefner (OK)
Rep. Carl Anderson (SC)
Rep. Tom Oliverson, M.D. (TX)
Rep. Barbara Dittrich (WI)

Other legislators present were:

Rep. Rita Mayfield (IL)
Rep. Erika Hancock (KY)
Rep. Michael Sarge Pollock (KY)
Rep. Bob Foley (ME)
Rep. Mike McFall (MI)
Sen. Jeff Barta (ND)

Also in attendance were:

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

QUORUM

Upon a Motion made by Sen. Walter Michel (MS), and seconded by Rep. Brenda Carter (MI), NCOIL Secretary, the Committee voted without objection by way of a voice vote to waive the quorum requirement.

INTRODUCTORY REMARKS: CHAIR LEBOEUF

Rep. LeBoeuf thanked everyone for taking the time to attend this meeting and stated that the purpose of the meeting is to conduct some business before our April meeting in Louisville. We're going to be continuing the discussion on the NCOIL Model Act Regarding Life Insurers Use of Genetic Information and taking any comments on the Models scheduled for re-adoption in Louisville. This will help ensure that we move through the April agenda in a timely manner.

CONTINUED DISCUSSION ON NCOIL MODEL ACT REGARDING LIFE INSUERS' USE OF GENETIC INFORMAITON

Rep. LeBoeuf noted that first on the agenda is continued discussion on the NCOIL Model Act Regarding Life Insurers Use of Genetic Information. There's been significant effort that's gone into shaping this model, with thorough consideration being given by the committee and the sponsor throughout the previous year.

The goal for today's meeting is to take final comments on the model so that the committee's prepared to vote on this at the spring meeting. As we've been discussing this issue for over a year, both I and the sponsor believe that the model is ready for a vote in Louisville, and we do want to have some last opportunities for comments today. I do want to note that the comment letters regarding the model have been posted on the NCOIL website, along with all other materials for this meeting. And with that, I will turn things over to the model's sponsor, Rep. Brenda Carter (MI), NCOIL Secretary.

Rep. Carter thanked everyone who has participated in the process throughout the past year. I'm very proud to sponsor this model as it deals with such an important issue. As I mentioned at the beginning of this process, this topic has generated a lot of discussion in state legislatures across the country in recent years and I think it's great timing for NCOIL to discuss this issue and develop some guidance for states to consider using.

This model is fairly straightforward, and as I mentioned previously, it largely mirrors a law that Tennessee passed a few years ago. This does not seek to outright prohibit life insurers' use of genetic information, as I don't think that's the right approach. Rather, it sets forth what I think are some reasonable guardrails around such use. And really this model somewhat codifies what the current process is right now in terms of life insurer use of genetic testing and I haven't seen yet enough evidence to go in an opposite direction and ban the use of such information. I really do appreciate all the comments that have been submitted throughout this process, and I've incorporated some of them. I'm certainly open to hearing further potential changes and that's why we're having this discussion today.

But overall, I do think the model in its current form is very strong and I don't anticipate making any drastic changes between now and Louisville. And related to that, I want to stress the overall NCOIL philosophy of developing its models. NCOIL models are meant to be a framework that states can use to add or remove things as they deem fit. If a state wants to use this model as a starting point and make certain modifications or even go in a different direction, that's certainly fine. The important thing is by discussing this issue at a national level and producing guidance, it sends a signal to states that this issue is worth devoting time to, and your legislatures should know that these safeguards are important and can be enacted for both consumers and insurers alike. I look forward to hearing the discussion today and hopefully getting this legislation across the finish line in April.

Alex Meixner, VP of State Policy and Advocacy at the ALS Association, thanked the committee for the opportunity to speak and stated that the ALS Association is one of many patient centered organizations that has been intrigued and interested in this legislation. Frankly, the ALS Ass'n is hoping to move forward the strongest possible model that would protect not only current enrollees in life insurance from potentially losing their insurance, although that's important, but the ALS Ass'n also wants to protect those folks that might not yet have chosen to buy life insurance but might be forced with the choice of going down one of two roads. One choice is getting genetic testing that could inform their own health future and help them make smarter, more informed choices about their own health. And the other is being able to purchase life insurance or long-term care disability insurance without the worry that the carriers are going to decide to not provide them with any option to buy coverage or to charge them much more than they would otherwise

be charged based on a genetic test which is not the same thing as an identified diagnosed disease.

It is a potential likelihood at some point down the road of developing something. It's not a certainty, nor is the certainty of what that diagnosis will mean if one day a diagnosis is made. That is, science may have progressed to the point that what might look like a life-ending or life-shortening disease today, may in 10 years, 20 years, 30 years be something that is curable or manageable and might become a chronic condition. So, we need to be very cognizant of that when we see how genetic testing might be used. Now I've already had the opportunity to speak to you at the Chicago meeting so I won't belabor too many of the same points I've already made. But I will say that when we look at the model, we think it is not strong enough and it does not go far enough. We do annual grades on various policies that impact the ALS community and the model as it currently lies, I believe would grade a D. While that's again better than an F, it's not as good as we'd like to see it. From our perspective advocating for our patient community, we would like to see a little bit of a stronger model that not only protects current enrollees, but also goes a little bit further to protect potential enrollees as they already do in the state of Florida, and have done for years as in Canada, the UK, and Australia.

And in fact, there are multiple bills out there on this issue right now. In fact, there's one bill that goes to committee in Massachusetts tomorrow that we think might be slightly stronger than this Model. And again, I have nothing but admiration and respect for Rep. Carter for bringing this up because we wouldn't be having this conversation if she had not chosen to make this a priority, and we want it to be a priority in multiple states throughout the country to follow Florida's example. And it's our hope that over these next weeks, that this language can be strengthened a bit more to produce that floor that can be then built upon. But we don't want to make the floor too low. We'd love to see this model get up to at least a C in our grading platform, if not even greater than that to ensure that it really does strike a good balance between all sides. And again, the ALS Assn's perspective is that patients and consumers come first. We understand there's a lot of competing interests here.

Lisa Schlager, Vice President of Public Policy at Facing Our Risk of Cancer Empowered (FORCE), thanked the Committee for the opportunity to speak and stated that I want to echo what Mr. Meixner shared. We have worked very closely with the ALS Association. FORCE is a national nonprofit focused on hereditary cancers, and the majority of our constituents do carry an inherited genetic mutation that is believed to increase the risk of cancer. Part of the reason I wanted to speak is because the research is evolving very quickly. And sometimes we have mutations that we thought conferred a very high risk of disease, and then the science comes back and says, oh no, we made a mistake - the risk is much lower than we initially thought. And on the flip side, we have individuals who test negative for a known mutation in their families, and they're still denied insurance based on the family history. So I think what the problem here is that we have little or no transparency from the insurers as to how or why they're making these decisions.

And we have no guarantee that the insurers are basing their decisions on the most current research and the most current information about the mutations. And so that leads to concerns for the consumers about how those decisions are being made. So, I just want to point out again how complex this topic is and that insurers did fine for many years without access to genetic testing information. It didn't exist. They based their decisions on family health history and that was that. So, this is really a new thing that's evolved in the past 10 or 15 years. And the reality is that the insurance industry did just fine before genetic testing was available. And just because an individual has a genetic test doesn't mean the person next to them doesn't have the exact same predisposition, but maybe they've chosen not to have a genetic test. So how do you level that

playing field? You level it by removing the genetic test results from the decision making. I know we've submitted comments on this, and we sincerely appreciate all of your time and consideration, but I just wanted to highlight some of the concerns. And again, we appreciate the committee's attention and dedication to representing consumers.

Jill Rickard, Regional VP of State Relations at the American Council of Life Insurers (ACLI) thanked the committee for the opportunity to speak and for really hearing out all of the concerns and working with all of the stakeholders in this process. I am speaking on behalf of ACLI's 275 member companies who support this model and think it represents a thoughtful, well-reasoned approach to life insurers' consideration of genetic information in underwriting. Most importantly, because it recognizes the importance of information symmetry between an applicant and an insurer. Information symmetry is the reason life insurance works and it's crucial for it to remain affordable and accessible. I wanted to take this opportunity to respond to some of the comments made by the patient advocate groups in both their letters submitted to the committee recently and also made on this call today.

First, ACLI agrees that a genetic marker does not guarantee disease onset or severity. Life insurers engage in a holistic evaluation of each applicant that accounts not only for genetic test results, but also other health factors, other test results, family history, lifestyle, and they reward proactive healthcare. If a medical record shows that an applicant is taking preventative actions to manage their risks, such as monitoring, medication and interventions, the insurer will take this into account when setting the appropriate rate. In fact, genetic testing can help a person get a better rate. If a person has a family history of a disease and then undergoes genetic testing to show they don't have the same genetic marker, then this factor will significantly improve their rate, and they will have a policy repriced to reflect it in the future. If they have a policy and they later get the genetic testing, they can ask for that policy to be repriced.

Second, the advocates claim that life insurers are permitted to use genetic test results in underwriting decisions with little to no transparency. This is simply not true. Life insurance rates are typically file and use, so insurers must submit detailed actuarial and financial data to state insurance departments to demonstrate that their rates are not excessive, inadequate or unfairly discriminatory and to ensure compliance with state regulations. Third, yes, genetic testing is new to the life insurance industry, and we have existed 100 years without using it, but it's also new to patients and again, information symmetry is what's important here. Life insurers did not use the genetic test results, but also patients did not have the genetic test results 20 years ago and the fact that we use them now and patients have them now really goes to that information symmetry that's crucial to the industry.

ACLI will now address the claim that has been made that a high percentage of individuals declined to participate in genetic testing due to concerns about insurance discrimination. I just wanted to point out some research that shows that this is just not the case. A 2023 survey found that fewer than 0.1% of respondents cited any unprompted reluctance to take doctor recommended tests because of concerns related to life insurance. The real concerns are convenience and confidentiality, not insurance. So again, ACLI members are committed to a robust and competitive life insurance market that offers a variety of products that are affordable and meet consumers needs. We're able to provide this affordable coverage because applicants share with consent their complete medical records. The proposed model would enact reasonable guardrails that protect consumers and preserve access to affordable coverage, and we again encourage this committee to adopt it in its current form.

Jillian Brady, Senior Manager of Science, Regulation and Policy at Faegre Drinker Consulting thanked the Committee for the opportunity to speak on behalf of the National Society of Genetic Counselors (NSGC) which is a professional society that is the leading voice for genetic counselors representing over 5,000 members nationwide. We submitted comments on Friday, and we appreciate the committee's consideration of those comments and entering those into the record. First and foremost, we also echo the appreciation of Rep. Carter and this committee for bringing this important issue forward. It's timely. We agree that this Model, if adopted with some of the suggestions that we've recommended, would benefit Americans by bringing consistency and greater clarity to the protections that they can expect when it comes to the use of their genetic information which while they may not be specific to life insurance as was suggested by Ms. Rickard, are generally a concern for consumers and Americans across the country.

So, anything that brings consistency and greater clarity to Americans, I think can lead to better choices. We also echo Ms. Schlager's and Mr. Meixner's comments. We believe minor changes with this legislation would significantly strengthen consumer protections and reduce that general fear of genetic discrimination and ultimately achieve what we really strongly believe is an important end goal, which is encouraging participation in genetic testing and research. Some of the things that we have suggested and noted in our comments are the benefits of broadening the definition of "genetic information" to reflect a little bit closely to what we see in existing federal standards. We think this is extremely important, given how rapidly this research develops and how rapidly genetic information has evolved. So, building in or considering how to build in a definition that allows for consideration of all of those various genetic testing and that genetic information is important.

We also believe in the suggestions that have been put forth by many in expanding the protections on the use of genetic information, not just in part, but using it in whole and in coverage denial, benefit limitations, and premium settings, not just policy cancellations. We think this would go a long way to really protect the use of potentially the misuse of genetic information or misinterpretation of genetic information. We also believe in expanding the protections that exist for requiring prior express written and informed consent, making that separate from general medical authorizations. We believe this will improve the symmetry Ms. Rickard referred to. And we also strongly support limiting life insurers' ability to request or encourage genetic testing. We think this is a decision that is deeply personal and should be made at the decision of the consumer based on what is best for them. We appreciate all of the thoughtful discourse that has gone into crafting the legislation and we think it could be further strengthened by a few minor tweaks.

Eric DuPont, on behalf of the ACLI, thanked the Committee for the opportunity to speak and thanked Rep. Carter for sponsoring the model. I'm a colleague of Dr. Deborah VanDommelen, whom you heard from in November at your fall meeting. Understanding medical risks that could affect the life expectancy as part of the underwriting process is necessary for life insurers to meet commitments to policyholders for decades into the future, even though we only get one chance to set pricing. Underwriting benefits the vast majority of consumers by allowing insurers to offer the most coverage to the most people for the lowest price. That fact does not change when it comes to genetic information. Underwriting is not based on a single piece of information. Predicting life expectancy with any accuracy relies on a holistic approach. Therefore, our medical directors and MDs consider treatments and interventions for inherited conditions in the same way they consider how well hypertension is managed with medication, for one example.

And our MDs do stay up to date on the latest information. We want to sell insurance. We're not looking to put up roadblocks. Privacy is an important part of the discussion, and the proposed language offers several consumer protections in addition to protections that already exist given

the sensitive information insurers review as part of the medical records. So too is consent, which is an important and standard part of the existing insurance application process. We appreciate the efforts of NCOIL to weigh the risks of all policyholders. The current language is a reasoned approach to maintain appropriate matching of risk with pricing, keep insurance affordable to the most consumers, support access for those stretching to afford to protect their families, and to ensure the consent process maintains privacy. There are two points brought up by previous speakers I'd just like to try to address. One is that current enrollees are losing coverage because of a genetic test. When we sell a life insurance policy. It's sold. We set the price. That's it. We don't re-underwrite as it goes along. And so, I cannot think of a way that it would compromise coverage of somebody who is already covered by life insurance that we've already underwritten. And as far as requesting this information, I'm not aware that any life insurers request genetic tests. We look at what's in the medical record.

Sen. Lana Theis (MI) stated that I appreciate the commentary from those pushing back against this legislation, and those asking for stronger protection. I also support insurers asking for significantly stronger information. Insurers insure risk, not guarantees. So, if I put a trampoline in my backyard, my rates go up not because there is a trampoline in my backyard, but because my risk went up. And so I think insurers have a right to understand risk and I think they have a right to understand it with the most recent information available. I want to commend Rep. Carter for bringing this forward. I think it's extremely important information that we have and I think its guardrails are important and avoiding a prohibition from the usage is what we need to focus on here. I think we're heading in the right direction.

Sen. George Lang (OH) thanked Rep. Carter for bringing this forward and stated that I am somewhat opposed to this legislation. Section 4(D) is the only reason why I think this may make some sense, but as someone who is fighting stage four colon cancer, and who is a carrier of the Lynch syndrome, I believe the life insurance companies have the right to know as much information as they can before they take on a risk such as me. And I think it is important that we look out to protect citizens and constituents and future enrollees but we also have to protect the life insurance industry and we cannot ask them to take on unnecessary risk that will raise the rates for the entire population. So, I would just encourage us not to consider anything that would make this legislation stronger or more anti-insurance companies because we need profitable insurance companies in order for them to continue offering their services. They need to be profitable and viable. Plus, we don't know what future technology is going to come out to really give them more tools in their underwriting process and I don't want to see us doing anything that puts handcuffs on the insurance companies as they try to make the best decision possible. And keep in mind their goal is to sell insurance – they don't make money without premiums.

Rep. Carter thanked everybody for the work they've done on this. All of the comments were very heartfelt, but regarding the argument that costs will increase for life insurers if they are restricted from using genetic information, I have a question - did the Florida, UK, or Canada ban result in increased premiums? Because one of the things that I'm looking at is balancing the issues. Can we protect our consumers without raising costs and premiums.

Ms. Rickard stated I think there are two different answers. First, in Florida, that is a brand new ban that's four years in effect and because life insurance policies can be ten, twenty, thirty, fifty years out from the time they pay claims, it's really impossible to know at this point whether this will impact rates. In terms of Canada and the UK, their systems for life insurance are entirely different. There is some mandatory minimum life insurance, which makes it different from our entirely voluntary market here in the U.S. where you don't have to buy life insurance. But in Canada and the UK, you have to buy some minimum amount, which makes it more along the

lines of a health insurance policy. So unfortunately, I don't think we can compare ourselves to those countries.

Ms. Schlager agreed that the systems in Canada and the UK are different. However, we have research from Florida. The Florida law is now five years old. That Florida data has shown that the Florida insurance rates increased only 2% over recent years when the average increase is 6% to 8%. So, obviously, there has not been a rush on the market, and we have data to back that up. So early signs are that there is no significant impact and definitely not a negative impact by banning the use of genetic information. I can't say what's going to happen long term, but we've heard, "oh, there's going to be a rush on the market, people are going to cross state lines to purchase policies." We're not seeing that. Most people just want to ensure that their family is protected, that they can cover their mortgage or basic expenses. They're not really out there to scam the system. So early signs are that there's no significant impact.

Christa Rapoport, NCOIL General Counsel stated that Rep. Barbara Dittrich (WI) posted a question in the Zoom chat asking: have we checked the model against the federal Genetic Information Nondiscrimination Act of 2008 (GINA) law to make sure we're not missing anything?

Ms. Rickard stated that Congress made a decision when passing GINA that it would specifically not apply to life and long-term care insurers. And the reason for that is that we can't change our rates, unlike property and casualty or specifically health insurers to whom GINA applies. Those rates are rewritten on an annual basis, and changes can be taken into account and then priced into the policy. Life insurers can't do that. We write a policy now that might be in effect for 50 years, and we are unable to reprice that policy. And unlike health insurance which is not mandatory but is essential for people, life insurance is a completely voluntary product. So, for those couple of reasons, Congress made the decision specifically to exclude life insurance from GINA and the protections are therefore different.

Ms. Schlager stated that it took 13 years to pass GINA and initially, life and long-term care and disability insurance was something that the community and the public wanted to see included. The only way that we were able to get the law passed was by removing those portions because of the opposition by the insurance industry. That being said, the existing GINA law only addresses health care and employment. It does not address life, long-term care or disability. So, there is no overlap at all between the model and the existing federal law.

Rep. LeBoeuf stated in a scenario where someone were to apply for a life insurance policy and they were under the impression that they had a family history of breast cancer, but then they do genetic testing and find out that they actually do not have that genetic marker, is there an opportunity for a kind of a re-underwriting? And how is that taken into account in regards to what rates are accepted? Are they allowed to have a better rate than the initial policy?

Ms. Schlager stated that s a person who has a mutation, I will say that it's a different scenario. I have a known mutation in my family. So, if my daughter tests and she's negative, she should be able to get a policy just like the average risk population because she's negative for the mutation that I carry. However, if you have a family with no known mutation, testing negative for a genetic mutation doesn't mean anything because you don't know what is causing the risk in that family. Unfortunately, because this is very sophisticated, we do have some unfortunate examples - there was an article in Forbes written by Ellen Matloff for somebody whose family had a heavy history of colorectal cancer and had a known mutation. He tested negative for the mutation but was still denied a policy based on that family history. And that just goes to show that the insurer doesn't really understand the implications or the science. But philosophically, yes. If you have a known

mutation and a family member tests negative, they should be able to obtain a policy without being penalized for their family history.

Ms. Rickard stated I would actually agree with most of what Ms. Schlager has said except that one insurance company denying you a risk does not mean that every insurance company will deny you a risk. That's why we have a competitive market. I can't speak to that case she mentioned and I can't speak to every individual insurance company underwriting policies but I do know if you have a family history of breast cancer, and that is the information that was available when a life insurer underwrote your risk, and you have a policy based on that or priced based on that fact and then twenty years later, you take a genetic test, and it shows you don't have the genetic marker for that disease, then you can apply for a new policy with that new information. And if the rate is less, then you can take the new rate and you won't be penalized in any way. I will also say if we're talking about the two year contestability clause for getting that genetic test, the contestability clause is really for fraud and applies if you had that information and didn't share it, it's not for if you just got a test within that period.

Anya Prince, Associate Professor at the University of Iowa College of Law, thanked the Committee for the opportunity to speak and stated that I just wanted to make one point about reapplying for life insurance. The insurers have mentioned many times that they can only underwrite one time for the policy. But as Ms. Rickard mentioned, somebody can apply 20 years later. Well, 20 years later they're 20 years older. And so then they will have higher rates because they are older or they could have developed a different condition. And so, while I absolutely agree that on principle, a new application might take that into account, there are other things that could occur that could mean that individual has lost the opportunity to have the lower rate application from the very beginning.

Rep. Camille Lilly (IL) asked if someone could summarize the main purpose of the model. Also, when it comes to health insurance, the families who are needing it are wanting to insure. The constituents and the citizens I represent, the reason why they're needing health insurance is to have access to health care and quality of life. And so, I am a little concerned that those who are in this space aren't really in it for creating access for care. And I am concerned about that because I hear it constantly that people don't have a lot of confidence in health insurance because of the preauthorization and denials and things like that. I just want to be sensitive to what I hear from my constituents around why they have health insurance.

Rep. Carter stated that this model addresses life insurance, not health insurance, and there is, as one of the speakers mentioned earlier, a different way of evaluating risk with life insurance versus health insurance. But the main reason for this model is to ensure that individuals are not treated unfairly and solely because of a genetic test. And it also prevents life insurers from requiring applicants to undergo testing. But it also protects the insurance industry to make sure that they're able to actuarially assess risk. So, it's a gentle balance between the two. What we're doing with this model is creating guardrails that protect the consumer and also protect the industry.

Mr. Meixner stated that Rep. Carter summed it up perfectly of what this model is seeking to do and trying to find balance. And again, from our perspective, the key question here comes down to how you orient that balance from the beginning. And if we are in a new world with regard to genetic testing right, where it didn't really exist 20 years ago. Now, every year, if you look at a graph of new conditions that are identified to have genetic links, it's going up almost exponentially. So, the number of us on this call that have some genetic link or predisposition to a disease, I don't know what that percent is today, but I guarantee in 10 years it'll be double. And in 30 years it'll be nearly all of us. Everybody will have some genetic link to something or other. And so, as we're

entering into this accelerating world of genetic information that is going to be more widely available. From our perspective, we would be wise to start with the balance of saying, let's limit access to that information until we figure out how it can be responsibly used in a fair way for all sides, and especially for the individual consumers who are going to have less power in this dynamic than the companies that are offering the insurance.

Now to do the opposite, to say, "Okay, all this information is usable, and we'll figure out additional guardrails as problems emerge down the road". Well again, those solutions are going to be a little bit late to the party. They're going to be coming after problems have been identified and have been felt on the consumer end pretty significantly until the legislative process can grind forward and make spot fixes. We think it would be a better balance to start with saying, we are going to set stronger limits on the use of this genetic information until we as a society get our heads around this new world in which we live as opposed to saying we're going to start from a point of insurers can use anything and everything as much as they'd like and then setting additional guardrails as problems emerge.

Ms. Schlager stated that in essence, this legislation and similar legislation is codifying the ability of the insurers to use this information and ultimately, it's going to be very difficult to reverse that in the future versus if it was the opposite and we said, "Hey, let's not use this right now. Let's not allow it. And then we can reassess in the future." I think that would make more sense given that the science is evolving so quickly. So again, we are in support of some stronger guardrails that are more aligned with some of the comments that have been received. And if the Committee members have not had the opportunity to read those comments, I sincerely appreciate taking the time to do so.

Rep. Carter thanked everyone for their passionate comments and work on this for the past year. And I did want to express the fact that NCOIL creates these models, but the states ultimately decide whether they want to accept the model and whether they want to modify it or whether they don't want to use it at all. This is just trying to standardize and put guardrails around something that has no guardrails. And as many people mentioned, the science is evolving rapidly. So once again, I appreciate everybody's comments and we look forward to talking with everybody in Louisville.

Rep. LeBoeuf thanked Rep. Carter and everyone for their comments and stated that we all are looking forward to this continued conversation. Thank you, everyone, for your engagement. If you do have any additional comments or questions, please reach out to Rep. Carter or myself or NCOIL staff to get more information. And I'm really confident that we'll be in a good place in April to have this discussion continue and have a vote.

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

Rep. Leboeuf stated that next on our agenda is an opportunity for comment and discussion on model laws that are scheduled for re-adoption by the committee at the upcoming spring meeting in April. The Committee has three model laws that are scheduled for consideration of re-adoption. As a reminder, per NCOIL bylaws, all NCOIL models are scheduled to be considered for re-adoption every five years. If a model is not re-adopted, it sunsets. The models that are up for re-adoption in front of this committee in Louisville are: the Beneficiaries Bill of Rights, the Life Insurance Consumer Disclosure Model Act, and the Long Term Care Tax Credit Model Act. I do want to note that these models will not be voted on for re-adoption today. Rather, this is an

opportunity for any initial comments and discussions on these models in advance of the meeting in April in Louisville, where the actual vote will take place.

No comments or questions were offered on the Models by legislators or interested parties.

ADJOURNMENT

Hearing no further business, upon a Motion made by Sen. Justin Boyd (AR) and seconded by Sen. Theis, the Committee adjourned at 1:00 p.m.

616 Fifth Avenue, Unit 106
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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 October 14, 2025. To be discussed and considered during the meeting of the Life Insurance & Financial Planning Committee on April 17, 2026~~November 14, 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 undergo genetic testing, including complete genomic sequencing, ~~take a genetic test~~ as a precondition of ~~insurability~~ coverage or pricing~~, and shall not require the complete genome sequencing of an individual's DNA~~.

(C) A life insurance provider shall not access, use, retain, or disclose 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, or using 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.

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CHIEF EXECUTIVE OFFICER: Will Melofchik

National Council of Insurance Legislators (NCOIL)

Long-Term Care Tax Credit Model Act

Adopted by the NCOIL Health Insurance and Executive Committees on July 10, 1998. Readopted by the NCOIL Executive Committee on March 2, 2001; July 11, 2003; March 4, 2005; and March 7, 2010; and February 28, 2016; and April 18, 2021.

To be considered for re-adoption by the Life Insurance & Financial Planning Committee on April 17, 2026.

Section 1. Title. This Act may be cited as the Long-Term Care Tax Credit Act.

Section 2. Main Provisions.

A. A taxpayer shall be allowed a credit against the state income tax in an amount equal to fifteen percent (15%) of the premium costs paid during the taxable year for a qualified long-term care insurance policy as defined in section 7702B of the Internal Revenue Code that offers coverage to either the individual, the individual's spouse, parent, or a dependent as defined in Section 152 of the Internal Revenue Code.

(Drafting note -- The long-term care tax credit has been defined as 10 percent in some states, and as much as 20 percent in other states.)

B. No taxpayer shall be entitled to such credit with respect to the same expended amounts for qualified long-term care insurance which are claimed by another taxpayer.

Section 3. Applicability.

A. The credit allowed by this Act may not exceed five hundred dollars ($500) or the taxpayers income tax liability, which ever is less, for each qualified long-term care insurance policy.

(Drafting note -- Legislation varies on this amount as well.)

B. Any unused tax credit shall not be allowed to be carried forward to apply to the taxpayer's succeeding years' tax liability.

C. No credit shall be allowed under this Act with respect to any premium for qualified long-term care insurance either deducted or subtracted by the taxpayer in arriving at [the state's] net taxable

income or with respect to any premiums for qualified long-term care insurance for which amounts were excluded for [the state's] net taxable income.

Section 4. {Severability clause}

Section 5. {Repealer clause}

Section 6. {Effective date}

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National Council of Insurance Legislators (NCOIL)

Life Insurance Consumer Disclosure Model Act

Adopted by the NCOIL Executive Committee on November 21, 2010, and by the NCOIL Life Insurance & Financial Planning Committee on November 19, 2010. Readopted by the NCOIL Executive Committee on February 28, 2016, and on April 18, 2021.

To be considered for re-adoption by the Life Insurance & Financial Planning Committee on April 17, 2026.

Section 1. Short Title

This Act shall be known as the Life Insurance Consumer Disclosure Model Act.

Section 2. Definitions

A. "Commissioner" means the [insert title per individual state] in this state.

B. "Insurer" means the insurance company that issued the policy.

C. "Insured" means an individual covered by a policy.

D. "Person" means an individual or a legal entity.

E. "Policy" means an individual life insurance policy owned by a person who is a resident of this state, regardless of whether issued, delivered, or renewed in this state.

F. "Policy owner" means the owner of a policy.

Section 3. Notice to Policy Owner Required

A. An insurer shall provide the written notice required by Subsection 3(B) to a policy owner, if an insured is age sixty or older or is known by the insurer to be terminally ill or chronically ill, and if:

1. The policy owner requests the surrender, in whole or in part, of a policy;

2. The policy owner requests an accelerated death benefit under a policy;

3. The insurer sends notice to the policy owner that the policy may lapse; provided, however, that the insurer shall not be required to include the notice required by this paragraph to the policy owner more than one time within a twelve month period from the date of the first notice of lapse of the policy; or

4. At any other time that the commissioner may prescribe by rule.

B. The commissioner shall develop the written notice, promulgated by rule, to apprise policy owners of alternatives to the lapse or surrender of a policy and of the policy owner's rights as an owner of a policy related to the disposition of a policy. The notice shall be developed at no cost to insurers or other licensees and shall be written in lay terms.

C. The written notice shall contain the following:

1. A statement explaining that life insurance is a critical part of a broader financial plan;

2. A statement explaining that there are alternatives to the lapse or surrender of a policy;

3. A general description of the following alternatives to the lapse or surrender of a policy:

(a) accelerated death benefits available under the policy or as a rider to the policy;

(b) the assignment of the policy as a gift;

(c) the sale of the policy pursuant to a life settlement contract, including that a life settlement is a regulated transaction in this state [as applicable]

(d) the replacement of the policy pursuant to [cite any regulation governing policy replacement];

(e) the maintenance of the policy pursuant to the terms of the policy or a rider to the policy, or through life settlement contract;

(f) the maintenance of the policy through loans issued by an insurer or a third party, using the policy or the cash surrender value of the policy as collateral for the loan;

(g) conversion of the policy from a term policy to a permanent policy; and

(h) conversion of the policy in order to obtain long-term care health insurance coverage or a long-term care benefit plan.

4. A statement explaining that life insurance, life settlements, or other alternatives to the lapse or surrender of the policy described in the notice may or may not be available to a particular policy owner depending on a number of circumstances, including the age and health status of the

insured or the terms of a life insurance policy, and that policy owners should contact their financial advisor, insurance agent, broker, or attorney to obtain further advice and assistance.

Section 4. Penalties

A violation of Section 3(A) shall be deemed an unfair trade practice pursuant to state law and subject to the penalties provided by state law.

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National Council of Insurance Legislators (NCOIL)

Beneficiaries' Bill of Rights

Adopted by the NCOIL Executive Committee on November 21, 2010, and the NCOIL Life Insurance & Financial Planning Committee on November 19, 2010. Readopted by the NCOIL Executive Committee on February 28, 2016 and April 18, 2021.

To be considered for re-adoption by the Life Insurance & Financial Planning Committee on April 17, 2026.

Section 1. Short Title

This Act shall be known as the Beneficiaries' Bill of Rights.

Section 2. Purpose

This Act will require complete and proper disclosure, transparency, and accountability relating to any method of payment for life insurance death benefits and require that beneficiaries are fully informed—in bold type and in layman's language—of their options.

Section 3. Definitions

A. "Policy" means any policy or certificate of life insurance that provides a death benefit.

B. "Retained Asset Account" means any mechanism whereby the settlement of proceeds payable under a life insurance policy, including but not limited to the payment of cash surrender value, is accomplished by the insurer or an entity acting on behalf of the insurer depositing the proceeds into an account, where those proceeds are retained by the insurer, pursuant to a supplementary contract not involving annuity benefits.

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

Section 4. General Requirements

A. An insurer may not use a retained asset account as the mode of settlement unless the insurer discloses such option to the beneficiary or the beneficiary's legal representative prior to the transfer of the death benefit to a retained asset account.

B. A beneficiary shall be informed of his or her rights to receive a lump-sum payment of life insurance proceeds in the form of a bank check or other form of immediate full payment of benefits.

Section 5. Disclosure Requirements

A. A complete listing and clear explanation of all of the life insurance proceeds payment options available to the beneficiary in written or electronic format shall accompany the tender of other than a lump sum payment of a life insurance death benefit.

B. The use of a retained asset account shall require in the description and explanation pursuant to Subsection 5(A) the following:

1. The recommendation to consult a tax, investment, or other financial advisor regarding tax liability and investment options;

2. The initial interest rate, when and how interest rates may change, and any dividends and other gains that may be paid or distributed to the account holder;

3. The custodian of the funds or assets of the account;

4. The coverage guaranteed by the Federal Deposit Insurance Corporation (FDIC), if any, and the amount of such coverage;

5. The limitations, if any, on the numbers and amounts of withdrawals of funds from the account, including any minimum or maximum benefit payment amounts;

6. The delays, if any, that the account holder may encounter in completing authorized transactions and the anticipated duration of such delays;

7. The services provided for a fee, including a list of the fees or the method of their calculation;

8. The nature and frequency of statements of account;

9. The payment of some or all of the proceeds of the death benefit may be by the delivery of checks, drafts, or other instruments to access the available funds;

10. The entire proceeds are available to the account holder by the use of one such check, draft, or other instrument;

11. The insurer or a related party may derive income, in addition to any fees charged on the account, from the total gains received on the investment of the balance of funds in the account;

12. The telephone number, address, and other contact information, including website address, to obtain additional information regarding the account; and

13. The following statement, “FOR FURTHER INFORMATION, PLEASE CONTACT YOUR STATE DEPARTMENT OF INSURANCE.”

C. The writings produced to satisfy the requirements of this Section shall be in easy-to understand language and bold or at least 12-point type.

Section 6. Insurer Reporting

A. Insurers shall, on an annual basis, report the following information to the [Insert State Insurance Department]:

1. The number and dollar balance of retained asset accounts in force at the beginning of the year;

2. The number and dollar amount of retained asset accounts issued/added during the year;

3. The number and dollar amount of retained asset accounts closed out/withdrawn during the year;

4. The number and dollar balance of retained asset accounts in force at the end of the year;

5. The investment earnings or interest credited to retained asset accounts;

6. Fees and other charges assessed during the year;

7. A narrative description of how the accounts are structured. The description shall include:

(a) all of the different interest rates paid to retained asset account holders during the reporting year and the number of times changes were made during the reporting year;

(b) a list of all applicable fees charged by the reporting entity directly or indirectly associated with the retained asset accounts; and

(c) whether the retained asset accounts were the default method for satisfying life insurance claims;

8. The number and balance of retained asset accounts in force at the end of the current year and prior year segregated within “aging categories” of “up to 12 months,” “13 to 24 months,” “25 to 36 months,” “37 to 48 months,” “49 to 60 months,” and “over 60 months;

9. The identity of any entity or financial institution that administers retained asset accounts on the insurer's behalf;

10. The number and amounts of retained asset accounts that are transferred annually to the state unclaimed property funds under abandoned property laws; and

11. Any other information relating to retained asset accounts as prescribed by the [Insert State Insurance Department].

B. An insurer shall immediately return any remaining balance held in a retained asset account to the beneficiary when the account becomes inactive. A retained asset account shall become inactive for purposes of this subsection if no funds are withdrawn from the account, and if no affirmative directive has been provided to the insurer by the beneficiary, during any continuous three-year period.

C. All marketing materials, disclosure statements, and supplemental contract forms utilized in connection with retained asset accounts shall be filed with the [Insert State Insurance Department] prior to their use. The commissioner shall disapprove any materials, statements, or forms submitted under this section that are inconsistent with Section 5 or are otherwise untrue, deceptive, or misleading.

Section 7. Unfair Trade Practice

Failure to meet any requirement of this Act is a violation of [Insert State Unfair Trade Practices Statute].

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

Section 8. Effective Date

This Act shall apply to claims for a death benefit under any policy or certificate of life insurance subject to the insurance laws of the state where the beneficiary resides submitted on or after [insert appropriate date].

PROPERTY & CASUALTY INSURANCE COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
PROPERTY & CASUALTY INSURANCE COMMITTEE
2025 NCOIL ANNUAL MEETING – ATLANTA, GEORGIA
NOVEMBER 15, 2025
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Property & Casualty Insurance Committee met at The Whitley Hotel in Atlanta, Georgia, Saturday, November 15, 2025 at 10:45 a.m.

Georgia Senator Larry Walker, Vice Chair of the Committee, presided.

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Rep. Matt Lehman (IN)
Rep. Michael Meredith (KY)
Rep. Michael Sarge Pollock (KY)
Rep. Edmond Jordan (LA)
Rep. Robert Foley (ME)
Rep. David LeBoeuf (MA)
Rep. Brenda Carter (MI)
Rep. Kristian Grant (MI)
Sen. Lana Theis (MI)
Sen. Paul Utke (MN)
Asm. Erik Dilan (NY)
Asm. Jarett Gandolfo (NY)
Asw. Pamela Hunter (NY)
Sen. Jerry Klein (ND)
Rep. Meredith Craig (OH)
Rep. Brian Lampton (OH)
Sen. George Lang (OH)
Rep. Ellyn Hefner (OK)
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:

Rep. Carolyn Hall (AK)
Rep. Naquetta Ricks (CO)
Rep. Eddie Lumsden (GA)
Rep. Elizabeth Wilson (IA)
Rep. Cindy Neighbor (KS)
Rep. Bill Sutton (KS)
Rep. Sean Tarwater (KS)
Rep. Daniel Grossberg (KY)
Rep. Camille Lilly (IL)
Del. Mike Rogers (MD)
Sen.. Michael Webber (MI)
Sen. Jeff Howe (MN)
Rep. Julie Miles (NH)
Sen. Tim McGough (NH)
Sen. Jeff Barta (ND)
Sen. Cale Case (WY)
Rep. Trey Wharton (TX)

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. Matt Lehman (IN), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Carter (MI) and seconded by Rep. Brian Lampton (OH), the Committee voted without objection by way of a voice vote to adopt the minutes of the July 19, 2025 and September 30, 2025 Committee meetings.

PRESENTATION ON DEVELOPMENTS IN
THE AUTONOMOUS VEHICLE MARKETPLACE

Brad Nail, on behalf of Waymo, thanked the committee for the opportunity to speak and stated that Waymo was pleased to be able to offer some demo rides for you here to show the service that is live for consumers here in Atlanta. And we thought it would be helpful for you to give you an overview of Waymo's operations and the future expansion of autonomous vehicles as it starts to come into more markets and you're likely to be addressing some issues in the legislature around that sometime in the future.

Ishtpreet Singh of Waymo thanked the Committee for the opportunity to speak and stated that Waymo actually stands for A Way Forward in Mobility and our mission is to make the road safer and more accessible by building what we call the world's most trusted driver. And the reason for that mission is that our roads have a problem. As you can see up here on the slide, every 26 seconds, someone loses their life on our roads. That's over 1.19 million people worldwide every single year, mostly due to human error. And in the U.S., that's roughly 43,000 people every single year. To put that in perspective, it's essentially a Boeing 737 falling out of the sky every single weekday on the U.S. roads alone. So, just a crazy number, and unfortunately, currently the status quo. Beyond safety, transportation also remains inaccessible to a lot of people, including people with disabilities and seniors who can no longer drive. And that motivated us to found Waymo in 2009 when we started actually as the Google self driving car project. And the reason I mention that history is that I think a lot of people have only recently started to hear and see a lot about autonomous vehicles, but it's something that we've been working on for over a decade and a half. And since then, we've put our technology through what we call the world's longest driver's test, driving hundreds of millions of miles on public roads, billions of miles in simulation, which is very important to train for those edge case scenarios. And we have driven in over 15 states across the U.S. meaning dozens of cities across the globe and that has actually taken us to the point where we are now operating and serving over a quarter million paid rides every single week, in the top five cities listed here - Phoenix, San Francisco, Los Angeles, Austin and Atlanta.

In addition to that, we've already announced 10 additional markets that we have intentions of operating in next year - Miami, D.C., Dallas, Denver, Seattle, Nashville, London, San Diego, Las Vegas, and Detroit. And I do want to take a second to clarify what we mean when we say fully autonomous driving. So, unlike the left side of the screen here, driver assist technologies actually require you to take control during your

journey versus Waymo being the driver always. So the automotive industry actually measures autonomy on this five-point scale and as you can see on the screen, at levels one through three, a human must remain behind the wheel, always ready to intervene. And we classify these as merely driver assist systems and not actually true autonomy. Waymo, on the other hand, operates here on the screen at level four, which means true autonomy, where an empty vehicle can pick you up and transport you from door to door while you relax in the backseat. So, the simplest way to understand it is that if you need a driver's license to operate it, it is not autonomous. And we've provided over 10 million fully autonomous trips, transforming how people move through life and what started as a technological wonder has become something even more valuable. It's a trusted, consistent experience that a lot of our riders now depend on day after day. But rather than take my word for it, I'm happy to show you and let you hear directly from our riders. (Video played)

All that magic that you just saw happens, of course, with a lot of hardware and software working behind the scenes. I think many of you have seen the vehicles and all the sensors that are around it, but I did want to just briefly chat through it. So, our fifth generation Waymo driver, which is the system that makes up our fleet today, uses a combination of 29 cameras, five LiDAR (Light Detection and Ranging) sensors, and six radar panels that work together to build a complete view of our surroundings day or night, rain or shine, 360 degrees up to three football fields away. So, just an incredible amount of perception. And with this comprehensive sensing capability, our AI-enabled software serves as the brain behind the Waymo driver. It simultaneously processes what's happening around the vehicle, anticipates what might happen next, and makes safe, confident decisions to navigate complex environments. Of course, always happening in the blink of an eye. Let's see how this comes together. On the next slide, I will show you actual footage from the Waymo driver of a trip that we took in Austin, where a scooter user unexpectedly entered the road.

So, you can see essentially how the Waymo driver's perception system immediately detected the scooter user, anticipated the next potential action, and the probability of it happening. And then we made a very split-second decision to safely maneuver around them, all at the same time as looking at the vehicles around us, making sure no one was to the left or behind us, everything like that. And of course, it's very striking to see it presented this way, where other people have commented that perhaps a human driver may not have been able to avoid that. So, this is just one of the countless complex scenarios that our vehicles navigate every single day. And the reason that that is the case is that since we drive millions of fully autonomous miles every single week, which is multiple human lifetimes of driving every single week, we encounter those rare events actually pretty frequently. And every single one of those interactions actually helps make the Waymo driver even better through continuous learning, improving road safety for those who choose to ride with us, and actually all the others that we share the street with. So, we've seen a lot of these cases. We have prevented a lot of red light runners

from hitting us. You can see images here showing countless examples of the Waymo driver navigating a lot of crazy real-world situations. Safety really is at the core of everything we do at Waymo and that's the thing we're most proud of out of all that operating experience and everything I've shown you thus far is that the data shows that we are already making roads safer, meaning we're reducing injuries and fatalities in those areas in which we operate.

This slide here is showing a study of over 96 million fully autonomous miles driven in the cities that we serve where the Waymo driver has proven to be safer than an average human driver across a range of metrics that you see here on the screen. And these are percentages, but the other way to look at it is that these numbers translate to 11 times fewer serious injury crashes, 5 times fewer crashes with airbag deployment, and 5 times fewer injury-causing crashes. And before you ask, essentially all of the crashes that we are involved with are things like people rear-ending us or hitting us where it's not actually the Waymo driver initiating. And the other thing that we're most proud of as it relates to safety is that we regularly publish insights into our safety performance and our validation methods to empower communities with a deeper understanding of our safety record and to actually serve as a guide to others in the industry. So, all this data plus much more is available at Waymo.com/safety and that essentially has allowed a lot of academics and researchers to reconstruct this safety data to see every single incident that we've reported in these over 100 million fully autonomous months driven and really get a true sense of our safety record.

And beyond internal safety data here on the next slide I wanted to share this other compelling set of data that I know may speak a little bit more directly to this room. So, we actually partnered with Swiss Re because we wanted to move beyond the engineering metrics and actually evaluate Waymo from the perspective of actuarial science. So we asked a global reinsurer to provide their independent risk assessment of our technology based on actual payouts. And the previous slide showed all contact events regardless of fault and this study here instead focuses specifically on liability, responsibility, calibrated benchmark. So, we looked for any claim where any adjuster assigned any level of responsibility even just 1% to the Waymo driver. So, even if we were partially at fault it counted against us and as you can see in the stats here, Swiss Re compared our data against a massive baseline of over half a million human claims and the results show a fundamental shift in risk. So, for property damage, for each metric, we saw 7 to 9 times reduction in claims compared to humans. And for bodily injury, we saw a 10 to 12 times reduction. So, to put that in concrete numbers, over the 25 million miles analyzed, a standard human fleet would be expected to generate 26 bodily injury claims and the Waymo driver generated two, which of course is a transformative reduction in severity and frequency. As we like to say, we're already living in the future, and many of you have been able to take rides here in Atlanta, and we're excited to be bringing this technology to more people in more places.

Rep. Daniel Grossberg (KY) stated: I had the good fortune of getting to ride in one of these rides yesterday and it was the experience of a lifetime, and I encourage everyone to do it. You give really compelling testimony as to the reduction in the frequency and the severity of accidents, but I'm curious, what is the process or procedure that takes place in an accident? We all know what happens if you have humans driving the car as you pull over safely, if possible. You call the police. You exchange information. If I'm taking a Waymo, I'm not responsible for the Waymo. Does someone show up? Does someone get on a speaker in the car? What happens with the car, with the accident, with the report, what happens if I have an injury?

Mr. Singh stated that beyond just developing the driver, we have to think about what it takes to run, maintain the fleet, and deal with these kinds of issues. And so, to directly answer your question, let's assume that we were rear-ended and had to navigate that situation. So, what we would do is actually very similar to what you or I would do as a human driver. We would pull over automatically. It's programmed to do that. And if authorities are not already on the scene or not around or not very shortly on the scene, our rider support team will actually be notified, and they will call the authorities and we will at the same time actually dispatch one of our roadside assistance fleets. So, in any of the areas in which we operate, we maintain a large presence for infrastructure, like charging and repairing the vehicles, as well as a ground operations team. So, at the same time, we will send out one of our roadside assistance teams to the scene, but we'll let the authorities lead. And the interaction with the authorities actually on the ground will take place such that the rider, as you're describing, does not need to be responsible for engaging. So, if we do have a passenger in the vehicle, we'll pull over, the windows will roll down, rider support will actually speak with law enforcement over the intercom and be able to exchange any information necessary there. So of course, all these things we've had to think through in the scale of our operations. And I'd also like to share that we're very proud of the partnership that we have with law enforcement. We've actually trained over 20,000 first responders in all the markets in which we operate to educate them on how to actually engage with these vehicles. There's also a special first responder hotline that any first responder can call. There's a QR code on the vehicle that they can scan if they don't remember the hotline. So, we''ve thought through a lot of different steps in order to make that process as seamless as possible.

Sen. Paul Utke (MN), NCOIL Vice President, stated it's fully expected that most rides are in cities but can these cars currently go out into the rural freeways and how does it handle that? If somebody needed a ride an hour out of town, are you doing that at this point? Mr. Singh stated that freeways are very high speed and relatively high risk so it's something that we worked on for many years before actually opening it to members of the public just this past week. So up until very recently, we were only doing surface streets, but we actually did just open up freeways after feeling very confident about our capabilities on freeways.

Rep. Camille Lilly (IL) asked for some details on the legislation that was passed in states and if there was any opposition? Mr. Singh stated that over 25 states have legislation on the books that allows for a commercial autonomous vehicle service to operate, and many more are considering it. We're fielding a lot of questions from other states that don't yet have it, but are interested in it. I'd say that the main provisions of the bill aim to establish a baseline. So, a good example is defining actually what a level 4 autonomous system is, meaning the fully autonomous system that I showed on the scale, versus a driver assist technology. There are a lot of definitions to clarify what a fully autonomous system is, which is very helpful so consumers and legislators have a clear sense of what that actually means. There are other things like including law enforcement interaction plans, which we're also very proud to have done and have been the first to do. So, laying out all the steps to operate a fully autonomous service, especially for things that are different than standard human drivers.

Rep. Lilly asked if there was any opposition to the legislation. Mr. Singh stated I would say it's more of I think folks being unaware and wanting to learn more and so it's less direct opposition and more of having to better understand the technology, which, of course, is completely understandable. It's a brand new technology, and it takes a lot of time to get used to. People are always curious or perhaps hesitant at new technologies, which is why we take our job so seriously by going across the country and answering questions and really trying to educate. But there’s a reason that half the country already has legislation on the books, where I think people have recognized the importance to start embracing this technology.

Rep. Elizabeth Wilson (IA) asked what is the cost compared to an Uber ride? Mr. Singh responded that it is very comparable to any other ride-hailing service.

Rep. Julie Miles (NH) stated that I did take a Waymo ride here and I felt entirely safe. It did exactly as you said. It stopped for a person walking across the road unexpectedly. It stopped for a bus who had its stop sign out. What I'm most excited for, and you alluded to it in your presentation, is the opportunity for people with disabilities to have an opportunity at freedom and independence that they probably have never had. I look forward to the day when there's a Waymo dealership in New Hampshire. Mr. Singh stated that another thing we're very proud of is the independence that this could bring to people with disabilities and we've developed a lot of features with our Waymo Accessibility Network consisting of a lot of advocacy organizations as partners to make this experience that much better. Things like screen reader support, the option to minimize walking time at pickup and drop-off. Things like having your vehicle have a chime instead of a honk to find it which is much more helpful in a busy area where there are a lot of other vehicles honking. So that’s very top of mind for us and we've been so proud to see so much support from those kinds of communities for autonomous vehicles.

Rep. Brenda Carter (MI) asked if the vehicles break for animals? Mr. Singh stated they do and you'd be amazed to see all the identifiers that we have for all the things you would expect like children, dogs, pets, cats, geese, birds, soccer balls - anything and everything.

Sen. George Lang (OH) asked what's this going to do to the insurance industry, especially as it pertains to insurance for automobiles? My assumption is this is going to really eliminate the need for consumer auto insurance. My assumption is if there's an accident, Waymo would be responsible and you guys would have insurance and my guess is based on what I believe is the safety of your car, it's going to be a much lower premium than exists today. Can you offer your thoughts on how it's going to impact the industry? Mr. Nail stated that's one of the reasons that we want to engage here with the policymakers and with other stakeholders so deeply embedded in the insurance industry. You're right, when we look at this from the perspective of a fleet and fleet utilization, I think you're thinking along the right lines there. We'd also like to expand the discussion to a future where there's individual ownership of these vehicles and how does the insurance marketplace adapt to that? How does it respond? And I think there's a lot to talk about that there. I don't think we're ready to have that conversation today, but we want to start marching down that road.

DISCUSSION OF A POTENTIAL CONSIDERATION OF A RESOLUTION ENCOURAGING STATES TO REQUIRE INSURERS TO PROVIDE AT LEAST 60 DAYS ADVANCE NOTICE WHEN NON-RENEWING A POLICY

Sen. Walker stated that next on the agenda is a discussion and potential consideration of a resolution encouraging states to require insurers to provide at least 60 days advance notice when non-renewing a policy. As you may recall, the committee was working on an aerial image model act and during the discussions on the model, there was some side discussion about the non-renewal notice for policies. And so several legislators, including me, felt like it would be an important topic to discuss and to pass a resolution on to encourage states to look at their non-renewal timelines, especially in the environment we're in now with many of us seeing a real hard market for property and casualty. In Georgia, we have seen this to be particularly problematic on homeowners insurance and we had a 30-day notice and it's by mail and we know how slow the mail can be sometimes and it was not unusual for it to take two weeks to get a first-class letter in Georgia. So, you're not giving the policyholder hardly any time to respond to find replacement coverage or to maybe address the issue that is causing the non-renewal. In Georgia, I sponsored Senate Bill 35 to extend the notice period to 60 days on homeowners policies. We're not trying to restrict insurers from making underwriting decisions on the front end. This is only on non-renewals after they are already on the risk. And in Georgia, we have a window of time where after a company initially writes a policy they can cancel it for any underwriting reason. So, there are protections built into our system in Georgia for the carriers. So, if they insure a home and they then do an

inspection and discover that it's an unfenced swimming pool or there's a vicious dog or there's a trampoline that wasn't disclosed, the carriers can cancel it immediately, I believe with a 10-day notice.

Paul Martin, VP of State Affairs at the National Association of Mutual Insurance Companies (NAMIC), thanked the committee for the opportunity to speak and stated we appreciate this being done via resolution. The resolution process, we think, particularly on matters that somewhat are new to NCOIL, is a great way to go about doing things. A couple of things have jumped out at us that we just want to share for your consideration. Companies need to be given ample time if you pass one of these extensions for non-renewal so that they can do the necessary computer programming to bring them to fruition. One of the concerns that has been raised is the scope of the resolution. We think this should be limited to homeowners, particularly homeowners if you have a 12-month policy. Having this apply to a 6-month auto policy can be really problematic. I gather that the intent, based on comments I've heard, was to limit this just to homeowners. And finally, in the penultimate paragraph there is a provision in the resolution that says that the non-renewal notice requirement should also apply to offering renewal with reduction in policy limits or coverage. We can come up with a number of examples where you could have a situation where you have a reduction in coverage, maybe a policyholder elects voluntarily to take a higher deductible or elects to have an endorsement on their policy removed because they no longer need it. Those are reductions in coverage. I don't think you mean for this to trigger a 60-day notice requirement for that to take effect, particularly for things like that.

Wes Bissett, Senior Counsel at the Independent Insurance Agents & Brokers of America (IIABA) thanked the committee for the opportunity to speak and stated that IIABA supports the resolution. What we're seeing is that states are increasingly moving across the country to establishing a more reasonable 60-day window for non-renewal notices mainly for all of the reasons Sen. Walker explained. The 30-day window, especially in the homeowner's market right now, is simply too short. It's a challenge for both consumers and their agents, and we want to avoid a situation where people have gaps in coverage or are forced to go to a residual market because there's not appropriate time to find replacement coverage. There are numerous states across the political spectrum that already have 60-day notice periods such as Minnesota and South Carolina. There are states that even have longer time frames like Kentucky and Florida. With these bills, when they come up, they are incredibly straightforward and succinct and stunningly non-controversial. Every state's got a non-renewal notice statute and it might say 30 days, so a bill of this nature simply strikes out 30, underlines 60 in its place. We're not changing anything else in that process. There are no other effects or unintended consequences as a result. And so, these bills have been non-controversial where they've come up. Recently, Colorado went from a 30 to 60 day time frame and Sen. Walker's bill in Georgia didn't have a single dissenting vote in either chamber. In the last couple years, Iowa, Louisiana and Texas have all addressed this issue in the same way, going from 30

to 60 days. In all of those cases, there was not a single dissenting vote in either chamber. I think that speaks to the point that we're talking about a fairly non-controversial issue that's a little bit different than some of the topics you've talked about in recent days. We thank you for considering this resolution and drawing attention to the topic. We urge you to support it and vote it out today.

Joel Laucher, Program Specialist at United Policyholders (UP), thanked the Committee for the opportunity to speak and stated UP has been helping insurance consumers all over the U.S. who are dealing with non-renewal notices from their insurance companies and who are now scrambling to find replacement coverage in a market that is extremely limited and in some situations where replacement coverage is pretty much non-existent with an admitted carrier. So, once the shock of that non-renewal subsides, policyholders really must rush to contact their agents to see if a reversal is possible or to search for replacement coverage. In our efforts, we're communicating on a regular basis with many agents and brokers. They're struggling to get quotes for their clients in this very restrictive market and since most agents represent only a small number of insurers, it's necessary to go out and find multiple agents to thoroughly search that market for them. So, you just can't go back to the same agent you might have had and hope that's enough. We have about 80 very viable homeowners insurers in California, but any one agent typically represents three or four so that tells you how much work you're going to have to do to search the market.

As noted, many insureds are also scrambling to retain their existing coverage, if at all possible. Often, they need to get a roofing contractor or an electrician or a plumber who can do the work necessary for the consumer to comply with the insurer's renewal requirements. But qualified contractors aren't always available to do the work today and it may be some time out and then they need some time to complete the work and for you to communicate that to the insurer. So, you need to have a timeframe that recognizes that it takes a while to get a roof done, for example. So, running out of time to find that replacement coverage, many homeowners concede coverage to their state's residual market and it’s causing those markets to swell. Shopping the current market just takes more time than it ever did. We don't want people to end up in a residual market if they don't have to so it's very important to give more time. Now, we appreciate that insurers don't want new laws or revisions to existing laws that would further restrict their business but this one just makes sense because it doesn't make sense to throw away so many policyholders who are willing to do whatever is necessary to mitigate the risk and qualify for the renewal if they just get a little more time to get that work done.

And it also makes sense to give policyholders a little more time to shop the market in this very challenging market that we are experiencing pretty much nationwide today. So, we at UP believe this resolution will greatly benefit insurance consumers in every state while imposing a very minimal burden on insurers. In fact, it would arguably benefit consumers and insurers alike. I hope we all agree that it is critical that consumer protections keep

pace with market realities, as well as with insurers' technological innovations in underwriting and rating. We are not asking insurers to amend their underwriting restrictions. Insureds will still only be renewed if they come into compliance with the insurer's standards. So, this is really a win-win for everybody. I think we all see plenty of insurance advertising on TV. Insurers spend millions of dollars to acquire new customers. Why throw away customers you already have who are willing to do whatever it takes to retain their coverage. So that's really a win-win for both sides.

Rep. Matt Lehman (IN), a sponsor of the resolution, stated that he agrees with Mr. Martin on his point about a 6 month policy being problematic with this but my question is more on you want to limit it to homeowners. I'm seeing more of an issue on the commercial side. Part of that reason is we're seeing more commercial carriers go to inspections before they'll bind coverage. So, if I have a situation where I'm losing a client due to a non-renewal, and a carrier tells me we'll get out there and inspect it in two months, because you guys are busy, how do I handle that? Mr. Martin stated candidly, I didn't get a lot of feedback on the commercial side. However, I think generally we've treated, understandably so, commercial different than personal lines. Usually with commercial folks, that's a more sophisticated client. If there are challenges with inspections, I think that's a conversation you need to have on a case-by-case basis with the company itself. I'm not hearing anything to refute what you're saying, but I will tell you that as a general rule, I think we've always erred on the side of if you're going to make a concession here on timing and things like this, that we start with personal lines and then we examine later on if there's sufficient concern to move to commercial lines as well.

Rep. Lehman stated as states go back and say I'm going to use this resolution as a reason to maybe go back and look at things, if you focus solely on homeowners I think it’s going to have to be addressed eventually. I’m telling the other members here don't ignore the fact that there's other aspects of this that deal with problematic things in the current underwriting world of insurance. Mr. Laucher stated I totally agree with what you're saying and I would say in any property where there are higher limits it becomes even more challenging. It's not only businesses but condominium associations and all types of property coverage are having issues finding renewal coverage.

Rep. Edmond Jordan (LA), NCOIL Treasurer and a sponsor of the resolution, stated I want to echo everything that Rep. Lehman said and say that in Louisiana, we just recently updated our law to 60 days as well. I always think that more time is better, especially for states that are coastal and hurricane-prone, because we have a period usually during hurricane season where nobody's writing new policies and it artificially sends people to our Citizens' market because if it's anywhere between August and November, you're not getting a new policy. Nobody's going to underwrite that when they don't know if any storm is going to happen in the next two or three months.

Rep. David LeBoeuf (MA), a sponsor of the resolution, stated I want to echo my colleagues' comments and reemphasize that this is a resolution and individual states can adopt it and modify it as they see fit. And similar to what Rep. Jordan said, especially for those states where we're starting to see a larger share of policies go into our Fair Access to Insurance Requirements (FAIR) plans, having more time for the consumer to shop and be able to look at the specific requirements I think is absolutely necessary.

Rep. Brian Lampton (OH), a sponsor of the resolution, stated that we're looking at this issue in Ohio and one of the questions as an agent I have to the companies is are there scenarios where 60 days is problematic? If you don't have them now, maybe bring them to me so we can maybe consider a carve out or something like that. We don't want to hamstring the industry but at the same time, as an agent, 60 days is much better than 30 for us to be able to navigate a non-renewal notice to try to find the customer adequate replacement coverage. Mr. Martin stated one of the benefits of these resolutions is sometimes it prompts us, not just the trades, but also the member companies to examine this and to identify those one-off situations where a 60-day window might be problematic as opposed to 30. One thing I'll draw to your attention, and it's somewhat unique to the NAMIC membership, is we have six of the ten largest writers in the country, but we represent a lot of really small, single state, companies who may only write in a handful of counties. So the concern you have in those situations is it is really easy for those companies to inadvertently get overexposed in a particular area. So sometimes they need less non-renewal notice time in order to adjust their books for all the inflation and the weather situations and the conditions that we've talked about multiple times here over the last few meetings. So, I could foresee a situation where the smaller companies, particularly those in a few states or one state, would say we probably need the flexibility of having a shorter renewal period.

Rep. Trey Wharton (TX) stated I am an insurance agency owner and this is an issue that we have happen to us all the time. We do not have enough time for our customers to make the repairs. Luckily, I have eight to ten companies, but I'm 100 miles north of the coast and we still have an issue because we're in the national forest area and they tend to say there's too much tree coverage and brush coverage and so now we have the fire exposure. And it's an issue on the commercial and personal homeowner's side so I support this fully because I see it happen every day in my agency. Sen. Walker asked if Rep. Wharton would like to be added as a sponsor of the resolution. Rep. Wharton replied yes.

Rep. Pollock stated I am an insurance agent and I think this is a very important issue. We've got a lot of states that have the 30-day language. In Kentucky, we have a 75-day requirement so I think 60 is fair but I also take into account the situations described by Mr. Martin regarding smaller companies.

Hearing no further questions or comments, upon a motion made by Rep. Pollock and

seconded by Rep. Mike Meredith (KY), the committee voted without objection by way of a voice vote to adopt the resolution. Sen. Walker thanked everyone and stated that the resolution would now be placed on the Executive Committee's agenda for final ratification.

CONSIDERATION OF RE-ADOPTION OF MODEL LAWS

a.) MODEL ACT TO REGULATE INSURANCE REQUIREMENTS FOR TRANSPORTATION NETWORK COMPANIES AND TRANSPORTATION NETWORK DRIVERS

Sen. Walker stated that we won't be taking any action on the proposed amendments today as they are still under development. The sponsor of the proposed amendments, Sen. Walter Michel (MS), had to leave the conference early but with us here today are some interested parties who will provide their thoughts on the proposed amendments.

Megan Sirjane-Samples, Director of Public Policy for Lyft, thanked the Committee for the opportunity to speak and stated that rideshare companies have transformed how people move within and between communities, offering flexible earning opportunities for drivers and affordable, reliable transportation for riders. Yet, the insurance and liability standards that apply to this sector were largely established more than a decade ago, when the rideshare industry was in its infancy and little claims data existed. Those outdated requirements now impose disproportionately high costs on riders and drivers alike without delivering commensurate benefits to consumers or claimants. Today, rideshare companies maintain robust auto liability coverage, typically $1 million per incident, whenever a driver is engaged in a trip. These high coverage levels were adopted before there was reliable data to guide risk assessment. Over time, experience and claims data have shown that the vast majority of rideshare-related claims are resolved well below these limits. In fact, more than 90% of bodily injury claims are resolved or valued for less than $100,000. Despite this, the extraordinarily high coverage limits continue to make rideshare companies prime targets for litigation. Because the company's policy already provides substantial protection for injured parties, adding the rideshare company as a defendant is unnecessary to fully compensate injured parties. It only prolongs the claims process, delays compensation for injured individuals, and increases legal and administrative costs. These inefficiencies also burden courts with unnecessary filings and extend the time it takes to resolve cases.

High insurance costs have become one of the most significant cost drivers in the rideshare economy. In many regions, as much as one-fifth of every ride fare goes directly to insurance-related expenses. This translates into higher prices for riders and reduced take-home earnings for drivers. These costs are particularly consequential given that a significant share of rides begin or end in low-income areas and that a vast majority of rideshare drivers use the platform part-time while balancing other jobs or

educational commitments. In order to modernize rideshare insurance requirements while still maintaining strong consumer protections, coverage levels should reflect actual risk exposure. For example, the period of time between when a driver has accepted a ride and has not yet picked up a passenger carries a level of risk much closer to the period when a driver is waiting for a trip request than when actively transporting a passenger. And yet, insurance requirements do not currently reflect that reality. Lowering insurance requirements for the time spent driving to pick up a passenger would be a rational, data-driven step that preserves coverage where it's needed most while reducing unnecessary costs. Clarifying liability rules would codify current law declaring that rideshare companies are not held vicariously liable for the independent actions of drivers when the company has met its legal and contractual obligations.

This reform would not limit an individual's right to pursue claims against a rideshare company that fails to uphold its responsibilities. Instead, it would reinforce fairness and efficiency by distinguishing between legitimate corporate liability, and situations where existing insurance coverage already provides adequate recourse. Taken together, these reforms represent a balanced approach to modernizing the rideshare regulatory framework. They would promote a sustainable and equitable market, reducing litigation costs, streamlining claims resolution, maintaining strong consumer protections, and ultimately making rides more affordable for riders and more profitable for drivers. As insurance costs continue to rise nationwide, thoughtful updates to rideshare insurance and liability policies are essential to preserve access to safe, affordable transportation options and flexible earning opportunities. We encourage policymakers to pursue data-driven solutions that right-size risk and assure accountability, while also supporting an efficient, modern, and economically sustainable rideshare system. Thank you for your consideration and we look forward to further discussion.

Dan Hinkle, Senior State Affairs Counsel for the American Association for Justice (AAJ), thanked the Committee for the opportunity to speak and stated on New Year's Eve 2013, Sophia Liu was six years old when an Uber driver, enroute to pick up a passenger, struck and killed her. Her mother and brother were sent to the hospital, severely injured. Uber's response at the time was, “this is not our problem.” The driver wasn't being paid yet, and so this was the driver's problem, not Uber's. This became a national news story, and the public's reaction was clear. That position is outrageous. Insurance companies rightly pointed out that when the driver was engaged in commercial operations, they should have the right to decline that coverage, and the company, Uber, should take responsibility. This is where NCOIL came in. This is why there is an NCOIL model law on transportation network company (TNC) insurance. NCOIL's model was tailored to crafting an insurance framework that became law in 48 states. It is a wildly successful model law that NCOIL passed and is now widely adopted. Uber and Lyft agreed to provide $1 million in coverage when a driver is en-route from when they decide to pick up a rider all the way until they drop off. That was the promise. And now Uber and Lyft are coming to you and asking you to rewrite this wildly successful NCOIL model to

eliminate that heightened insurance requirement when a driver is en-route to a pickup. They want to go back on the promise they made after Sophia Liu was killed. And that's not even the worst part of these amendments.

These amendments are a wish list from Uber and Lyft that would completely eliminate their responsibility for how they operate, including their role in sexual assault. That is why we're here, because they are trying to eliminate responsibility for their actions, and they are asking for your help in doing so. First, the amendments would eliminate responsibility for building a safe app. Uber's rider and driver app control what information you see, what safety features are or are not made available, how distracting it is for the drivers when they are driving, and when you are aware if a driver is high risk or not. As you can see from the article on your table on page 7, Uber matches rides that it knows are high risk without even giving a warning to the rider. Lyft recently settled a claim brought by Teresa Brooks after she was thrown 44 feet and suffered a skull fracture, because Lyft's app was distracting its own driver at the time of the crash. When ride shares launched in cities, we now know that fatality rates go up 3%. It's because gig drivers are all forced to use their phones while they're driving, which we all know increases crashes by over 600%. This has been a problem from the beginning, and Uber and Lyft have both promised that innovation in their product design was the key to making these services safe. By saying that their product is not a product, that innovation stops. They're asking for zero responsibility in their design choices, no matter how dangerous they are.

Second, the amendments would eliminate their responsibility for the safety representations that they make to riders. Here's the reality, ride-hail companies don't have to treat their drivers like agents, but they choose to. They advertise that you are riding with Lyft or you are riding with Uber. They make you pay before you even are introduced to who your driver is. They assign drivers and penalize you for rejecting them. They assign passengers, control driver behavior through penalties and rewards based on acceptance rates, cancellations, surge pricing, and an Uber Pro status. They dictate who drives, when they drive, where they drive, under what conditions they drive, and they take a cut from every single ride. From the perspective of the rider, you are riding with Uber or you are riding with Lyft, and they are sending an agent to facilitate that transaction. That is intentional. That is their business model. But the moment something goes wrong, the amendments let them walk away from that responsibility. They can't have it both ways. They can't build brand loyalty by positioning themselves as a safe transportation provider and then walk away when they fail to live up to the promises that they made.

The third thing that the amendment do is they eliminate their responsibility for their own unreasonable actions. Transportation companies generally owe their passengers an utmost care standard. But these amendments say Uber and Lyft only face liability for gross negligence or criminal wrongdoing. These amendments say that they don't have to

take responsibility for their own negligence in hiring, retention, app design, or anything else. Ignoring assault patterns? Immunity. Covering up reports of sexual assault? Immunity. Putting profits over implementing reasonable safety practices? Immunity. These provisions make it crystal clear that Uber and Lyft do not want to be responsible even for their own actions connected to dangerous drivers who are committing sexual assaults. To briefly conclude, the second document you have before you is from U.S. House Republicans that recently launched an oversight investigation into Uber because it poses a persistent safety hazard to those who rely on ride sharing for transportation. In this letter to the CEO, they highlight the need for enhanced and expanded safety tools to better prevent sexual assault and misconduct. These amendments are directly aimed at eliminating accountability for Uber and Lyft for sexual assault. We ask that you reject them.

Kara Phillips, Esq. of Deitch + Rogers, LLC, thanked the Committee for the opportunity to speak and stated that I am an Atlanta-based attorney and my practice is limited to representing crime victims and particularly sex assault survivors. This article by the New York Times is drawing some important things to the national attention and to your attention as well. I'm also here because as someone who represents sexual assault survivors, many of my clients are silenced through the trauma of what they experience and they're also silenced through efforts to have them sign non-disclosure agreements and non-disparagement agreements. And when it comes to corporations such as Uber and Lyft, that is a general practice. So, I am sitting here as someone who's able to speak out about the kinds of cases that are coming up just in the past two years in my office and who's calling and why. And I wanted to do that this morning in the spot of a lot of mothers, a lot of daughters, and a lot of fathers. Just the other day, I had a call of a 15-year-old who was sexually assaulted by a 27-year-old Uber Eats driver while taking a walk, a sexual assault where a driver pulled over and attempted to rape the rider and took her phone and purse. An Uber driver sexually assaulted her in her car. Physically assaulted by a rideshare passenger, this is a Savannah case. And that's something I want to point out. I'm a Georgia lawyer. I'm not one of the lawyers mentioned in this New York Times article. I don't go and find multi-district litigation with 1,000 clients. But this is a problem that I'm seeing increasingly and it's because of the platform. Much like we all understand with the Catholic Church, for example, it created an environment, if unchecked, that would feed on vulnerable people and that's what we see with ride shares now. If you think back in time, one of the earliest lessons I had was don't get in the car with someone that you don't know. And that is the basis of this entire company. And so, the resulting issues that we're seeing are heartbreaking. And I'm speaking to people who are trying to navigate what can be done.

So, when I got a call about this group coming together here I was very concerned because of what I'm dealing with as a lawyer hearing calls like the ones I'm getting. And it's basically like a dog bite case - you can have a dangerous dog and they can hurt somebody but once they've hurt somebody, then you know they're a danger. And that's

what we're dealing with these drivers. And so, when it comes to direct action against Uber, it's important that these vulnerable people in these cars have an opportunity to hold Uber accountable if they know about things and don't protect, don't warn, and don't use their power for good. The other one that I just want to briefly talk about is in the products area and that's because like we're seeing with artificial intelligence (AI) and every other new innovative thing on the market, products is a route that has historically regulated through the civil jury system whether something is being safe. And that's because if you are killed or your loved one is killed in a rollover car crash and Ford Motor Company decides not to spend $100 on fixing their cars, then you don't care if there were other people who didn't get killed. You care that somebody made that profit over people choice, resulting in your loved one no longer being with you by no fault of their own. So, I just want to bring that up because this issue is very much building and the momentum of it is building and it's because of choices that are being made, sometimes, and that's where the civil jury system provides an opportunity for real ordinary people to let real ordinary people decide if a big corporation has chosen making money over taking care of them. Lastly, I would have preferred for one of the people that I know who is currently involved in litigation with Uber sit here. I don't represent them, but they were available to come, but in light of the time constraints here, you're not able to hear from them. But in that case, this young 14-year-old girl was picked up by an Uber driver at 1:40 in the morning in order to be trafficked a distance away from her home to a grown man who had convinced her to come and over the course of three days, he raped her repeatedly. And so I just want to say that these are real things that happen to real people.

Brad Nail, representing Uber, thanked the Committee for the opportunity to speak and stated just as a reminder, we're not expecting a vote on this today. We knew that this would be a topic that needs some discussion, and our hope is that through this discussion with the committee and with other stakeholders we can get to a set of amendments that everyone is comfortable with and maybe vote on in the spring meeting next April. I'd like to go through and rebut some of Mr. Hinkle's points, but I'll try to just do so in the context of talking about the actual language that's proposed. I do want to first say that without reservation, safety is a core value at Uber, and we've invested billions of dollars and countless hours to reduce safety incidents during trips particularly when it comes to sexual misconduct and assault. This is an enormous challenge. It is not limited to Uber. It is societal. More than half of women in the U.S. have experienced sexual violence in their lifetimes, and Uber is not immune to this problem, but I believe that Uber has done and is doing more than any other company to try to confront it. We make public tremendous amounts of information and data on this. I would invite you all, in the interest of time, to look at uber.com/safety and other resources that we make public on that.

So, getting back to the language of the proposed amendments, there are a couple of minor and more technical changes that are proposed, but in the interest of time, I'll focus

on the major ones. The first is the clarification that the TNC app is not a product in the definition of “digital network.” Now, traditionally, our product liability laws, both through statute and case law, have only treated physical, tangible items as products for the purpose of product liability. So we think about consumer goods, we think about machinery, we think about appliances. To treat a mobile application as a product would be a change in the law, but that is what we're seeing in some pleadings in some instances in litigation So, the logical reasoning behind trying to attach product liability to the mobile app is that strict liability then applies and then the plaintiffs would not have to prove actual negligence on the part of the TNC to succeed in its claim. We think the logical approach is to reaffirm in statute that a mobile app is not a product under this paradigm. That's all we're asking for there.

Next up in Section C is a reworking of how we define the periods of operation of a TNC driver and changing the limits that apply specifically to period two. Here, we borrowed language from North Dakota. I know Sen. Jerry Klein (ND) helped work on that, and we think it clearly and simply defines the periods of operation. And then we pair the period two limit requirement with the period one limit requirement of $50,000/$100,000/$25,000 instead of the period three limit requirement of $1 million. The discussion around this really started, if you remember, a couple of years ago when NCOIL adopted the Delivery Network Company (DNC) Insurance Model Act. We realized that the risk profile for period two is almost identical to the risk profile of the DNC operation, so we thought it would make sense to have those limits pair up. The third area is the addition of the new Section F at the end that lays out a test for employee versus independent contractor. This language is borrowed substantially from California law, but also there are some other states that have put a specific TNC test in there, and we think this is the best approach instead of something like an ABC test.

And then finally, the new Section G addresses vicarious liability and this is the key point. Mr. Hinkle spent a lot of time talking about this, and I just want to make clear what our goal is in this language. There are countless cases where the only allegation in the lawsuit is that the TNC driver negligently operated his or her vehicle, but they also named the TNC simply because the ride was booked through our app. The negligence of the driver is covered under the $1 million policy, so there's no lack of available insurance. Those are the only claims we're trying to address here. We're just trying to address claims where the TNC has been named by virtue of operating the app, but the only allegation is that the driver was negligent, and they're trying to impute that negligence to the TNC. We don't think that's appropriate, and that's what we're trying to address. We're not trying to address any situation where the TNC was actually negligent in its own right, where we failed to conduct a background check, where we failed to act upon some information that we needed. If we need to continue working on the language to make that clear, then we're happy to work with you all to get it right, but I just want everyone to understand that is the intent behind that section.

Rep. Lehman stated that having been a part of this initial discussion years ago, the issue was period two so I'm going to focus on that because period two is the issue. Because period two is when the insurance industry says we're not going to go up there, and Uber said we're not going to go down there, and you ended up with this gap because nobody would go in either direction. Legislation was passed in 49 states that said somebody's got to fill the gap. It's going to fall to you, Uber. And the industry can do it, and they haven't. I wish they would, but they haven't. So, the point is in this area two where you want to lower the limit, my concern is this - you equate it a little bit to the DNC, and the argument is, well, you've got a sandwich in the back of my car versus a human. But I'm talking about the human in the walkway. The driver driving the sandwich can hit that person as easy as a person driving with a human being. That period two to me is still a big issue because I don't think we want to go down to a state minimum limit in that space because the industry is not going to be there to fill that gap. And as we go forward on this, I think that's the issue we've got to focus on. The rest of the stuff you have, a lot of it I support, but I think we've got to get around that issue of that period two.

Mr. Nail responded that I know where you stand on this and I appreciate you speaking with me earlier on it. I would characterize it differently in that the most important piece when we were first doing this was really the period one, not the period two - figuring out when they just have the app on was the more controversial piece. Rep. Lehman stated you're right about that because the industry wanted to say no when an app was simply on. I think we got that taken care of. That's fine. Now it's the period two that we're still having an issue with. Mr. Nail stated I would just say that like all the model laws, if it were modified to change the limits in period two, within your states folks are free to put the limits in place that you think are appropriate. I know when the DNC model came into Indiana, Rep. Lehman wanted higher limits than what were on there, and that's where we ended up. So, we perfectly understand that.

Mr. Hinkle stated just to provide context for the period one for the people who haven't been following this as closely as obviously those who've been involved with it since the beginning. If I pull up the Uber app and I say that I'm going to pick up a ride but I'm not actually going to do it and I'm just driving around with the app on, there was a controversy as to who should provide the insurance during that period. And that was how the period one was created in order to address that. But since the nationwide controversy over Sophia Liu, nobody has really been advocating to distinguish between period two and period three.

Rep. Naquetta Ricks (CO) stated that in Colorado, we had a sexual assault bill for more safety and expanded and enhanced safety tools. One of our lawmakers was actually sexually assaulted in an Uber and there is ongoing litigation with that. The bill didn't pass in Colorado, but I really want to say that NCOIL should look at any amendments that will limit liability for sexual assault or any of their responsibility. There are too many women that are being sexually assaulted and these are our constituents and we have a duty to

ensure that they're taken care of if they are sexually assaulted in an Uber, Lyft, or any of the rideshares. Ms. Sirjane-Samples stated that safety is of the utmost importance to us, and we're always looking to new safety features that we can have to make the platform as safe as possible. But to reiterate, our intention is to limit this model to actions that would be covered by auto insurance and auto insurance only, not anything related to sexual assault. We're always willing to have conversations around that. Sexual assault is obviously an issue that is not tolerated on our platform, in any way, shape, or form. But just to be clear, our goal with this legislation around vicarious liability is for auto accidents only and we're happy to work to make sure that is very clear within the language.

Sen. Walker stated that in light of the proposed amendments to the model, he'll entertain a motion to re-adopt the model until the April meeting as opposed to the full five years. Hearing no questions or comments, upon a motion made by Rep. Pollock and seconded by Rep. Meredith, the committee without objection by way of a voice vote to re-adopt the model until the April meeting.

b.) STORM CHASER CONSUMER PROTECTION MODEL ACT

Sen. Walker stated that we had Hurricane Helene come through Georgia a little over a year ago and it was an unprecedented natural disaster and a storm like we had never experienced before in Georgia with a swath of devastation. Many communities really looked like a nuclear bomb had gone off in the community, and it was terrible. And because of the widespread devastation and people in desperate situations, unfortunately you had unscrupulous people come in and try to take advantage of their desperation and exploit them at their time of most need and rushing people into signing contracts and assigning benefits and making deposits and then not following through with the work or not following through with quality work. In Georgia, we had a good statute already on the books with regard to fraudulent activity surrounding roofing, but it was just narrow to roofing and we expanded that to cover all types of construction activity to give some consumer protections. NCOIL has a model already regarding roofing which is similar to what we had in Georgia. Now I'm sponsoring amendments to the NCOIL model to give broader consumer protection to our constituents by expanding it beyond roofing like we did in Georgia.

Brent Walker, Director of Gov't Relations at the Coalition Against Insurance Fraud, thanked the Committee for the opportunity to speak and stated I just want to commend what was done in Georgia around consumer protection and I'll kind of frame the request and the proposed amendments pretty briefly. What we did in July was readopt the model with the understanding that we would have proposed amendments. Since then, we've done our homework. We've spoken with the roofing contractors. We've spoken with the restoration industry and our anti-fraud stakeholders and industry stakeholders. The amendments that we've agreed upon, we've reached consensus around it, and do just

what you mentioned. We not only expand the consumer protection in the existing model, but we modernize it and bring it closer to what happens in the real world of restoration and property repair after a storm. So, we are asking to expand the definition of “contractor,” not only to roofers, but all contractors post-disaster, and prohibit assignment of benefits (AOBs), and there's drafting notes around the emergency services as a carve-out and an exception so that we don't slow down the property damage mitigation post-storm.

Kyle McCollum, VP of Strategy, Policy & Gov’t Affairs at the National Insurance Crime Bureau (NICB), thanked the committee for the opportunity to speak and stated that NICB sits at the intersection of the industry and law enforcement, and we've seen over the years that fraud is committed by more than just unscrupulous contractors in the roofing industry. We see it across the board and I use the term unscrupulous contractors a lot, but I think that almost gives them too much credit. These are just good old-fashioned fraudsters that are masquerading as contractors, so I think what we're doing today is a great step forward, and I just really appreciate the partnership with the Restoration Industry Association (RIA) and the Coalition Against Insurance Fraud and the great work that we did with all the stakeholders on this, and your leadership, Sen. Walker, in moving this forward.

Vince Scarfo, Legislative Task Force Chairman at the RIA thanked the committee for the opportunity to speak and stated that he is a chief operating officer of an independent restoration company near Annapolis, Maryland. This is the first time the RIA has done anything like this. I appreciate the opportunity to be before you. The RIA is an 80-year-old association, but advocacy is kind of new to us. We've been working on many other things for the last 80 years. We are the group that arrives in North America, immediately after an emergency takes place. It's our teams and groups that immediately follow a fire, flood, storm, and other disasters, protecting lives, stabilizing structures, and helping families and businesses return back to normalcy. I am very proud to tell you that earlier this year we took a step. Every five years, the Office of Management and Budget will hear petitions for a new North American Industry Classification System (NAICS) code. We applied for a new NAICS code this year for our trade association because we're trying to do exactly what you all are trying to do - ensure that it's only professionals that show up at your door when an emergency takes place.

Sen. Walker thanked everyone and stated that based on comments received on the proposed amendments, he has agreed to make some changes to what was included in the materials. Specifically, new Section 4.C. has been removed which would have compelled an itemized statement of repairs ahead of the work being done after a natural disaster. We felt like that was not practical and would slow down the emergency repair process and didn't add a lot to consumer protection. We also clarified Section 6 to ensure that emergency services in a work authorization are paid for at their reasonable value, which was already really provided for in the original Model. We also added a

drafting note to Section 2 to ensure that emergency services are not impeded by this Model. It should serve to protect consumers and the industry against fraudulent contractors, not impede legitimate emergency services in the wake of a disaster. And finally, we clarified in the definition of “contractor” that the Model applies to both resident and non-resident contractors. In a case like Hurricane Helene we needed all hands on deck and non-resident contractors were needed to take care of the massive devastation we had. Again we've talked to several stakeholders and we've had no pushback and we agree that this is good for the consumer and good for the insurance industry and good for the contractors that do the important work and so I’m hoping today that we can adopt the proposed amendments.

Hearing no questions or comments, upon a motion made by Rep. Lehman and seconded by Rep. Kristian Grant (MI), the Committee voted without objection by way of a voice vote to adopt the amendments. Then, upon a motion made by Rep. Pollock and seconded by Rep. Lehman, the Committee voted without objection by way of a voice to re-adopt the Model as amended. Sen. Walker thanked everyone and stated that the amended Model would now be placed on the Executive Committee agenda for final ratification.

c.) MODEL ACT REGARDING THE USE OF CREDIT INFORMATION IN PERSONAL INSURANCE

Sen. Walker stated that up next is the Model Act Regarding the Use of Credit Information in Personal Insurance. As a reminder, the Model does not advocate for the use of credit information in underwriting one way or the other. No comments on the Model have been received since the Summer Meeting in July.

Hearing no questions or comments, upon a motion made by Rep. Lehman and seconded by Rep. Meredith, the Committee voted to re-adopt the Model with Sen. Walker determining that the yes votes clearly outnumbered the no votes.

ANY OTHER BUSINESS

Asw. Pam Hunter (NY), NCOIL President, stated that it was very unfortunate that the NCOIL Model Act Regarding Insurers’ Use of Aerial Images was not adopted during our interim committee meeting last month. I really feel the model is pro-consumer and we should not let the issue go away. I think we can certainly make some changes to it and address some outstanding concerns, but it's something that is certainly going to be introduced in states either way, so NCOIL should definitely not let the opportunity pass to provide guidance on this issue. I've already introduced the model in New York and I'm certainly willing and wanting to support working on the model again next year to get things right and move it forward to adoption.

Sen. Walker stated I couldn't agree more and I think we will have similar legislation introduced in Georgia in January so I hope NCOIL will continue to work on that.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Pollock and seconded by Asm. Jarett Gandolfo (NY) the Committee adjourned at 12:30 p.m.

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

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. Re-adopted by the Property & Casualty Insurance Committee on July 19, 2025 and by the Executive Committee on July 19, 2025 until the 2025 November Annual Meeting. Re-adopted by the Property & Casualty Insurance Committee and Executive Committee on November 15, 2025 until the 2026 Spring Meeting in April.**

***To be considered for re-adoption, along with potential amendments, by the Property & Casualty Insurance Committee on April 18, 2026.**

****Proposed amendments sponsored by Sen. Walter Michel (MS).***

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 for-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. A digital network is not a product under the laws of this State.

3. “Transportation Network Company (TNC)" 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 under the license of the TNC ~~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 DEFINITION 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 information ~~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

1. The following additional definitions apply to this Section:

a. “Application-on stage” means the time period the driver is logged on to the digital network of a transportation network company and available to receive ride requests but is not engaged and there is no passenger on board.

b. “Engaged stage” means the time period from the moment a participating driver accepts a ride request on the digital network of a transportation network company until the passenger on-board stage begins or the ride request is canceled, whichever is sooner.

c. “Passenger on-board stage” means the time period when there is a passenger or passengers in the vehicle participating in a prearranged ride.

2. 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:

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

b. 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

3~~2~~. The following automobile insurance requirements shall apply during the application-on stage and during the engaged stage ~~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).

4.~~3~~. The following automobile insurance requirements shall apply during the passenger on-board stage ~~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.

F. Independent Contractor Status

A Transportation Network Company Driver is an independent contractor and not an employee or agent with respect to the driver's status with a Transportation Network Company if all of the following conditions are met:

1. The TNC does not unilaterally prescribe specific dates, times of day, or a minimum number of hours during which the driver must be logged in to the TNC's digital network;

2. The TNC does not terminate the contract of the TNC Driver for refusal to accept a specific ride request except where refusal constitutes a violation of governing federal, state, or local laws or regulations;

3. The TNC does not restrict the driver from performing services through other Transportation Network Companies except during a prearranged ride; and

4. The TNC does not restrict the driver from working in any other lawful occupation or business.

G. Liability of Transportation Network Companies

A Transportation Network Company shall not be liable

a. by reason of owning, operating, or maintaining a digital network accessed by a Transportation Network Company Driver,

b. by being the Transportation Network Company affiliated with a Transportation Network Company Driver, or

c. by virtue of any allegation that the Transportation Network Company owed common carrier, non-delegable, or similar duties

for harm to persons or property that results or arises out of the use, operation, or possession of a motor vehicle in connection with a digital network as long as there is no gross negligence under the statutes and regulations governing the Transportation Network Company and no criminal wrongdoing under the State or Federal criminal code on the part of the Transportation Network Company that is the proximate cause of the harm to persons or property.

JOINT STATE-FEDERAL RELATIONS & INTERNATIONAL INSURANCE ISSUES COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
JOINT STATE-FEDERAL RELATIONS & INTERNATIONAL INSURANCE ISSUES COMMITTEE
2025 NCOIL ANNUAL MEETING – ATLANTA, GEORGIA
NOVEMBER 14, 2025
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Joint State-Federal Relations & International Insurance Issues Committee met at the Whitley Hotel in Atlanta, Georgia on Friday, November 14, 2025 at 3:15 p.m.

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

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Rep. Brenda Carter (MI)
Sen. Jeff Howe (MN)
Sen. Jerry Klein (ND)
Rep. Meredith Craig (OH)
Rep. Brian Lampton (OH)
Rep. Tom Oliverson, M.D. (TX)
Rep. Jim Dunnigan (UT)

Other legislators present were:

Rep. Carolyn Hall (AK)
Sen. Larry Walker (GA)
Rep. Camille Lilly (IL)
Rep. Sean Tarwater (KS)
Rep. Chad Aull (KY)
Rep. Daniel Grossberg (KY)
Rep. Edmond Jordan (LA)
Rep. David LeBoeuf (MA)
Rep. Robert Foley (ME)
Sen. Michael Webber (MI)
Rep. Garland Pierce (NC)
Sen. Jeff Barta (ND)
Sen. Bill Gannon (NH)
Sen. Tim McGough (NH)
Rep. Julie Miles (NH)
Asm. Jarett Gandolfo (NY)
Rep. Tim Barhorst (OH)
Sen. George Lang (OH)
Rep. Matt Morgan (TX)
Rep. Trey Wharton (TX)
Rep. Calvin Roberts (UT)
Rep. Calvin Callahan (WI)
Sen. Mary Felzkowski (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. Meredith Craig (OH) and seconded by Rep. Tom Oliverson, M.D. (TX), NCOIL Immediate President, the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Sen. Justin Boyd (AR) and seconded by Rep. Brenda Carter (MI), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 17, 2025 meeting.

PRESENTATION ON INDIVIDUAL COVERAGE HEALTH REIMBURSEMENT ARRANGEMENTS (ICHRAS)

Sen. Theis stated we'll start with a presentation on Individual Coverage Health Reimbursement Arrangements (ICHRAs). I am excited to hear about ICHRAs as they are an emerging health product and I look forward to the Committee learning more about them during our conversation today. This topic was brought forward by Rep. Meredith Craig (OH), who sponsored a bill in her home state dealing with ICHRAs.

Rep. Craig stated as noted, I'm currently sponsoring a bill in Ohio. You can view the legislative analysis of the bill on page 184 in your binders. The bill itself is on the website and the app. The bill is pretty straightforward. It authorizes a non-refundable tax credit for any small business that has 2 to 50 employees who offer an ICHRA. First and foremost, I should ask the room, who knows what an ICHRA is? For those that don't, it is an individual coverage health reimbursement arrangement. This was something that the first Trump administration tried to push forward. Part of the conversation earlier today revolved around the marketplace and trying to get healthy individuals into the risk pool. So, this was formed to help provide an option to employers to contribute a pre-tax amount of money into an ICHRA, similar to a health savings account (HSA), for an individual to go buy a plan on the individual exchange so that person can shop around for what works for them. And again, that alleviates the cost and the burden on the employer by allowing the individual to take control of that. Overall, the bill encourages those employers at that 2 to 50 employees mark which are not required to offer health insurance. Ohio, and I think other states, are looking at work requirements for Medicaid, and so as that is rolled out, we're going to want to incentivize folks to get insurance some way and this should help with health care choice and accessibility. So, it's a great topic for the committee to discuss and I look forward to working on potentially looking at a Model Law here at NCOIL.

Peter Nelson, Director of the Center for Consumer Information and Insurance Oversight (CCIIO), thanked the Committee for the opportunity to speak and stated I'm really happy to be here. I've been working on public policy issues, mostly at the state level, but as you all know, state and federal health care policy intersect in many ways. And so, at the state level, I always had to deal with the federal laws, and I was always trying to think through ways to give states more flexibility within a federal framework across so many dimensions in federal law. I come from Minnesota, so my experience in Minnesota, starting off, we had a Republican Governor with mostly a Democrat legislature. And we were thinking a lot of different, more bipartisan opportunities to improve our health care system when I started working. Some of my first reports were on state exchanges and the potential benefits of state exchanges. Another report that I led off with was a report

on some problems with employer-sponsored health insurance. And not that employer-sponsored health insurance is bad, but they create some obstacles for consumer choice. Mostly, usually when you get a health plan through your employer, you really don't get that many options. Oftentimes, you don't get any options at all. That's, of course, driven by the tax preference for employer-sponsored coverage. There was always this sense back before the Affordable Care Act (ACA) was passed that you couldn't have the type of health insurance coverage through your employer that gave employees choice and gave them basically a defined contribution of dollars that they could then use and go out into the individual market and shop for their own coverage that would then be portable if they left their job.

Potentially, if another employer offered a similar defined contribution approach, they could then, in that other job, carry their insurance with them. But fundamentally, it's about choice. It's about being able to, as a consumer, have a choice over your health plan and have more decisions over factors like what sort of level of premium do I want compared to the cost sharing and the deductible amount that I want. Before the ACA passed, there really wasn't that much of an opportunity. There were some opportunities for that sort of arrangement. After the ACA passed, I was very optimistic that this was going to be able to take shape and the reason why I was optimistic is because the regulatory structure between individual market plans and small group plans pretty much equalized and that was one of the obstacles. And so, there's a lot of us that thought you could do that. However, in 2013, the Obama Administration issued some guidance that restricted that. Then I spent several years looking at the law and making some arguments that, no, actually, you should have some opportunities here. And I had the honor of being hired in the first Trump Administration and when I got there, we immediately set to work on developing rulemaking to allow what we're talking about today, ICHRAs. And these are health reimbursement arrangements that an employer can set up and put a defined contribution of dollars into the health reimbursement arrangement that allows the employee to pay for an individual market premium and have that choice. And this cures a lot of issues for employees over choice and gives them a lot of power to basically define what's good for them and their families, but it's also really important for employers. There are a lot of employers that just don't offer health coverage because it's very complicated and this can be a simpler way to allow employers to provide a pre-tax contribution for their employees that they otherwise wouldn't provide. Before the first Trump Administration, there really wasn't that structure in place. We put in place rulemaking that provided a structure.

I'll just give a high-level overview of that rulemaking. One of the issues with health reimbursement (HRAs) could be that employers would try to separate their employees by their healthy employees and their sicker employees. So, we had to draft some careful rules to ensure that employers weren't dumping sick people into the individual market. And so, we did that, and that rulemaking is now in place, and I'm really pleased to say that the Biden Administration left that rule in place, and I think they left it in place because they saw that there are substantial benefits potentially for some employers in this situation. It's a good option. And we have seen some bipartisan support for these policies. We are seeing Connecticut, they have developed tools through their state exchange to facilitate this. We're seeing Georgia, who's here today, I understand we're

making some progress on that front there and I think Colorado is also doing some work on this. But there are some issues that we still have, and that's what I'm really excited to hear about from the panel here, because we issued these rules, and we have a lot of policies in there to ensure that this works, that we're not undermining the individual market. That doesn't mean there aren't some obstacles, and we recognize that. And there are also some enrollment challenges that we might experience in the market, because there's not right now yet, I think, the simplified tool for the small employer to just take off the shelf and use, which is why some state exchanges are jumping into this game to help support that. So there needs to be better support tools for businesses.

And there's also a lack of awareness and one of the reasons why is because right when we did the rule, COVID happened, and no business was going to change their business health benefits at that time. And then when the Biden Administration came in, there was some questions over whether this policy was going to stick. It has stuck now. I think moving forward, we're going to have some more interest in this. We've already seen a lot more interest from a lot of companies and we're really excited to see that. I'll just conclude that from a federal level, we see ourselves as facilitators. We want to facilitate this approach to make sure there's a fair level playing field for this approach. One of the things we just did is ahead of the open enrollment period, we released data for off-exchange pricing and plan attributes to make sure you can set up those tools. So, we're creating the framework for this. We're still creating that framework right now, and that's where we think with this framework in place and with the interest we're seeing from insurance companies and from other states, I'm excited to see this take off.

Danielle Winiecki, Director of Business Development at Ambetter Health, thanked the Committee for the opportunity to speak and stated Ambetter Health is a subsidiary of the Centene Corporation. We focus on Medicaid, Medicare, and marketplace insurance. ICHRAs are very meaningful to us. We have it as a major part of our strategy. We want to be able to offer more benefits to more consumers and have them select those plans under an ICHRA. A lot of us have already talked about sort of the base level of what an ICHRA is. I'm just going to highlight some of the key things. We've talked about how it was established in 2020 and that the Biden Administration further reinforced it, where now we're coming back to a place where it's starting to increase in adoption. We're starting to see more consumers enrolling under an ICHRA and the reason that they're doing that is because we're finding that costs can be more predictable for employer groups. So, they're saving money out of their own pocket from a business perspective and being able to offer that defined contribution or subsidy to their employees to then go choose the plan that's personal for them. So, getting into my second circle here of plan personal, it's really focusing on being able to choose the plan that's right for you and your family as an individual and as a family. And then lastly, it makes coverage possible. We're finding more small businesses are able to offer benefits to their employees under an ICHRA. We talked about tax subsidies as it relates to small business owners from that 2 to 50 employee space. More consumers are able to be insured because of ICHRAs.

I love to do this comparison here between group insurance and ICHRAs just to better set what this looks like. From a group insurance perspective, employers typically create that

benefit offering for their employee base. They look across their employee base and they decide maybe 2 to 3 different plan options for their employees. That doesn't create a lot of choice, to Mr. Nelson's point earlier. What we're looking to do is create more options and more individuality when it comes to that consumer's need for healthcare. So, group insurance really makes it look like one T-shirt size fits all and we know that that's not really what works. It's good to take some of the good things about group insurance and carry them over and carry them forward into an ICHRA, being able to offer dollars to that employee base so that they can then select the plan that's right for them. You'll see those 5 different images here under ICHRAs. It's really a whole lot more choice than that. I'll give you a good example case that we have. In the last two years we had a group that implemented an ICHRA with 500 employees. The reason they did that was because they faced a really heavy increase in the group insurance market, over 40%. So, they went to their broker and said, what are our options? What can we do? An ICHRA was presented to them on the table, and they said, "okay, what does this look like? How do we implement this for our employees?" It comes with a communication strategy, a plan of attack to help educate those consumers and those employees on what works well for them. They went from 3 different plans to now 180 different options. Now, 180 is a huge number, but the cool thing is a lot of the enrollment platforms that leverage ICHRA that help promote it for us will offer decision support. That doesn't necessarily always mean it's technology-based decision support, but they also have licensed professionals on phone calls to help people enroll in those plans. So, alongside an ICHRA, we're also educating people how to utilize their health care based upon their needs.

So why now? Why does this make sense? I think this is really an important time. There's a lot happening in the world, a lot happening in the U.S. with healthcare. I think it's important for us to have more choice for employers to offer benefits to their employees that are accessible, affordable, flexible, and individual. So right now, it feels like the right time to make this happen. The image that you'll see on this slide just showcases that small group premiums are typically increasing at a faster rate than the individual market is. So, our individual marketplace that we've developed under the ACA has been able to help us to mitigate those cost increases. Even though we see some increases year over year and this year especially, we're still increasing at a slower rate than the group marketplaces. So, it's important to note that there are other options out there for employers, small, mid, large sizes. And there are plans that are ACA compliant as well as showcasing options across HSA compliant plans, Preferred Provider Organization options. Bronze, silver, gold plans. So, there's still a lot of choice there for those consumers. And then lastly, what's next? How can you all help us to push this forward? We want to work with you all to help educate people about what an ICHRA is, increase the awareness, increase the adoption, work with local organizations and associations such as Chambers of Commerce to help push this forward alongside you all. One statistic that I'll leave you with is there are over 170 million Americans covered on group insurance today. It's a little bit broken. We want to be able to offer more choice. The individual marketplace has roughly 25 million Americans covered today. We don't expect that to be a huge shift, but we do expect ICHRAs to be a viable solution for employer groups to offer benefits to their employees.

Brooke Tiner, Director of State Government Affairs at Oscar Health, thanked the Committee for the opportunity to speak and stated that stated Oscar Health is a healthcare technology company that was created in 2012. We are in 18 states currently, 20 as of January and we offer ACA individual marketplace plans. We do not do that as our only line of business, so we are expanding our reach and continue to expand our reach into different states and into different markets, and this is a place that we look at as being able to expand our offerings and expand our options to our members and to those that are currently either without plans altogether or cannot afford them. You've already heard a lot about what an ICHRA is and how it works. I'm going to talk a little bit about what's already in place right now across the federal and state landscape. I'm not going to go through all these, but the point of this slide is to just to show you the state activity that's already taken place this year and will take place next year. One of the bills that's left off this slide, unfortunately, is the New Jersey bill. There is a bill in New Jersey that creates a tax credit. Most of these bills are fairly similar to what Rep. Craig described in the Ohio bill and creates a tax credit for employers who offer ICHRA plans. The Georgia bill has a sunset of that tax credit for 5 years. So, they differ a little bit, but most of them are fairly similar, and the idea behind these bills is to create awareness and to create an incentive for employers to look at these plans and to look at these options, especially those that may not be able to even offer plans to their employees.

The education is a really important piece, and using these pieces of legislation and places like this to educate on what ICHRAs mean is critical. I do want to point out that the Florida bill is a little bit different in that it actually creates a marketplace for ICHRA plans in the state, and it creates a platform for ICHRA plans in the state. It does not have a tax credit attached to it. So, it's a little bit different, but it's similar to some of the activity that Mr. Nelson spoke about and some of the things that the state-based exchanges are doing to allow a place and to create a place where employers can go and buy these plans and administratively access these plans. We are very hopeful and we are continuing to advocate for these bills in states because we think it's really important that if we are able to offer additional affordable options, especially in this time that we're in right now, to those who need them, that's where everybody wants to be. We really appreciate the partnership and want to continue the partnership on the state and federal level. My next slide just talks about what's going on with the federal legislation. We do have two bills right now that are active at the federal level. What's interesting about the Choice Act (S 2875/HR 5463) in particular is that the acronym ICHRA is sometimes a little bit difficult for people. This rebrands ICHRA as Choice - Custom Health Options and Individual Care Expense arrangements, which actually I think explains it a little better. It's a choice option and we're all talking about choice. What's interesting about the other bill from Representative Van Duyne (TX) is it is an education bill on ICHRAs (HR 5498). It does not approach the tax credits. It is a bill that directs the Small Business Administration to do education on ICHRAs. We believe that will also be extremely helpful in getting brokers engaged, getting other states engaged, and it's another interesting approach to getting awareness out there about these plans and about what's happening in the marketplace.

Martin Sullivan, Chief Deputy Commissioner and Chief of Staff at the Georgia Department of Insurance and Safety Fire, thanked the Committee for the opportunity to

speak and stated that at the Georgia Department, we're very fortunate that we have such strong support in our legislature who give us the resources and tools we need to make sure we accomplish our goal, that there is no wrong door when it comes to finding healthcare options. Several years ago, they gave us the authority to create Georgia Access, which has been extremely successful. That's our state-based marketplace in Georgia that we've gotten 1.5 million people enrolled in. And one of the greatest things as we've gone around and talked to Chambers of Commerce and different business groups around the state is that they love that kind of access and support of offering insurance to their employees. That is where we came up with, in speaking about ICHRAs, rebranding it in Georgia as Georgia Access for Business (GAB). GAB is going to be a state-administrated platform for managing ICHRAs. Its core mission is to expand access to affordable, flexible health care coverage for employers and employees. This is being built in partnership with Georgia Access, our state-based exchange, NFP, and Zizzle Health. GAB offers a turnkey solution for ICHRA adoption across employer sizes and sectors. It's designed to support both currently insured Georgians and those who remain uninsured, bridging gaps in coverage through employer funded benefits.

GAB provides the digital backbone for ICHRA setup, administrative, and compliance and it employs our agents, and we currently have over 20,000 agents writing on our state-based exchange. It gives them the training and the certificate programs they need to be able to write ICHRAs and it connects certified agents with interested employers. The platform will also provide onboarding assistance, planned configuration, compliance guidance, and dedicated support for navigating both Internal Revenue Service (IRS) and ACA roles. NFP and Zizzle Health deliver full-service ICHRA administration including documentation, billing, and reporting to make sure we provide this simple and easy for Georgia employers. The ecosystem will help simplify the transition from traditional group health plans to define contribution ICHRAs. It supports employers seeking cost control and flexibility, multi-locations or remote teams, and organizations with low performance in group plans, which I think is highly important. If you've got employees all over the state of Georgia, and you pick a plan from the Kaiser network which is not available outside Atlanta, your employees wouldn't be able to take advantage of it. So, GAB ensures that all stakeholders, agents, employees, and vendors operate within a compliant, ethical, and efficient framework. And why can employees choose GAB over traditional group plans? Because rising group costs make ICHRAs an attractive alternative. It enables defined contributions based on employees' class or criteria and employee empowerment through plan choice and portability and payroll integration for additional employee contributions. Employers shift from managing benefits to managing budgets, with GAB handling all the complexities. GAB will also help employers understand how ICHRAs interact with the Advanced Premium Tax Credits (APTCs). ICHRAs disqualifies APTCs if deemed unaffordable, and employees may opt out if it is cheaper and better for them to choose APTCs. GAB provides tools and guidance to assist affordability based on household income versus benchmark plan costs, ensuring compliance and transparency. Our Department's goal is to make sure every Georgian has access to affordable, quality health insurance, and we believe ICHRAs will help us move forward to reaching this goal by leaps and bounds in the years to come.

Rep. Jim Dunnigan (UT), NCOIL Secretary, stated if an employer gives an ICHRA allowance to an employee and they take that to the marketplace, are they also eligible for the APTC? Mr. Nelson stated within the framework of an ICHRA, they would not be qualified for a tax credit. That would be considered a group health plan. That would disqualify them from a tax credit. However, there is something called a qualified small employer HRA, which adds some further complications to this question and there is a circumstance where they could, if the employer gives them a contribution that's not big enough to deem that affordable, under the ACA framework for a group health plan, if that happens, then the employee can use the employer contribution alongside. Rep. Dunnigan stated that's going to be a very limited subset. Mr. Nelson said yes, and that's clearly not the ideal situation. We would, of course, want employers to offer a contribution that allows someone to buy an affordable plan.

Rep. Dunnigan stated healthcare costs and insurance premiums for healthcare are not going down. So, if I'm an employer and I want to control my costs with a defined benefit, maybe I give an employee $400 a month, you go to the exchange, we've got an ICHRA, and that stabilizes my contribution. The employee buys a plan. Next year, rates go up 10% or 15% and I still keep it at $400. Somebody's going to pay that. It's going to be the employee. So, the sales pitch about being stable for an employer can be true, the same thing is true on an employer-based plan. The employer can say, “I'm not providing an increase. I'm just keeping my group contribution the same.” But then it's going to be shifted to the employee. They'll have more choices. Maybe they can find a plan. But it doesn't take very long unless the employer escalates that. The employee's going to have a challenge. I know in our state, the individual rates are higher than the group rates already. In January, they're going to be significantly higher. So, the question is, are you better off to be on an employer-sponsored plan where they're contributing? Maybe you only have two or three choices or are you going to be able to take that defined benefit and maybe not be eligible for a tax credit so your employer contribution is not going to go as far and you may be better off in not even doing that and just going to the marketplace. So, the question is, if an employer offers an ICHRA, can I opt out and go get a subsidy, or the fact that it's offered to me, does that prohibit me from getting a subsidy tax credit?

Ms. Tiner stated the short answer is yes, you will be able to opt out. Rep. Dunnigan stated ok, and I understand it's a strategy like we have employer groups and they have somebody that's got really high claims and it's killing their group and they want to take them to the individual market to unload the risk. Ms. Winiecki stated the other strategy that we didn't talk about today but I want to call out for your question is that you can develop eligibility classes across your employee population. So, you could say for all full-time employees in Indiana, we're going to offer them an ICHRA because it makes sense because the individual rates are less than group rates in that state. But in your state, where they are not, you could offer a group health plan still and that could be affordable for both the employer and the employee and then everybody wins. So, this is really just an alternative, another option to try to help mitigate the cost of healthcare.

Rep. Dunnigan stated it's going to be very state specific. I've got to say one more time, the concept that this is going to control the employer's costs and defined benefit, yeah,

but that just means we're shifting it to the employee and how long can they bear that? And then one other thing with ICHRAs, and it sounds like you're all working on it in Georgia especially, they're clunky to set up and they're not easy. Mr. Sullivan stated that's why Georgia specifically is working on this platform. There will be a website, and we're working with two organizations, NFP and Zizzle, to be able to simplify it and make it easier. We'll be training agents specifically on it that are ready to sell ICHRAs so they can hit the market and run and make it seamless for both the employer and the employee. Ms. Winiecki stated one other thing is I've been in the employee benefits industry for over 15 years, and I think group benefits are also clunky. But ICHRA is new and young so it's going to be even clunkier as it's going to take time to build. Rep. Dunnigan stated they're both clunky but this one's clunkier. Ms. Winiecki agreed.

Rep. Dunnigan stated to Georgia, on the 1.5 million in the marketplace, what are you going to do with them now that they're losing those enhanced subsidies? Mr. Sullivan stated while I wish we could control what Congress is doing, we're holding over 100 events around the state, signing up people for coverage. We are having a multimedia approach to remind people that it's open enrollment. Unfortunately, the state does not have the resources to subsidize the plans like the federal government, but we're doing everything in our control to make sure every Georgian knows their options, whether it's the plan that they currently have, maybe it's a bronze plan, and it's why we are the first state-based exchange that is enhanced direct enrollment and agent-focused, and we encourage all Georgians to talk to an agent to help them figure out the plan that best fits their needs.

Rep. Tim Barhorst (OH) stated I just wanted to follow up on the hook and the carrot, obviously it sets up a great framework for an option and a choice employers have, and that's a great thing. How do we create the vibrant market that goes along with it, and what does that look like in Georgia? Are there any other states that have got the seeds already out there and moving, and how does Ohio in particular help ourselves germinate such a seed to maybe make Rep. Craig's bill when it gets through useful? Ms. Tiner stated the key to this is getting involvement from people like the Chamber of Commerce, which we're doing in Ohio. We're holding events with the Chamber in Ohio educating on these plans and educating on what Rep. Craig is doing with her legislation. We are working to do that in other states as well because one of the issues is, and I think all my colleagues would agree with me, people just don't know about this. Once they start hearing about it and once you start describing it, we may have disagreements, we may have questions, but those are the discussions we want to have. We want people to understand what's available and then how can we best serve. To do that, we need the businesses. We have partnerships with the National Federation of Independent Business (NFIB) and a number of states that are working with us on this and especially the brokers that already offer and can help us educate. So, it's a combination of all of that.

Mr. Sullivan stated I think one of the core things is educating agents because we see ICHRAs really as another great tool in the toolbox to help people get covered. We like to remind people all the time, as the Department of Insurance, we love every type of insurance. We love it if you have small group. We love it if you're on the marketplace.

We love it if you have an ICHRA. We want to have the insurance that best fits you and your employer's needs. And this is the best way. We don't want a single person in Georgia to not have access to insurance. We think this is another great tool for employers to be able to offer a plan to get their employees to stay if they can't afford small group coverage. Because in Georgia, a lot of times the ACA plans are cheaper than the small group plan. Some counties, they're not. One of the great things when we roll this out is if an employer puts in all their information, it might come back and say, “Hey, a small group plan might be best for you”. A Qualified Small Employer Health Reimbursement Arrangement might be best for you. A Multiple Employer Welfare Arrangement might be best for you. So, we want to make sure we use this platform to connect agents, employers, and employees with the best plan that fits them. The best way to do that, I think, is to get the word out, and we're working with agents and companies to get the word out as quickly as we can.

Rep. Barhorst stated that was helpful but I probably didn't frame the question as accurately as I wanted. When I say vibrant, I mean the carriers and the plans want to be involved in this and they actually file rates and have plans out there for it. So, what does Georgia look like? How many carriers do you have? How many plans are out there? How would Ohio bring that to a vibrant marketplace that an ICHRA with the tax advantage and an employer administration platform be able to take advantage? Mr. Sullivan stated we currently have 10 carriers writing in our marketplace and I can't tell you the exact number of plans offered, but it is a significant number of plans. We have 159 counties in Georgia. Each county has at least 3 carriers writing in it. So, no matter what county you're in in Georgia, whether you're in the metropolitan area of Atlanta or you're in the small rural area of Tolliver County, you're going to have options with an ICHRA. You'll probably have more options than you would in some of the rural areas with small group plans, because you're going to have 3 or 4 different tiers, whether it's gold, silver, bronze and in a lot of companies, they only offer you one or two plans. I was talking to my Dad about that who owns a small business and he said he always felt bad because his employees got the plan that best fit our family because he was going to pick the plan that supported our family, not necessarily the rest of them. So, this will give every employee the right to do it. When my boss speaks to Chambers of Commerce he likes to point out, “why do we let employers pick our healthcare? We never let our employer pick out our car insurance.”

Sen. George Lang (OH) stated currently, a large self-funded employer can utilize a Medical Expense Reimbursement Plan to incentivize their employees to move into a spouse's plan. Is an ICHRA limited just to the exchanges, or could an employee use it to pay for coverage available in a plan through another employer that they have access to? Mr. Nelson stated I'll try to answer it, but this is also maybe one of those questions that I would need to take back. I believe through a different sort of HRA arrangement, which would be a group coverage HRA arrangement, that an employer could establish an arrangement where you could use HRA dollars to help fund a spouse's plan. But that's a different arrangement than we're talking about today. Sen. Lang stated so the ICHRA is just for the exchanges? Mr. Nelson stated it’s not, it's for the individual market and the reality is off or on exchange.

Sen. Lang stated my other question has to do with the $400 tax credit, that feels about right. In Ohio, that would be similar to a $15,000 tax deduction, which is probably the equivalent of family health coverage in Ohio in general. But how would a state with no income tax utilize a tax credit? I'm sure there's a way. I just don't understand it. And does it make sense to consider expanding it beyond 50 employees, and also indexing it not for inflation but for trend? Because we all know health care costs go up significantly higher than inflation. Ms. Tiner stated regarding the number of employees, yes, it could be expanded. Typically, as we're discussing and starting with these pieces of legislation, it is about the 2 to 50 market simply because that's typically the market where you see coverage not available, and you see coverage not offered and it gives the ability for a step to then expanding that once people understand how the tax credit works and how it will work for the employer. As to how the tax credit will work, I can't specifically answer that question for a couple of reasons. Number one, specifically in Texas, the legislation did not pass yet. So, the legislation directs the Department of Revenue to do rules around how this will work. So, I can't answer that specifically. It's a good question, and it's something that will have to be discussed on a state-by-state basis as we work on these bills and as we work with the Departments of Revenue in the different states, depending on how it looks.

Rep. Tom Oliverson, M.D. (TX), NCOIL Immediate Past President, stated we don't have an income tax, but businesses do pay a gross margins tax called a franchise tax. So, it's a $400 credit against the franchise tax. That was the bill that we filed this year.

DISCUSSION ON CCIIO PRIORITIES

Mr. Nelson stated I just want to start by talking a little bit about just how much I appreciate the role of the legislators in this process. I come from Minnesota, and I've worked in my prior career at a state-based policy organization. I work directly with state legislators, and I know how important the state legislature is in obviously developing the laws for the state and actually developing the policies. And that's where the innovation happens, with policy at a state level.

And so, most of what I'm going to talk about today is how state lawmakers right now can look to some flexibilities in federal law around 1332 waivers and potentially a 1333 compact. But before I get into that conversation, I did want to just touch base a little bit on where we are with the open enrollment period. These open enrollment periods for the individual insurance market and the insurance exchanges across the country opened up on November 1st, and we are seeing some higher premiums in that market space right now, but we still have a lot of affordable premiums out there. The average person that actually is in the market right now is still going to see premiums that are actually less than $25. So, there's still some high-level affordability in the markets, but we are going back right now to the standard ACA premium subsidy structure. We are seeing the COVID-related enhanced subsidies falling away, and we made sure to have some flexibility this year to make sure people have time. We had originally proposed to have the open enrollment period go from November 1st to December 15th. We want to make sure that people have time to enroll and so we extended that to January 15th but if you

talk to people the one thing I want to make sure everyone knows is that if you don't get coverage by December 15th you're not going to get January 1st coverage.

I just want to be clear about that and so with that I want to jump in and talk a little bit more about 1332 waivers and this is something I hope a lot of you are familiar with, section 1332 of the ACA which allows states to waive certain requirements under the ACA that allows states to set up some alternative programs. This is an important flexibility for states especially for this time when the enhanced subsidies are expiring, and people are talking a lot about affordability issues in the individual market. There's a lot of things you can't waive under the ACA, for instance the guaranteed issue requirements, the community rating requirements, a lot of those sort of fundamental requirements around the individual health insurance market, but you can waive some other requirements. You can waive things around the essential health benefits. You can waive things around the premium subsidy structure. You can provide some more flexibilities in plan design. Those are really great, but one thing that is now clear and has clearly provided a huge benefit for the states that have done this is the ability to implement a reinsurance waiver.

Eighteen states have implemented a reinsurance waiver. In 2016, I was in Minnesota, and I was working on policy issues in Minnesota, and we saw a huge spike in premiums, just like many states are seeing today. We knew we needed to do something to provide some premium relief, and we ended up relying on a reinsurance program, and the way that it's structured within this framework is we actually waive the single risk pool requirement in the ACA, and in doing so, you can then provide state contribution to a reinsurance program that pays high-cost claims. And you pay high-cost claims in a range that usually starts at an attachment point say at $50,000 and then pays a portion of the claims up to a cap which is usually around $250,000. And when the state pays a claim, that reduces the premiums which then would reduce the premium tax credit the state would otherwise receive. And when the state reduces the premium tax credit, within the ACA there's an allowance for pass-through funding. Then you're able to get federal pass-through funding to help leverage those state payments that reduce premiums even more. In Minnesota when we did this, we were able to reduce premiums by about 20%. When you look at the states across the country that have the lowest premiums on the individual market, the last time I checked, I think 8 of the 10 most affordable states in the country had a reinsurance program. I want to make sure everyone understands that this is an option for your state going forward. We implemented 18 of these reinsurance waivers in the first Trump administration and we definitely encourage states to look at this option.

Under a 1332 waiver, there's also other opportunities, and we are happy to work with states on some other opportunities. We released in the first Trump Administration some concept papers about how to maybe use different types of waivers so you could maybe use more of an account-based approach. We talked about health reimbursement arrangements and how they provide some more choice and opportunities. You could create some different subsidy structures around an account-based approach. You could also change some subsidy structures to encourage young people to sign up for coverage. And I'm happy to speak to any of those ideas with anyone after this session.

I'm definitely willing to have some calls about other opportunities. I also want to speak briefly to 1333 compacts. The ACA also provides the opportunity to basically buy insurance across state lines, which is something that Republicans have talked about a lot, but the compact approach is a little bit different which does this in a way that actually was pretty much a bipartisan approach to the idea of buying insurance across state lines before the ACA passed. It was really a program to help smaller states create a larger market space to be able to attract more issuers into their markets and to make it easier because it basically allows you to potentially equalize some of the requirements and a lot of the administrative procedures around form filing and those sorts of things within the insurance space and so it fundamentally allows for that sort of thing. Another thing it can do is it can potentially allow the group of states that create these compacts to bring back some level of federal authority that exists around qualified health plans. We've seen that there are basically certain things that just sort of flip-flop from Administration to Administration and that creates regulatory instability. One of the things states consider is grouping together to take some of that flexibility back. We've seen regulatory instability around network adequacy requirements, around the requirements around standardized health plans, and states can potentially bring some of that regulatory authority back to sort of remove themselves from some of this flip-flopping that happens from Administration to Administration. So, there's some potential there. That's just a very brief overview of that. Please come to me if you have any questions regarding that.

And I heard about how to create that thriving market and we talked about affordability of premiums. I just want to just conclude with sort of a vision that I have for the individual market. When the ACA passed, it kind of envisioned that there would be a subsidized portion of the market and an unsubsidized portion of the market. We are now at a place where we're largely a subsidized portion of the market, where you don't have a very large number of people who are paying the full premium and communicating the value of the full premium to them by actually paying that full price. And in any competitive market, you need a consumer that's paying the full price to communicate the value of the product that's being sold on that market. And without unsubsidized people in the market, that market will lack competition. And that's one of the reasons why I think we're seeing premiums go up as much as they have over the course of the time the ACA has been around. If you had more unsubsidized people in the market, you'd have more competition to drive premiums down. And that's one of the reasons why I'm so excited about ICHRAs. I really encourage you to think about them because yes, premiums are going up this year. I will note they have stalled over the past 4 years, but they are still going up more than we would like, and I do think this can help.

Sen. Theis asked what is your sense of what this Administration is thinking about doing with respect to additional 1332 waivers? Mr. Nelson stated we are open for a lot of ideas, whether it's reinsurance waivers and maybe some modifications to that or other types of waivers. We have regulations in place that are more restrictive than I think we'd like to see, so we're thinking through whether there's some more flexibilities that we can provide through future regulations. But there is a lot of stuff that we can still do under the current regulatory structure, and so that's how we're operating right now but we're definitely looking for some advice on where states think we should be going to provide some more flexibility on 1332 waivers because we ultimately do think that states are

where this sort of policy should lie. I think when it comes to the individual health insurance markets and the small group insurance markets, these are state-focused, and states are in the best position to regulate in this space. We think it's better policy to the extent we can devolve authority back to states. And you can do that through 1332 waivers. You can do that through 1333 compacts. We're just looking at ways to make sure states have as much authority to do that as possible under the law.

Sen. Theis stated my next question is with respect to mandates. There was a discussion previously about state mandates and how after the ACA and in the marketplaces, it was developed that the states were supposed to absorb additional costs associated with new state level mandates. Has CCIIO done any analysis on what those look like and if it was actually charged to the states how much that would be? Mr. Nelson stated referring to the defrayal requirements under the ACA for essential health benefits, in the first Trump Administration, we asked states to do some better accounting for that. That regulation actually got pulled back by the Biden Administration, but states are still supposed to be defraying the cost, and that's not really a change right now to the system. And so, if there's a benefit that a state requires and it's not an essential health benefit, then the state's still supposed to defray that cost.

Sen. Theis stated my last question has to do with ACA mandates that may have driven cost. Is there any research out there showing mandates that don't have significantly better health outcomes or large-level health outcomes but are driving costs? Mr. Nelson stated the way that the Obama Administration put the regulations in place, they allowed states to choose a benchmark plan and for the most part, most states are still operating under the benchmark plans that they chose or something similar, and that benchmark plan was tied to a small group that basically the default was the largest small group plan in the state. And most states are under that framework. That is often a lower benefit plan. It still has good benefits but compared to some maybe large group employers or the federal health benefits that are available, there may be a little bit lower benefit. I haven't actually seen any research out there to suggest that the individual market benefits before the ACA were that much different from the essential health benefits after the ACA in terms of driving up costs. Sen. Theis said interesting - that's not the feedback I got.

Sen. Paul Utke (MN), NCOIL Vice President, stated regarding the 1333 compact and being able to buy health insurance across state lines. If I was buying insurance from North Dakota, wouldn't they have to sell us a plan that meets the Minnesota set of benefits? Or is this compact something that allows us to pick and choose different plans according to what's being sold in that home-based state? Mr. Nelson stated when you've heard a lot of people talk about this in the past, one of the selling points is, and this is under what I would call a preemption approach to buying insurance across state lines where, say, the federal government were to step in and require this to be provided where a consumer could choose whichever state they wanted to. If they chose North Dakota and it had fewer benefits and they were in Minnesota, then they could choose the plan with the fewer benefits if they wanted to maybe choose a lower premium option with less benefits. And if that was a federal approach and the federal government required that, then yes, that's how that would work. But the compact approach depends

on North Dakota and Minnesota agreeing on it together and so if Minnesota and North Dakota wanted to create that arrangement under a compact, they could. And I didn't get into the details for time reasons on how the compact operates, but the way the statute is drafted, it says that you can enter into a compact to allow the sale of a Qualified Health Plan (QHP) into another state, and only the laws and regulations of the state where the QHP is issued or written will apply. However, there's important exceptions and these exceptions make sure that the state where the person lives, where certain requirements are still applied from the state, the insurance company still has to be licensed in the state where the person lives.

And also very important consumer items like if a consumer has a complaint, they still go to the state where they live. Other requirements where we think the state's where the person lives is better equipped to make determinations, like network adequacy, and rate review. Those things still stay with the state where the person lives. And so, there's those exceptions in place. But something like the essential health benefits, that's something like the benefit structure, could differ between states if the states agreed to allow that but the states would have to agree to that. So, there's a lot of things that might differ, but there's also some things where the state retains control. I should add, within that structure, there's also guardrails, just like the 1332 waivers, that to be able for the federal government to approve it, the compact has to meet a set of guardrails that make sure that any compact provides coverage that's at least as affordable and comprehensive as they can get under the ACA, and also provides coverage to at least the same number of people as under the ACA, and also it can't increase the federal deficit. And the final thing is that a compact can't weaken the state protections under those exceptions that I just talked about.

Sen. Utke asked if any states are doing this currently? Mr. Nelson replied no. The ACA actually required regulations to be drafted by 2012 or 2013 but that didn't happen so there's actually no federal regulations on the books. We're currently looking at compacts right now. We looked at this in the first Trump Administration, but there's still no regulatory structure. But I'm encouraging states to start thinking about compacts because we're looking at issuing regulations. We're actively looking at that. We just want to make sure states have a heads up that, “Hey, look, this is an opportunity under the statute”. We want you to start thinking about it right now because you’re state legislators, you're looking at January. Many of you are looking at January for your sessions to start and if you want to start this process, one of the key things under the statute is you have to pass a state law to get this going. You all are very important in this process and I want to make sure you have a heads up on that.

CONSIDERATION OF RE-ADOPTION OF MODEL LAWS

Sen. Theis stated next on the agenda is the readoption of the NCOIL Insurance Business Transfer (IBT) Model Act. This Model was initially adopted in 2020. It largely followed an Oklahoma law which was considered very innovative at the time and they've been a leader in the IBT space.

Robert Redpath, Senior Vice President, Regulatory & Special Projects Director at Enstar, thanked the Committee for the opportunity to speak and stated I actually did a presentation here before the implementation of the Model. Really what I want to do is provide an overview of what's happened since then and I'll be very high level. So just a little bit of a reminder as to what the IBT process and Model is. Basically, an IBT is the ability to transfer a block of insurance business from one insurance company to another without the need for policyholder consent. It's a very rigorous process, and this is the process under the NCOIL Model and other states such as Oklahoma and Rhode Island that had statutes prior to the Model. So, there are a number of key elements. You require an independent expert report. You require the regulatory non-objection of the insurance regulator of the transferring company, the state where the business is coming from. You need the approval of the regulator of the assuming company. After the regulatory approvals, then there is a court approval process which includes the notification to policyholders and other stakeholders, regulators, reinsurers, and guaranty funds.

Ultimately, you end up with a court hearing and an enforceable order. So, just to reiterate, at the completion of this IBT process, all the insurance policies and corresponding assets, which would include reinsurance, are statutorily novated to the assuming company and the transferring company has no further liability to those policyholders. Rhode Island had a statute prior to the Model and has amended it so it's much closer to the Model. Then followed Oklahoma. Then the Model was adopted. Then Arkansas, Illinois, and Georgia now have the IBT Act. And Texas has had two attempts. It has passed in the House twice, but it's not made it through the Senate to date. Illinois did have some changes. They decided to exclude life, health, and accident & health insurance.

So what I wanted to talk about is back in 2018, it was all very new. Since then, there have been four IBTs, all into Oklahoma domestic companies, three of which I'll talk about that we at Enstar did. We have a company called Yosemite Insurance Company. It's a 49-state licensed company, which we moved into Oklahoma for this process. The first IBT we did was actually the most complicated. It was a mix of business. This was Providence Washington Insurance Company. It was also owned by Enstar. It was the second oldest continuous writer founded, I think, in 1799. So, a lot of old business there. We transferred all the remaining business out through this process into Yosemite. It was a mix of direct insurance, all commercial. So, no real consumers involved, but it did involve a lot of notifications and we did look back in some instances 50 years for old policies which involved 60,000 notifications. Ultimately, the transfer went very smoothly the only difference here with this transfer was that New York has been reluctant to grant a license to Yosemite. That's the one missing state so we had to retain the New York policyholders transfer by way of reinsurance. The other transactions that have happened have all been assumed reinsurance again to Enstar and one of them with R&Q. Just of note, the two of our transfers were internal, so between intercompany, two different owned companies. But in both instances, what we did was we transferred all the policies out of a company, so all the liabilities were gone, and then we sold those companies as clean shells. There's a very big market for shell companies in the insurance industry.

Having done this now for the last 5 or 6 years, looking at some of the positives off IBTs. Really, what we've seen is it's a good method to restructure a group of insurance companies. It gives the ability to align portfolios. If you think about some of the bigger insurance companies that have maybe 5 or 10 writing companies, there may be circumstances where it makes sense for them to streamline their business. They may have little pockets of types of insurance in multiple companies that they would prefer to have in one company. So that's one thing. The main thing we found, and what we did again with two companies, was it is a very good way of creating a clean-shell company. What you're doing is you're making a clear division of old and new business. Historically, shell companies were sold with reinsurance. So effectively, if you were buying a shell company, the old business was being reinsured out usually to the selling company. So, it was done through reinsurance. So, you had economic transfer of the business, but you never had full finality of that business. So, if theoretically one of those two elements, the old company or the new company, if there was an insolvency, there would be all kinds of problems in the sense that either new policyholders could end up in an insolvency mixed up with the old policyholders or vice versa. This gives clarity. It cuts out disputes. Really what it is, you can have finality, you can move. You can have a clean shell that does not have any concern about the financial strength of the old company, the policyholders are split. The other thing, and again, two of the transactions I talked about, they were legal finality for companies who were looking to divest non-core books of business, so the R&Q transaction with Sentry, again, Sentry had a non-core book they wanted to move out, and the same with the Hanover Insurance Company, the last transaction we did, they had some non-core business they were looking at old legacy liabilities to get off and get finality. And then my final comment is the IBT is a very useful restructuring tool, but it may not be appropriate in all situations, it's just a tool, it's to be used carefully in certain situations.

Oklahoma Insurance Commissioner Glen Mulready thanked the Committee for the opportunity to speak and stated that this process started when I was an Oklahoma legislator at a National Association of Insurance Commissioners (NAIC) Meeting and learned about Part 7 transfers. These are transfers that have been done in the U.K. and in Bermuda and elsewhere across the country. There have been over 300 transactions done over the last 20 plus years without a failure, without a problem. And so, it just made sense to us, and we thought, as legislators, this is a tool that could be a business tool for companies, and we need to do this back in our state. So, we did, and we started with Senate Bill 1111 in 2018. That created the IBT Act. Now what I'm going to just hit on quickly is just how we have tweaked that and most of that was just learning as we went along. And so, in 2019, we updated the language to require a specific listing of documents and things that are included in the opinion report. Mr. Redpath just talked about the independent expert that's involved, and so this specified some things that should be included in that and made in the application for that IBT confidential while we are reviewing it. So, once it gets filed with the court is when that becomes public. But right now, we have four transactions that are what I call in-house that are in with us. So those are confidential at this point. When they get filed with the court, those become public.

And then in 2022, we modified and updated some definitions, expanded the definition for "district court." The original legislation specifically cited Oklahoma County District Court. What we ran into was we had a judge that had been assigned to a case and they were promoted up to the appellate court, and that just delayed that process until they assigned someone. We also had the situation with the pandemic. We were two weeks away from a case coming and then the courts closed so we expanded that based on population. So, we now have three district courts that those could be heard in. We increased the number of days for notices. These are just some of those tweaks that were in 2022. We created a process for international locations. As you just heard about Part 7 transfers, this type of transaction is very familiar elsewhere. It had never been done in the U.S. before we did that first transaction, but there are international players in this. It also clarified requirements for notification for the policyholders and we added reinsurers as far as their notification process. When someone is notified of a transaction, we notify all 56 regulators as part of the NAIC.

As Mr. Redpath just hit on, it's the transferring State who has to, well, not approve it but they just at least must have a letter of non-objection to make that happen. And then we added language related to guaranty funds having to do with policyholders outside of the U.S. We've now completed 4, as you heard. Those came from Rhode Island, Wisconsin, Missouri, and New Hampshire. The first one was October of 2020, and our last one that was finally completed in May of 2025. We have 4 in-house that involve Arizona, Wisconsin, and Connecticut. There's been a lot of attention because we are the only state that's been able to accomplish this. We have other states, as you saw, that have brought on legislation that's not been able to put a deal together yet. We are hopeful that other states will accomplish that, and this becomes more of a normal way of doing business in the U.S. And a couple looks at some of the differences quickly. Rhode Island's is a lot more limited than ours is. The business has to be in runoff. In other words, they have not sold a new policy in at least 5 years, and its P&C only, not in the life and health business. Arkansas and Oklahoma permit transfers that are both open and closed and don't limit the line of business. That final bullet is about corporate divisions, which is similar. It's a restructuring mechanism that some other states have. It is not IBT, but Illinois, Connecticut, and Pennsylvania do allow those. And as mentioned earlier, Illinois also excludes life and health. Legislation was run in Texas. I believe next year there's legislation that's going to be run in Florida, so there's a number of states that are now picking up on this. I will say, too, the Restructuring Mechanisms Working Group at the NAIC has been working on a white paper on this. We hope to finalize that. We have a final draft right now. It has gone on for literally years, but hopefully in Florida at our next meeting, that will be finalized with that.

Rep. Brenda Carter (MI) asked the speakers to talk about the consumer protections or guardrails that are in place with this process. Cmsr. Mulready stated the first thing is the notification. Policyholders receive notification of their requirements in the law and how that has happened. I will tell you that, Enstar was our very first one, and they would come in with their communication plan, and I sent it back to Mr. Redpath to say, "no, it's not good enough. We've got to do better in notification." And because that was a block of business where policies hadn't been sold in 35 years, this is not active business. I teased Mr. Redpath that I have three sons, and I was much harder on my first one than

my last two, and he's my first child coming through with this process, so we were a little tougher on him. But it really is about that communication plan. Mr. Redpath stated I would agree, but also note the court process. The court approves it, and people have the ability to come along and object if they want to and there is full notification there. Cmsr. Mulready stated the phrase that I don't know that you heard here, but it's the key that we are looking at and the independent expert is looking at, and the judge is looking at, and that is that no policyholders are “materially adversely impacted.” That's the key phrase.

Hearing no further questions or comments, upon a Motion made by Rep. Oliverson and seconded by Rep. Carter, the Committee voted without objection by way of a voice vote to re-adopt the Model.

Sen. Theis stated there are two other Models that we need to consider for re-adoption - The Market Conduct Surveillance Model Law and the Market Conduct Annual Statement Model Act.

Hearing no questions or comments, upon a Motion made by Sen. Justin Boyd (AR) and seconded by Sen. Jeff Howe (MN), the Committee voted without objection by way of a voice vote to re-adopt the Models.

ANY OTHER BUSINESS

Rep. Oliverson stated I raised an issue during the Summer Meeting in Chicago regarding the 340B drug pricing program. I know it's a topic that a lot of us in the room are interested in and care about and are concerned about. And I would propose that NCOIL look at developing a policy requiring transparency in 340B through requiring some of the same data points that are communicated to the federal supervisors of the program be made available to our states as well so that we can see the value of these discounts and how much money is being collected, and most importantly, whether or not that money is being used on charity care and indigent care, which is what it's supposed to do. I think it would be a great idea for a Model next year.

Sen. Theis stated I completely support that and thank you for bringing that forward. Rep. Carter also thanked Rep. Oliverson and stated that I will definitely work with you if this is something you're willing to take on.

ADJOURNMENT

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

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CHIEF EXECUTIVE OFFICER: Will Melofchik

NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

Individual Coverage Health Reimbursement Arrangement Model Act

Sponsored by Rep. Meredith Craig (OH)

Draft as of February 19, 2026. To be discussed and potentially considered during the Joint State-Federal Relations & International Insurance Issues Committee Meeting on April 18, 2026.

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Section 1. Title

This Act shall be known as the [State] Individual Coverage Health Reimbursement Arrangement Act.

Section 2. Purpose

The purpose of this Act is to authorize a nonrefundable income tax credit for a small employer that offers an individual coverage health reimbursement arrangement to its employees.

Section 3. Definitions

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

(A) An Individual Coverage Health Reimbursement Arrangement (ICHRA) means a health reimbursement arrangement established pursuant to 45 C.F.R. 146.123.

(B) A "Health Benefit Plan" and "Health Plan Insurer" have the same meaning as [insert citation to relevant portion of state insurance code].

Section 4. Income Tax Credit for ICHRAs

(A) There is allowed a nonrefundable credit against a taxpayer's aggregate tax liability under [insert citation to relevant state tax code] for a taxpayer that, during the taxable year is either of the following:

i. An employer that employs more than one and less than fifty-one total employees, cumulatively and regardless of any particular employee's length of tenure, provides an individual coverage health reimbursement arrangement to some or all of the employer's employees, and contributes at least xxxxx dollars per employee to that arrangement during the taxable year;

ii. The owner of a direct or indirect interest in such an employer that is a pass-through entity.

(B) The credit shall equal xxxxx dollars multiplied by the number of the employer's employees who were provided benefits under an individual coverage health reimbursement arrangement, cumulatively and regardless of any particular employee's length of tenure, during the taxpayer's taxable year.

(C) The credit shall be claimed in the order prescribed by [insert citation to relevant state tax code]. A taxpayer described in subsection (A)(ii) of this section may claim its proportionate or distributive share of the credit allowed under this section.

(D) The tax commissioner may request that a taxpayer claiming a credit under this section furnish information as is necessary to support the claim for the credit under this section, and no credit shall be allowed unless the requested information is provided.

Section 5. Unfair and Deceptive Practices

The following are hereby defined as unfair and deceptive acts or practices in the business of insurance:

(A) Using any underwriting standard or engaging in any other act or practice that, directly or indirectly, due solely to any health status-related factor in relation to one or more individuals, does any of the following:

i. Terminates or fails to renew an existing individual or employer-provided health benefit plan for which an individual or employer would otherwise be eligible;

ii. Excludes, induces to exclude, or causes the exclusion of an individual from coverage under an existing employer-provided health benefit plan;

iii. Steers an individual from coverage under an existing employer-provided health benefit plan to coverage under an individual health benefit plan;

iv. Offers employers or individuals financial or other benefits as incentives for individuals to not enroll in, or to terminate enrollment in, an employer-provided health benefit plan, including by offering individuals an alternative to an employer-provided health benefit plan.

(B) Subsection (A) of this section does not prohibit either of the following:

i. Providing information to an employer about an individual coverage health reimbursement arrangement or related tax credits available under Section 4 of this Act;

ii. Establishing or advising an employer in the establishment of an individual coverage health reimbursement arrangement in accordance with 45 C.F.R. 146.123, et seq.

Section 6. Rules

The [insert relevant state entity] shall adopt rules to effectuate the provisions of this Act.

Section 7. Effective Date

This Act shall take effect xxxxx. The provisions of this Act applies to taxable years ending on or after the effective date of this Act.

Indiana SB 118 will guide discussion on the 340B drug pricing program topic: https://iga.in.gov/pdf-documents/124/2025/senate/bills/SB0118/SB0118.05.ENRH.pdf

FINANCIAL SERVICES & MULTI-LINES ISSUES COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
FINANCIAL SERVICES & MULTI-LINES ISSUES COMMITTEE
2025 NCOIL ANNUAL MEETING – ATLANTA, GEORGIA
NOVEMBER 14, 2025
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Financial Services and Multi-Lines Issues Committee met at the Whitley Hotel in Atlanta, Georgia on Friday, November 14, 2025 at 9:00 a.m.

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

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Rep. Matt Lehman (IN)
Rep. Mike Meredith (KY)
Rep. Edmond Jordan (LA)
Rep. Brenda Carter (MI)
Rep. Mike McFall (MI)
Sen. Lana Theis (MI)
Sen. Jeff Howe (MN)
Asm. Erik Dilan (NY)
Sen. Pamela Helming (NY)
Sen. Jerry Klein (ND)
Rep. Tim Barhorst (OH)
Rep. Brian Lampton (OH)
Sen. George Lang (OH)
Sen. Mary Felzkowski (WI)

Other legislators present were:

Rep. Carolyn Hall (AK)
Rep. Emil Bergquist (KS)
Rep. Sean Tarwater (KS)
Rep. Chad Aull (KY)
Rep. Mike Clines (KY)
Rep. Daniel Grossberg (KY)
Rep. Robert Foley (ME)
Del. Mike Rogers (MD)
Rep. Mark Tedford (OK)
Sen. Bill Gannon (NH)
Rep. Garland Pierce (NC)
Sen. Jeff Barta (ND)
Asw. Catalina Cruz (NY)
Rep. Brian Lorenz (OH)
Rep. Greg Scott (PA)
Rep. Barbara Dittrich (WI)
Rep. Matthew Morgan (TX)
Rep. Try Wharton (TX)
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. Justin Boyd (AR) 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. Pam Helming (NY) and seconded by Sen. Mary Felzkowski (WI), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 17, 2025 meeting.

CONSIDERATION OF RE-ADOPTION OF MODEL LAWS

Asm. Gandolfo stated that first on the agenda is the consideration of readoption of three model laws: the NCOIL Rebate Reform Model Act, adopted on March 8, 2020; the NCOIL E-Tilting Model Act, adopted on March 8, 2020; and the NCOIL Model Act Concerning Statutory Thresholds for Settlements Involving Minors, adopted on September 26, 2020. To date, no comments or proposed amendments have been submitted.

Hearing no questions or comments on the Models, upon a Motion made by Sen. Mary Felzkowski (WI), and seconded by Sen. George Lang (OH), the Committee voted without objection by way of a voice vote to re-adopt the Models.

DISCUSSION AND POTENTIAL CONSIDERATION OF PROPOSED AMENDMENTS TO NCOIL INSURANCE FRAUD MODEL ACT

Asm. Gandolfo stated that next on the agenda is a discussion and potential consideration of proposed amendments to the NCOIL Insurance Fraud Model Act. In Chicago in July, we heard a very compelling presentation from the Louisiana Insurance Commissioner, Tim Temple, detailing the state's aggressive efforts to combat insurance fraud. These include legislative expansions to the definition of fraud, increased staffing and funding for the Department of Public Safety's fraud unit, and heightened enforcement actions against insurers for post-claim underwriting and other violations. Today, we will hear about proposed amendments to the Model, sponsored by Rep. Gabe Firment (LA).

Kyle McCollum, Vice President of Strategy, Policy, and Government Affairs of the National Insurance Crime Bureau (NICB), thanked the committee and expressed NICB's strong support for the pending amendments to strengthen the Model. He also extended NICB's thanks to Rep. Firment for his leadership in sponsoring the amendments and to the Coalition Against Insurance Fraud for their great work on this effort. NICB sits at the intersection of the insurance industry, law enforcement, and departments of insurance across the country. Our membership includes more than 1,200 property and casualty insurance companies, vehicle rental companies, auto auctions, vehicle finance companies, self-insured organizations, and other strategic partners. Through advocacy, intelligence, education, and investigations, NICB works to detect and prevent insurance crime and fraud. The amendments pending today would help combat inflated and

exaggerated billing, one of the oldest forms of cheating someone else out of money. Despite nearly all states having an insurance fraud statute on the books, inflated and exaggerated billing remains a loophole that fraudsters can still exploit. Over the past few years, NICB has witnessed a significant increase in questionable claims referrals to our organization related to inflated and exaggerated billing. From 2022 to 2024, we saw a 41% increase in questionable claims related to faked or exaggerated harms on auto policies. And a 62% increase in questionable claims related to fictitious losses. From 2022 to 2023, NICB saw a 15% increase in questionable claims related to inflated damages on roofing claims and a 46% increase in questionable claims related to fictitious losses. And finally, from 2022 to 2024, we saw a 53% increase in questionable claims related to inflated towing invoices.

The pending amendments to the Model would provide valuable guidance for states in combating these trends. If adopted, it would help ensure that anyone who knowingly presents a statement, estimate, or invoice that, “misrepresents the scope of damages or cost of repairs,” may be found guilty of insurance fraud. This language is inspired by similar anti-fraud legislation that's been enacted recently in Louisiana in 2024 and in Kentucky this year. We also applaud the proposed new drafting note that we have worked on that encourages states to expand the venues for insurance fraud prosecution. This will help ensure that resources are available and that cases can proceed. In short, the amendments will further strengthen the Model, protect consumers, and improve deterrence against insurance fraud. We encourage the committee to take up and adopt the amendments today.

Brent Walker, Director of Gov’t Relations at the Coalition Against Insurance Fraud stated that the Coalition is a consumer advocacy group, and our membership is quite diverse, from consumer groups to carriers to government agencies and other organizations like the NICB dedicated to fighting insurance fraud. Thirty years ago, the Coalition is actually the one who proposed this Model. Since then, it's been adopted by several states and amended twice here since its first adoption. These proposed amendments will further strengthen the fight against insurance fraud. In the preamble of the Model, it says that insurance fraud is expensive, and it is. According to our research studies with the Coalition, insurance fraud costs every American $308.6 billion. It also steals lives. Tragically, we've heard the tale of Alice Ross, the 71-year-old grandmother who was an innocent victim in a staged accident scheme. So, we have to confront insurance fraud head-on, and that's exactly what this Model does. Adding a third element to the definition of “fraudulent insurance act” will help strengthen the recurring problematic issue of billing fraud and inflated estimates. The proposed drafting note also aims to remind states that in their jurisdictions, when it makes sense, to expand venue and clarify venue. In preparing to speak this morning, we spoke with the Louisiana Department of Insurance, and they tell us that the reason they passed this law in 2024 was that it does close prosecutorial loopholes, and it gets rid of that he said, she said, and it is the individual or the firm that actually creates the fraudulent estimate who should be held accountable. So, for those reasons, we thank you for this consideration, and we strongly support the passage of these amendments.

Asm. Gandolfo then recognized briefly Hilary Segura of the American Property Casualty Insurance Association (APCIA), who expressed her support of the proposed amendments.

Hearing no questions or comments, upon a Motion made by Sen. Lang and seconded by Rep. Brian Lampton (OH), the Committee voted without objection by way of a voice vote to adopt the amendments. Then, upon a Motion made by Sen. Justin Boyd (AR), and seconded by Rep. Matt Lehman (IN), the Committee voted without objection by way of a voice to re-adopt the Model, as amended. Asm. Gandolfo thanked everyone and noted that the Model would be placed on the Executive Committee's agenda for final ratification.

CONTINUED DISCUSSION ON NCOIL MODEL ACT REGARDING INSURERS' USE OF ARTIFICIAL INTELLIGENCE

Asm. Gandolfo then stated that next on the agenda is a continued discussion on the NCOIL Model Act Regarding Insurers' Use of Artificial Intelligence. We also have an alternative proposal to discuss that was submitted by the American InsurTech Council.

Asm. Erik Dilan (NY), sponsor of the NCOIL Model, thanked everyone who has weighed in on this model since it was first introduced. This Model is meant to be a conversation starter. It's based on a bill that has been reintroduced into Florida for next session, and it borrows from similar concepts on the health side of things with prior authorization that has been passed by several states. As I mentioned in July, I think we as policymakers should at least discuss whether or not these concepts make sense across all lines of insurance. I think the concern that I had from Chicago is the information that we received from the industry was, "no, we don't want anything at all," which I think could be short-sighted. I think it is incumbent upon all of us to try to get this to the best workable Model as possible so we can collectively bring it back to all of our states. I want to give kudos to the American InsurTech Council for stepping up and offering a different approach. I think we all need time to digest that but I do think that it's worth having the discussion on both proposals to see if it makes sense to come up with a framework for combining both proposals, do something different, or adopt each model independently.

J.P. Wieske, representing The American InsurTech Council, thanked the Committee for the opportunity to speak and stated that the Council is a group of over 125 small Insurtech's through our partnership with the InsurTech Alliance, as well as having members that are legacy insurers, sponsors that are legacy insurers, solutions providers, and AI providers. We brought forth this proposal because we have some concerns with the simple solution of just having a human in the loop. We think that the NCOIL model is potentially both too narrow and too wide. We think it's too wide because of its application from a claims perspective across multiple insurance lines, which deal with things differently, and the concerns in P&C and life are very different in the use of AI than they are with health. And even inside health, there are some significant differences. When I started as a claims analyst in 1993, the number of claims that were auto adjudicated was very small, and my company was experimenting with a small company. By the time I left, the claims department was one of the smaller departments, and IT had

grown to be the largest department. Over 50% of the claims were auto adjudicated in 2003. Now we move to today. It is certainly true that in a lot of cases, from a health perspective, 90-plus percent of claims are auto adjudicated. The concern that I have is the cost that's going to be incurred by having a human in the loop. We understand the concerns when you're dealing with medical and other pieces and making those medical judgments. We do think that the way the insurers go through this process, those claims are treated differently and go through an entirely different process. But just adding a human in the loop is also not enough. And so, our proposal builds on the National Association of Insurance Commissioners (NAIC's) AI model bulletin that has been adopted by over 25 states. The idea is that we need to have a starting point for the regulation of AI, and it is not the last step. There's no intention for our bill to be necessarily the last step. We think the policy needs to develop. We're in an area where we've got a lot of promise around AI, and some of that is going to take a lot longer than the optimists believe is going to happen.

The AI policy needs to develop. If you take a look at our model, it's a multiple approach where we have requirements on the insurers to ensure that they have governance, that they're checking for bias and other things inside those models. This applies not just to claims. This also applies to the use of AI across multiple systems that insurers use. It's certainly used in rating. It's certainly used in customer service. It's certainly used in a variety of ways inside insurance companies. And our intent is not just to focus on claims. It's to focus holistically and include requirements that the insurers are going through this governance process, that the executive team is actually monitoring and ensuring compliance with their stated goals and rules for the use of AI. And then having a look in by the insurance departments to be able to verify. This is not an easy discussion, and we really appreciate the start of the conversation. As the saying goes, "to every problem there is a solution that's easy, elegant, and wrong." We're concerned that focusing only on the human element is not enough and can be subverted and create other problems. We think the alternative approach we've suggested will provide good oversight. As you're able to look inside the companies, you'll be able to better understand how to regulate as we move forward, and we need to look at this as an evolutionary regulatory process rather than this being the endpoint.

Dave Almeida, Senior Director of State Gov't Affairs at Blood Cancer United (BCU), thanked the Committee for the opportunity to speak and stated that BCU's mission is to cure blood cancer and improve the quality of life of all patients and their families. We fund life-saving blood cancer research around the world, provide free information and support services for patients and their families, and are the voice of those seeking access to quality, affordable, coordinated care. The integration of AI into healthcare has slowly changed how health insurers and providers deliver care to patients. As we know, AI is increasingly being used by health insurers to automate a host of functions, including process utilization management like prior authorization requests. An NAIC survey earlier this year found that approximately 68% of health insurers are already using or planning to use AI for reviewing their prior authorization requests. While we believe that AI presents opportunities for plan efficiency, the unregulated use of AI could also exacerbate existing bias and discrimination, particularly for marginalized and

disenfranchised communities who already experience disparate health outcomes and lack of access to insurance.

AI is moving fast. The speed of technological advances in AI is far outpacing the changes in state and federal insurance regulation, and oversight is needed to protect consumers. When used appropriately, AI has the potential to quickly analyze patient data and historical records to make evidence-based recommendations to overseeing physicians, expedite approvals, minimize delays in patient care, while reducing administrative burdens for both providers and insurers. BCU supports the development of a model law and urges you to continue on this path. While we understand this is a rapidly developing area, states are at the forefront of regulating the use of AI in insurance, and a model law will help create a regulatory floor across the states, promoting fairness and transparency for consumers and industry alike. We think the proposal from the American InsurTech Council is a step in the right direction to achieve this level playing field. As it relates to health, we would encourage a specific focus on plan use for AI utilization management practices, including prior authorization to ensure patients do not face additional roadblocks to receiving medically necessary care.

Matt Overturf, Ass't VP of State Affairs at the National Association of Mutual Insurance Companies (NAMIC), thanked the Committee for the opportunity to speak and stated that NAMIC maintains the position that the development of a model law as it pertains to property and casualty insurer use of AI is both premature and unnecessary. While legislative and regulatory guardrails may seem well-intentioned, they ignore how existing insurance code already applies to the use of AI and the existing consumer protections they provide. Further, efforts often mistakenly assume that the use of AI creates a higher degree of risk to consumers than human decision-making while ignoring how AI used in the furtherance of insurance-related activities can create consistency, remove potential subjectivity, and enhance efficiency. The strength of the existing insurance code is that it is focused on outcomes and consumer impacts, regardless of the tool used. According to the insurance code, if it's illegal for a human to do it, it is also illegal when using AI, a computer, a cell phone, or whatever technology comes next. So, for these reasons, NAMIC continues to urge caution for the development of a model law as it pertains to property and casualty insurer use of AI.

Sen. Felzkowski asked Mr. Wieske if we should legislate differently around health insurance and P&C for purposes of AI? Mr. Wieske stated that I think the nice thing about our proposal is the intent is to require governance inside the insurers and that they go through that process. And as NAMIC indicated, what's illegal is still illegal and what's wrong is still wrong but from our view, you want to ensure that everybody has a minimum standard that they're looking at the operations and that they're making sure they're compliant because the difference with AI, it's just another tool but the difference is that it can run amok really fast and it can accelerate where the problems come in. So, what we're suggesting is it is the same, at least at this level, and we're only focusing on ensuring that there's a governance process and management and oversight over that process and that there is a reporting and a look in by the insurance departments to be able to make sure that they're complying with that. Down the road, there may have to be different rules for different lines so that may be true when you look at things like figuring

out what the pricing of a house is that's destroyed, or a car, but in the short term, I think we're more focused on getting the governance right and seeing where the policy generally grows up with AI.

Rep. Lehman stated that we had a situation where I had an agent reach out to me that they were stopped mid-quote because the home was ineligible and they reached out to the underwriter who said, “between AI and other factors used for underwriting this doesn't qualify.” So, when you tell me it's premature to regulate AI, but yet AI is actively being used in the underwriting process, help me understand the prematurity of regulation over the actual use of it. Mr. Overturf stated that if the existing insurance code was followed, I don’t think it matters if it was AI or just a human or both. To Asm. Dilan’s point earlier, the reason we're not necessarily offering anything in terms of amendments or an alternative is because at this point in the development of AI, we feel that it falls under the existing insurance code. If we identify gaps in the existing insurance code and regulatory structure that for some reason AI doesn't fit, then we should have that conversation but I don't think we're there yet, at least as it pertains to P&C.

Rep. Lehman stated I don’t necessarily disagree and I don't want to take away this tool but my bigger concern is that AI was used to make a decision on an underwriting issue, not on a claim or anything, and then no explanation was offered other than “it was AI.” A human in the past would finish the quote and then provide feedback but we're getting now this midway through the process of being told it's ineligible due to AI. So, to me, we're crossing a little bit over from the human touch. AI is intuitive, that’s what we always hear. Intuition is the ability to make a decision based on data with no cognitive reasoning. So, you're not thinking about stuff. You're just doing it. So AI now is kind of taking over that piece and this is an issue for NAIC as well. How do you regulate technology? Mr. Overturf stated I think in that point, the underwriting guidelines are what they are so the human is going to follow the underwriting guidelines just like they're going to load that into the AI platform so it's more just building the efficiency of completing that process for a property that isn't eligible and stopping halfway through to not waste that time further down the line. It's just coming to that decision a bit quicker that ultimately would have been come to if you didn't have AI. You're coming to the same decision following the underwriting guidelines whether that's the person doing it or computer.

Mr. Wieske stated that the concern is making sure that it's not used as a sort of a cop-out and there's no sort of ability to point fingers back and forth. Mr. Overturf’s exactly right - the insurer is responsible, but I think what we're trying to do is ensure that the insurer is taking responsibility and not pointing fingers, especially if it's a third party that's doing the work, and that they're doing the work up front to make sure that there is a process in place for making decisions.

Asm. Dilan stated I certainly feel like we should take our time and get this right, and that's a position I maintain. To Mr. Wieske, it looks like the biggest difference between the two models is yours sets up a governance structure that's a little bit broader that goes beyond claims. And mine is strictly related to claims but basically says that an

insurance company can't deny a claim solely using AI and a human has to be involved. It looks like that's the biggest hang-up in this. Would you say that's accurate?

Mr. Wieske replied yes and stated that I think that distinction is important. As I talked about, there's 90% of claims in health auto-generated, and even inside health, there's significant differences across the way they operate. And some of the concern I have is if you look at specific cases, for example, if you're dealing with excepted benefits generally, typically there's a policy limit, and the policy limit would require the claim to be denied, and that's not looked at by a human now because it has hit the maximum amount that the policy has indicated they're going to pay and having a human involved just adds cost to it. There are cases where, again because the model is broad and uses the term “algorithm,” if you're looking at denying a claim because it's exactly the same as maybe a claim that's already been paid - it's a duplicate, same data service, same doctor, same procedure, same coding - and you now don't have the ability because you have to have a human take a look at that, that creates a different issue. If you have a diagnosis that is clearly not coverable under the policy, say again with fixed indemnity, that might be automatically denied and there's not a lot of sense in having a human look at it. Or in the case where you have something that is purely cosmetic with no secondary diagnosis that comes in on a claim and that would need to be denied because again that becomes an algorithm issue as well. So I think there are issues there that will add costs and not a lot of value to consumers. I can't speak for the insurers, but my guess is they would agree generically to say, “Look, we would expect that if you have a complicated medical decision that's attached here, there should be somebody looking at this and some oversight.” Generally in the prior authorization world, it used to be a nurse could say “yes,” but only a doctor could say “no.” I think a lot of them are implementing similar policies for AI that AI might be able to say “yes,” and then you have to have a human in the loop for the more complicated cases. I do have concerns that just adding a human in a loop doesn't solve the fundamental problems and doesn't provide oversight and it doesn't mean that even if the person is qualified, that they're going through a process and not just closing out the edits and denying it because that's what the AI is and that's what their expectations are.

Asm. Dilan continued stated I certainly don't know how insurance companies internally use AI to go through the various processes that they go through, which is why we kept it to claims because it was more narrow and it was more focused on the consumer protection element, which I'm interested in. But I know just in my daily use of AI as a practical measure, if I give AI a task, I certainly step in and review it for accuracy before I send it out into the world for applicable use. And I think that would be good practice for any insurance company to do as well. In your instance, it looks like the first human contact would be at the governance model structure but at what point through any of an insurer’s processes, whether it be claims or underwriting, does a human look at any of the work that AI does?

Mr. Wieske stated you're exactly right because I will fully disclose that the first draft of this model was done by AI, as was the second draft and the third draft and then I edited it ultimately and still, not all of the language is probably right. But that's in part the idea of the governance process. When you're processing as an industry, again, to use health

as an example, three billion claims a year, the expectation when you're doing governance, and similar to market conduct exams, when you look at the way they operate, they take a percentage of the claims to make sure that when humans are processing, they're processing correctly, and they're making a lot of mistakes. I was just meeting with the Georgia Department of Insurance and they had fined insurers $20 million for noncompliance in a specific piece that they're going through. So in those cases, it's not like having a human is necessarily an infallibility. And so the idea that we've got is that you are monitoring and going through this process and the human in the loop is not just on a claim-by-claim decision, but the expectation is that you're looking at it holistically, and that even in the cases where you're approving claims or you're coming up with rating, you're coming up with pieces, that there is a process where a human is overseeing that. So, it's more focused on human oversight than sort of directly in the claims process requiring a human to be in the loop whenever there's an adverse determination. I think even if you go down that route, I think there's going to be problems, honestly, functionally, and there's going to have to be some significant changes if the insurers are willing to offer them. I can't give you any of those because I'm not inside the operations. But having it apply just to claims is going to be really expensive for a lot of insurers from a cost perspective. Even if it's just that. And narrowing that scope and getting it line by line is going to be even harder. Because, again, you've got pricing issues inside, and valuation issues inside P&C, which is very different. You may have evaluation of case files inside life insurance, which may be different.

Mr. Overturf stated I can't speak to exactly when inside an insurance company a human is in the loop, but insurance companies still have claims departments and underwriting and rating departments, and then there's the compliance department. So, there are humans within those departments that are looking at these processes as they come in. As claims are filed, as claims are either paid or denied or whatever it is, they're there. When do they exactly see them, I'm not sure, but it's not like AI has replaced an insurance company's claims department or compliance department. And then on top of that, you have the market conduct statutes in every state where the Department of Insurance can go in and look at how an insurance company is conducting business in that state. There's no exception for AI. So, if they're doing something that violates the insurance code, they're going to find that. So that's why our position is the current existing insurance code is adequate until we identify a gap where it isn't. Asm. Dilan asked if as a matter of practice, there's still humans looking at basically every aspect of what you do? Mr. Overturf responded I would imagine so in some way, shape, or form.

Sen. Lang stated we know AI is coming. We know AI is going to save just about every industry considerable money. We know that if the insurance companies have a way to save money, there's many things they can do with that savings from increasing Earnings Before Interest, Taxes, Depreciation, and Amortization (EBITDA) to lowering costs to consumers. So, I believe in the long run, AI is going to be consumer-friendly. My question is how prevalent is AI usage in the insurance industry today? And we know for a fact, when it comes to underwriting and adjudicating a claim, there are going to be human errors. That's a fact. I believe there's also going to be AI errors. Today, is AI superior to humans? I don't know. I think it will be one day. It may not quite be ready for

prime time yet, but one day, as it gets perfected, it will be. So, my question is, how prevalent is it today? And if a decision is made based on AI, not human interaction, is there a disclaimer to the applicant or the insured, depending on if they are applying for an insurance policy or going for a claim, that says this has been created by AI and if you would like a human intervention in this, please let us know? And if that's not the way it is today, would that be a potential amendment that would give everybody a level of comfort - let the AI have its way, but make sure it's clear to the affected individual that this was AI, and if you want to appeal, here's the process?

Mr. Overturf stated regarding the prevalence of AI, at least for NAMIC members, we represent some of the largest companies in the country and all the way down to some of the smallest. So, it varies. Some of these companies are very sophisticated. Some of them are less sophisticated. So, I think it varies depending on what makes sense for their business so I don't have a good answer as to how prevalent it is. I think it's developing. It's growing. As insurance companies continue to try to find ways to gain efficiencies, that's one of the areas that they're looking at. But, again, it's going to vary based on that individual company. And then, in terms of the disclosure, I don't know that there is currently a disclosure in terms of AI is doing it today. It's something we can take back and talk to our members about.

Mr. Wieske agreed with Mr. Overturf and stated I don't think there's a huge difference other than a sense of tactics in the way we sort of look at this issue. We think that the ideas are developing. And the AI bulletin that this proposal is based on is in over 25 states and this puts it in law. There are a number of states that don't do bulletins consistently, so it provides this. It also provides some ability to enforce that AI bulletin around the governance procedures. That's sort of what we were thinking about when we put this together. The other piece is we do have some disclosures that are sort of required. It's nonspecific, but the insurer is required to disclose in the areas where they're using AI and to the consumer so the consumer is aware. I think there's really strong variance in the way it looks. This is coming and it's changing and our hope is that this is the first step. I don't think it's a huge step, if we're being honest about it, but I think over time, there's going to be some development. There's work on other ways to look at this. There's certification processes. There's other things that the private industry is doing. There's some discussion about a URAC-style accreditation as an alternative. That's expensive and problematic and may only be available to large carriers, at least until it develops over time. So, we think it's important to take a first step and that's how we were looking at it.

Sen. Lang stated that we do so many things with mandates on carriers that drive up costs. The carriers don't eat those costs. They pass it on to the consumer. I think AI is one of the things that has the tremendous amount of potential value to lower costs and give the carriers the opportunity to pass that cost on to the consumer.

Rep. Mark Tedford (OK) stated what I hear you saying is the real protection for the consumer is the code of conduct rules and that as long as the carriers are following those, it doesn't really matter whether those decisions are made by AI or a person. What I'm hearing is if we really want more protection for the consumers, it maybe should be

through the code of conduct rules rather than restricting AI from making these decisions. Is that a fair assessment of what you're saying here? Mr. Overturf stated I think so. If we identify a gap, then we should fill that gap, or at least look to fill that gap. At this point in the development of AI and the utilization as it pertains to property casualty insurers, there hasn't been a gap identified yet so, yes, to your point, if we identify a gap there, then it should be looked at to be addressed, but until that is identified, we feel that the existing statutory and regulatory framework is adequate. Mr. Wieske stated and from our perspective, we're just asking for assurances that all the carriers are going through that process and that they have their own internal process and code of conduct that they've worked on to establish their rules around AI, that they've put it in place, they're consistently testing those rules, they're going through the processes they should be going through. But we know there's going to be carriers that, for one reason or another, that it may fall off, but they have some ability to sort of make sure that they do, in fact, have a code of conduct and are working through it.

Sen. Lana Theis (MI) stated in the 1990s, I used to process health insurance claims, and I've been sitting here trying to think of a single thing that couldn't have been done more accurately and more quickly with AI, and there's not one. It's going to be infinitely fast. So, whoever's doing that, find another job right now. But it's going to be trained off from the statute and the guidelines and whatever rules you're handing it, and then any conflicts associated with those are going to create problems. And so we're going to need to make sure that we're overseeing those. Is there anything that we can do in advance? Because we've got federal guidelines and state law where we're going to be able to review those and find out where those conflicts exist and would you bring those back to us so that we could address them? My second point is data capture. AI is, if nothing else, built for data capture. Do you see a way that we're going to actually be able to put guardrails on that so that that data doesn't move beyond the walls that it's supposed to be in?

Mr. Wieske stated regarding data capture, there is growing case law around pieces of it. Again, our governance structure is intended to say, look, if you're training it, you need to be training it on data that you have access to that makes sense and that is legal. I think in health there's certainly Health Insurance Portability and Accountability Act (HIPAA) privacy pieces, and what you're seeing is pretty consistently that the HIPAA standard is a pretty good framework for health and that's a pretty high bar and a pretty high standard. When you're dealing with the other pieces, the NAIC is continuing to work through their privacy piece to better understand where to go with those. I think there's going to be some sensitivity to consumer data and I have some concerns when we take a look at some of this as we go through and we do some governance. And a couple of years ago we brought a data privacy piece here to NCOIL, and the concern we had was ultimately the bad data privacy law that resulted in Montana not having access to clinical trials for a good bit because the way they structured that law. Our concern, and where we're different than NAMIC is that there's going to be bad AI laws that are going to be introduced and potentially passed and create problems. And so we think an interim step makes some sense, and we think it can deal with both your issues. Those problems that you're talking about where there's conflicts, there should be a process inside the company that looks at those. That doesn't necessarily need a direct regulator oversight

or other piece but it does mean that the company has to look at that and has to solve that. That's what we're looking at. They may be doing some of this but again, there are going to be outliers that don't do it on a regular process and they forget and that's where our concern is.

Mr. Overturf stated from our perspective, there are existing data privacy and cybersecurity laws that insurance companies already have to comply with. The data that is coming in is already coming in. Insurance companies already have that data on policyholders. They're taking in these policies. They're filing these claims and all those things so it's already kind of there. The AI is just making that a little bit more efficient. So there are laws there and if, again, we identify a gap where there's not something that's being addressed then we should have that conversation.

Sen. Justin Boyd (AR) stated AI is a form of automation, and so the initial thing that got me thinking is recently I was approved for a long-term disability policy, and the whole policy didn't show up. So, somebody somewhere else wound up with my name and Social Security number and stuff like that. So what mistake could happen with AI that gets magnified and sent out, whether it's a data breach or something I can't even think of right now, and then who's going to be accountable for that? Because if the insurance company just says, “Hey, we're new to the market, we had all these fancy tools, but we're out,” then the consumers are going to be hurt by that. How do we ensure AI doesn't accidentally consider something? Yesterday, we had a discussion on genetic information, and maybe AI finds that it's been programmed to look for that, but it's also been programmed to not tell anybody. The final thing is, again, as a health care provider, there's lots of articles now on just, “hey, somebody reprogrammed it and said, hey, let's amp up the claims denials,” which I get. But where else could that happen where that could affect the consumer? It's great for the insurance company, but it's bad for the consumer. And then finally, what if we're talking about life insurance and we're using AI underwriting and we all of a sudden approve some people who shouldn't be approved? Now who's paying for that? I just want to make sure that whatever models we have are prepared for those type challenges.

Mr. Wieske stated you haven't even gotten into the agentic AI piece where it’s going beyond and it's actually taking independent decisions and not just going through a process and there are agentic AI bots that you can have as a person to work through as well which creates a whole different set of issues. I do think that the framework is really important here. There's no reason you can't do the same thing with AI that you do with a human regarding amping up the claims denials if you want to do that. You can just sort of create new rules and new edits that sort of go through and make it a little bit harder for claims to get approved. I think it may be a little bit easier but again, our approach is there's an expectation that there's governance and documentation around your AI processes that you're doing and you're using. And so as you're going through this, there are requirements that you're going through the testing, that you're ensuring that you're meeting the targets and you're going through that process. You can have the same problems you've discussed with having humans do it and making a mistake because they've gotten old guidelines that they've put in paper in front of them from an underwriting standpoint. And pricing I think is going to be the biggest one where there is

potentially some issues as there are hundreds of thousands of page rate filings that are coming into departments with numerous factors that clearly use some significant data to understand and micro-target increases. So, the idea that we're focused on is making sure that the companies are not just having a governance process and they're checking it regularly and making sure it's accurate and that they're documenting that as a matter of process. And again, I think some would say they're doing that already but there's always been a standard that if you were requiring insurers to do something in the insurance industry you don't have the ability to look at every single claim. The number of complaints that departments deal with are probably running around 11,000 a year roughly, depending on the size of the state. Some are bigger, some are smaller.

And so there's not a lot that are coming through the department that they can use as data points and you have to rely on something that allows you to look into the company and understand that they've got processes in play. We do the same thing on financials. The idea now is you want the accounting right, but it's not just the accounting. There needs to be a risk-focused exam to understand that the insurer understands where the risks are. This is sort of that same approach. There's an expectation that the insurer is making a risk-based look at all the ways they're using AI and making sure it's accurate and that that if they're using it in rating, it's predictive, and if they're using it in underwriting, that it doesn't lead to too many denials or that they're approving too many where there's going to be financial problems down the road. So, there's a lot of pieces there and there has to be a standard and we're just requiring it in law, which is where the big difference is. I think a lot of insurers would say we're already doing this, but requiring it and allowing the departments to look in creates a stronger standard from our perspective.

Rep. Matt Morgan (TX) stated I believe AI already is here. We just heard about it in underwriting and we've seen it in other places so it already exists. It's expanding, it's changing, and I think it will dynamically change how insurance is done across all the states, which is not necessarily a bad thing. So, I think every legislator up here wants to ensure that the insurance companies have the data they need to make good, accurate assessments of risk when it comes to underwriting and handling and what they're going to charge for their product. And I think it also goes to the other side of claims handling where more accurate and better information should lead to better results. There could be many instances where an AI could review a human's estimates on a car claim or a property claim and say, “Hey, you forgot these 10 line items”, and add more to it to assist. And I think for us as legislators, it's just ensuring that there are those checks that go both ways, not looking just to deny, but looking to ensure complete accuracy across the board. And I think having whatever we can to ensure checks and balances are there and that it's an even playing field for everyone and that it's working to ensure accuracy on both sides is what's important and I think that is what Asm. Dilan was trying to get at earlier.

Mr. Overturf stated you all want insurance companies to have fair and accurate prices and process claims, but nobody wants that more than the insurance companies themselves, at least as it pertains to the NAMIC members and member companies. Mr. Wieske agreed.

Miranda Motter, Senior VP of State Affairs & Policy at America's Health Insurance Plans (AHIP), thanked the Committee for the opportunity to speak and stated I'm going to make sure that it's really clear that I say that health insurers are not using AI to deny prior authorizations when there are clinical issues at hand. I know that there was some conversation and statements about that. I just wanted to be very clear about that. The second thing I wanted to say is I would encourage you all to look at the study that Mr. Almeida mentioned. The methodology that they used in terms of making some of the statements included one health insurer. So again, I just think it's really important to make sure that there's an understanding of where some of those statements are coming from and whether it's valid to just include one health insurer. The last thing I would say is we stand ready and look forward to working with members of this committee and the sponsor on this issue. I can't reiterate enough how important all the discussions were that took place at the NAIC on the AI model bulletin. Many of these discussions were had in depth with multiple stakeholders at the table, all focusing on the topics that were talked about today. Definitions, for example, what is actually included in the definition of AI? Is that automation? What are the standards to make sure that there's uniformity? And then last but certainly not least, the regulators concluded that regarding the underlying statutes that apply to insurers, it doesn't matter if insurers are using humans or if they're using AI. There are clear standards, there are regulations that they have to adhere to. And so they thought it was very important to reiterate those things and put some of those reminders in the bulletin. I know that one of their efforts this year is to make sure that in the states that have not adopted that bulletin that they move forward and really try to encourage that.

Asm. Gandolfo thanked everyone for their input and stated this is an issue that's not going away, and NCOIL does have a real opportunity to provide leadership for all the states here.

PRESENTATION ON RETENTION AND RECRUITMENT OF INSURANCE TALENT

Asm. Gandolfo stated next on the agenda is a presentation on the retention and recruitment of insurance talent. Talent retention and recruitment remain critical challenges and opportunities for the insurance industry. Attracting and retaining skilled professionals is essential to sustaining innovation, regulatory compliance, and consumer trust. Insurers, regulators, and stakeholders can work together to build a resilient talent pipeline.

Noelle Codispoti, Director of Emerging Insurance Program at the Risk & Insurance Education Alliance thanked the Committee for the opportunity to speak and stated that you may previously know us as the National Alliance for Insurance Education and may see the insurance education designations that we provide and continuing education through the Certified Insurance Counselor (CIC) and Certified Risk Manager (CRM) designations. We are generally and most importantly an education institution for insurance professionals. What I oversee is our emerging talent programs that are geared towards bringing in new entrants, both at the high school and university level. We started talking about a talent gap, at least as far as I can remember, back in 2009 when

Deloitte released their first study, followed quickly with a white paper by McKinsey urging the industry to come together to solve the pending talent gap. The number from the Bureau of Labor Statistics that we've heard quite consistently over that time has been 400,000 available jobs or vacant jobs or job opportunities and that number hasn't largely changed, but what has changed is the date in which that 400,000 jobs was set to come due. And what the research suggests, what the numbers suggest, is that it's not that we are not actively bringing in new participants or that the folks who were slated to retire aren't retiring, but that generally we're not seeing the magnitude of the situation that continues to be upon us. We do have a higher median age workforce in our industry compared to the national average, 44 compared to 42, and 25% of insurance professionals are age 55 or over, and depending on when they decide to retire, that certainly generally would suggest that 25% is of retirement age.

We do have other factors impacting the need for talent. Generally, we have one of the lowest unemployment numbers of any industry, recently at 1.5% as determined by some recent employment studies. Voluntary turnover of 9%, which generally shows a really healthy turnover as well. And 53% of insurers are planning to add staff, or I should say now that we're in November, were planning to add staff in 2025, and that number is largely unchanged for 2026. I left my job as an underwriter at the end of 2010 to focus largely on this issue. I was inspired by a session held by the Institutes Griffith Educational Foundation, which I'm sure know very well, that brought together 100 industry leaders to try to tackle this problem. And much of the tackling of the problem involved two solutions. One, educating more folks about careers in insurance at the earliest stage possible, and ensuring that we are providing them the opportunity to see how great our industry is. We have since been compounded by AI and automation and the evolving skill set. It is certainly reshaping the skills that our industry needs, and certainly putting a different focus on the available jobs that we are hiring for. The same Bureau of Labor Statistics data suggests that over the next several years through 2032 that there will be fewer underwriting and claims adjuster roles because of the advancements in AI and automation and what roles AI can do for those job roles.

Those are the two primary job roles that we've actually heard discussed today and the need for human interaction, but what it's also suggesting, because many of those roles are where we see our entry-level talent come in, it certainly presents to me a very real fear that the education and training that we're providing to entry-level talent isn't going to be the same. Only 14% of insurers are expected to reduce their staff this year, so we're seeing that number in comparison to the 53% on the previous slide that were expected to add to their staff. So, where are the roles going? They're all tech, automation, data analytics, but these are very hard roles to fill, not only in our industry, but in all of the industries across the board. So, what is it that we need to do? Because we've already had a talent issue. We already have a perception issue with what careers in insurance look like. So, how will we not only train those individuals, but recruit individuals who are now pursuing a different skill set?

Just to finalize that final bullet point there, insurance executives state that the data IT expertise is the hardest to recruit for. So, what do we need? We need smart policy that not only builds smart consumers, because at the end of the day, that is what you're

talking about here as well. We're protecting consumers with the tools and advancements in AI and regulation, but those same protections come from education, knowing those policies, and knowing what's important to them. At the same time, that education builds a talent pipeline. It opens up the opportunity to know what careers exist, how individuals can come in and shape this industry, but also that great careers and the things that we do in insurance, like protect individuals, protect balance sheets, and really contribute to the overall society, is good and sustaining work. I would love to be sitting here one day talking about some model acts or laws related to insurance education or insurance employment across our states. Some of the things that are already happening from classroom to career, the organization I work for, the Risk and Insurance Education Alliance, rolled out the Certified Insurance Service Representative (CISR) high school program back in 2019 to help high school students earn a nationally recognized credential.

We also have states who have career and technical education, that's the (CTE) and financial literacy requirements. There are insurance pathways in some of our finance curriculum across states but many of those are opt-in pathways. We also see some great work being done at the community colleges. For example, Ivy Tech Community College in Indiana has an insurance certificate where students will also be able to earn the CISR designation coming up. But what I love about Indiana is they put so much focus on connecting the dots from high school through to their four-year institutions that it really is trying to capture insurance education at every part. They have the CISR high school program, which helps students then bring in nine credits to their associate's degree at Ivy Tech, and then students then can transfer their associate's degree at Ivy Tech to one of the main institutions, four-year institutions like Butler and Indiana State. Community colleges also are putting a heavy emphasis on learners getting certifications, and at this point is one of the main ways that they're helping their institutions stand apart from others. So, career-ready certifications where they can leave the institution and go right into the job market, which certainly with the skyrocketing tuition prices, community colleges are becoming an increasingly important decision. Our program at the Risk and Insurance Education Alliance allows students to study five modules of information to give them a really broad cross-section of the insurance industry, starting with risk management, which is an everyday tool all of us need to use, introduction to both personal and residential. How much cooler would it have been if you knew what your auto policy might look like instead of the Pythagorean theorem? It's insurance literacy, its financial literacy, it's what makes good consumers but also builds trust as we are getting into changes in how we do underwriting, both in commercial and personal lines and health insurance. We also do a commercial property and casualty course and life and health. So not only does it allow us to introduce different aspects of the industry for a career perspective and provides literacy, but for those students who think they're going to own their own business or manage one day and have employees, the curriculum is transferable.

The students earn the same designation that you or I might earn if you took the CISR, and actually three years ago when I was here at NCOIL, someone at the table did actually have that designation from a previous career as an insurance agent. On this most recent academic year, we were in seven states and we saw 77 students across

those states earn that designation while also providing 348 students the opportunity to learn more about insurance. So, from our perspective, what does the state of insurance retention and recruitment look like - I think we see low unemployment and good retention rates or voluntary attrition rates. You can't speak to an insurance professional, for the most part, that doesn't love their job and that has a storied past on how they got into it. What we need to do is ensure that this education is getting to our students in the best ways possible and adopting it at high schools can be challenging if it's not mandated by the state. By next year, I believe the number of states requiring financial literacy courses will be 29, which is up from six in 2019, but most of those financial literacy courses now are around investing and finances. Certainly, that took us a significant amount of time after 2008 financial crisis to get financial literacy into high schools but the next step is ensuring that insurance education is part of that which is not only for good consumers, but it opens up the opportunity for potential careers.

We have seen states implement AI literacy in their education models, K-12, which will help us at least in terms of the upscaling of jobs and the types of technical knowledge that will be required should our insurance companies, brokers, claims analysis, go towards AI and automation roles. We've also seen at the state level mandated work-based learning at the high school level before they are permitted to graduate, which is fantastic. Experience often leads to what you want to do. What we need to do is ensure that our agencies, our insurance companies, are the ones providing those opportunities too, because if it's other industries, we will lose out on the opportunity to recruit new entrants into the industry at the earliest possible point and hope that they just fall into it after they don't have a good experience in another career.

Rep. Tedford stated I hold my CIC and CRM designations, so I'm very familiar with this. In your presentation, it seemed that the labor statistics were more on the carrier side and not on the agency side. Do you have any statistics on what those numbers look like on the agency side as far as in the future growth in that industry or a reduction of staff? Ms. Codispoti replied the 400,000 open jobs is across all industry job roles that the Bureau of Labor Statistics tracks, and certainly there are some that they don't track. We have not seen a decline in the number of agents or agency roles from the Bureau of Labor Statistics, generally speaking, but they do allow for you to dig into certain states and sometimes into certain counties to see what the attrition rates might be. So, I do not have information right now on that.

Rep. Tedford asked what percentage of your designees are in the agency side compared to carrier side? Ms. Codispoti responded I'm not the best person from the Risk and Insurance Alliance to comment on that, but as you're aware in holding the designations, our organization was created as a means to provide continuing education for insurance agents, and so the vast majority of our designees do continue to work in that space. It also happens to be the space that we see the most interest in bringing in high school interns. In fact, one of our best success stories is out of Laredo ISD in Texas, where IBC Insurance Agency actually guaranteed employment for any student in high school who earned their CISR. And today, the president there has run out of physical space for the number of students he's able to employ and has brought on several full-time employees and some that are going part-time and going to community

college at the same time. So, we have seen the greatest interest from insurance agencies as it relates to providing opportunities for high school students.

Rep. Mike McFall (MI) stated on your second slide where you showed the jobs that will be in demand, those all look to me like things that could be replaced easily by AI. So, I'm a little curious as to why those would be listed as in demand and I'm always afraid that we're going to be setting people up to train people, and then once they come out of school or college, those jobs are no longer available. Ms. Codispoti stated I would say that as AI and technology are developing, you're still going to need system engineers, you're still going to need folks monitoring. There are still jobs and roles to train those. I don't think that in data analytics that AI is going to replace those at the same rate that they are replacing the underwriting and claims roles. But those are the jobs that are listed as most in demand for insurance companies today. And if you visit any insurance company job board, those are the ones that are there.

Rep. McFall stated it just surprises me because I went into a battery factory that's in my district, and it makes batteries for electric buses. There were about 10 people working there because it was mostly robots and they were very well paid, but there were just 10 people. Whereas before, there would have been probably dozens of people. And so I'm always curious as to when we start training people for future jobs. And I don't completely agree. I do think these are all replaceable. And insurance companies with their AI, is it their own AI that they're using or is it another company's AI because oftentimes that's farmed out as well, kind of like a salesforce where they're the ones that maintain it and they're the ones that do everything. So I'm just curious since those seem like weird jobs to me to list as new roles in demand. They might be in demand right now, but in a very short amount of time, I feel like they're not going to be in demand at all.

Ms. Codispoti stated that's a fair point because two years ago, underwriting claims adjuster roles were still projected to increase over the next several years and so technology is changing everything that we're talking about very seamlessly. There's a number of insurance companies right now that are developing their own AI. If we know one thing about big insurance companies is that they don't want InsurTechs to own the technology. They want to bring it in-house. They'll buy those folks up or bring the people in that will develop it. But those are the specialists that they're hiring for. And so, as quickly as that technology comes on, those job roles are changing. And so, the underlying principle still remains the same. We still have to educate on what insurance and risk management is. We have to educate on how AI and automation is changing roles, and it's changing it more rapidly than any other thing that has come in our space.

I remember an internship where I was faxing out quotes and binders, and by the time I came back full-time I got to change them into a PDF and email them. How long did it take for us to transition from a fax machine to email across the whole industry? It was a long process. We're not there anymore, but we are an industry that takes our good old time changing, and I think what we're seeing here is that we can't wait anymore. We can't drag our feet, and we've been talking about this talent issue since at least the Deloitte study in 2009 and what we do really well is talk about things in this industry rather than act on them. I think there's a lot of urgency, and your comments support that

if we don't start acting now, where are we next year or three years from now when we're sitting in this room as it relates to talent? Do we want to take those chances? I don't think so. And we're grateful to the friends at the Griffith Foundation who come in and educate legislators on insurance. I think the same thing needs to happen quite regularly with the vast majority of young people so that they are prepared for whatever change is coming.

Sen. Felzkowski stated when you look at this, if you look at a practical aspect and if you're in the insurance industry, we're going to use AI a lot on personal lines because it's pretty cut and dry in your underwriting. But when it comes to the commercial aspect, I think it's going to be much harder because you're looking at credits. No two risks are alike. You're looking at financials. You're not going to be replacing your commercial underwriters with AI at the extent that you might be on the personal line side. And also, everyone in my office is either a CISR or a CIC, and I used to sit on the board of directors for CISR and it's a great program. And AI will replace some, but it's never going to replace the human element. And I don't see AI replacing insurance agents. And even people that are going online to purchase their insurance, once they go through a really bad claims process, they're coming back to the agency force and wanting to interact with that agent. They might only want to buy from us in person, and then they want to just communicate through e-mail or whatever and never walk in the agency again. But they still want that original interaction. We're seeing that once they have a bad claims experience, they're coming back, they still want that agent so you're not going to be replacing that personal contact with AI. I've been doing this 40 years and seeing the ups and downs and you're not going to be replacing people.

Ms. Codispoti stated I hope that's true and as a former underwriter, I really enjoyed my job and I love the human aspect of it. My concern lies with those companies or agencies and brokers who make decisions about cost savings because they believe that automation or AI can replace the human element. It's done solely on a cost perspective, and they make decisions in haste. I think those are the ones that will lose out and those that remain committed to understanding the insured, understanding the risk, and making sound decisions will win out.

Rep. Lehman stated I'm a CIC as well, but I want to give a shout-out to Ms. Codispoti. You mentioned Indiana, and I can kind of maybe answer Rep. Tedford's question. We're seeing the kids coming out of those programs going more to the carrier side, so I think you're seeing a lot more employment there and maybe the excess and surplus market brokers than you are the agencies because I think agencies are more focused on trying to recruit from people who are connected to our communities and things like that. So, it has been a fantastic program between Ivy Tech, Ball State, Butler, and Indiana State. If anyone has any questions on that, I'm more than happy to tell you about that. And I think as more of these models focus on the human touch, even with AI, you're not going to eliminate those jobs.

Asm. Gandolfo stated to Ms. Codispoti that one of her slides had the number of active students in the programs. Are those all states that mandate this type of curriculum in schools or individual districts did it voluntarily? Ms. Codispoti responded no state is mandating the curriculum, but there are states who have insurance pathways that have

recommended learning objectives to complete that pathway. So, Texas, Indiana, and Alabama are some of those states so where possible, we make sure that we're meeting 100% of those requirements. But in a lot of states, it's just a teacher wanting or a school wanting to give an opportunity for a student, or they have requirements on kids getting certifications. And not all schools in states that have requirements actually need to fulfill them. So, it is not a one-size-fits-all approach and it’s really flexible to fit each school.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep Lehman and seconded by Sen. Boyd, the Committee adjourned at 10:30 a.m.

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732-201-4133
CHIEF EXECUTIVE OFFICER: Will Melofchik

National Council of Insurance Legislators (NCOIL)

Resolution Affirming U.S. State-Based Regulation of Artificial Intelligence in Insurance Consistent with the McCarran-Ferguson Act

Draft as of February 19, 2026. To be discussed and potentially considered by the Financial Services & Multi-Lines Issues Committee on April 19, 2026.

Sponsored by Asm. Erik Dilan (NY)

WHEREAS, in 1945, Congress enacted the McCarran-Ferguson Act, 15 U.S. C. §§ 1011-105, affirming that the regulation and taxation of the business of insurance by the states is in the public interests and that federal law shall not preempt state insurance law unless such law specifically relates to the business of insurance; and

WHEREAS, since that time, States have consistently exercised primary authority over the business of insurance in a manner that protects policyholders, ensures insurer solvency, and promotes fair, competitive and stable insurance markets; and

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

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

WHEREAS, the state-based system of insurance regulation has consistently adapted to advances in technology throughout the years in ways that are efficient and protective of consumers and the insurance marketplace alike; and

WHEREAS, artificial intelligence has increasingly been deployed by insurers in areas such as sales, marketing, underwriting, rating, claims handling, fraud detection, customer engagement, and customer service; and

WHEREAS, the use of artificial intelligence in insurance presents both opportunities for great efficiency and innovation, and risks relating to things such as opacity, data governance, and overall consumer protections; and

WHEREAS, continued respect for state legislative and regulatory authority over the business of insurance promotes certainty, consumer protection, and market stability while avoiding duplicative and/or unnecessary federal action; and

WHEREAS, state insurance legislators and regulators possess the authority, subject-matter expertise, established frameworks, and enforcement mechanisms uniquely suited to develop policy overeeing insurer use of artificial intelligence; and

WHEREAS, there has been a concerning trend at the federal level to seek to wrongly curtail state legislators' ability to develop policy surrounding artificial intelligence and insurance, such as the 10-year moratorium on state legislative and regulatory authority over artificial intelligence that has been proposed by Congress, and the recently signed, constitutionally questionable, Executive Order that aims to preempt state legislation and regulation of artificial intelligence; and

WHEREAS, NCOIL believes that it is vital that state legislators have the ability to develop policy and laws that protect their constituents, many of whom have been steadfast in asking for consumer safeguards against the current unknowns surrounding artificial intelligence; and

WHEREAS, absent any affirmative Act from Congress relating specifically to the business of insurance, states retain their authority to legislate and regulate within the business of insurance pursuant to the McCarran-Ferguson Act as established by Congress over 80 years ago; and

WHEREAS, there being no affirmative Act from Congress to legislate insurer use of artificial intelligence;

NOW, THEREFORE, BE IT RESOLVED, that NCOIL encourages states to:

- take appropriate steps, which may include the enactment of legislation, to protect consumers while not hindering innovation and impeding the benefits that artificial intelligence can offer, and to ensure proper legislative oversight of its regulators in the realm of insurance;
- legislate and regulate insurer use of artificial intelligence in a principles-based manner that promotes innovation, transparency, accountability, data integrity, fair discrimination, and consumer protections;

- coordinate and harmonize legislative, regulatory, and educational efforts surrounding artificial intelligence and insurance to promote consistency while preserving state flexibility to address local market conditions;

AND, BE IT FINALLY RESOLVED, that a copy of this resolution will be distributed to the Senate Majority Leader, the Senate Minority Leader, the Speaker of the House, the House Minority Leader, the Senate Banking Committee Chairman, the Senate Banking Committee Ranking Member, the House Financial Services Committee Chairman, the House Financial Services Committee Ranking Member, federal and state insurance legislators and regulators, the Financial Stability Board, the International Association of Insurance Supervisors, the Federal Insurance Office, the Department of Treasury, the Federal Reserve Board, and other interested parties.

EXECUTIVE COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
EXECUTIVE COMMITTEE
2025 NCOIL ANNUAL MEETING – ATLANTA, GA
NOVEMBER 15, 2025
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Executive Committee met at the Whitley Hotel in Atlanta, GA on Saturday, November 15, 2025 at 12:30 PM.

NCOIL President, Assemblywoman Pamela Hunter (NY), Chair of the Committee, presided.

Other members of the committee present:

Sen. Justin Boyd (AR)
Sen. Larry Walker (GA)
Rep. Matt Lehman (IN)
Rep. Bill Sutton (KS)
Rep. Michael Meredith (KY)
Rep. Michael Sarge Pollock (KY)
Rep. Edmond Jordan (LA)
Rep. David LeBoeuf (MA)
Rep. Brenda Carter (MI)
Sen. Lana Theis (MI)
Sen. Michael Webber (MI)
Sen. Paul Utke (MN)
Sen. Jerry Klein (ND)
Rep. Brian Lampton (OH)
Sen. Georga Lang (OH)
Asm. Erik Dilan (NY)
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:

Rep. Eilzabeth Wilson (IA)
Rep. Daniel Grossberg (KY)
Rep. Kristian Grant (MI)
Sen. Jeff Barta (ND)
Rep. Meredith Craig (OH)

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. Matt Lehman (IN), and seconded by Rep. Carl Anderson (SC), 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 Asm. Erik Dilan (NY) the Committee voted without objection by way of a voice vote to approve the minutes of the Committee's July 19, 2025 meeting in Chicago, IL.

FUTURE MEETING LOCATIONS

Asw. Hunter stated that looking ahead to 2026, we have a great lineup of cities. The Spring Meeting will be from April 16th- 19th in Louisville, KY; the Summer Meeting will be from July 15th – 18th in Boston, MA; and the Annual Meeting will be from November 19th – 21st in Sanibel, FL.

ADMINISTRATION

Will Melofchik, NCOIL CEO stated there were 414 registrants for the Annual Meeting with that number including 74 legislators from 33 states. There were 13 first time legislators from 10 states, 5 Commissioners participated and 14 insurance departments in total were represented. That makes all three Meetings in 2025 with over 400 participants so thank you everyone for the support.

Mr. Melofchik gave the 2025 unaudited financials through October 31st of this year which shows revenue of $1,666,550.12 and expenses of $1,368,521.30 leading to a surplus of $298,028.82.

Mr. Melofchik stated related to the financials, for the past two years we have retained Dianne Batistoni, a partner in EisnerAmper's insurance practice, for the audits for both NCOIL and the Insurance Legislators Foundation (ILF). We have been very pleased with the quality of the audits, and they have rotated staff to keep fresh eyes on the audits each year which is a best practice. Accordingly, we recommend retaining EisnerAmper for another year.

Hearing no questions or comments, upon a Motion made by Rep. Michael Meredith (KY) and seconded by Sen. Lana Theis (MI), the Committee voted without objection via a voice vote to retain Eisner Amper for the 2025 NCOIL and ILF audits.

CONSENT CALENDAR

Asw. Hunter noted that the consent calendar includes 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 Prior Authorization Reform Model Act and re-adopted, with amendments, the NCOIL Transparency in Dental Benefits Contracting Model Act.

- The Workers' Compensation Insurance Committee adopted the NCOIL Experience Rating Modification Model Act.

- The Financial Services & Multi-Lines Issues Committee re-adopted the NCOIL Rebate Reform Model Act, the NCOIL E-Titling Model Act, the NCOIL Model Act Concerning Statutory Thresholds for Settlements Involving Minors, and the NCOIL Insurance Fraud Model Act, with amendments.

- The Joint State-Federal Relations & International Insurance Issues Committee re-adopted the NCOIL Insurance Business Transfer Model Act, the NCOIL Market Conduct Surveillance Model Law, and the NCOIL Market Conduct Annual Statement Model Act.

- The Property & Casualty Insurance Committee adopted a Resolution Encouraging States to Require Insurers to Provide at Least 60 Days Advance Notice When Nonrenewing a Policy and re-adopted, with amendments, the NCOIL Storm Chaser Consumer Protection Model Act, the NCOIL Model Act Regarding the Use of Credit Information in Personal Insurance, and the NCOIL Model Act to Regulate Insurance Requirements for Transportation Network Companies and Drivers until the 2026 Spring Meeting.

- The Articles of Organization & Bylaws Revision Committee adopted amendments to NCOIL Articles of Organization & Bylaws.

- The Budget Committee adopted the 2026 NCOIL Budget.

Asw. Hunter asked if any Committee member wanted anything removed from the consent calendar or had any questions.

Hearing no questions or comments, upon a Motion made by Rep. David LeBoeuf (MA) and seconded by Rep. Lehman, the Committee voted without objection by way of a voice to adopt the consent calendar.

OTHER SESSIONS

Asw. Hunter stated the Institutes Griffith Foundation delivered great presentations during their lunch and breakfast, one on Risk Based Capital, and the other on Catastrophe Bonds. We also had three very interesting and timely General Sessions focusing on the 60th anniversary of Medicare and Medicaid, lessons learned from Hurricane Katrina, and developments in Vision Care Services legislation. Last, we had a very interesting luncheon presentation from Dr. Joseph Crespino, Professor of History at Emory University.

NEW EXECUTIVE COMMITTEE MEMBERS

Asw. Hunter stated that pursuant to their status as Chair of their state's committee with jurisdiction over insurance issues, legislators attending the Executive Committee are recognized as new Executive Committee members. Those legislators are Sen. Jeff Barta (ND) and Rep. Barbara Dittrich (WI).

Hearing no questions or comments, upon a Motion made by Sen. Jerry Klein (ND) and seconded by Sen. Felzkowski, the Committee voted without objection by way of a voice vote to add Sen. Barta and Rep. Dittrich to the Executive Committee.

NOMINATING COMMITTEE REPORT/ELECTION OF OFFICERS

Rep. Tom Oliverson, M.D. (TX), NCOIL Immediate Past President, stated that the Nominating Committee met on Thursday and voted to recommend a new slate of Officers for next year. I'm proud to report the Committee's recommendation was unanimous with Rep. Brenda Carter (MI) as Secretary, Rep. Jim Dunnigan (UT) as Treasurer, Rep. Edmond Jordan (LA) as Vice President, and Sen. Paul Utke (MN) as President.

Hearing no questions or comments, upon a Motion made by Rep. Lehman and seconded by Sen. Theis, the Committee voted without objection by way of a voice vote to adopt the new slate of Officers.

Asw. Hunter thanked Rep. Oliverson for his work on the Nominating Committee and congratulated Rep. Carter as the newest Officer. It has been a pleasure to work with you and be able to see you get to this point. I know exactly what it feels like to get to this point and be in your first Officer position. I appreciate your passion about insurance, your constituents, and your dedication to NCOIL. You will be an exemplary fit in our Officer ranks so I look forward to seeing your leadership.

A few brief remarks before I hand over the gavel, I just want to say this has been an awesome year. I think we did a lot of great work this year, including setting NCOIL attendance records. Also, in an NCOIL first we had a sitting U.S. Cabinet member speak to us as well as the Chairman of the Chicago Cubs. We had a great year not just relating to those things but also elevating NCOIL in a strong way so that when you go back to your State Houses and say you are carrying an NCOIL Model, people will take notice of that, whether it be fellow legislators or interested parties. We have a lot of work to do in this insurance space and this is the time for us to work together and move things forward because lives and businesses are at stake. Last, I think we should have more meaningful conversations about tort reform as that will bring greater affordability. It is now my pleasure to pass the gavel to Sen. Utke.

Rep. Jordan stated that I started around the same time at NCOIL as Asw. Hunter and we both know how it feels coming into our first Officer position as Rep. Carter is doing now and I just want to say Asw. Hunter has been too humble and it has been an honor and a privilege to serve under her during her Presidency. You have served with dignity and honor and done great work such as elevating the Women's Caucus and taking time with the new members. You are a tough act to follow and I'm glad I don't have to follow you.

I think every President we've had since we've been here has raised the bar and been excellent. You not only met that but you exceeded it. So I think I speak for everyone when I say thank you for your service.

Sen. Utke stated we'll have plenty of time to discuss these issues over the next year but right now I just want to say thank you to everyone around the table for your support and thank you to those that are in the room as we've created a lot of relationships over the past few years. I have been coming to these Meetings since July of 2018. I look forward to the next year and we have a lot to discuss and work to do. I understand the attorneys in the room may have taken offense to the tort reform suggestion but I like your idea and we'll do what we can to drive that forward. With that, I just want to thank everyone and we look forward to a great year ahead.

ANY OTHER BUSINESS

Rep. Lampton stated that he wanted more information about the process to submit an amendment to a Model. Sen. Utke said we can definitely do that.

ADJOURNMENT

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