NATIONAL COUNCIL OF INSURANCE LEGISLATORS
FINANCIAL SERVICES & MULTI-LINES ISSUES COMMITTEE
2026 NCOIL SPRING MEETING – LOUISVILLE, KENTUCKY
APRIL 19, 2026
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Financial Services & Multi-Lines Issues Committee met at the Hyatt Regency Hotel in Louisville, KY on Sunday, April 19, 2026 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. Michael Meredith, KY
Rep. Sarge Michael Pollock, KY
Rep. Edmond Jordan, LA
Rep. Brenda Carter, MI
Sen. Lana Theis, MI
Sen. Paul Utke, MN
Rep. Timothy Barthorst, OH
Rep. Brian Lampton, OH
Sen. George Lang, OH
Rep. Ellyn Hefner, OK
Sen. Mark Mann, OK
Rep. Tom Oliverson, MD, TX
Rep. Trey Wharton, TX
Sen. Mary Felzkowski, WI
Del. Walter Hall, WV

Other legislators present were:

Sen. Jesse Bjorkman, AK
Rep. Justin Wilmeth, AZ
Rep. Adrielle Camuel, KY
Rep. Mike Clines, KY
Rep. Wendy Dant Chesser, IN
Rep. Erika Hancock, KY
Rep. Peggy Mayfield, IN
Rep. Shaun Mena, LA
Rep. David LeBoeuf, MA
Sen. Jeff Barta, ND
Rep. Gregory Scott, PA
Rep. Perry Warren, PA
Sen. Keri Heintzman, MN
Rep. Kellie Deeter, OH
Rep. Meredith Craig, OH
Rep. Yusuf Hakeem, TN
Rep. Barbara Dittrich, WI
Sen. Cale Case, WY

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 Rep. Matt Lehman (IN) and seconded by Rep. Brian Lampton (OH), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Lampton 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 November 14, 2025 meeting.

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. Gandolfo stated that the first agenda item is a continued discussion on a resolution affirming the U.S. state-based regulation of artificial intelligence (AI) in insurance, consistent with the McCarran-Ferguson Act. As a reminder, the sponsor of this resolution, Asm. Erik Dilan (NY), could not be here today but I'm happy to step in and pinch hit for him, and I will certainly be supporting the resolution. A little background - as most of you know, last year, Asm. Dilan introduced a model act regarding insurers use of AI in this committee. Asm. Dilan still supports the model and believes strongly in the concept of ensuring that there is a human involved in the insurance process, especially when talking about claims and claim denials. Throughout the process, however, it was clear that we were having a difficult time reaching a consensus, which is what we like to do here at NCOIL. So, we discussed this issue with Asm. Dilan and he felt at this time, it would be appropriate in the interim to adopt a resolution reaffirming NCOIL's support of the state-based regulation of AI and insurance.

So as the resolution states, there has been a trend at the federal level to curtail state legislators' ability to develop policies surrounding AI and insurance, such as the ten year moratorium on state legislative and regulatory authority over AI that has been proposed by Congress. And there was that executive order signed to preempt state regulation and legislation of AI, which in my opinion is constitutionally questionable. NCOIL has pushed back on both of those federal actions. So, we feel that this resolution is an important next step in that process. As I mentioned during the interim meeting last month, I agree with the resolution and think it sends the right message for NCOIL at this time. I am also very interested as Chair of this committee in continuing to discuss AI throughout the year as there is still so much for all of us to learn. It's a very rapidly evolving field and it seems tough for state legislatures across the country to keep up with that. So, today, we have an interesting presentation here on healthcare and AI on our agenda following the discussion and vote on this resolution. So, I'll stop there and reiterate that I really appreciate Asm. Dilan taking this initiative and starting some really important conversations last year at NCOIL with the Model law and I think this resolution is a good approach for NCOIL to take at this time when dealing with these issues.

Miranda Motter, SVP, State Affairs and Policy at America's Health Insurance Plans (AHIP), conveyed appreciation of the work on the resolution and certainly appreciated the language in the resolution that talks to the importance of uniformity and states working together and focusing on high risk.

Hearing no further questions or comments, Asm. Gandolfo stated that as a reminder, per NCOIL bylaws all votes are voice votes, except that a roll call shall be taken at the direction of the chair upon the request of a committee member in instances where there are dissenting votes. Then, upon a Motion made by Rep. Lehman and seconded by Rep. Edmond Jordan (LA), NCOIL Vice President, the Committee voted without objection by way of a voice vote to adopt the Resolution. Asm. Gandolfo thanked everyone and stated that the resolution will now be placed on the Executive Committee's agenda for final ratification.

PRESENTATION ON ARTIFICIAL INTELLIGENCE IN HEALTHCARE ACCREDIDATION PROGRAM

Dr. Sean Griffin, MD, President and CEO of URAC, thanked the Chairman for the opportunity to share our experiences with healthcare AI. My specific focus is on healthcare AI. I'm not too worried about AI guiding you to your grocery store, but when you want to have it guide your grandma's chemotherapy, I have some concerns. We want to talk about accreditation. Many of you are familiar with accreditation, but I want to cover our role in accreditation, our development of standards, and then questions. I would encourage you to read URAC's white paper available on our website on healthcare AI accountability in practice. Also, I will stick around after this discussion if anybody wants to exchange information. URAC was founded back in 1990. We are nonprofit, we are independent, and unlike almost every other healthcare accreditor, we don't sell any consulting services. We take our integrity very seriously, and we work very hard to avoid conflicts of interest. Our job is basically a quality auditor. So, we come in independently, we check out organizations and we accredit their quality. Accreditation is all that we do at URAC.

A few years ago, accreditors who sell consulting services came under scrutiny at the federal government level and we were very proud to say that we don't do that. We think that's a little bit like selling the answers to the test that you're going to give. But we do believe that education is part of accreditation so we established national best standards. We actually date back to when there was a concern about utilization review criteria. So, your concerns about AI in insurance business and a patchwork of standards on each state is a problem that we helped solve 35 years ago and we're putting forth a possible solution today on how to do this within healthcare with regards to AI. URAC accredits everything from little corner pharmacies all the way up to multi-state health plans. We have multiple government deemed programs. We've had state deemed programs in the past, where we worked with state governments to meet their needs. And the fact that we are independent is incredibly important to us. We know how important it is in healthcare that you don't have the foxes guarding the chickens.

So, when people say, who is URAC? There are organizations who have sat on our board for the past 35 years. Everything from the American Psychiatric Association to the American Medical Association to the American Hospital Association, and also employer groups. The National Association of Insurance Commissioners (NAIC) has a seat on our board also. And what we say is we have a lot of stakeholders because we want all these voices around the table, and everybody gets a voice, but nobody gets a veto. I actually trained in rural family medicine in Iowa and Missouri and practiced for a couple decades and I still say that every day my job is to take care of patients and that's what we see our role at URAC as being, that sort of good housekeeping seal of approval, that somebody who knows what they're doing has checked behind the scenes. And we think that with AI, that's incredibly important. We actually have over 45 different accreditation programs. You may know us from our pharmacy work. We do specialty pharmacy, but we also do independent review, utilization review, Medicare Advantage, and digital health. We were the largest telehealth accreditor, workers comp, and we also have the only mental health parity accreditation. If you're concerned about whether organizations, whether insurance companies are achieving mental health parity, we have a program that checks to make sure they're following the best practice processes. Healthcare AI is our newest program, launched in September 2025, and we believe that it serves as an independent nationwide leveling of healthcare AI.

As for the role of accreditation. When we talk about accreditation, we say that very often regulation sets the bar for safety, but accreditation sets the bar for quality. When I practiced, I was licensed in the states where I practiced, but I was also board certified. And that board

certification spanned the entire country, and it was by an independent organization. And no matter where I went in the country, my board certification followed me. It's not like a state licensure, which when I moved to Texas in the middle of my career, it took me almost a year to get my Texas license even though I had been licensed in Iowa and Missouri prior to that. So regarding the accreditation process, organizations can't buy accreditation. They apply for accreditation. And what that means is we actually have to meet the standards that we have published on the web about what are best practices, and then an organization applies to become accredited. In that process, we make sure that they have all of the policies that they're supposed to have and that they're doing things the right way. But then we actually go in and we investigate. So, we go in and we say, "You say that you do this with a quality committee. Show us the last four quarters worth of meeting minutes for your quality committee. Show me how you credentialed those people on the committee." We dig into the processes to make sure that they're not just talking a good game, but they're actually living it out. And then an accreditation is generally good for three years. But in the middle of that three-year period, we randomly select a number of organizations to do a monitoring review. I talked before about regulation. Regulation can be very hard to update and can be very hard to change, especially now at the federal level when it's tough to do anything. That's one of the places where accreditation can move and change and continue to raise the bar as you move down the road. So, I've actually talked with federal regulators who say that accreditation can move faster than they can move. And in an area like AI that is moving so quickly, we think that is incredibly important.

So why does accreditation work? Well, most of your states already use accreditation for things. Especially when it comes to healthcare, you accredit hospitals, you accredit health plans, you accredit Medicare Advantage. Accreditation is best practices reviewed by experts based on multiple stakeholders. One of the things that we talk about is data protection. When it comes to AI, data protection is incredibly important because the Health Insurance Portability and Accountability Act (HIPAA) still rules, even if we're not sure what's going on inside the black box of a lot of AI. We believe that it brings confidence to patients, payers and providers. It is a seal of approval. But we also say that these are trusted standards. You know us, you've worked with us for decades, and that's why we think this is important. So, let's talk specifically about the development of the standards. So, the landscape is that there are legislative proposals in almost every state regarding AI. We said specifically that what we want to do is we want to focus on healthcare AI. I'm not that concerned about what you do in other areas, but when it comes to healthcare, we've always had a higher standard. We used to talk about double blind controlled trials before a drug would ever hit the market. We're not doing those things with AI, and that brings significant risk. We've already seen horror stories of bad things that have happened with AI, and that's what we're trying to prevent. There's also a lack of clarity and transparency. A lot of contracts for AI usage in healthcare don't even delineate who has liability responsibility. So, providers are taking on liability that they may not even understand what's going on. It's very much like taking somebody off the street and saying you're going to let them work in your hospital and you haven't even done a background check on them. We are providing that background check.

We also know that there are statutory and regulatory requirements that are a mixed bag. When I practiced in Missouri that meant that I had to deal with jurisdictions in Missouri, Iowa, Nebraska and Kansas and if each state has their own set of rules around healthcare AI, that is a very difficult patchwork in which to operate as AHIP mentioned in their thoughts. But we also believe that it needs to be flexible. We don't believe that there should be a separate set of healthcare AI standards for hospitals, a different one for doctors, a different one for pharmacies. We believe that we have put forth a set of standards that apply to anywhere within healthcare. But they are flexible enough for the little corner pharmacy to meet it, but also for the health insurance

organization to meet it. So, as I said, URAC is multi-stakeholder. We actually put an open call out for advisory committee members. We had over 70 different organizations apply to serve on our AI advisory committee. These are some of the organizations that came on. You have technology organizations. You have pharmaceutical organizations. You have academic medical centers. You had practicing physicians. AHIP was there. And we had small startups. It's very dangerous if you let the big players write the rules, because generally, the rules are only going to be satisfied by the big players and we believe there's a real risk of the haves and the have nots when it comes to healthcare AI. I trained in rural family medicine and I don't want most of the country being left behind because rural hospitals can't afford to have accredited programs.

Our objectives when we got this group together was a framework for developing and using AI in healthcare, recognizing that it changes by the day. When I used to implement systems, I could trust that the order set that I put in in July was the same one that was going to be there in September. Now you put in AI in July and it's different July 2nd. Some of these programs are moving that fast, and they're moving in ways that we don't always understand. We want quality best practices. We want to have room for innovation. But in healthcare, when there's innovation, you still have to have guardrails. But we're not shutting any streets. We're just putting some guardrails down so that people can be protected as things grow and mature. We also want to provide that sort of framework. If the federal government says the states can't regulate AI, we think that you can still encourage accreditation, and that will provide some regulatory oversight at least for these programs as they move. And like I said, we plan to continue to change. We have about 15 organizations right now who are going through the AI accreditation process. Once we do that, we will probably be updating our standards this year because we're going to learn what's happening in real practice and we will need to update our standards to stay up to date with that.

So, when we got our group together, we were planning on one accreditation program just for AI users. I was very concerned about providers and patients not being protected. But when we got together our advisory group, they said we really need help with the developers. AI developers, quite honestly, all look good in a booth at a convention. You can't tell whether you're dealing with six guys in a garage or Google, because they all have a nice shiny booth and a great pitch deck. And so, what we said is, we're going to build two programs, one for the users, and one for the developers. The developers are about transparent in design and deployment, data control and bias, user education, fair contracting and patient safety. The users are about training, and oversight. A very good analogy for our AI accreditation program is thinking of it like credentialing. If you had something that was being done in healthcare with AI right now and you asked a person to do that, what would you want to know about that person before you turned them loose in your organization? You'd want to know where they went to school, how are they trained, how are we keeping an eye on them, who's going to be checking their work before we trust them? That's what our AI User program is focused on is sort of that credentialing and oversight as it rolls into practice. We also say you need to understand the risk involved. I'm sad to say that right now, most healthcare AI has less oversight than the hospital cafeteria. That's kind of scary. And that's why we built our program and we think that there needs to be somebody checking on those things.

If you reach out to me, I'm happy to share with you what our program looks like. URAC standards at a glance are available on the web. We put them out there for free on the web because we want everybody to be able to look at what best practices look like. Again, we're nonprofit, we're independent. We're not doing this because we're going to retire to a nice place. We're doing this because we care about patients. But our two areas within our program, everybody has what are called foundational focus areas. These are things about contract

management, risk analysis, scalability. Think about a lot of AI programs that are going out into pilot right now, and they work great in one place, but then you roll them out to five more places, and they break down. Also, if you roll out an AI program in healthcare and your people come to depend upon it, what happens if that business shuts down? What if you based something very important to care on a small group organization that has only been around for six months? So, a business continuity plan is needed so that this can be trustworthy and reliable. Then we also talk about clinical credentialing, employment screening, code of conduct. And then one of the things I want to point out here is in our leadership requirements. We have different types of leadership standards. We say there's clinical leadership, there's technical leadership and there's ethical leadership. URAC actually requires someone be designated for the ethical leadership and oversight of a program before it can be rolled out. And then when it comes to our users, for users it comes down to things like system management, annual assessment of all of the programs, a risk assessment on every program before it's rolled out. And based on that risk assessment what is going to be your monitoring? Like I said, if you're using AI to generate a shopping list for your hospital cafeteria, I'm not so concerned about it. But if you're AI to write up grandma's chemotherapy, I am concerned about it.

Appropriate use. We've seen AI systems roll into healthcare, where it's a pediatric system that then gets used on adults, and it doesn't work. We've also seen episodes where an AI tool has great data, great performance in a small trial, and then it's rolled out broadly and it worsens its performance. The AI degrades over time and that drift, bias, and hallucinations are unique to healthcare AI, or AI in general. We've never dealt with that before in healthcare. Generally, if you had a hallucination, it meant that the first year resident was making the diagnosis and you didn't trust him anyway so you were going to be checking on it. But now it's making decisions and people are leaning on it too much before it should be trusted. Also, there are disclosure procedures to consider. Many of you have been to the doctor's office in the past year, and there might have been something called ambient AI listening, which is a documentation tool in the doctor's office to do the documentation for the physician. Interestingly enough, the most common use of healthcare AI right now is to make up for the last big technology implementation in healthcare, which was the EMR (electronic medical record). And we turned doctors into slaves to keyboards. And now we're rolling out a new tool to help fix that.

Now we will discuss our developer focus, pre-deployment testing, validation and evaluation. What's the feedback loop when healthcare AI makes a mistake? Do you actually listen to your users if there's a problem that shows up? How are you going to share with your community? How are you going to get informed consent from people before something is used? If you go to Google's homepage and you type in something about healthcare, and it's a question, and Google offers you an AI answer, which they've been doing lately in their search results. If you look at down at the bottom of the page, it says, "AI can make mistakes. Please verify this before you do anything with it". So, why do we believe that this is a good thing? The existing AI landscape is quite honestly the wild west and we think there at least needs to be a sheriff. We're not saying there needs to be only one sheriff, we think multiple sheriffs are fine, but somebody needs to step into this space, someone who knows healthcare and who knows technology. If you remember how wild telehealth got during the pandemic, there were all these companies that popped up offering telehealth services. Most of them are gone. Many of the healthcare AI companies, the small independent ones, will be gone in a few years. And we need some monitoring of them while stuff is going on. It's already being used. The horse is out of the barn. And one thing that I want to point out is that unlike telemedicine, there are billions of dollars being spent on AI right now and one of the challenges that you will have with any type of strict regulation is that this will be like nailing Jello to the wall. If there is a regulatory ban on some function of AI in healthcare, the developers will change the name of that function to get

around it. Or if they can't get around it, they will probably sue you with their billions of dollars to stall this in the courts so they can keep moving and keep selling.

So, that's one of the challenges that we think is going to happen from a regulatory standpoint. Also, if people are concerned about a patchwork of state laws, I would be concerned about a patchwork of healthcare laws or accreditations to where something applies to hospitals, but not to doctor's offices or not to pharmacies. We think that it needs to be one level set of rules that everyone can play by. And we think that it needs to be independent, because if you have the accreditation, or if you have a program of oversight developed by the people who are selling this, their incentives are all messed up. They're going to be wanting to make money as opposed to worrying about putting patients first. We believe that because we have been a trusted name in this area for over three and a half decades, that we offer a unique opportunity as the first healthcare AI accreditation. I would encourage you to download our white paper where we talk to users of healthcare AI which is available on our website at www.URAC.org.

Asm. Gandolfo asked Dr. Griffin a question about guardrails. When you're talking about guardrails, is it in terms of guardrails on the use of these AI programs or in the development of the AI programs themselves? Dr. Griffin stated that URAC's program was originally going to be for the use of the AI programs but when we got together the users and they said that they also needed one for the developers. So, we have two separate programs. The other unique thing about healthcare AI right now is that you have users who are becoming developers. The Mayo Clinic will talk about 1,000 different AI algorithms that they are using right now and if you think about that, they're developing a tool, deploying it to patients with no external oversight whatsoever. If they were doing that with a pharmaceutical, it would have to go through the U.S. Food and Drug Administration (FDA). There would have to be clinical trials and institutional review board. And there are some organizations who are doing a fantastic job and a good job of that oversight, but as a patient you can't tell. So, our program is actually built to cover both of those. And some of the organizations who are going through our accreditation right now are developers, some are users, and some are both.

Sen. Justin Boyd (AR) stated that board certification in medicine has clearly been successful and is well adopted. I can't imagine going to a non-board certified physician. Certified financial planners, that's another area where I think certification has clearly set a market standard. But there has to be consistency and marketing in order to do that so people know what that means. I guess then the concern is that in the political world we live in, are we going to lean one way or the other and not focus on legislative policy, but we're going to drive policy through an accreditation process? Meanwhile, certain states might not appreciate that. So tell me about URAC and what you're going to do to stay down the center and really focus on things that keep people safe and not partisan politics.

Dr. Griffin stated that I think that's one of the reasons why when I talk about our 35-year history, we have multiple government deemed programs. We've worked with administrations on both sides. We're a Medicare Advantage deemed accreditor, we're a Medicare home infusion therapy services deemed accreditor. So, the government actually comes in and actually investigates our processes on a regular basis, and we have to reapply to have that deemed accreditation status. Now for our accreditation, if an organization is accredited, they can display our URAC symbol on their website, informing the public. Also, URAC's concern is to be trusted. The Joint Commission accredits hospitals. They've been doing that for years and that's actually been written into a condition of participation for the federal government to get paid for services. There have been states in the past that have required a URAC accreditation. I'm not looking to create a monopoly here. We just happen to be the first to create this program. When

you look at my board, my board is made up of organizations who don't agree on anything. I can promise you that the AMA, AHIP, AHA, the employer groups, they're not all holding hands and saying kumbaya. But they're coming around the table, and they are telling us what is important to them and then from that we distill a path. And our accreditation is public. It's out there. You can see our standards.

Now you could say, because we talk about ethical and technical leadership, are we leaning one way politically? So that's one of the reasons why I think that our trusted history is so important to this, because we aren't just a bunch of AI organizations who built our own program and then want to certify ourselves. We've been trusted in 45 different areas in healthcare, and that's why we believe in staying on that middle road. Now, that road is going to change because what we know about healthcare AI usage right now will be different six months from now, will be different a year from now. And we need to be able to have the flexibility to grow and change and adapt as these programs grow and change and adapt. We're not a political organization. We're nonprofit. We're independent and we've been navigating those waters for three and a half decades is the best that I can say. In the past, certain states have approached us and they said, "would you build a program specific for our state where we have these concerns?" So, we can create designations based upon particular state needs to make sure that we're reinforcing what the state wants. But still have a national program and a national framework, which we think is so important.

Rep. Tom Oliverson, M.D. (TX), NCOIL Immediate Past President, stated that I'm a big believer in accreditation and I think from the popular culture perspective, I think the best example I can give is the Geico commercial with the surgeon. I mean, we all want to know in the healthcare space that the system, the hospital, the insurance company, the doctor, the nurse, that everybody is better than just okay. And I think accreditation is useful for that and what you're proposing certainly solves some problems. My biggest question to you, as somebody who's working in this space but is also a provider, is something that's always in the back of my mind. I think one of the things that keeps healthcare at least somewhat honest and somewhat pointed in the right direction is the fact that there's liability for providers, for systems, for hospitals, for companies when they make mistakes. The problem in my mind with AI is when we try to superimpose AI in a healthcare space, there's no license. There's no board certification. There's no standard by which you could judge that construct's medical knowledge, and there's no mechanism for an injured person, whether that be an AI construct that's doing prior authorizations or an AI construct that's on Google that's telling people to, for example, drink a whole bunch of caffeine and you'll lose weight. What are your thoughts on that? How do we create that incentive? I think you would agree with me as a doctor that the threat of being sued, even when you know you're doing the right thing, is something that stays in the back of your mind so you practice in the best way that you know how and you don't get lazy and you don't get sloppy.

Dr. Griffin stated that unfortunately right now many of the AI contracts between AI developers and users shift all of the liability over to the users. So, doctors are actually getting tools rolled out to them where they haven't been sufficiently trained, where they haven't been sufficiently informed. They haven't given informed consent to know what's going on here. When I practice, one of the things just along the lines of liability, I never let them make a signature stamp of my signature. I wanted my signature to always come from my hand. I wasn't going to delegate my signature to someone else. AI is being delegated responsibility now. And that's what we're trying to address is the transparent understanding as to where the liability lies. What was going on with development, making sure that people are actually trained to use these tools before they're rolled out, and that they have a feedback loop as to if problems are

found because problems will be found. No doctor is perfect. No AI system is perfect. We're not trying to oversee perfection. Our program actually doesn't talk about the algorithms because to us, this is about the quality oversight of a tool in healthcare, and that has to remain with licensed providers.

So, there is nothing about delegation of responsibility in any of our programs because I still see that as a physician sticking with the licensed providers. And I think that most states have the framework that licensure and liability go together. Now, there are states that are trying to let AI practice autonomously. Whether it be refilling prescriptions or some other things. Some states are approaching this just from a transparency standpoint. That you have to tell the patient that it's an AI tool that is doing this. We don't think that's good enough. So, our accreditation actually continues to require a clinician in the loop. We also caution against the clinician becoming a reflex in the loop. The clinician needs to oversee the implementation, the design, and the rollout. But then also the continuous monitoring, and that's how we're approaching this right now. I am not in favor of AI having any sort of licensure by itself unless it's going to carry the liability by itself. Does that address your question?

Rep. Oliverson stated it absolutely does. And you're obviously worrying about the same stuff I am. I just wonder if we get to that point in the world where AI is functioning autonomously, who do you hold accountable for that? Is it the company that designed the AI? Is it the user that's using it? Is it the company that's employing the AI tool? Dr. Griffin stated that if there's negligence in the tool design, it should go to the tool. Just like if a respirator breaks or something like that, there is product liability. AI is not taking on any of that product liability right now. They're shuffling it over and I think that that is a changing environment. I will also say there are people on Capitol Hill right now who want to write rules allowing AI practicing autonomously. I have met with them, and I have heard from them, and they say your accreditation requires a clinician in the loop. We need to get rid of that. And I said, it's not qualified yet.

Sen. George Lang (OH) stated some of the concerns I have is how can you trust the standards that you set this morning are still valid this afternoon understanding that AI is developing at an amazing pace that none of us can even imagine. And my other concern, and I appreciate your answer to my colleague that your board is not all aligned, but if you look at them, they're all made of big industry players. I have zero doubt 100% of your board members are interested in quality patient care. But they're also going to be interested in protecting their own profit center. And if you look at business, and I don't know anything about delivery of health care, I trust Rep. Oliverson far greater there, but I know a little bit about business and if you look at business over the years, tremendous amounts of wealth and jobs have been created by creating new industries. In the last 20 years, the creation of new industries is still there, but it's more shifted to disrupting current industries. And I can give you example after example in automobiles and pharmacy and construction, even in healthcare delivery. You brought up telemedicine. Tremendous winners and tremendous losers, as you pointed out. At the end of the day, there's bad operators and good operators. Right now, data centers are being way overbuilt. You can go back to the dot-com bubble, or the financial services bubble, but both of those took about a decade to burst. And the data center bubble will burst or at least fizzle out. But at the end of the day, there's going to be amazing winners and amazing losers. And often times these amazing winners don't come from six people in a garage. They come from two people in a garage that come up with this innovative idea to disrupt the industry. So, I'm concerned that your standards are relevant today that were established yesterday, and I'm concerned that we may be holding down or squashing innovation that can change the health of the entire planet.

Dr. Griffin stated that when I talk with people within the AI industry, they actually say that the lack of oversight is a hindrance. For example, I've talked with hospital associations and they say we can't tell whether these developers are any good or trustworthy or anything like that. If we could accredit them then we would know that somebody has at least checked their business processes and those things. I would say that accreditation changes over time. Our specialty pharmacy accreditation that we offer is on its eighth version over the past decade because what is quality has moved over time, and we anticipate that this program will move like that also. I will also point out that our board has a conflict of interest policy. And that has to do with they're bringing their expertise, but they're not allowed to vote for their organization. Our telemedicine program has some organizations on our board who are not in favor of a telemedicine accreditation because they may be a hospital system, and they are concerned about other independent operators. But we still create those programs because our vision and our mission and our organization has been dedicated to patients.

And AI is a great danger of the haves and the have-nots where if the Mayo Clinic has 1,000 algorithms, I'm not sure that a local hospital in Iowa can afford two of them. And how are you going to make sure that rural people have access to good quality tools? That they're not just in the major academic medical centers? That's why when it came to our advisory group, we had a practicing ER physician out of New York. We also had UT Southwestern. We had MD Anderson. It has to be all those multiple stakeholders, because if we don't have those voices around the table, what we build won't apply. Now, our standards aren't perfect. We just happen to be the bravest one to put something out there to actually step into this space, recognizing how changing and dangerous it is. So, I will tell you we're doing the best that we can with the tools that we have trying to fill this gap. And we believe that those guardrails are going to let organizations drive faster and not be shut down because of liability concerns that are unclear or contracting concerns that are unclear. Hospitals trust us for their credentials verification, an accreditation to make sure your doctor actually went to the school that they went to. It is not so different to say, is your AI built the way that it's supposed to be built before it comes into our healthcare system?

Sen. Lang stated I do appreciate that you've given me a high level of comfort that we're going to pick the accreditation in a way that is going to be long-term best for the delivery of patient care because we truly have no idea what innovation is coming out tomorrow that an accreditation today can block. Dr. Griffin stated the board certification analogy is very good. If you're board certified, you don't just do it once and it's for a lifetime. You have to repeat that board certification, and it makes sure that you're keeping up with the latest research and the latest findings and that you're doing things with the quality as it changes over time. And accreditation is meant to be the same way. Board certification in family medicine is every seven years, our accreditation is every three years. And people have trusted board certification, and I think they can trust accreditation also.

Sen. Jeff Barta (ND) stated that one of the issues I have with AI is that it's used as a generic term and as we get deeper into it there are so many differentiations of it. I think some of the concerns with AI comes more from the predictive AI, rather than the agentic and they each have different end goals and applications and I see value in both of them. How does your accreditation address both of those? Dr. Griffin stated that the way our accreditation addresses both of those is that before any implementation of any AI tool in healthcare, there is a risk assessment and that risk assessment rates either high, medium or low risk. And that determines both the implementation and the monitoring that have to happen. Most of the AI usage right now is behind the scenes in the business process, and it's working on efficiencies as they describe it. What we're seeing right now is an arms race forming between

the health systems AI use, and that by the health insurance companies. So that they're battling over prior authorizations and payment and those sorts of things. Agentic AI is useful in some ways. Agentic AI is giving you canned answers and those sorts of things, but you're also introducing variability within an AI algorithm. And that's why we don't accredit the algorithm; we accredit the program and the oversight on the AI tools. And so, how we would address that is agentic AI is not that high of risk. You need to have some guidelines. You need to have some oversight. We say clinical, technical and ethical oversight for any AI program but if you want to talk about an AI tool being used to look at skin cancers, that's higher risk. The risk of false negatives, where something is not picked up and those sorts of things. And I recognize everybody's glomming together AI from all these different buckets. What we're saying is that any technology tool needs to be evaluated for risk before it comes in. It needs to be monitored appropriately, rolled out appropriately, and then if it's low risk, then you need to check on it every month. If it's high risk, when you roll it out, you need to check on it tomorrow. And that's how you deal with those different types of risk. Because I'm not sure what AI is going to be next Thursday. And so our program isn't getting so specific where we say agentic AI is going to be guarded this way, because if we say that and the agentic AI builders don't like it, they're going to call it something else. They're just going to change the name so we can't catch it anymore and that's why we're not that specific in the tool's naming. It's about the quality oversight, just like a transplant program. A transplant program has a series of rules for all transplants, but then different rules for a heart transplant, different rules for a kidney transplant. And that's how we approach AI also.

Sen. Lana Theis (MI) stated that this is an area that I'm very interested in. You were talking about AI fighting between industries. I am concerned about the national security with AI. So, in your accreditation process, are you considering the sourcing of the AI beyond its algorithm or how it's programmed? Are you considering where did this actually come from? Because understanding the underlying purpose of it is extraordinarily important, particularly in the healthcare space. Dr. Griffin stated that I hate to say this, but some AI tools being used in healthcare, the developers don't know the data sources. And so, one of the things that we talk about is we talk about data governance among the developers, and we talk about transparency. But when developers are using or developing these tools, if they don't understand it, the way you address that is with transparency and governance and fit for use and bias in the data. Unfortunately, we've seen AI tools that use data just from men for tools built for women. We've seen AI tools built for children being used for adults. And that's where you get into the AI developers aren't necessarily disclosing these things when they're going to write a contract and that's why contracting was such an important part for the development side of this is the transparency for the users so that you know what you're buying. To us, that's like the stamp as to where your pineapple came from. You really want to know if it was Hawaii or if it was Brazil, because it might make a difference to you. But data is the big strange commodity here, and there's no rules about where it can come from, and that's how we address with transparency.

Sen. Theis stated I have international concerns. National security data capture for personal health care data is something we should be extraordinarily cautious about. That's something that's got to transcend state lines. So, I just want to plead that in your accreditation process that beyond transparency, you're recognizing the national security concerns associated with the programming that you're accrediting. Dr. Griffin stated one of our first rules in all of our programs is that you're following appropriate regulations and laws. Now, you'd think we wouldn't need to say that. We actually go in and we don't just say, are you following them? We say, show us your process for making sure that you're keeping up to date in laws and changes in law, and changes in regulation and that you're not just sort of, well, we checked it five years ago, but we haven't checked it since then. I'm sad to say that because it comes to patient

data there's patients today who are seeing a doctor who are talking about incredibly sensitive personal medical things and there is no guarantee that tomorrow they're not going to log into their shopping cart and find recommendations based upon that discussion that they had. And that's one of the reasons why we think accreditation is so important, is the protection of patients, but also to make sure that that the players are playing by the rules because some of them, their whole business plan is to grow big, fast and sell out to a bigger company and go retire on that money. They're not in healthcare for the right reasons. They just see this is where all the money is to be made.

PRESENTATION ON WYOMING'S FIRST-IN-THE-NATION CRYPTOCURRENCY FRAMEWORK

Asm. Gandolfo stated that we will now turn to a presentation on Wyoming's first-in-the-nation cryptocurrency framework. Cryptocurrency and other new assets have created tremendous buzz. We also know that insurance companies have very conservative investment and accounting rules can limit their purchase of new assets. Wyoming has created the first stablecoin created by the state. A stablecoin is designed to maintain stable value by pegging it to a reserve asset, most commonly the US dollar, to minimize price volatility. Here with us today is Deborah Brooks, Chief Risk and Compliance Officer from the Wyoming Stable Token Commission. Debra will speak about the creation of the stablecoin and financial recognition by the state financial regulators.

Ms. Brooks thanked the Committee for the opportunity to speak and stated that a little bit about myself before I get started, before my current role I worked as a regulator for the New York State Department of Financial Services so I have some experience on the insurance side as an insurance and banking regulator, although my last position was in the virtual currency space. Previous to that, I worked for the U.S. Department of Justice as a trial attorney prosecuting white collar crimes. And prior to law school, I worked for State Farm Insurance as a bodily injury representative. Before I begin, I will give the typical disclaimers. Any opinions, explanations, comments that I make are my own, and they do not reflect the state of Wyoming, the commissions, the commissioners or the commission staff. I think the audience here is crypto curious and I'm very happy to walk through what is virtual currency and particularly, how we should be thinking about it in the insurance space. But before that, I'm going to give a brief history of virtual currency. It is intricate, but recognizing time, I'm just going to give a high level.

Let's go back in time. The year is 2008. And financial institutions, as many of us remember, were collapsing. And it also coincided with a hotly contested presidential election. From that, people felt distrust in the financial institutions because it was learned that their balance sheets were not up to snuff. Financial reporting was dishonest in many ways, and it was inaccurate resulting in the collapses of financial institutions. Thus, what was the solution to this problem where people and citizens were losing faith in their financial institutions? A white paper was released on Halloween – "Bitcoin, A Peer-to-Peer Electronic Cash System" was released. That really discusses a solution to the problem, which is bypassing the middle person. Instead of you as the consumer going through a bank that may or may not be around, you could deal directly with an individual in a peer-to-peer setting. What's interesting about this particular white paper is that it was allegedly written by a Satoshi Nakamoto. That person does not exist. To this day, we don't know. But needless to say, Satoshi had a vision and created Bitcoin. And I'm sure everyone here has heard of the term Bitcoin and if you haven't, you can talk to me afterwards and I'll be more than happy to explain Bitcoin. But I'm giving a 35,000 foot view. Now, you're going to hear a lot of terms being thrown about. You probably heard of cryptocurrency, crypto asset, virtual asset, virtual currency, digital asset. They are essentially the same. So you look at virtual currency and you hear these terms. Just know that they're

ostensibly the same, although they might have some variations. And particularly I highlighted digital asset because, this is just my opinion, I believe there is going to be a move away from the previous bullet points to the use of the term digital asset to encompass virtual currency.

Now, I prepared this slide a long time ago, but I still think it's pretty interesting to show you how the evolution of definitions has changed over time. Virtual currency, according to Investopedia, is a digital representation of value. It is stored and transacted through designated mobile or computer applications. And despite the Genius (Guiding and Establishing the National Innovation for US Stablecoins) Act, virtual currency still remains largely unregulated. Meaning that anyone can issue a digital asset, and people are getting scammed at great lengths. And the term that's used is "rug pull", but I'm not going to discuss it on this presentation. Now, the Genius Act was passed into law last year but what I wanted to highlight is its definition of "digital assets", which I think will now become standard. Digital assets are defined as any digital representation of value that is recorded on a cryptographically secured distributed ledger. All that just means is in layman's terms, digital money that's recorded on a blockchain. And I'm sure folks here have heard the term blockchain. It is pretty much the same as distributed ledger. So, if you hear the term distributed ledger, just think blockchain. And I'll explain what that is with a pretty good picture.

Now, I created this picture when my daughter asked me, "Well, what's the difference between virtual currency and the dollar bills that are in our wallet?" And I essentially told her that the dollar bill in your wallet is backed by the federal government or any central authority or governmental agency. They backed the money that is printed. They print it and they circulate it. Conversely, virtual currency is decentralized, which means it is computer generated and there's no backing of that Bitcoin, which is why there is a big debate on whether these virtual currencies, starting with Bitcoin, have any value. And it can go either way. I checked the value of Bitcoin as of a couple of days ago, one Bitcoin is over $60,000. If you look on the lower right-hand side, that is an example of what digital cash or virtual currency looks like. It's just a series of codes. Now, there are many different types of virtual currency. As of last week, there are over 15,000 different types of virtual currency. But let's just focus on the one that counts. It has the largest market share with about 60%, which is Bitcoin. And that's what everyone looks at as the dominant market maker or leader in virtual currency. Every other coin that's not Bitcoin is considered an altcoin. Now that term is not used as much anymore, but you can see that there are several different types. The second largest digital asset or virtual currency is what we call Ethereum or ETH. That is the digital coin that exists on the Ethereum blockchain, and I'll explain what a blockchain is in the next couple of slides. You also have XRP, which is another digital asset. You also have what they call the meme coins or the internet jokes, like the Dogecoin. Also, they are subject to a lot of fraud. I'm sure many of you have constituencies that have approached you and said, "I just got, I just bought this particular coin that went up in value," and then 30-seconds later, the original designers cashed out and now your meme coin is worthless. That happens a lot more than people are willing to admit publicly.

Then you also have what you call the privacy coins. These are anonymous. Just to go back a step, the blockchain technology and the virtual currency is what they call pseudonymous, which is different than a bank transaction. In the blockchain technology, you have every piece of information. You have the transaction, the amount it went from this particular number to this particular number, but the only information that's not listed is the names. So, you don't see that Deborah sent Raquel $100 worth of Bitcoin. You just see XYZ1234 sending that $100 to ABCDEF. So, that's what we call pseudonymous. So, you do have some visibility on what is happening on the blockchain technology. Privacy coins take visibility away. You do not see anything. You don't even know if those $100 were sent. It is anonymous you might just see

transaction 000 sent $89 to 000. It actually distorts the amount of money that's transacted. And there are legitimate reasons for sending privacy coins, but there are times where it's being used for illicit purposes. And finally, you have what you call the stablecoins or the stable tokens, which are three types: fiat-based backed by the US dollar. You have commodity-based, like oil. And you have the algorithmic, which is essentially computers.

Now blockchain technology is the decentralized distributed public ledger which is a database that uses encryption to store blocks of data and store them together in chronological order. It serves as the source data, and once that data is attached to the blockchain it is immutable. It cannot be moved or altered. Now, I'm going to focus on how a Bitcoin is created or minted. You need three requirements. You need a node, miners and data. Now, nodes are just computers. Anyone with a computer with a significant computing power can be a node. Now, miners are those who use the computers to mint the bitcoins. And the blocks are just the information that stores the data or transactions. And this is the example that I use again when my kids ask me, well, how is a Bitcoin created? I use the train analogy. You have the train car, which is the block. You have the crane, which are the miners, and then you have the blockchain, which are the train tracks. So, using that example of me sending my daughter $100 worth of Bitcoin. That information will go into the train car. Now, the miners or the nodes will use the nodes, and they would solve this complex mathematical formula. The first miner to solve it becomes the crane operator. And its role is to validate the transactions in that particular train car and then put it on the blockchain and all the other nodes will verify that particular block. And once there is a consensus, thus the term consensus mechanism, it will be added on to the blockchain. And it will be added on to the last transaction. So, it would look similar to what we see in a train car. Once it's validated, that particular train car or block will go to the back of the line. And I know there's questions and skepticism of Bitcoin and whether it does have value but you are seeing, as I discussed, the evolution of money. It started with trading cows. It's now moving into Bitcoin. And we're going to be discussing what I think is the next evolution, which is stable tokens. I work for the Wyoming Stable Token Commission, and recently we issued the first stable token to be fully reserved by a US government entity, the Frontier token or FRNT for short.

Here is a brief overview. Legislators in Wyoming have been very active and have been enacted over 40 pieces of legislation in the 2015-2016 time period which culminated into the Wyoming Stable Token Act. It was created with the singular purpose of issuing a stable token. And we, unlike the other stable token issuers, are a public goods project. And I'll explain that in a little bit. The act itself also designated an executive director, Anthony Apollo, who was appointed in September 2023. The Commission is comprised of seven commissioners. Three of those commissioners are elected officials, including the Chairman, Mark Gordon. The four other Commissioners or what we call subject matter advisors are experts in audit, law, and banking. And Commissioner Flavia Navares is the general counsel for Circle, which is the issuer of USDC, which is one of the larger stable tokens issued in the country globally. We are looking at it from the use cases to the stable token from a state perspective. We don't consider ourselves to be a competitor of the trillions of dollars of stable tokens in circulation because our mandate is different. Our mandate is that any proceeds that we earn must be given to the school education system, similar to the lottery system. So, what we look at and what we look for is to utilize the tokens in meaningful ways. We have been approached by several states to consider a white label service so that you don't have to go through the growing pains that the Wyoming legislators had to endure. We also look at it from accepting payments or taxes in stablecoins. We are working with vendors, and we have been paying our vendors with front tokens. We've also been looking into from the state of Wyoming to use stablecoins to process quickly and cheaply unclaimed property.

How are we looking at it from the insurance industry? Again, one of the great benefits of stable tokens is the low fees and near instantaneous payouts that could be utilized from auto accidents to rapid natural disasters, premiums could be paid on a large scale in lieu of cash. Stable tokens could be used to hold as collateral. Again, the Wyoming stable token is attached to the US dollar. It must be reserved. And we are required by law to be over collateralized by 102%. So, for every dollar you give, we must have a dollar and two cents. It will have collateral like you have at a financial institution so that customers who use the token have faith and transparency. The Wyoming Stable Token Commission meets monthly. We have our audit processes or attestation processes that are currently available online issued each month in a report. I spend 10 hours of my time each month reviewing the paperwork with the chief financial officer. The commission staff, including myself, we're pretty small. We're five people in total, whose job is to issue stable tokens on a large scale. And lastly, the Bermuda Monetary Authority (BMA) issued a paper looking at the advantages of using sable coin in insurance for many purposes, including reinsurance, as underwriting collateral and risk pools. Please reach out to me directly by email. If you're curious as to our website, the QR code is available for your pleasure. As I said, our meetings are monthly. They're publicly available and recorded.

Sen. Lang stated that when we went off the gold standards we changed the verbiage on the dollar to a Federal Reserve note. And our forefathers warned us about the dangers of fiat money. But every dollar says this note is legal tender for all debts, public and private. Is that the same for cryptocurrency? Ms. Brooks stated for stable tokens, particularly in Wyoming, the answer is no. It is by statute. It is clear that the tokens are not subject to full faith and credit like the US dollar. They are a special interest or special purpose.

Sen. Lang stated that since we are off the gold standard today, the dollar is only backed by the full faith and credit of the U.S. government. Now there are a few states, Texas being the leader, that have created gold and silver as legal currency and I would consider my colleagues to look at what Texas has done. I'm trying to get it into Ohio. There's a lot of benefits for your consumers. Is there there an underlying asset that protects the holders of any type of Cryptocurrency, or is it just the full faith and credit of the entity issuing it? Ms. Brooks stated that I'm glad you asked that question. I just want to be very clear that stable tokens are different from the other crypto assets that I discussed, particularly Bitcoin. Bitcoin, there are serious debates about its utility and its value. It's used as a hedging tool many times and I've seen it when I worked at NYDFS. The stablecoins, by design, have to be attached to a real world asset because the challenge was the fluctuating price of Bitcoin. It could be worth $20 today and you buy a pizza. And then next thing that $ 20 pizza is now you spent maybe $60,000 or more as the value of Bitcoin rises. But to answer your question, the stablecoin has to be attached to an asset. Putting aside algorithmic stable tokens which is a completely different animal, the fiat backed is the US dollar, or commodities backed like gold or oil. That is something that Wyoming is considering tokenizing, if you will, like gold. Now, there's a whole process by which you have to hold on to the gold and hold on to the oil and make sure it's secured. I did that at NYDFS and I can answer any questions on how you're supposed to monitor to make sure that the gold is where it's supposed to be, which has always been a challenge. And there's a whole process by which you have to examine the gold. You have to do an audit. When I was at NYDFS, I made sure there were surprise audits so that they can come in and look to make sure that the product that's there is there, and reports have to be public. Even when I was at NYDFS, every one of our stable token issuers, including Paxos which issues Pax Gold, had to attest that the monies and the gold is where it needed to be, and that information had to be publicly available on its website. So, you have an independent auditor who will publish based on the information to which they attest, which is different from an

audit. They'll attest that the monies are in the bank, and that the gold is in the bank. And then annually, you have to conduct an audit trail, and that also has to be published.

RISK RETENTION GROUPS 101

Asm. Gandolfo stated that we will now move on to the last item on our agenda which is the topic of risk retention groups (RRGs) and how they can help secure liability insurance coverage. Some brief background. In 1986, Congress passed the Liability Risk Retention Act in response to a crisis in liability insurance availability. The act allowed businesses with similar liability risks to self-insure or purchase group liability insurance. Risk retention groups are primarily regulated by just one state and do not have to comply with 50 different state laws. This will be a great opportunity to hear somewhat of a 101 presentation on risk retention groups and hear different perspectives on them.

Joe Deems, Executive Director of the National Risk Retention Association (NRRA) thanked the committee for the opportunity to speak and stated that I'd like to say what my discussion today is not about. My discussion today is not about social inflation versus capital surplus. It's not about regulators versus legislators. It's not about writing new laws. And the only thing it has to do with artificial intelligence is I'm just trying to stay out of the way and stay out of trouble on that. What it is about, however, is clarifying existing laws. Addressing the issues of misinformation versus accurate information. And taking a 50,000 foot view at what's going on in the industry, where there seems to be an effort that is aimed at conflating regulator safety or safety regulation with insurance regulation. So, that's basically what I'd like to talk about. But also, while I'm at it, I'd like to talk with you a little bit about the NRRA. We will be 40 years old next month.

So, we were formed a year after the Liability Risk Retention Act was passed by Congress. It's actually an amendment of the Product Liability Risk Retention Act which was actually adopted in 1981. To go back to something that happened 50 years ago compared to what's happening right now, we had a crisis involving liability insurance in the 1970s. Major manufacturers, product liability manufacturers, were getting hammered by runaway jury verdicts and they couldn't get insurance. And Congress came up with this idea of creating this new type of an insurance company, which simplified the whole process, allowing them to be licensed and admitted in one state, called the state of domicile, and then under the rules, they could issue their policies in the other 49 states with certain limited types of regulatory activity. So the idea of unavailability versus affordability is just here with us today, isn't it? And two ends of our country we've got states that are facing a crisis of insurance, not just liability but all kinds of insurance. And ironically, one of those states is controlled by a super majority of Republicans. The other one is controlled by a super majority of Democrats. So, this is a situation, which isn't necessarily something that should be handled on anything other than a bipartisan sort of relationship.

In the course of our 40 years, what NRRA does is serve as an advocacy group. We advocate changes with regulators. We advocate activities with legislators, and we advocate in judicial cases as well. To give you a little point of view on it, 98% of the regulator cases are resolved pretty amicably with phone calls and letters once we educate them as to how the law works. The 5% of the cases are the times we deal with legislators when there are issues that we need to address. And 100% of the time we win judicial cases. We have won in the majority of case law in state and federal courts of appeal, including two state supreme courts, among others that categorically uphold the wisdom and the accuracy of the liability risk retention act. And I want to say that NRRA is not a pay-to-play organization. We are an advocacy group. I'd like to say we instead of putting our money where our mouth is, we put our education where our

mouth is. So I have some slides today. This will be your cheat sheet from this point going forward on risk retention groups. Because what it does is lay out exactly how risk retention groups are licensed and admitted, and how that compares with traditional insurance companies. You'll be blown away when you see how much effort goes into the work by a domicile state in regulating and licensing and admitting a risk retention group. After that, you will see a couple of slides that shows you the things that the non-domiciliary states are allowed to do. And I have encouraged them to do, as a matter of fact, they never seem to do it. They always seem to resort to less expensive ways of trying to engage in regulatory activity that's not permitted by the federal law. So, what I've done here is I've created the slides for your benefit to keep with you because we're going to talk a little bit about some of the things that affect this industry and why NRRA makes it a practice to give a lot of this away and put it up on our website.

First of all, some examples of misinformation. Now, clarifying the problem of misinformation versus accurate information is highly relevant to this conversation. For example, some of you may have heard that risk retention groups are not legitimate insurance companies. The slides I've given you show otherwise. I actually had a case with a legislative aide in another state, which will remain nameless who wrote a review of a particular piece of legislation where this aide put in there that risk retention groups are not legitimate insurance companies because they're not regulated. That is misinformation that's given actually to the legislators. There are 30 states which have laws on their books which were adopted legitimately by the legislature of those states that are preempted by the Liability Risk Retention Act. And so, when you look at things from this sort of a perspective, we resolve those amicably and they get resolved in appropriate ways. There's misinformation about guaranty funds compared with the reinsurance that are applied and allowed for risk retention groups that are required, by the way. Many states believe that they can issue cease and desist orders. They are not authorized to issue as the case law has clarified cease and desist orders don't work.

Also, some states may try to rely on administrative courts versus what the federal law requires, which is courts of competent jurisdiction. So, as we roll forward in some of this conversation, I've noticed lately a trend that seems to be developing here, and that is what appears to be a conflation of the distinction between safety regulation, and insurance regulation. And we're seeing more of this now happening around us where you'll see articles written that talk about safety. A good example is from the trucking industry right now. In trucking they talk about the FMCSA (Federal Motor Carrier Safety Administration) and their safety regulations. But a lot of times, the people that write these articles do not understand that safety regulators do not regulate insurance. And insurance regulators do not regulate safety. But you will see examples of this coming up. Another area we see things happening are efforts on the part of certain groups to increase limits on risk retention groups. Now, the federal law permits increased limits for certain types of licensed activities. And it doesn't designate what those licensed activities specifically are. It just generically says there are certain types of licensed activities for which the state can dictate what the minimum limits are. A good example of that is in trucking. In the trucking industry, the federal law has a minimum limit of $750,000 for big rigs. Most all of them carry about $1 million because that's what the carriers will write.

But there's talk that goes on about why aren't we increasing the limits for this? And my response to that is, and this is just my opinion, how much money you have does not dictate how safe you're going to be. How safe you're going to be is a function of good risk management. And by the way, one of the reasons why many experts consider risk retention groups to be a very ingenious type of structure is the sophistication of risk management. Think about it. We don't sell insurance to members of the public. We only sell insurance to members of the group who have to be in the same business, trade or profession. Well, who better to know about what

safety issues can affect a hang gliding training school other than hang gliding professors who teach that? 30% of our people in the industry are in the medical profession. 30 to 35% are actually healthcare providers. 17% are truckers. The rest are just this wide variety of other professions and businesses. And so, all of them face the same problem, they aren't able to get the kind of insurance that they need, or they can't afford it. The way I like to describe it is if you take unavailability and unaffordability. They're actually two points along the same line if you think about it. And we're only allowed to write liability but every now and then we'll have a state come and say, well we don't like this insurance policy as we don't think it's a liability. And they find out the hard way that it's the state of domicile that decides whether or not it is a liability policy. And there's mechanisms built into the Liability Act that will give the non-domiciliary states a variety of options that are very potent for regulating risk retention groups. Unlike the misstated belief that they have no regulatory power at all. They have no regulatory power to do illegal things. But they do have tremendous regulatory power when it comes to applying the law the correct way, and the way in which the Congress decided this law should be done.

So, I also want to share with you a thought, and it's what I call the purpose-driven RRG. If you have a risk retention group that's formed the right way, for the right reason, and which has a purpose for its existence, it will outperform and outlast a traditional carrier of the same size and complexion. For example, some of you have heard of OOIDA, the Owner-Operator Independent Drivers Association (OOIDA). They have their own radio station. It's a vast association of independent drivers. They got their own radio station, they have all their programs, they've got a lobbying group in Washington DC, and they have a program on Sirius. These truckers are rolling down the highways of life, and they're listening to things that are going on in Washington, what OOIDA is doing for them. That's a purpose-driven risk retention group right there. They are the earliest trucking group. They were formed in 1995. National Catholic is another risk retention group. They've been around for almost the whole 40 years. And very highly regarded, very well received group with some of the best now risk management processes available. So, let me digress for just a moment and talk a little bit about what I think NCOIL can do to help us. This is my ask. I'm going to give you an example. Help us clarify the distinction between licensed and admitted on the one hand and authorized on the other hand. Now, I don't bring this up because I'm worried about risk retention groups. We're more worried about the members of the public who are being denied the ability to get service by companies that are insured by these. Couple of examples. Down in Florida, I saw a case a while back where a contractor was building a small fence around a nursing home. It's a little metal fence around the nursing home, the primary purpose of which was to keep them from wandering off. They get stopped by the county. Oh, you're not insured by a licensed and admitted insurer in Florida, therefore you can't do the job. The problem eventually got resolved.

Here's another great example out in California. The Contractors State License Board will not issue a contractor's license to a contractor doing business as a limited liability company unless they are insured by a licensed carrier, and that's been on the books since 2009. If there's any state that needs contractors right now, it's California and Florida. You need these people out there to do work to help address the issues caused by these catastrophic losses. They can't get it. By the way, that statute for those who want to write it down is Business and Professions Code 7071.19 subsection C. We can change that entire problem in California by replacing the word licensed with the word authorized. That's how simple it is to fix this problem in most of these states. And this is the reason why we do what we do and why we spend our time going out, educating people, talking with people. We've had no problems. The judges, court of appeals judges, state and federal have agreed with us completely.

And so in the back end of those slides I gave you, you'll see about five or six cases in there. Those are cases that involve state laws. For example, a couple of them are direct action statutes. A couple of them are anti-arbitration statutes and things like that. So, on a go forward basis, I like the idea and I want to get the point across that we see some deep value between what we do and what you are doing and the things that you are trying to do. Because whatever effort can be put into this process of enhancing uniformity among state laws is going to help everybody. We fill a niche. We fill a niche that many other carriers cannot and will not fill, which is why we're small. We're less than 10% of the entire captive industry, but we are a $5.5 billion industry now and we're growing all the time. Our companies perform very well, and they perform much better than most people believe, and they perform incredibly better than they're given credit for. So, in closing, all I would say that if the trial lawyers get to a point where they get their way, I don't think we're going to be seeing any tort reform anytime soon. If they also get their way, I see our industry going to a point where the law starts getting morphed into a situation where big things become liable to little things, and hard things become liable to soft things. And those who want to increase limits will not be happy until there's enough money there to be picked off.

Paul Martin, VP of State & Policy Affair at the National Association of Mutual Insurance Companies (NAMIC), thanked the committee for the opportunity to speak and stated that I want to make sure that everyone understands it's not we're necessarily opposed to RRGs, they do have a limited place. But I would ask you, when people come to you and say, we need to change the laws or we need to do something on RRGs, ask yourselves two questions. The first question is what is happening in the marketplace that necessitates formation of the RRG. Historically that has been litigation trends, but there could be other things. And then maybe fix that problem first. Address that litigation problem first. What is causing people to think they need to create some sort of other non-admitted product to write coverage? Is it because of litigation? Is it because of TPLF (third-party funding litigation)? Maybe address that first. And then the second thing is, ask yourselves, how come the RRG can do this cheaper than the admitted market? Now, I don't necessarily know the answer to the first question because it may be peril, it may be state-by-state specific. But we do know some of the answers to the second questions of why the RRG can do it cheaper and it's simply because there's less regulation. There's less oversight. There's generally no, or minimal rate and form filings. Once the domiciled regulator does their thing, the other regulators in other states have less authority to regulate the RRG than they do for companies in admitted market.

Traditionally, there is no statutory accounting; it's all done by GAAP accounting. Nothing wrong with GAAP accounting but there is an emphasis in the admitted market on solvency and our friends at the NAIC tell us that there is actually a higher insolvency rate for RRGs than there is in the admitted market. Typically, RRGs don't participate in the guaranty funds. So, when you ask yourselves, how come they can do it cheaper? Well, it's because they don't play by the same rules necessarily as the admitted market. So, if you have a situation where the admitted market is not meeting a need, ask yourselves, why is that happening? Is there anything we need to fix? We would encourage people to look in the surplus lines markets. To look at residual markets, and then if there's a true market need where there are no products available and no capital from the admitted market coming in, then we can have a conversation about whether the RRG is the right solution to that particular problem.

Rep. Matt Lehman (IN) stated that I've been around this market a long time and I get what RRGs do and I love competition. If I'm fencing a line, and I'm the fencing contractor. I joined fencing alliance and I become part of this RRG. I'm now the carrier. I'm the insured, I'm the company. I'm putting my assets at risk. If I'm a municipality or a school, which we're now seeing

them get into these trusts and these RRGs, now I'm putting tax dollars at risk. Should these expand into those public sector risks that actually are funded by taxpayers? Because if they are insolvent, the only place they can get their money back to even is through the taxpayer. So, I'm just curious if in your expansion of the RRGs is there anything that requires tax dollars to be funding it off limits?

Mr. Deems stated that one of the slides I gave you points out that RRGs serving the government institution sector have done particularly well long term. United Educators, Housing Authority, National Catholic are all Vermont domiciled and active since 1980s. And so I would say that what gives the risk retention group the edge over most insurance companies is the fact that all of the insured members have skin in the game. Safety is the primary concern, not limits. Risk retention groups fill the bill and you can you can see that. Rep. Lehman stated if I'm a municipality, it's not my skin. It's not my money. It's the public's money. So if there's a failure, you don't go to my bank account. I don't go to my friends to borrow money. I go to the taxpayer to pay this loss. Mr. Deems stated that I'm not talking about governmental entities per se. I'm talking about entities that serve governmental entities, for example, United Educators. They probably insure 1,600 colleges and universities and schools across the U.S. National Catholic, for example, nowadays runs significant youth protection programs in different states where they are allowed to enter into contracts because they have developed risk management protocols that are vastly superior to anything else when it comes into situations that involve bad conduct among people. They are the entities of choice that several municipalities want to have by way of contracts. So, they enter into those kinds of things. In the Housing Authority's case, I don't know housing authority that intimately, but most of them are sub entities or contract entities within different municipalities. I don't see any actual governmental entities that live off of taxpayer money forming their own risk retention group if that's responsive to your question.

Mr. Martin stated that again, NAMIC is not necessarily opposed to RRGs. And Mr. Deems makes a good point that when you have certain trades you can hire the underwriters where everyone is in that certain trade or that certain part of the marketplace where they can share best practices and write products that are best suited for them. You know who else does that? Mutuals in the admitted market. We have many who do that. So, it's not that there's a difference of opinion as to whether or not truckers or fence builders should get together and form their own entities. There's a lot of benefits to that. But let's make sure that if we're going to do this, that we're going to go into that with eyes wide open and understand the risk that are inherently involved in this.

ADJOURNMENT

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