30 DAY MATERIALS AND GENERAL SCHEDULE
NCOIL SUMMER MEETING
JULY 15 - 18, 2026

As of June 16, 2026, and Subject to Change

The Westin Copley Place Hotel
Boston, Massachusetts

NCOIL SUMMER MEETING
Boston, Massachusetts
July 15 - 18, 2026
SCHEDULE

Note: There will be a room (St. George D on the 3rd floor) available throughout the duration of the conference for informal meetings. Attendees should feel free to meet with legislators there throughout the meeting.

WEDNESDAY, JULY 15TH

NCOIL & Institutes Griffith Foundation Insurance Fundamentals Legislator Workshop	1:00 p.m.	-	4:00 p.m.
	(lunch served at 12:30 p.m.)		

****Open to legislators & staff only.*
*Reach out to pgilbert@ncoil.org to RSVP as space is limited****

Tour of the Massachusetts State House	2:30 p.m.		

****Reach out to pgilbert@ncoil.org to RSVP as space is limited****

Budget Committee	3:30 p.m.	-	4:00 p.m.
Audit Committee (Members Only)	4:00 p.m.	-	4:45 p.m.
Welcome Reception	5:30 p.m.	-	7:30 p.m.

Sponsored by MassMutual
View Boston Observation Deck (0.5 miles from hotel)

THURSDAY, JULY 16TH

Registration	8:00 a.m.	-	5:00 p.m.

Exhibits Open: 8:00 a.m. – 5:00 p.m.

Welcome Breakfast	8:15 a.m.	-	9:45 a.m.
First Time Attendee Legislator & Staff Meeting	9:45 a.m.	-	10:00 a.m.
Networking Break	9:45 a.m.	-	10:00 a.m.

Sponsored by Aflac

Life Insurance & Financial Planning Committee	10:00 a.m.	-	11:30 a.m.
Joint State-Federal Relations & International Insurance Issues Committee	11:30 a.m.	-	1:00 p.m.
The Institutes Griffith Foundation Legislator Luncheon	1:00 p.m.	-	2:00 p.m.

A Primer on Insurance Entities: Explaining Different Types and Purposes
Open to Public Policymakers and Staff Only

General Session Insuring Autonomy: A Discussion on Autonomous Vehicles and the Insurance Industry	2:00 p.m.	-	3:30 p.m.
Networking Break	3:30 p.m.	-	3:45 p.m.
Financial Services & Multi-Lines Issues Committee	3:45 p.m.	-	5:30 p.m.
Adjournment	5:30 p.m.		
CIP Member & Sponsor Reception ***Open to Public Policymakers, CIP Members, and Summer Meeting Sponsors***	6:00 p.m.	-	7:00 p.m.

FRIDAY, JULY 17th

Registration *Exhibits Open: 8:00 a.m. – 5:00 p.m.*	8:00 a.m.	-	5:00 p.m.
Workers' Compensation Insurance Committee	9:00 a.m.	-	10:30 a.m.
Networking Break	10:30 a.m.	-	10:45 a.m.
NCOIL – NAIC Dialogue	10:45 a.m.	-	12:00 p.m.
Luncheon with Keynote Address **Sponsored by Liberty Mutual**	12:00 p.m.	-	1:30 p.m.
General Session Tort Reform: Perspectives on What's Worked and What Hasn't	1:30 p.m.	-	3:00 p.m.

Health Insurance & Long Term Care Issues Committee	3:00 p.m.	-	4:45 p.m.
Adjournment	5:00 p.m.		
Women's Caucus Reception	5:00 p.m.	-	6:00 p.m.

Open to all Women Attendees
Please reach out to Pat Gilbert at pgilbert@ncoil.org with any questions.

SATURDAY, JULY 18TH

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	8:00 a.m.	-	9:00 a.m.

Understanding Reinsurance: A Primer for Public Policymakers
Open to Public Policymakers and Staff Only

General Session Developments & Innovations in Disease Screening and Testing Methods	9:00 a.m.	-	10:30 a.m.
Networking Break	10:30 a.m.	-	10:45 a.m.
Property & Casualty Insurance Committee	10:45 a.m.	-	12:30 p.m.
Executive Committee	12:30 p.m.	-	1:00 p.m.

Please note all speakers listed are scheduled to speak as of June 16, 2026. There will be modifications between now and the start of the Meeting.

Note: There will be a room (St. George D on the 3rd floor) available throughout the duration of the conference for informal meetings. Attendees should feel free to meet with legislators there throughout the meeting.

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

Wednesday, July 15, 2026

NCOIL & The Institutes Griffith Foundation Legislator Workshop
Wednesday, July 15, 2026
1:00 p.m. - 4:00 p.m. (Lunch served at 12:30 p.m.)
*****Open to Legislators and Staff Only*****
*****Please reach out to Pat Gilbert at pgilbert@ncoil.org to RSVP. Space is limited.*****

Tour of Massachusetts State House
Wednesday, July 15, 2026
2:30 p.m.
*****Reach out to pgilbert@ncoil.org to RSVP as space is limited*****

Budget Committee
Wednesday, July 15, 2026
3:30 p.m. – 4:00 p.m.

Chair: Rep. Jim Dunnigan (UT) – NCOIL Treasurer
Vice Chair: Rep. Barbara Dittrich (WI)

1.) Call to Order/Roll Call/Approval of November 14, 2025 Cmte. Meeting Minutes
2.) 2027 Budget Planning Discussion
3.) Any Other Business
4.) Adjournment

Audit Committee (Members Only)
Wednesday, July 15, 2026
4:00 p.m. – 4:45 p.m.

Welcome Reception
Sponsored by MassMutual
View Boston Observation Deck (0.5 miles from hotel)
Wednesday, July 15, 2026
5:30 p.m. – 7:30 p.m.

Thursday, July 16, 2026

Welcome Breakfast
Thursday, July 16, 2026
8:15 a.m. – 9:45 a.m.

1.) **Dominick Ianno – Head of State Gov't Relations – MassMutual**
 -Sponsor's Welcome
2.) **The Hon. Michael Caljouw – Massachusetts Insurance Commissioner**
 -Welcome to Boston
3.) **Will Melofchik**
 -Introductory Comments from NCOIL CEO
4.) **The Hon. Andrea Campbell – Massachusetts Attorney General**
5.) **Sen. Paul Utke (MN)**
 -President's Welcome
 -New Member Welcome and Introduction
6.) Any Other Business
7.) Adjournment

First time Attendee Legislators & Staff Meeting
Thursday, July 16, 2026
9:45 a.m. – 10:00 a.m.

Networking Break
Sponsored by Aflac
Thursday, July 16, 2026
9:45 a.m. – 10:00 a.m.

Life Insurance & Financial Planning Committee
Thursday, July 16, 2026
10:00 a.m. – 11:30 a.m.

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

1.) Call to Order/Roll Call/Approval of April 17, 2026 Committee Meeting Minutes
2.) Presentation on Mortality Drivers: Practical Insights from Society of Actuaries Research
Kara Clark, Senior Research Actuary – Society of Actuaries (SOA)
3.) Discussion on Developments in Unclaimed Life Insurance Benefits
Jill Rickard, Regional VP, State Relations – American Council of Life Insurers (ACLI)
Brendan Bridgeland, Director – Center for Insurance Research
4.) Understanding the Elusive Life Insurance Consumer
Steve Wood, Research Director, Consumer Markets - LIMRA
5.) Update on Interstate Insurance Product Regulation Compact (IIPRC) Activities
Karen Schutter, Executive Director - IIPRC
6.) Any Other Business
7.) Adjournment

Joint State-Federal Relations & International Insurance Issues Committee
Thursday, July 16, 2026
11:30 a.m. – 1:00 p.m.

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

1.) Call to Order/Roll Call/Approval of April 18, 2026 Committee Meeting Minutes
2.) Introduction and Discussion on NCOIL Strengthening Transparency in the 340B Drug Pricing Program Model Act
Rep. Tom Oliverson, M.D. (TX) – Sponsor; Sen. Paul Utke (MN), NCOIL President – Co-sponsor
Sayeh Nikpay, PhD, Associate Professor, Division of Health Policy & Management – University of Minnesota
American Hospital Ass'n (AHA) Representative
3.) Presentation on Developments in the Flood Insurance Marketplace
Jake Clark, Managing Director, U.S. Public Sector – Guy Carpenter
4.) Discussion on Recent Federal Executive Orders on "Increasing Medical Marijuana and Cannabidiol Research" and "Accelerating Medical Treatments for Serious Mental Illness"
Jeff Burt, VP of Market Access – Definium Therapeutics
Daniela Sharfstein, Director of State Gov't Affairs – Jazz Pharmaceuticals
5.) Any Other Business
6.) Adjournment

The Institutes Griffith Foundation Legislator Luncheon
A Primer on Insurance Entities: Explaining Different Types and Purposes
Thursday, July 16, 2026
1:00 p.m. – 2:00 p.m.
*****Open to Public Policymakers and Staff Only*****

David M. Pooser, Ph.D.
Herbert Wertheim College of Business's Dr. William T. Hold/The Alliance's Program in Risk Management and Insurance
Florida State University - Effective August 2026.

General Session
Insuring Autonomy: A Discussion on Autonomous Vehicles and the Insurance Industry
Thursday, July 16, 2026
2:00 p.m. – 3:30 p.m.

Moderator: Rep. Edmond Jordan (LA) – NCOIL Vice President

Bryant Walker Smith
Professor of Law
Univ. of South Carolina Law School

Tilia Gode
Head of Risk and Insurance
Waymo

Scott Fischer
Head of Gov't Relations, General Counsel
Lemonade

Matt Overturf
Assistant VP, State Affairs
Nat'l Ass'n of Mutual Insurance Companies (NAMIC)

American Property Casualty Insurance Ass'n (APCIA) Representative

Networking Break
Thursday, July 17, 2025
3:30 p.m. – 3:45 p.m.

Financial Services & Multi-Lines Issues Committee
Thursday, July 16, 2026
3:45 p.m. – 5:30 p.m.

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

1.) Call to Order/Roll Call/Approval of April 19, 2026 Committee Meeting Minutes
2.) Presentation on Insurance and Artificial Intelligence – Level Setting and Discussing the Road Ahead

Steve Armstrong, SVP and Chief Actuary – Allstate

3.) Private Credit and Insurance 101

Bridget Hagan, Managing Director & Global Head of Insurance Regulatory Solutions – Blackstone Credit & Insurance
Caitlin Colvin, Managing Director, Insurance Regulatory Solutions - Blackstone Credit & Insurance

4.) Discussion on Federal Executive Order "Ensuring a National Policy Framework for Artificial Intelligence"

Oliver Engebretson-Schooley, Partner – Sullivan & Cromwell

5.) Any Other Business
6.) Adjournment

CIP Member & Sponsor Reception
Thursday, July 16, 2026
6:00 p.m. – 7:00 p.m.

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

Friday, July 17, 2026

Workers' Compensation Insurance Committee
Friday, July 17, 2026
9:15 a.m. – 10:30 a.m.

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

1.) Call to Order/Roll Call/Approval of April 17, 2026 Committee Meeting Minutes
2.) "State of the Line" – An Update on the Status of and Trends in the Workers' Compensation Insurance Marketplace

Jeff Eddinger, Senior Division Executive – National Council on Compensation Insurance (NCCI)

3.) Presentation on Air Ambulances in Workers' Compensation: Use and Costs Across States

Ramona Tanaba, President & CEO - Workers' Compensation Research Institute (WCRI)

4.) Discussion on the State of Work Comp Coverage for Mental Injuries

Mark Walls, Corporate Senior VP and Chief Marketing Officer - Safety National

5.) Consideration of Re-adoption of Model Laws
  a.) The Trucking/Messenger Courier Industries Workers' Comp Model Act; and
  b.) Model Agreement Between Jurisdictions to Govern Coordination of Claims and Coverage
6.) Any Other Business
7.) Adjournment

Networking Break
Friday, July 17, 2026
10:30 a.m. – 10:45 a.m.

NCOIL-NAIC Dialogue
Friday, July 17, 2026
10:45 a.m. – 12:00 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 April 17, 2026 Committee Meeting Minutes
2.) Update on U.S. Treasury Meetings with Insurance Regulators on Private Credit Markets
3.) Discussion on NAIC's Natural Catastrophe Risk and Resilience (EX) Task Force and NAIC Development of Model Law on Mitigation Grant Programs
4.) Discussion on Artificial Intelligence Matters
5.) Update on Work of NAIC Working Groups
  a.) Market Conduct Regulation Modernization (D) Working Group
  b.) Healthcare Affordability and Mitigation (B) Working Group
  c.) Child Care Insurance (C) Working Group
6.) Any Other Business
7.) Adjournment

Luncheon with Keynote Address
Friday, July 17, 2026
12:00 p.m. – 1:30 p.m.

Sponsor's Welcome:
Liberty Mutual Representative

Keynote Speaker:
John Ashford
Chairman & CEO
The Hawthorn Group, L.C.

General Session
Tort Reform: Perspectives on What's Worked and What Hasn't
Friday, July 17, 2026
1:30 p.m. – 3:00 p.m.

Moderator: Rep. Ellyn Hefner (OK)

The Hon. Mike Yaworsky
Florida Insurance Commissioner

Tiger Joyce
President
American Tort Reform Ass'n (ATRA)

Kyle McCollum
VP - Strategy, Policy, & Gov't Affairs
National Insurance Crime Bureau (NICB)

NY State Trial Lawyers Ass'n (NYSTLA)
Representative

Health Insurance & Long Term Care Issues Committee
Friday, July 17, 2026
3:00 p.m. – 4:45 p.m.

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

1.) Call to Order/Roll Call/Approval of April 17, 2026 Committee Meeting Minutes
2.) Presentation on Improving Access and Affordability in the Healthcare Marketplace
Natalie Leino, General Counsel and Chief Compliance & Risk Officer - Sidecar Health
3.) Continued 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
Randi Chapman, Managing Director, State Affairs – Blue Cross Blue Shield Ass'n (BCBSA)
American Optometric Ass'n (AOA) Representative
4.) Continued Discussion and Consideration of NCOIL Charity Care and Medical Debt Reform Model Act
Rep. Tom Oliverson, M.D. (TX) – Sponsor; Rep. Brenda Carter (MI), NCOIL Secretary; Sen. Paul Utke (MN), NCOIL President – Co-sponsors
Joe Burchfield, National Director, State Policy – Ascension
5.) Discussion on Proposed Amendments to NCOIL Telemedicine Authorization and Reimbursement Model Act
Asw. Pam Hunter (NY), NCOIL Immediate Past President – Sponsor
Robert Baratta – On behalf of American Telemedicine Ass'n (ATA)
American Specialty Health (ASH) Representative
6.) Any Other Business
7.) Adjournment

Women's Caucus Reception
Friday, July 17, 2026
5:00 p.m. – 6:00 p.m.
*****Open to all Women Attendees*****
*****Please reach out to Pat Gilbert at pgilbert@ncoil.org with any questions.*****

Saturday, July 18, 2026

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

The Institutes Griffith Foundation Legislator Breakfast
Understanding Reinsurance: A Primer for Public Policymakers
Saturday, July 18, 2026
8:00 a.m. – 9:00 a.m.
*****Open to Public Policymakers and Staff Only*****

James Hilliard, PhD
Professor of Instruction, Fox School of Business and Management, Temple University

General Session
Developments & Innovations in Disease Screening and Testing Methods
Saturday, July 18, 2026
9:00 a.m. – 10:30 a.m.

Moderator: Rep. Deanna Gordon (KY)

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

Matt Brane
VP, Market Access/Managed Care
Guardant Health

Carter Harrison
Sr. Dir. of State Regulatory & Legislative Affairs
Alzheimer's Association

Andrew Spiegel
CEO
Global Colon Cancer Ass'n

Networking Break
Saturday, July 18, 2026
10:30 a.m. – 10:45 a.m.

Property & Casualty Insurance Committee
Saturday, July 18, 2026
10:45 a.m. – 12:30 p.m.

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

1.) Call to Order/Roll Call/Approval of April 18, 2026 and June 8, 2026 Committee Meeting Minutes
2.) Continued Discussion and Consideration of Proposed Amendments to NCOIL Transportation Network Company (TNC) Model Act
   Sen. Walter Michel (MS) – Sponsor of Proposed Amendments
3.) Continued Discussion on NCOIL Model Act Regarding Insurers' Use of Aerial Images
   Rep. Matt Lehman (IN); Rep. Brian Lampton (OH) – Sponsors; Rep. Matt Morgan (TX) – Co-sponsor
   Amy Bach, Executive Director – United Policyholders
   Wes Bissett, Senior Counsel – Independent Insurance Agents and Brokers of America (IIABA)
4.) Replacement Cost Value and Actual Cash Value Coverages - Discussion on the Federal Housing Finance Agency's (FHFA) Homeowners' Insurance Rule
   Paul Martin, VP of State & Policy Affairs – National Ass'n of Mutual Insurance Companies (NAMIC)
   Amy Bach – United Policyholders
5.) Consideration of Re-adoption of Model Laws
   a.) Post-Assessment Property and Liability Insurance Guaranty Association Model Act – Originally Adopted 11/17/07; Amended 4/18/21
      Rep. Matt Lehman (IN) – Sponsor of Proposed Amendments
   b.) NCOIL Distracted Driving Model Act – Originally Adopted 4/18/21
   c.) NCOIL Coronavirus Limited Immunity Model Act – Originally Adopted 4/18/21
   d.) NCOIL Peer-to-Peer Car Sharing Program Model Act – Originally Adopted 12/13/19; Amended 4/18/21
   e.) Property/Casualty Insurance Modernization Act – Originally Adopted 7/13/01; Last amended 4/18/21
   f.) Property/Casualty Flex-Rating Regulatory Improvement Model Act – Originally Adopted 2/27/04; Last re-adopted 7/17/21
6.) Any Other Business
7.) Adjournment

Executive Committee
Saturday, July 18, 2026
12:30 p.m. – 1:00 p.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 April 19, 2026 Committee Meeting Minutes
2.) Future Meeting Locations
3.) Administration
    a.) Meeting Report
    b.) Receipt of Financials and Audit
    c.) Consideration of Audit
4.) Consent Calendar
5.) Other Sessions
    a.) General Sessions
    b.) Featured Speakers
6.) Any Other Business
7.) Adjournment

BUDGET COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
BUDGET COMMITTEE
2025 NCOIL ANNUAL MEETING – ATLANTA, GA
November 14, 2025
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Budget Committee met at the Whitley Hotel in Atlanta, GA on Friday, November 14, 2025 at 4:45 PM.

NCOIL Treasurer, Representative Edmond Jordan (LA), presided.

Other members of the Committee present were:

Rep. Michael Meredith (KY)
Rep. Brenda Carter (MI)
Rep. Brian Lampton (OH)
Sen. Mary Felzkowski (WI)

Other legislators present were:

Rep. Matt Lehman (IN)
Sen. Lana Theis (MI)
Sen. Paul Utke (MN)
Asw. Pamela Hunter (NY)
Sen. George Lang (OH)
Rep. Carl Anderson (SC)

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

MINUTES

Upon a Motion made by Rep. Brenda Carter (MI), and seconded by Rep. Michael Meredith (KY), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 16, 2025 meeting in Chicago, IL.

CONSIDERATION OF 2026 NCOIL BUDGET

Rep. Edmond Jordan (LA), NCOIL Treasurer and Chair of the Committee, thank everyone for joining and stated that we're here today to consider NCOIL's 2026 budget. You should have a copy of the proposed budget before you along with a document showing the organization's 2025 financials as of October 31st and a document showing year end 2024 and 2023 financials. As a reminder, the Committee met in July during our Summer Meeting where we were provided the proposed budget, and we had the opportunity to go through it and ask any questions. Before we vote on the budget, I'll turn things over to Will Melofchik, NCOIL CEO, for some brief remarks.

Mr. Melofchik stated as you can see with the financials as of October 31, NCOIL is having another strong year. With the budget for next year, nothing has changed since the Committee's discussion in July. The only open item we have from that meeting that we wanted to resolve here

was the discussion around whether it would make sense to waive or reduce the meeting registration fee for legislators. Staff was instructed to crunch some numbers so the Committee could see what that would look like. Using last year's attendance numbers, and granted these can fluctuate, if you waive the fee entirely you are looking at about a $70,000 reduction and if you lower the fee to $250 that would be about a $50,000 reduction. So those are some numbers to think about. I know there was split thinking in July with a feeling that you kind of get what you pay for and the optics of making it free may not look the best, but we could also start with reducing the fee to see if that would lead to a slight uptick in attendance - or we keep it status quo. I'll say from the staff level at the office, we've never received a complaint that the registration fee has been too high. Sometimes we hear of scenarios that with things such as cross country flights, the stipend or scholarship may not always cover all travel expenses but that is fairly rare now that we increased the reimbursement amount to $1,500 in travel expenses plus the registration fee.

Rep. Meredith stated one other thing that I thought about since the discussion in July is that I don't know if the dollar amount makes a difference truthfully as far as participation goes. I know some other state legislative organizations bill the state directly for registration fees instead of the individual legislator so instead of having to do a direct reimbursement, the state takes care of it. I'm not sure what it's like in other states, but that works for us in Kentucky so that may be a possibility.

Mr. Melofchik stated I think that differs state by state so it might be a little tricky knowing what the mechanism is in every state. Rep. Jordan stated in Louisiana they cannot do it that way. Sen. Paul Utke (MN), NCOIL Vice President, stated it does not work that way in Minnesota so I agree with Mr. Melofchik that it differs state by state. Rep. Carl Anderson (SC) stated they could not do that in South Carolina.

Asw. Pamela Hunter (NY), NCOIL President, stated that based on our conversations at the last Budget Committee Meeting and during the Strengths, Weaknesses, Opportunities, and Threats (SWOT) Exercise, we need to think about this through the lens of increasing membership and getting more legislators to come. A thought that I had was we have 70 legislators from 30 states attend usually and even if it was all 50 states participating and you got two members per state, that's 100 legislators. Based on that, I'd think the maximum amount of total attendees would be about 500 people. We are purposefully more niche and not like other state legislative organizations. People are still coming at the current price and my thought is what is the purpose of reducing the price if we already have people coming and we have stipends and scholarships to offer. We're in good times and I think it was good to go through this exercise, but we need to have that plateau plan and think about the maximum amount of people who are going to come here. In my thought process, strategically, we need to look at that. I don't think removing the registration fee is a mechanism that will entice many more people to come.

Rep. Matt Lehman (IN) stated one of the concerns I have is that there are people who took the stipends or scholarships but never attended the meetings. I'm thrilled that we now have to add a second row of legislator seating at meetings, but if something is free and you go to a destination location are you going to attend the meetings since it isn't costing you anything and you aren't really accountable for being at the meetings? So we potentially set up a problem with the value of attending if we remove the registration fee.

Rep. Jordan stated that to Asw. Hunter's point, it's hard to justify lowering the fee when we are having record attendance. I think this is the most well attended NCOIL Meeting we've ever had. I do think we are trending in the right direction. There may be some tweaks we can make to have registration easier, but I don't think we need to look at removing the fee right now.

Asw. Hunter stated Rep. Lehman's point is a good one. It's good to have a mandatory amount of meetings that someone has to attend because they need to have skin in the game and there is a real concern that people will just use the stipends and scholarships as a free trip.

Sen. Mary Felzkowski (WI) agreed with Asw. Hunter and stated that in Wisconsin, we just turned down stipends on some legislators that attended a conference and didn't go to any events.

Sen. George Lang (OH) stated that if you do make any tweaks, please make them voluntary.

Sen. Lana Theis (MI) stated I like the accountability aspect. In our meeting minutes, do we list who attended? Asw. Hunter stated yes and we sign the attendance sheets at each committee meeting. Mr. Melofchik agreed with Asw. Hunter and stated that a component of legislators getting reimbursed is them certifying they attended a certain number of meetings. Everyone at this Committee meeting almost attends every meeting at our conferences so that's not a problem, but for some we have to make sure they meet that requirement.

Rep. Anderson stated I agree that we should maintain things as they are now.

Hearing no further question or comments, upon a motion made by Rep. Carter and seconded by Rep. Meredith, the Committee voted without objection via a voice vote to adopt the budget.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Brian Lampton (OH) and seconded by Sen. Felzkowski, the Committee adjourned at 5:15 p.m.

LIFE INSURANCE & FINANCIAL PLANNING COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
LIFE INSURANCE & FINANCIAL PLANNING COMMITTEE
2026 NCOIL SPRING MEETING – LOUISVILLE, KENTUCKY
APRIL 17, 2026
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Life Insurance & Financial Planning Committee met at the Hyatt Regency Hotel in Louisville, KY on Friday, April 17, 2026 at 4:45 p.m.

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

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Del. Mike Rogers (MD)
Rep. Brenda Carter (MI)
Sen. Mark Huizenga (MI)
Sen. Lana Theis (MI)
Sen. Jerry Klein (ND)
Asm. Jarett Gandolfo (NY)
Asw. Pam Hunter (NY)
Rep. Tom Oliverson, M.D. (TX)
Rep. Barbara Dittrich (WI)

Other legislators present were:

Sen. Jessie Bjorkman (AK)
Rep. Justin Wilmeth (AZ)
Rep. Stephen Meskers (CT)
Rep. Brett Barker (IA)
Rep. Elizabeth Wilson (IA)
Rep. Wendy Dant Chesser (IN)
Rep. Peggy Mayfield (IN)
Sen. Beverly Gossage (KS)
Rep. Mike Clines (KY)
Sen. Donald Douglas (KY)
Rep. Mike McFall (MI)
Sen. Paul Utke (MN)
Sen. Keri Heintzman (MN)
Sen. Jeff Barta (ND)
Sen. Bill Gannon (NH)
Sen. Tim McGough (NH)
Rep. Julie Miles (NH)
Rep. Kellie Deeter (OH)
Rep. Mark Tedford (OK)
Rep. Perry Warren (PA)
Rep. Yusuf Hakeem (TN)
Rep. Calvin Callahan (WI)
Sen. Jamie Wall (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 Sen. Jerry Klein (ND) and seconded by Sen. Justin Boyd (AR), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Sen. Boyd 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 13, 2025 and February 23, 2026 meetings.

CONSIDERATION OF NCOIL MODEL ACT REGARDING LIFE INSURERS' USE OF GENETIC INFORMATION

Rep. LeBoeuf stated that we will begin with consideration of the NCOIL Model Act Regarding Life Insurers Use of Genetic Information (model). We've had a vigorous discussion about this topic going back to last year's spring meeting. I think we've made great progress on this model and I'm comfortable with voting it out today as it is, and I believe that is also the sponsor's intent. I will now turn over things to the sponsor of the model, Rep. Brenda Carter (MI), NCOIL Secretary.

Rep. Carter stated that I'm very proud to sponsor this model, and I agree with you that we've made great progress with this topic since first discussing it last April. And I'm particularly pleased with the interim meeting we had in February where a large group of both legislators and interested parties were able to offer their feedback. Thank you to everyone who has participated in this process. As I mentioned at the beginning of this process last year, this is a topic that has generated a lot of discussion in state legislatures across the country in recent years so it's great timing for NCOIL to develop some guidance for states to consider using. The model is fairly straightforward in that rather than outright prohibiting life insurers from using genetic information, reasonable guardrails around such use are set forth, similar to what the state of Tennessee enacted a few years ago. And as I mentioned during the interim meeting, this model essentially codifies what the current practice is right now in terms of life insurance and genetic testing and I haven't seen yet enough evidence to go in the opposite direction and ban the use of such information. I think the model in its current form is very strong, and I encourage the committee to support it. And lastly, I want to stress that overall NCOIL philosophy of developing its models. They are meant to be a framework that states can use to add or remove things as they deem best for their state. 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 in their legislatures. It's important that guardrails can be enacted for both consumers and insurers alike.

Patrick McNulty, Director of State Relations at Northwestern Mutual Life Insurance Company thanked the committee for the opportunity to speak and stated that I'm delivering this testimony on behalf of the American Council of Life Insurers (ACLI) in support of the proposed Model. First, we thank you all for your commitment to developing a thoughtful, well-reasoned approach to life insurers' use of genetic testing information. The model recognizes the fundamental principle of information symmetry in life insurance underwriting. By doing so, it will help protect against adverse selection and ensure that life insurance remains accessible and affordable for all American families. As ACLI has stated on numerous occasions, genetic information is not fundamentally different from other health data such as blood pressure and family medical history. Access to all relevant health information is essential for maintaining the voluntary life insurance market. The very core of life insurance underwriting involves pooling the risks of individuals with similar health and life expectancies, and information symmetry is essential to this. Again, we thank you for your hard work and dedication to an approach that will help sustain a healthy and affordable life insurance market. ACLI appreciates your support of the model.

Rep. Stephen Meskers (CT) asked if the intent of the Model could be clarified. Rep. Carter stated that the intent is to put guardrails in place that would allow the life insurance industry to

utilize actuarial information to determine risk. Rep. Meskers stated so is the intent to prohibit them from using it for the policyholder who's applying but they could potentially, with their permission, collect the data? Rep. Carter replied the model is intended to make sure that we put guardrails in place to make sure that the consumer is protected and not use it as a discriminatory factor.

Sen. Bill Gannon (NH) stated if I wanted to take a test and I find out that I'm a low risk and I don't have any bad genetic factors and then I'm a much less likely person to need to utilize the insurance so are you not stopping me from joining a pool of very healthy people without bad genetic factors? Now, you're going to make me pay more and be in a higher risk pool? Rep. Carter stated that's not what the model aims to do.

Sen. Tim McGough (NH) stated that this legislation reminds me of the first time we dealt with the BRCA genes and genetic testing and the desire of underwriters to utilize that known history of a deadly cancer that's so very much hereditary. And we dealt with that in 1996 in my first term in the House. I offer an amendment that we strike section 4D because that very much opens the door for inappropriate medical underwriting for the daughters and granddaughters of breast cancer victims because most certainly that information would be obtained within their medical record, regardless of whether they tested themselves for BRCA1, 2, A, B, etc.

Rep. LeBoeuf stated that only members of the committee can introduce amendments.

Asw. Pam Hunter (NY), NCOIL Immediate Past President, stated that I'd like to applaud Rep. Carter and stated that this model follows work that we have done for the past several years in trying to be on time and innovative and on topic to where we are in healthcare today. And this mirrors in some ways the biomarker legislation that we passed several years ago in trying to make sure that we're using all information available to make sure that people can utilize their genetics in making sure that they have appropriate diagnoses and getting the appropriate treatment. So, I applaud you and I make a motion to adopt the model.

Sen. Lana Theis (MI) then seconded the motion. Rep. LeBoeuf then stated that as a reminder, per NCOIL bylaws, all NCOIL votes are voice votes except that a roll call vote shall be taken at the direction of the chair or upon the request of a committee member in instances where there are dissenting votes. The Committee then voted to adopt the model without objection via a voice vote. Rep. LeBoeuf thanked everyone and stated that the model will now be placed on the Executive Committee's agenda for final ratification.

PRESENTATION – THE COMMON THREAD: WHAT'S WOVEN INTO THE MOST SUCCESSFUL STATE RETIREMENT PLANS

Rep. LeBoeuf stated that next up is a presentation on the common thread - what's woven into the most successful state retirement plans. Also, if you look at the informational card distributed before you, the QR code will link to information that is discussed during this presentation.

Josh Freely, Managing Director of State Government Relations at TIAA, thanked the committee for the opportunity to speak and stated that for those of you who are not familiar, TIAA was founded by Andrew Carnegie in 1918 to provide a secure and dignified retirement for those in the higher education space. And 108 years later that is still what we're doing. We still are the largest provider of retirement services to those in the higher education and not-for-profit space. We also are an asset manager with about $1.5 trillion in diversified assets under management. And since 1918, we've paid out about $545 billion in lifetime income benefits. That's really

second only to Social Security. And last year, this committee passed a resolution that encouraged states to look at their state retirement plans and determine whether or not you were providing enough lifetime income. Well, after that resolution came out, we said “Well, you know this is something we could do.” And so we turned to our dear friends at the TIAA Institute and said, “Is there a way that you could look at the amount of lifetime income that is available to state workers and help states understand whether they have what they need and what are the pathways to get to what they need?” And now you’ll hear research and then I’ll come back and talk about some of the ways we can help you in your individual states.

Surya Kolluri, Head of the TIAA Institute, thanked the committee for the opportunity to speak and stated that I want to start with a little bit of context. So, at TIAA, when educators and folks working in healthcare and educational organizations retire, we cut them paychecks. The oldest recipient of such a paycheck is Professor Jerry Myers who when I interviewed him two years ago was 104 years old. So today he is 106. And so, when we look at the plan data that we have of 4 million participants, the number of people who are over 90 is in the tens of thousands. My father himself is a retired professor who’s 90 years old. And so, this fact that we live in an aging society racing towards 100 years is a very important context for the study that you’ve asked us to take a look at to say, “Are the employees in our state in a position of having financial security?” And so, the first benchmark that we established to answer your question was what should that replacement rate be when somebody retires? And so, that benchmark that we established was 80%. And you might say, “Why 80%? Why is it not 85%? Why is it not 75%?” And if you think about when we are working, we pay Federal Insurance Contributions Act (FICA) taxes. We do contribution to retirement plans, we have working expenditures we have. So, generally in economics, we agree that 80% replacement rate would be suitable for a secure retirement. So, we use that 80% benchmark as the lever to analyze plans in all 50 states. So, now when we look at the landscape of 50 states, what we find is it’s a variety of plans across the 50 states. So, for example, 35 states primarily have defined benefits plans. Twelve have hybrid plans which means that employees can get income from three sources. One could be a defined benefit plan, one could be a defined contribution plan. And also, Social Security. And there are several states where employees do not get Social Security. And then there are defined contribution plans. And then finally, there are also something called cash balance plans. So, how do you kind of get your mind around all these different plans and come up with a common thread to say, “What’s a solution that each state can take to get to this 80% replacement ratio?” So, that was the challenge of this analysis. So, I’m going to come up with four recommendations that I would ask the group to consider to get our state residents to that 80% replacement ratio.

So, the first recommendation that we have is providing qualified payout options. So, what do I mean by that? By that I mean, we climb a hill to kind of save for our retirement. But once we get to the top of the hill, we say, “Good luck. Here’s your lump sum.” But how about we give people a way to kind of climb down the hill? What are those lifetime income options that we can give them? It could be a guaranteed income amount. It could be managed payouts. Could be systematic withdrawal. So, adding lifetime income choices to defined contribution plans would be one recommendation. The second recommendation is the floors that we have. So, for example, I mentioned a cash balance plan. The floor there is 4%. And our economic modeling shows that you can’t get to the 80% replacement rate, if you have 4%. So, moving it up to 7%. So, the second suggestion that we have is to move the floor up so that people can work off a higher base. The third is the majority of the states that have defined benefit plans and some of them that don’t have Social Security. What do we do there? The suggestion there is provide at no cost to the states a supplemental plan, like a 457 with lifetime income options. So, we feel that if these three suggestions were adopted, this variety of plans that there are across the 50

states, wherever the state is starting at can get to that 80%. We're pretty confident. We are glad that you gave us this prompt. We are glad we did this analysis and I'm happy to say that this is not mission impossible. We can do this.

Mr. Freely stated that you all have this card and that'll lead you to this report and in the report, it gives you what we think is a really good news story, which is it doesn't matter what your state does. Whether, you have a defined benefit plan partnered with Social Security or you have a hybrid plan without Social Security. No matter what your approach to providing retirement income to your public employees is, you can get to this 80% benchmark. You just have to understand where you are, where your gaps exist, and what are the best tools to replace those gaps. And so here we have kind of a general example which are the various pathways depending on how you approach retirement to get to that 80% income replacement rate. But we've actually taken it a step further and we've done this analysis for every one of your states. And so we can produce a chart that looks like this that actually shows you where your gaps are. If you are a state that does not participate in Social Security, for instance, there's inherently going to be a gap between what you provide and that 80% benchmark. But there are again ways that the industry understands to make those gaps up. And so my encouragement is take a look at the report and come talk to us and we would love to share with you your specific results for your state and work with you on how you can get to that 80%. We want to thank you again for having us. We look forward to continuing the conversation. We think it's important to focus on giving people the ability to replace their income in retirement, and to make sure that retirement lasts throughout that retirement, so that the professors who live to 106 can continue to have money all the way through that perhaps 40 years of retirement.

Sen. Boyd stated that when we talk about TIAA and we're talking about a lump sum, is there any reason we can't talk about using a private annuity for that? Mr. Freely stated that those are absolutely options. We provide private annuities ourselves so that is one option. And depending on the state's approach, you may not need a private option if you have a defined benefit and Social Security. But in a lot of cases where you perhaps don't provide that there are options like private annuities, other qualified payout options and there's actually a lot of different options that are provided by different companies and different providers in the space. Mr. Kolluri stated the only point to kind of emphasize is that we have options while we save. We have mutual funds, we have equities, we have bonds. But we don't have options coming down the hill so what we're calling for is payout options when we retire.

Sen. Boyd asked where are you coming up with the 80% mark? I know there's kind of a 70% to 80% industry standard, but I also see people who don't need anywhere near that. Mr. Kolluri stated it's a fair point. When we did the analysis across all 50 states, across all plans, we just needed a benchmark. But the model is flexible enough to say: "what does it show when you make the benchmark 70%?" So, it's all scenario planning, but we had to anchor the analysis on a number, and we started with 80%, which is generally accepted, but we could easily flex it.

PRESENTATION ON RETIREMENT SECURITY AND GIG WORKERS

Matthew Sonduck, Director of Public Policy at the Academy of Actuaries, thanked the committee for the opportunity to speak and stated that the Academy is an independent nonprofit organization that legislators regularly turn to for nonpartisan, objective advice, analysis and research on many of the complex insurance and retirement topics that demand actuarial expertise. Of interest today is gig workers, which represent a growing segment of the total workforce who face particular risks pertaining to meeting their financial needs in retirement. Gig workers are prevalent in your districts and include many of your constituents. It's important to

note that the Academy's analysis of improving retirement security for gig workers falls under the framework of current labor law. Now, I will turn the presentation over to my colleague Claire Wolkoff, a former chairperson and current member of the Academy's Retirement Policy and Design Evaluation Committee.

Ms. Wolkoff thanked the committee for the opportunity to speak and stated let's start with who are gig workers? Part of what is confusing here is there is not a universal definition. Generally, these are non-traditional workers who are not covered by a regular employer-employee relationship. The main reasons that some individuals choose to be gig workers or independent contractors are for the lifestyle, the flexibility, and the desire to be their own boss. The Pew Charitable Trust did a lot of work on this, and they use the term "nontraditional workers" for these people. So, if you look at the pie chart on the left of the slide there, you'll see that 38% of the surveyed people had one non-traditional job. 22% had multiple nontraditional jobs, but 40% had both a traditional and a nontraditional job. And that's an important distinction because especially if someone is an employee of a large company that offers a good benefits package that individual would not have some of the problems that the other people do.

So, there's a whole variety of types of work that gig workers do and we've classified them here on the right-hand side of the slide broken down by income level and the type of work. The highest income people here are professionals such as doctors and lawyers. And these are sole proprietors. They're not employees of another organization. At the mid-level group, we see a lot of platform workers, Uber, Lyft, DoorDash, Etsy, freelancers. And then when you get to low income, that's when you're looking primarily at temporary workers, on-call, seasonal day labor. So, there's a huge range here of the types of work that people do and the resulting pay they have. And given that variety, that's why it's very hard to answer the question, what percent of the workforce is gig or non-traditional. So, when we were doing our research for the paper, the studies we examined had ranges from 4% to 40% so that's why it's a confusing topic for some people. So, we'll start by going over the challenges that these gig workers have and then we'll talk about what's available to them and what the potential solutions are. So, first of all, by not being in a traditional employee-employer relationship they don't have the ability to have a convenient automatic savings option as part of their plan. And since gig workers tend to have irregular work, that's not everybody, but a lot of them, they have a lack of job security and they have a volatile income. As a result, they have to focus on their immediate cash needs and the emergencies that inevitably come up. And finally, they don't have sufficient financial education and tools and if someone is working for a large employer with a big 401k plan, that's kind of part of the package they get.

So, let's look at what retirement savings options they do have and let's start with government programs of which Social Security is the largest. Now, any worker with FICA return, any worker who works under Social Security coverage for at least 40 quarters gets a Social Security benefit. But that is based on reported incomes. If you're an employee, you get a W-2, that's reported to Social Security, you pay taxes, etc. But some gig workers and independent contractors do get 1099 forms, and the reporting limits for that have jumped around. But aside from that, a lot of what gig workers do and get in pay is not reported to the government by a third party. Therefore, we find that a lot of these workers do not report their full income to Social Security. They feel they need those earnings to live on now, and they don't realize what they are giving up. So, that is an issue. The federal government provides certain tax incentives and subsidies to lower-paid individuals who contribute either to a qualified plan like a 401k or 403b or to an IRA. Through this year that's in the form of a saver's credit. It's for lower-paid people. It gives a maximum credit of $1,000. But that is a credit. If you don't end up with taxes to pay, it's not a refundable credit, so you get nothing from this.

Starting next year, that saver's credit becomes a saver's match. So, the government will be making a matching contribution into the individual's account based on income and up to $1,000. But that's on the qualified plans like 401k and on traditional IRAs. Under the law as written that will not apply to Roth IRAs and that's an important point when we get to the state programs. And finally, we have the state-facilitated retirement savings programs, which I assume most of you are familiar with them. We're up to 22 states who have enacted these programs and most of them are auto IRAs. I think 17 of them are and most of those are Roth IRAs. Now, gig workers can generally self-enroll. That's not part of the law that was written, but it's something that is dealt with during the implementation process. However, very few gig workers do that and there's not direct outreach to them the way you have an employer community with the basic programs and the employers have to automatically get these people into the plans. So, it's an option, but it's limited at this point in time. Employer-based retirement programs only are applicable when there's an employer or employee. But self-employed people, and that's generally professionals, sole proprietors, can establish one. And frequently these people who tend to be high income take advantage of that. For other people, the personal savings options are IRAs, both the traditional deferred and the Roth IRA, and other personal savings. That could be bank accounts, mutual funds, brokerage accounts. However, most gig workers, especially the lower-paid ones, and even going beyond gig workers to other people who are employees don't take advantage of what they're entitled to because they feel they need the money now and it's more of an effort if you have to go out and set up an account yourself.

So, that's kind of the current landscape until very recently, and now we're going to talk about what you, the states, have been doing with the new portable benefit programs. And these are pretty new. When we started our project back in 2022, none of these were in existence. So, Utah was the first state enacted one in 2023, followed by Tennessee and Alabama the next year. And this year, we're only in April, but we have four states shown up there who have enacted new programs. So, these are all voluntary programs. And I kind of use the word employer in quotes but we know that's not an employer. It's a high earning party but both that party and the contractor can make contributions and those contributions go into an account which belongs to the contractor. It's fully portable and can be used to provide a variety of types of benefits. One specific provision in these laws that's important is that these deemed employer contributions cannot be used to determine employment classification. In other words, the fact that an organization, be it Uber or Lyft or whoever it is, gives contributions to an independent contractor you use for benefits, that cannot be used to say that person is now an employee, and the organization is an employer. So that is very important. And also, we noticed that some of the states specify that the contributions are tax deductible. I believe that's only for state income tax purposes. And just an example of an organization that has set up one of these programs is Lyft, who started it for Utah drivers in 2025 and there are others who are doing that now as well.

So, on this slide, we're showing you the range of programs that have been under consideration. The voluntary programs shown in the middle column there are what we were talking on the previous slide. The right-hand column is mandatory programs. And they're different in that, first of all, they specify the amount of contribution that the, and here it's called contracting agent, must put in. And maybe a percent of fees or dollars per hour. And usually the programs that are out there right now are designed for app-based drivers. And you see that there's a limited number of types of benefits. Well, you see the huge list of states under the voluntary and only a handful under the mandatory so that kind of shows us where things seem to be going. And the state names are color coded there. So, green means the state has actually enacted the program. Blue means it's under consideration. And red means they considered the program, but either it was vetoed or failed to advance to the next stage.

Now, I thought it would be interesting to review the experience under certain DoorDash pilot programs that were adopted by Pennsylvania first in 2024 and then by Georgia and Maryland in 2025. Because that might show you what might end up happening as typical kind of plans. The initial timing period was six months, but Pennsylvania extended it to 12 months. The eligibility for these programs was you had to have at least $1,000 of earnings and 100 in-state deliveries in the specified three-month eligibility period before the program was going to start. The driver had to create a free account. It was an interest-bearing account in order to receive the DoorDash contributions. Those funds could then be used for a variety of types of benefits, and they were fully portable so even if the driver went to work for somebody else, it was his or her account. The DoorDash contributions were 4% of pre-tip earnings, and the driver could make voluntary contributions as well. So, now we're going to look and see what happened under those programs. In terms of enrollment, less than 25% of the eligible drivers actually enrolled. Now remember, all they had to do was sign up and get an account in order to receive the DoorDash contributions of 4%. So, perhaps if the program were permanent, more would have taken the initiative to sign up for an account.

And this information is in a footnote on the bottom of the slide that you're not seeing right now on the screen, but it was a separate firm, NVP Analytics, who did the research and developed the report. So, you see the average contributions. And the $200 range is not a lot of money but for the top earners and these are the top drivers, some got as much as a $1,000. So, it provides a useful benefit. And you see the statistics and italics on the right that show that people are happy with this idea. They felt more financially secure, and if they knew it was going to be permanent they would feel more that way. The top use of the funds was either for paid time off or for emergency savings. Only, about 5% or 6% of the people use the funds to put into a retirement account. Now, of course, our paper is about retirement but it's clear that people have more immediate needs, and these types of programs are beneficial for them. So, that's pretty much the lay of the land now in these state programs and what's available to gig workers. So, what changes could be made to improve retirement security for these people? First, under the State auto IRA plans, further adoption by more states to include gig workers and more outreach to them and the states are doing a lot now; they're setting up partnerships, they're making every attempt to expand the people who are covered by this. But we also need federal legislation so that the saver's match that is coming next year, which could be an additional $1,000 a person, could apply to Roth accounts as well as regular IRAs.

Now, we've gone over these current state portable benefit programs and I know sometimes you consider model legislation. I don't know if this is something that would be of interest to you or not, but we noted that some other entities are doing that as well now. In our country as a whole, we have a concern about the low level of financial literacy and the need for more financial education but this is especially important for gig workers. They don't have employer provided plans that are doing this for them. So, if you're a gig worker, you have to figure everything out for yourself. What are your goals? How are you going to come up with the money to contribute for this? How are you going to invest the money? And ultimately, when you retire, how are you going to draw down on this money to give you hopefully lifetime income? But a second part of this is the need to include more education about the importance of income reporting for Social Security. And we go into this in more detail in our paper. People don't understand what they are giving up by not paying into the system and I think they know about Social Security benefits for retirement, but if you're young that's a long time in the future. But Social Security also provides disability benefits and survivor benefits. So, more education and examples would be helpful.

Now the next couple of slides here talk about Federal proposals. And these are all in our paper and if you have questions, I'm glad to handle all of them but I want to move on because I want to make sure we can answer your questions. And one thing I want to point out to you is if you go to the end of the deck where we list the resources available. You'll see that Georgetown University Central Retirement Initiatives is listed with the recent report they did. Now Georgetown is the one who's been tracking all these state programs but the reason I think you'd be interested in the report they came out with last year is that this discusses the issue of access and it does this on a state by state basis. So, they have everything they've done on a national level, they give you the information for each state and they also have a focus in this paper on gig workers. So, included is a lot of data about gig workers on a state by state basis. So if you are considering these issues and you're not aware of this resource, I recommend you look at it.

Rep. Mike McFall (MI) stated that I have been working for the last four years on a retirement savings program that I've been working with Pew Charitable Trust on, the Auto IRA. One of the difficulties is if there's not a mandate for businesses to participate, how are you getting the private sector to partner with the Treasury of the state? Because in the ones where it's not mandated, they find very few people sign up and so it's not really worth them participating. Ms. Wolkoff stated that's why the DoorDash study was interesting because DoorDash was putting in 4% of these workers' pre-tip earnings. Nobody told them how to do that. That was their decision to try that. And admittedly, they've done these as pilot programs and then they can consider the results and what they want to do going forward. But they found that by having that program, workers did more driving for DoorDash because they were getting something extra out of it. And DoorDash benefited because they had good drivers who were working for them. And there was no mandate there at all. And if you look at that slide that showed all the states in the voluntary column and none enacted in the mandatory.

Rep. McFall stated that the investment firm that controls the IRA along with the treasury, if there's not any sort of mandate, none of those investment firms bother putting in a bid to be part of the program because there is no mandate. One of the hurdles that we're having is whether or not a business on the auto IRA has to do this. The employee does not have to sign up, but the employer has to offer it to them. And that's where the hurdle is, is that if we don't require the business to do that there's not enough participation because participation is obviously much higher when the business offers it to their employee. But if there's not that mandate, not very many people sign up. So when the Treasury tries to set up the IRA, they're not getting those businesses to participate because they say it's not worth our time.

Ms. Wolkoff stated that the auto IRA in the state we're talking about the retirement side, not the portable benefit side, they have like a million people with accounts. They've got almost $3 trillion of assets. So overall, a lot is happening there. The other thing that happened, and this is based on you know the Georgetown reports, is they found that once the employer was told that he was mandated to offer a plan. All he had to do was have the people auto-enroll, and take the money out of their pay and move it over. That was basically his sole responsibility. But when these employers, and we're talking about small employers here, when they started looking at this, they said well if I have to do something this particular program is not what I really want for my people. A lot of companies ended up establishing their own plans. So, they've seen that the state programs didn't lead to people pulling out of their own programs, rather the whole thing grew. So, the mandate was just set up a program where honestly there wasn't that much for the employer to do. So, they started with employers say of at least 100 people. And then they moved it down. And now they're generally if you have at least five people, I think. So, employers found it easy to deal with, a lot easier than if they were setting up their own plan. And I don't want to go on too long on this, but with one of the more recent laws, the federal SECURE Act,

they set up this private sector set up this concept of Pooled Employer Plans (PEPs) so that different companies could band together and have an administrator, the asset manager, etc. And the thought was these would be primarily small companies and it also cuts down on their fiduciary liability but they found that large firms also started moving over to them because it made it easier for them.

Rep. LeBoeuf stated that there's been a lot of ballot questions around gig workers. Most of them have been around classifications, but sometimes there's been compromise legislation or legal settlements that have avoided those that end to a collective bargaining agreement or the beginning of that. Have you noticed a pattern of this discussion around the retirement benefits in any of those states with ballot questions? Or have you seen any emerging legislation around this once a particular ballot question one way or the other has been passed? Ms. Wolkoff stated that I'm not personally familiar with these the ballot questions. I know California several years ago had a lot of issues and concerns about this. And I know on the federal side, there are various proposals out there and a lot of them do have bipartisan support as ways of expanding access to programs for people. But Congress is dealing with other things now and looking at a SECURE 3.0 for instance, but I'm not familiar with specifically what you're talking about.

CONSIDERATION OF RE-ADOPTION OF MODEL LAWS

Rep. LeBoeuf stated that last on our agenda is the consideration of the re-adoption of model laws. The model laws are the NCOIL Beneficiaries Bill of Rights, the NCOIL Life Insurance Consumer Disclosure Model Act and the NCOIL Long Term Care Tax Credit Model Act. As a reminder, during our interim meeting in February, we offered an opportunity for comment on these models from any interested parties and legislators and we haven't heard anything then or since so today we will not be taking any testimony from interested parties, but we are opening up the floor for any questions or comments from legislators.

Hearing no questions or comments, upon a Motion made by Sen. Boyd and seconded by Rep. Carter, the committee voted without objection by way of a voice vote to re-adopt the Models. Rep. LeBoeuf thanked everyone and stated that the models will now be placed on the executive committee's agenda for final ratification.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Boyd and seconded by Sen. Theis, the Committee adjourned at 6:00 p.m.

JOINT STATE-FEDERAL RELATIONS & INTERNATIONAL INSURANCE ISSUES COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
JOINT STATE-FEDERAL RELATIONS & INTERNATIONAL INSURANCE ISSUES COMMITTEE
2026 NCOIL SPRING MEETING – LOUISVILLE, KENTUCKY
April 18, 2026
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Joint State-Federal Relations & International Insurance Issues Committee met at the Hyatt Regency in Louisville, Kentucky on Saturday, April 18, 2026 at 2:00 p.m.

Kentucky Representative Michael Meredith, Vice Chair of the Committee, presided.

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Rep. Justin Wilmeth (AZ)
Rep. Elizabeth Wilson (IA)
Rep. Matt Lehman (IN)
Rep. Erika Hancock (KY)
Sen. Jason Howell (KY)
Rep. Brenda Carter (MI)
Sen. Lana Theis (MI)
Sen. Paul Utke (MN)
Sen. Tim McGough (NH)
Rep. Tim Barhorst (OH)
Rep. Meredith Craig (OH)
Rep. Brian Lampton (OH)
Rep. Greg Scott (PA)
Rep. Tom Oliverson, M.D. (TX)

Other legislators present were:

Sen. Jesse Bjorkman (AK)
Rep. Stephen Meskers (CT)
Rep. Brett Barker (IA)
Rep. Peggy Mayfield (IN)
Sen. Beverly Gossage (KS)
Rep. Mike Clines (KY)
Sen. Donald Douglas (KY)
Rep. Daniel Grossberg (KY)
Sen. Franklin Foil (LA)
Rep. Mike McFall (MI)
Sen. Keri Heintzeman (MN)
Sen. Jeff Barta (ND)
Sen. Kristin Roers (ND)
Sen. Bill Gannon (NH)
Rep. Julie Miles (NH)
Rep. Kellie Deeter (OH)
Sen. George Lang (OH)
Rep. Perry Warren (PA)
Rep. Yusuf Hakeem (TN)
Rep. Barbara Dittrich (WI)
Sen. Jamie Wall (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 Sen. Lana Theis (MI) and seconded by Sen. Jason Howell (KY) the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Meredith Craig (OH) and seconded by Rep. Brenda Carter (MI), NCOIL Secretary, the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's November 14, 2025 and March 12, 2026 meetings.

DISCUSSION ON THE 340B DRUG PRICING PROGRAM

Rep. Michael Meredith (KY) stated we're going to start today with a discussion on the 340B drug pricing program. As many of us know, this is a topic that's been frequently discussed at both the state and federal levels over the past several years. Last year, Rep. Tom Oliverson, M.D. (TX), NCOIL Immediate Past President, expressed interest in discussing this at NCOIL. Before we go on to the presenters, I'd like to recognize him for some brief remarks.

Rep. Oliverson stated I'm not sure about other states, but the 340B Program is one thing that we talk about all the time in Texas with regards to health insurance that we as state lawmakers can do very little about, despite the fact that it appears that not only the house is on fire, but the garage is on fire, and the neighbor's house is now catching on fire. Our friends in Washington don't seem to want to be able to do a whole lot about it. So, I became aware of a law that had recently passed in Indiana that was a transparency piece. It got me thinking that although we cannot control the structural nature and who qualifies and who should be in the Program and how much money should they be able to make off the Program, and what are they doing with the money, we can certainly require participants in our states to identify their costs for purchasing the drugs, the amount that they're selling the drugs for, and what exactly are they doing with the money that they're getting.

I believe that would be very eye opening. As someone who sits on the Appropriations Committee in Texas, people come into my office all the time and say if they don't get this amount of money, they're going to go bankrupt. And so I would like to know how much this Program actually means to the various participants and what exactly they're spending the money on because it helps me make better decisions at the state level. I would propose this for something that we could consider as a model law. We've done transparency Models before at NCOIL and they've been highly successful and adopted by a great number of states and so this would be yet another transparency Model which I think would better inform us and our states about a program that is consuming an ever larger portion of the pharmacy spend in our states.

Bill Smith, Senior Fellow and Director of the Life Sciences Initiative at the Pioneer Institute thanked the Committee for the opportunity to speak and stated let me just make a couple of preliminary remarks before I go into my slides, and I'll try to do them quite quickly. One, I think it's inaccurate to describe the 340B Program as either a bad program or a good program. I have a much more nuanced view of it and that is, there are some good actors in the 340B Program who use the resources from 340B to extend care to low income people and patients and then there are some not so good actors in the 340B Program who see it largely as a revenue generator and a profit center. With that, I want to explain where it came from and how it works. The history of 340B goes back to 1990 when Congress passed a reconciliation bill where they required drug makers to give the best prices to the 50 state Medicaid programs in the country that any customer got. This created a problem for some safety net hospitals because pharmaceutical companies were extending discounts voluntarily to some hospitals, in safety net hospitals, all around the country. And so, the hospitals were fearful that the drug companies were going to yank those discounts because of the requirement that they extend the lowest prices to all 50 states.

So, the hospitals went to Congress, and in 1992, they passed the 340B Drug Discount Program where they require the discounts be given to the hospitals. You just have to understand the scale of this Program. It is massive. In 2000, the Program had about $1 billion in sales running through it. In 2025, according to the Berkeley Research Group, $215 billion in sales went through the 340B Program. And in 2000, there were 9 contract pharmacies that contracted with hospitals to give out 340B drugs. Today, there are 32,000 contract pharmacies. So, this is a massive program. One in 4 branded prescriptions are 340B prescriptions. How does it work? Well, how do hospitals and clinics get revenue from this program? The way they get it is they arbitrage the discounts. And what does that mean? Arbitrage is a Wall Street word. It just means you buy low and sell high if you want to make a profit. So, a Medicare patient, they go into a 340B hospital. This is an anecdotal example. And they're prescribed a $100,000 cancer drug. That hospital can potentially buy that cancer drug for $25,000. And then they can bill Medicare at 106% of average sales price, or about $95,000. So, the hospital's profit on one prescription is $70,000. And that's what I mean by arbitraging the prescription.

And the same thing happens with commercial insurance. Patients go in, the hospital buys the drug for $25,000 or so and the health plan is billed $75,000 and the hospital makes a profit of $50,000. Now notice the incentives. So, if an uninsured patient comes in, and the hospital buys that product for $25,000 and they give it to the uninsured patient for free, the hospital has zero profit. So, the incentives are balanced towards ensuring patients have good insurance, that's how the hospitals profit the most. This has unintended consequences. For example, there are massive takeovers of oncology and rheumatology practices going on by hospitals all around the country because they want access to those wealthy patients and patients with good insurance. The program has unbelievable growth, as I said and the most disconcerting thing, I think, is that charity care levels peaked. Despite this growth in this program, charity care levels by 340B hospitals peaked in 2013 and fell from 3% of operating revenue to about 2% of operating revenue. This is Rand Corporation data on charity care by 340B hospitals. You'll see in 2013, it peaks at about 3% of operating revenue and now it's gone down to 2% last year. Now, that said, there are hospitals that are doing the Lord's work as far as charity care. Cook County Hospital, for example, in Chicago gives 11% of its operating revenue in charity care. And the national average again is 2%. So, there are good actors and bad actors in this scenario. Here's the charity care numbers for Disproportionate Share Hospitals (DSH), which qualify for 340B through their Medicaid population. And, you'll see the charity care is declining, while the sales in 340B is rising, which shouldn't be happening. And again, this is another slide on the growth of the program. Again, less than 1,000 pharmacies in 2010 and now 22,000 pharmacies.

This an advertisement for the Pioneer Institute's web tool. We created this web tool where we loaded as much data as we possibly could get. We got it from the Health Resources and Services Administration (HRSA), we got charity care data from Rand Corporation, and we created this web tool. You'll see the data set on program growth and you'll see that the line is straight up for both contract pharmacies and hospitals participating in the program. This is a neat tool that we created called Legislative District Mapping. So, you can go on the website, and you can look up your legislative district, and you can see 340B resources in your legislative district. And we did this for every legislative district in the country because it was our impression that 340B resources were over-serving wealthier areas and under-serving certain low-income communities. And I went on the website, and I looked at Beverly Hills, California, and I compared it with South Central, L.A. Beverly Hills had more 340B resources, contract pharmacies, and clinics than South Central did. So, this is the kind of data you'd pull up, the number of hospitals, the number of health centers, the number of clinics and the number of pharmacies and the poverty rate in each legislative district. And you also can go on and look at contract pharmacies and where they're located within a district. For charity care, you can do

charity care not just nationally, you can do it on a state level what the average state level charity care is. Texas is number one in charity care. New Jersey is number two, which is strange because New Jersey expanded Medicaid and generally, what you see is States that have expanded Medicaid have lower charity care rates than states that have not.

And again, you can go on the charity care website at Pioneer, and you can look at individual hospitals and how much charity care they're giving out. You also can go to the state one pager section of the website, and you can see where contract pharmacies are located. You can see in Massachusetts and New York, 64% of the contract pharmacies for 340B hospitals are located in upper income areas, not low income areas. So, I want to agree with the remarks of Rep. Oliverson. What this Program needs more than anything, particularly because there are some good actors in this Program that you don't want to harm, is some transparency. We need to know exactly how much revenue a 340B institution is taking in and where exactly are they spending it. I would even improve upon the Indiana bill. I would make the hospitals deposit their 340B revenues in a separate account that could be audited, and the expenditures could be audited so that you could see exactly where they're spending. I would also use the Pioneer web tool to look at your state and find out if wealthy areas are being overserved by 340B and poorer areas are being underserved.

Bharath Krishnamurthy, Director of Pharmaceutical Policy at the American Hospital Association (AHA) thanked the Committee for the opportunity to speak and thanked Rep. Oliverson for his interest in the 340B Program. I'm going to of course offer a different perspective from Mr. Smith, but I think there is something that we can agree on and that is the 340B Program is about patients first and foremost. It is about delivering access to care for patients. I'm going to start where Mr. Smith started as well, and that is why was the Program created? Mr. Smith kind of laid out the timeline, but the reason the 340B Program was created was for one reason and one reason only, and that is because drug prices have continued to increase dramatically. It was true in 1992 when the program was created and as you can see on the graph on the left here, it is even more true today. As you can see, the delta is growing more between inflation for pharmaceuticals compared to other commodities. You can see on the table on the right here, just a smattering of some brand name drugs. Some of these are used to treat cancer. You can see the percent change in their prices over time. So, this is why the 340B Program was created, to allow eligible providers that care for high numbers of low income and other underserved populations to be able to access medications at a discount and then use those savings to further access to care. Don't take my word for it, Congress told us what the purpose of the Program was. They said it was to allow eligible entities to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services.

I highlight the word "more" here that shows up twice in this purpose statement because it was the intent of Congress for the Program to reach more people and to enhance access to care for more populations. It was never meant to be this small little program. It was meant to reach more and more patients, and that is exactly, as I'll talk about in a minute, what the program has achieved. Mr. Smith talked about how the Program works, so I won't belabor that point but I do want to highlight two things. One thing is the 340B Program was structured in a way that the discounts go to the hospital or other covered entity, as we call it. That's because Congress recognized that the hospital or the provider is best positioned to determine how to deploy these savings that they're generating through their program. Nonprofit hospitals every 3 years have to do what's called a community health needs assessment that tells them what are the healthcare needs of the patients and communities they're serving. So, they're able to leverage that community health needs assessment to determine how to use their 340B savings to address the unique healthcare needs of the communities they're serving. As you can imagine, the

healthcare needs in rural Kentucky may not be the same as the healthcare needs in inner city New York. That is why the savings go to the provider and the provider determines how best to use those savings. I do want to highlight one of the big misconceptions that I often hear when I go and speak about 340B around the country - the discounts in the program are not funded by taxpayer dollars. They're funded directly by the discounts that pharmaceutical companies have to offer.

And let me also add that drug companies don't have to participate in the 340B Program. It is optional for them. There are several drug companies in the United States that do not participate in the 340B Program. But if they want their drugs to be covered by Medicare Part B and Medicaid, then they do need to provide these discounts to safety net institutions. I just want to make that point. I also want to emphasize that when we talk about 340B savings, we often hear that it's the difference between what the hospital purchases the drug at and how much they're reimbursed. But that's not accurate because in most cases, the insurance reimbursement, whether you buy the drug at the 340B price or a non-340B price is the exact same. Mr. Smith talked about Medicare paying 106% of the average sales price. That is the same reimbursement that a hospital gets whether they're purchasing at 340B or not. When we talk about 340B savings to the hospital, it's really the difference between what the hospital would have paid for the drug, absent the 340B Program and what they did pay for the drug under the 340B Program. That is what 340B savings really is. I have two examples really quickly here that illustrate this. Just like Mr. Smith talked about a drug with a $100,000 price tag. Under 340B, the minimum statutory discount is 23.1% for brand name drugs. So, the acquisition price is $76,900. As you can see, the insurance reimbursement is the same under both scenarios. Ultimately, the margin is the difference between the reimbursement and the acquisition cost. But the actual savings that the hospital generates is the difference in that net margin between buying a drug at 340B and not buying a drug at 340B. And those savings then go directly to patients.

I want to highlight another example. Here, the 340B discount is not 23.1%, but it's 50%. The only reason that the discount can go above 23.1% is if a drug company chooses to raise the price of that drug faster than the rate of inflation. They then get hit with what's called an inflationary penalty that pushes the discount higher. So, as drug companies increase their prices, they have to pay more of a discount and that's what you see in this example here. Instead of a $3,100 discount, it's now a $30,000 savings all because the drug companies have decided in this particular scenario to raise the price much faster than the rate of inflation. So, they were hit with a higher penalty and a lower 340B price. And so, Mr. Smith talked a lot about charity care and charity care is important. As he alluded to, there are many hospitals that provide a lot of charity care to their populations. But charity care is only one, albeit important, way that 340B hospitals use their savings. There are so many other services and costs that hospitals incur that are supported by their 340B savings. For example, if you look at uncompensated care, it's charity care as a part of that, but there's also bad debt from government payers. There's also total unreimbursed care. So, these shortfalls that hospitals incur from government payers. There's also a whole host of specialty services that are made possible by 340B. Think in your rural communities, many rural communities have access to oncology care because of 340B, because your hospital has 340B in your community. If not for 340B, those communities would not have cancer care. I was just at a hospital a couple weeks ago in Yakima, Washington. They were telling me that if they didn't have 340B, their patients would have to travel two hours over the mountains to the Seattle suburbs to be able to access oncology care and because of 340B, they're able to make cancer care available to their patients in their local community, which is so important for a family and a person going through cancer treatments.

These are just some of the many ways that 340B savings are used by hospitals. Charity care is again important, but certainly not the only way. And a myopic focus on just charity care does a disservice to the amazing benefits that the Program affords patients and communities across this country. I want to end by talking about a couple of different things that have been raised about the 340B program. Mr. Smith talked about this. The 340B Program has grown over time, and it certainly has. I'm not here to tell you that the 340B Program has not grown. It certainly has. But I think it's important to put that growth in context. When we look at, for example, between 2017 and 2022, the 340B Program grew by $30 billion, which is a lot of money. I understand. But if you compare that to the growth in the U.S. drug market, $300-plus billion in pharmaceutical revenues, it pales in comparison to what we're seeing across the board or at the very least it follows what's happening across the broader market. And the biggest growth driver of the 340B Program, as I alluded to earlier in my examples of how 340B savings work, is high and increasing prices. The more drug companies increase their prices, the more discounts they have to provide and that ends up growing the Program. There's also other phenomena happening across the board that have nothing to do with hospitals that are also helping to drive growth in the 340B Program. A couple of examples is one, there is more regulatory effort from the federal government to shift care from the inpatient setting to the outpatient setting. So, 30 years ago, procedures that were being done in the inpatient setting are now being safely done in the outpatient setting. And as a result, since this is an outpatient program, when more care is delivered on the outpatient side, that helps to grow the 340B Program. The other thing that's happening is there have been a number of scientific advancements that have allowed drugs to substitute care for what otherwise would have required complex medical procedures. The best example of this is GLP-1s. A great breakthrough and they have been around for a long time, but they're now being used to treat obesity and other weight related issues that may have required complex gastric bypass surgeries or other costly interventions that now can be achieved using drugs. And so, the more we use drugs, the more that especially on the outpatient side, that helps to grow the 340B Program.

I think the question that we should be asking ourselves is not whether the 340B program has grown. Yes, the 340B program has grown. But the question we should be asking is, if the 340B program has grown, have the benefits that Congress intended for the Program to achieve for patients and communities also grown? And the answer is unequivocally yes. When you look at the growth in 340B discounts, and you compare that to the growth in the community benefits that hospitals are providing to the communities that they serve, you see that the growth in community benefits is outpacing the growth in 340B discounts. I like this sentence I put here which is, in 2022 for every $1 in a 340B discount that a hospital received they provided $2 in benefits to the communities that they served. Now, I don't know what everyone's opinion is on return on investment (ROI) and I hate to put it in sort of economic terms when we're talking about patients, but I would argue that's a pretty good ROI. That for every $1 in discount that again is not funded by taxpayer dollars, that's funded by pharmaceutical discounts, is resulting in $2 in benefits to the community - I think that is a successful program. In the interest of time, I won't talk about this, but happy to take questions on program integrity.

I think that when we talk about some of the allegations that have been put out there that there's rampant abuse in the program, that is just not supported by the data. The data that the drug companies are using, as you can see here from some of the citations I've pulled from recent letters by the drug companies, they're citing data back from back in 2018. The more recent data show that there is simply not the level of "abuse" that they are alleging. I want to end again by saying that 340B hospitals are committed to transparency. Transparency is important in any program, not just 340B. And hospitals are committed to transparency. That is why the AHA created the Good Stewardship Principles of which approximately 1,300 hospitals around the

country have signed on to. It's a publicly available list. You can look it up online. In fact, many Members of Congress have asked for this list, and we provide it to them because they want to know if hospitals in their district have committed to transparency, and many have. And it requires them to communicate the value of the program, disclose how much they're saving from the program, and of course maint rigorous internal review of their 340B programs. What can you do and what can states do to protect 340B? Many states have passed legislation to protect against the drug companies' efforts to restrict contract pharmacies. But I think when we talk about transparency, it has to be equally applied across all stakeholders. This can't be a one-sided effort. There needs to be transparency in the 340B Program, but it can't all be about hospitals. It needs to be about drug companies as well. How they disclose their price increases. Require them to justify why a drug should increase by 100% in two quarters. Require them to provide an itemized list of what their costs are for production. How much margin they're producing on each of these drugs that they're selling for tens of thousands of dollars. And what their sales and marketing dollars are for these drugs.

Rep. Mike McFall (MI) stated the Michigan Hospital Association has been fighting tooth and nail when we've tried to do transparency. If hospitals and the associations are so committed to this why are they fighting so hard on any transparency? I cannot even begin to tell you how hard they are fighting and it does not make the hospitals look very good in my opinion, because it looks like you're hiding something. Your presentation was really good explaining what the 340B Program is and the importance of it and I don't dispute that. But on the transparency aspect, you're asking for the drug companies to be extremely transparent, which in our state, the drug companies were actually on board with the more stringent transparency, and it was the hospitals that would not support that legislation. Can you explain to me why that would be?

Mr. Krishnamurthy stated I don't know exactly what was in the Michigan law or bill but a lot of what I've seen including in the Indiana law, is that a lot of the data that's being required is duplicative. Hospitals already provide a pretty comprehensive accounting of their costs and their revenues in their annually filed Medicare cost reports with the federal government. I also will note that a lot of the laws that I've seen have again, a myopic focus on charity care, which I think does a disservice to the broad range of benefits that the 340B Program affords. If you just compare charity care to how much a hospital saves through the Program, then yes, you're going to get a very skewed picture of the benefit of the 340B Program, and we don't want that. We think if you're going to have an accurate accounting of the 340B Program, you have to look at the broad range of services and costs that hospitals incur. I can't speak for the Michigan Hospital Association, but I can tell you from the AHA perspective, we would be supportive of efforts that provide meaningful transparency, not transparency for the sake of transparency, but actually meaningful transparency that allows a hospital to tell you everything that it's doing with its 340B savings. Because if it's not for 340B somebody's going to have to pay for these services. It could be the state, it could be the federal government, but it's not going be the hospital because a lot of them have limited resources. So, that would mean that services go away unless somebody else pays for them. I think it's important that if you're going to do transparency, that you allow hospitals to explain all the different things that they're doing for their patients and community.

Rep. McFall thanked Mr. Krishnamurthy and stated to Mr. Smith, I went to that website that you had and is there any way to update that? We had a federal lawsuit that caused us to have to redistrict and my district is still the old district. Mr. Smith stated yes, we're in the process of updating it currently. The last data on there is 2022, so we are working to get 2024 data on there.

Sen. Beverly Gossage (KS) stated that I've chaired two committees in Kansas on 340B. What I've yet to find out is, what is the cost to the private payer? Because the individuals that are really bearing the cost of 340B is the private payer that has to pay more to make up for this "discount" that's going. Can somebody answer that question? Mr. Smith stated if I were you, I'd look at the treasurer's report from North Carolina on 340B. The treasurer, who's responsible for running the state employee plan, pointed out that the oncology drugs that they were paying for in the state employee plan were marked up 5 or 6 times what the acquisition costs were. That may be due to price increases, but I think more transparency would help all of this. And hospitals, as my colleague here has pointed out, there are all these community benefits that are paid for by 340B, okay, what are they exactly? What are they and exactly what did you spend the money on? That's the problem. We don't know.

Sen. Gossage thanked Mr. Smith and stated I'm one of 7 commissioners that oversees our state employee plan, and we are finding the same. Where can we find out how much money each hospital in my state is making on 340B? Shouldn't we be able to know that? Mr. Smith stated it's not available. Sen. Gossage stated, how would we know then what the savings is if we don't know how much money they're making? Because what I'm discovering is that if a hospital is a 340B hospital and I come to get a prescription filled there, I'm now a 340B patient whether I'm low income or not, is that true? Mr. Smith stated yes.

Rep. Brenda Carter (MI), NCOIL Secretary, stated that I come from one of those populations that the 340B Program is supposed to support. I stay on the phone with the A. Philip Randolph Institute that is livid because the intent of the Program is not reaching the very populations they're supposed to serve. In this particular case, it's not reaching the African American community. But you can do some research, and you'll find out that a lot of the 340B Program is going to our more affluent communities instead of the underserved communities. And I echo the sentiments of Rep. McFall as it has been brutal trying to pull the truth just with transparency and before I make a vote on this type of program, I have to answer to my community and if my community is saying they're not getting the services they're in need of or some of the things that we're going through may jeopardize our federally qualified health centers then it really makes it very difficult. All we need to know is just one thing, where is the money going? Why is that so difficult? Mr. Krishnamurthy stated I appreciate your comment and I think that the way I would characterize it is, when you're talking about 340B savings, I point to the fact that it is not revenue coming in, like other things where it's a line item that you can easily track. It is savings that you are earning because you're purchasing the drug at a lower price. So yes, hospitals track this information. And again, we encourage hospitals to share this information with their community, so that they know what the kind of programs and services are being supported by their participation in the 340B Program. But I don't want to undersell how complicated it is to track all of this because it's not just like revenue coming in through the door. It is basically savings that they're they're accruing, and it's not like it's bucketed into sort of different cost centers at the hospital. Hospitals are buying these drugs at a lower price and then because they're able to buy those drugs at a lower price, that frees up more money across the board to be able to do all the things that they are doing to serve their community. Rep. Carter stated what is the intent of the 340B program? Mr. Krishnamurthy stated the intent is to stretch scarce federal resources to reach more patients and to provide more comprehensive services.

Rep. Meredith Craig (OH) stated there were a lot of things said that I could debate but I'll point out a few things that I disagree with. So, you say it's not taxpayer funded, it's a subsidized program. As soon as you start subsidizing anything, someone else is going to pay. So, we have data that was given to us and from Ohio alone, 340B costs the Ohio employee health plan and taxpayers $50.2 million. So, while it is pharmaceutical manufacturers that are providing the

discount, you're subsidizing that and someone else is going to pay and it's the taxpayers. I just wanted to clarify that. Second point, I guess you're talking about fraud in the Program. There's a situation in my district with the Cleveland Clinic. They have a family medical practice that's just right up the road from my community independent hospital. My independent hospital lost their 340B status, but Cleveland Clinic right up the road has theirs because they have learned to leverage this Program. Do you think that is fraud? Do you think that's something that needs to be looked at and addressed?

Mr. Krishnamurthy stated I'm not aware of this specific situation, so I don't want to comment on something I don't know but I absolutely think hospitals like Cleveland Clinic that provides state-of-the-art care to millions of patients every year is deserving of 340B. The Cleveland Clinic is a comprehensive cancer center and provides care for some of the rarest diseases that patients from across the world come to. I think they should be deserving of the 340B Program. Mr. Smith stated let me go back to your first point about taxpayer money. I think that's one of the most misleading statements by supporters of the Program, that there are no taxpayer monies. Medicare pays billions of dollars to reimburse for 340B drugs and last time I checked, Medicare was a taxpayer funded program.

Sen. Justin Boyd (AR) stated I don't want to belabor the point about taxpayer funded dollars but the simple question is, do taxpayers ultimately not pay for these discounts by subsidizing it? The real question kind of gets to the root of what my concern is with what I perceive is going on in the market. Why should the government mandate an incentive to some providers but not all the providers of a service? Isn't this one more way the government is saying, "Hey, this provider is going to be the winner. This provider over here is going to be the loser."
Mr. Krishnamurthy stated in order to qualify for the 340B Program, there's a calculation to it. Either you have to be a rural provider, or you have to treat a specific patient population like cancer or children's hospitals. But then you need to maintain a certain percent of your population that's low income. It works out to about 28% of your population needs to be either low-income Medicare or Medicaid. That's not a low bar in my view. That is a significant amount of your payer mix that has to go to your low income population. So, I don't think it's picking winners and losers. I think it's providing resources to hospitals that care for a bulk of the low income patients in the communities that that they're serving. Mr. Smith stated there are many community-based oncologists that feel like they need access to those discounts in order to compete with the hospitals and they don't get them and they're losing money and they're getting bought up, and I personally would favor more community-based care, and they end up being captured by the hospitals.

Rep. Oliverson stated I appreciate this conversation. Obviously, it sounds like a lot of folks are very interested in this. I welcome your support. I welcome your co-sponsorship of a model law if you're so inclined. I will point out to our guests from the AHA that NCOIL already has a pharmaceutical price transparency model, so we don't need to add that to this because we've already done that. In fact, that's actually been adopted by a great many states across the land. I'd love to work with anybody that wants to work with me on this.

CONTINUED DISCUSSION AND POTENTIAL CONSIDERATION OF THE NCOIL INDIVIDUAL COVERAGE HEALTH REIMBURSEMENT ARRANGEMENT MODEL ACT

Rep. Meredith stated next on the agenda is the continued discussion and potential consideration of the NCOIL Individual Coverage Health Reimbursement Arrangement (ICHRA) Model Act. We had a great discussion on this at our Fall Meeting, as well as during an Interim

Meeting last month. Based on how this discussion goes today, we may entertain a vote if that is how the sponsor, Rep. Craig, would like to proceed.

Rep. Craig stated as Rep. Meredith noted, we have had two great conversations on ICHRAs and I'm proud to be sponsoring this Model. You can view it in your binders on page 123, and it's also on the website and app. As many of you know, this Model essentially mirrors a bill that I am sponsoring in Ohio and we used Indiana language to start. This concept is something that has bipartisan support at both the federal and state level and it was formed really to enable flexibility for both employers and employees when it comes to health coverage. Importantly, this model doesn't involve any type of mandate. If a state adopts this Model or similar type of law, it just enables them to use a framework for ICHRAs. I think that's part of the reason why this has such widespread bipartisan support. I also think this is great timing for NCOIL to be discussing this because it really is a trend across the country. States are already working to implement this and Mississippi recently became the latest state to have this signed by their Governor.

In response to some feedback, I have agreed to make a couple of changes which are underlined in the Model here, specifically in new section 4(E) on page 124, I've included language that requires taxpayers that claim the tax credit to report to the Department of Insurance whether or not that taxpayer continued to offer the ICHRA or reverted to a traditional employer-sponsored plan. This is something that Indiana included in their law, and I know Rep. Matt Lehman (IN) brought it up in our Interim Meeting earlier this Spring. Also, beneath that language is a drafting note that says that states may wish to give a specific expiration date to the tax credit. In Ohio, we're having conversations on runaway costs and trying to narrow the cost to the state as best as we can so that's something there that states may wish to consider if they have a fiscally conservative legislature like we do in Ohio. I think this Model is in a great place. As Rep. Meredith noted, we have moved pretty quickly on this Model and I would love to see us vote on this today. I know it's a little bit quicker than usual, but this is a great Model and bipartisan. We passed it out of the Ohio House unanimously, and I know other states have passed it unanimously as well.

Brooke Tiner, Director of State Gov't Affairs at Oscar Health, thanked the Committee and thanked Rep. Craig for her leadership on this issue. We have been before you a number of times. I lead state government affairs at Oscar, which is a healthcare company that is solely focused on the individual market where ICHRAs are offered. This is obviously a very important policy issue for us and we are very encouraged by the attention that this is getting across the country. Rep. Craig mentioned some of that. I will mention there is a study committee being considered in Arizona right now regarding ICHRAs application to the state health plan and school districts. As Rep. Oliverson knows well, there have been interim charges issued in Texas and a special select committee on affordability in Texas to study more broadly the issue of affordability and accessibility and ICHRAs will be part of that discussion. So, we really look forward to all of these discussions across the country and utilizing this Model to work with the states on their laws and with the individual stakeholders. We appreciate the opportunity and encourage a yes vote on the Model.

Brendan Cossette Senior Director of Public Policy at Centene Corporation, thanked the Committee and thanked Rep. Craig for her willingness to move this important issue forward. This doesn't need to be rehashed as it's been discussed quite a bit but ICHRAs simply are a vehicle to offer more choice in healthcare for both the employer and the employee. And while ICHRAs can be used for large and small employers, this one is especially important, because only 56% of small businesses in this country offer health insurance. So, this is a really strong incentive for small businesses to not only get more people covered and offer benefits, but to

additionally be able to compete with larger businesses for talent and employees. I will note regarding bipartisanship and agreement, the vote in Mississippi on their bill in the House was 113 to 0, and the Senate vote was 48 to 2. Additionally, there are bills being considered in New Hampshire, Connecticut and Georgia so this is something that is percolating around the country.

Bruce Johnson, Head of Policy at Thatch, thanked the Committee and thanked Rep. Craig for her leadership on this Model. Thatch is a health benefits administrator. We focus specifically on ICHRAs. We work directly with employers of all sizes, but particularly small businesses, and help them manage and offer ICHRAs to their employees. We also work directly with employees and give them the tools they need to take a look at the individual market, select the plan and enroll in the coverage that they own. I wanted to share briefly why we believe this Model matters, particularly for small businesses and workers who we particularly serve. Today, you actually heard a statistic about the percentage of small businesses that offer health care coverage. When you drill down to just those businesses under 50, the very businesses addressed by the Model, it's a little bit more stark than that. For businesses with fewer than 50 employees only about 1/3 of those businesses offer health coverage today. And so that leaves millions of working Americans with a very difficult choice. If your employer doesn't offer coverage, you can either go uninsured, you can pay full sticker price for individual market premiums, or if you happen to qualify, you can seek a government subsidy. And that's a recipe for higher uninsured rates, greater dependence on government subsidies, and a small business sector that can't meaningfully compete for talent. ICHRAs changed that equation. They give small employers a straightforward, easy to manage, tax advantaged way to contribute toward their employees' health care coverage without taking on the complexity and cost of a traditional group plan. And they give employees genuine choice to select a plan that fits their specific needs.

This isn't a theoretical issue for us. At Thatch, 87% of the employers on our platform have fewer than 100 employees and 60% have fewer than 10. And yet they're able to offer healthcare because of the innovation offered by ICHRAs. Many of them are offering coverage to their employees for the very first time because of ICHRAs. This is exactly the kind of outcome that this Model supports and is designed to encourage. As Rep. Craig stated, this is not a mandate. It simply gives businesses that choose to act a little bit of an on-ramp to offering health benefits. There is real momentum, and you heard about some of that in other states today. It's important that momentum has been largely bipartisan. There is clear consensus with this policy. It's field tested and it works. We are proud to support this Model and we think it's sound policy that expands access to quality, affordable health coverage. And importantly, it supports small business competitiveness. We also think that it serves a central purpose in driving our health insurance market to a more consumer-centric model which will ultimately help to drive down costs and continue to put employees, people who own the coverage, in the driver's seat for making their own health choices.

Miranda Motter, SVP of State Affairs and Policy at America's Health Insurance Plans (AHIP) thanked the Committee and thanked Rep. Craig for bringing this concept forward. AHIP is supportive of tax credits that as you heard provide employers choice. We stand ready to partner with any of you, certainly, as legislation may be brought to your state to tailor it or make it state specific.

Sen. George Lang (OH) thanked everyone for being here today to talk about this very important Model that's going to help to level the playing field between the large guys, the self funded guys, and those that are stuck under our regulatory authority. My only concern with the Model has to do with section 5, Unfair and Deceptive Practices. This would exclude or induces us to exclude

or cause the exclusions of an individual from coverage under an existing provided health benefit plan. It would prevent someone from steering an individual to coverage under an existing employer provided health benefit plan and it would prevent an employer from offering individuals financial or other benefits as incentives not to enroll in the plan or to terminate enrollment in the plan. And my only concern with these is currently, if you are under the Employee Retirement Income Security (ERISA) model, you can discriminate any way you want, as long as you don't discriminate in favor of the highly compensated employees. Now, there are some legal opinions whether this has to be done on a voluntary basis or if you can do it through a scheme known as a foundation model and make it a mandatory basis, but currently, it's being practiced on a voluntary basis with high participation, helping those that are truly sick to leave the plan or incentivizing those with other coverage to take the coverage elsewhere. So, why would we not get rid of some of those definitions for unfair or deceptive practices to help level the playing field even more between the small employer risk pool and the large self- funded groups?

Rep. Craig stated this language was actually raised from a few health plans back in Ohio. There are certain situations happening where litigation is pending, where they are, in fact, using these steering practices to get folks off of their employer sponsored plan into an actually unregulated plan and so that was something they raised with us. They wanted to make sure that's clarified in the Model here. I don't think there's really any intent to hold the employer, to arm wrestle them down, and by any means they can choose what's best for their employees and have those conversations. So, this was mainly to address other situations that are currently happening. Sen. Lang stated I appreciate that. So currently, if you're under ERISA, you can incentivize your employees to leave your plan, go on your spouse's plan or any other plan that you are entitled to or eligible for benefits. And you can pay the cost to go into that plan. You can pay the deductible. You can pay the copay. So, for the employee, their costs go to zero. And I'm not just talking about a spousal carve out. I'm talking about moving the kids, the cats, the dogs, moving the spouse, the employee, moving the entire family over. And giving the employee incentives to do that, financial incentives which will significantly lower the cost of the base plan. Is there anything in your Model that would stop that from happening? Rep. Craig stated no - nothing in this prevents that from taking place. Sen. Lang stated thank you - I withdraw my questions and concerns.

Sen. Gossage stated I'm so pleased that we're talking about ICHRAs. I'm proud to have helped with that federal legislation. Just to clarify for the body, 100% of the expenses for an ICHRA for the employer are 100% tax deductible as a business expense. They are completely tax free to the employees so they're a great idea. They're going to be even greater if we could get rid of the Affordable Care Act (ACA) guidelines because as it is now the employee must declare that they receive an HRA or have an ICHRA, and they would lose all subsidies on the exchange causing the employer to pay more for this plan than what they could have qualified on the ACA. So, if I could just address what was mentioned about coercing an employee to pick another plan, that's actually against the Department of Labor (DOL) rules and they could be heavily fined for doing anything like that by the DOL. As to state guidelines, I'd like for someone to address if they're 100% tax deductible as a business expense, is this double dipping if they're exempt from state tax?

Mr. Johnson stated as a benefits administrator, we see the tax incentive in the form of a tax credit as being a meaningful on-ramp for small businesses. Currently, all employer-sponsored insurance is tax deductible for small businesses. Yet only 1/3 of small businesses of this size offer insurance today. So, clearly the tax deduction as it currently exists isn't a sufficient incentive and this is a way that allows those businesses and basically gives them an incentive to lean in and think about how benefits can be part of their compensation design and the tax credit

is fairly modest in the states that have introduced them. Most states have introduced tax credits of $400 per year per employee and we think that really just gives the opportunity for a business to get started, get their feet on the ground when it comes to offering benefits. In our experience, when businesses start with ICHRAs, they tend to stick around. We have greater than 100% retention rate because we know that businesses, when they find this model, they realize how much it works for them and their employees.

Sen. Gossage stated on the federal level, we're looking at trying to allow you to pay your premium from your Health Savings Account (HSA). That's some of the reform we're trying to look at for HSAs, which would actually be even better because if you could pay for your premium directly out of your HSA, you would have that 100% deduction, as would the employer if they were to contribute to that. You could still go out and pick the plan you like. I'm not opposed to ICHRAs at all. I think it's a very great idea. I'm just a little bit concerned about the state credit for that. It seems like we're going to be double dipping in giving them this kind of a credit.

Rep. Meredith stated that per NCOIL bylaws, all NCOIL votes are voice votes except that a roll call vote shall be taken at the direction of the Chair or upon the request of a committee member in instances where there are dissenting votes. Hearing no further questions or comments, upon a motion made by Rep. Brian Lampton (OH) and seconded by Sen. Boyd, the Committee voted without objection via a voice vote to adopt the amendments to the Model as described by Rep. Craig. Then, upon a Motion made by Rep. Lampton and seconded by Sen. Boyd, the Committee voted without objection via a voice vote to adopt the Model, as amended. Rep. Meredith thanked everyone and stated that the Model will now be placed on the Executive Committee's agenda for final ratification.

PRESENTATION ON DATA FROM THE NO SURPRISES ACT BALANCE BILLING INDEPENDENT DISPUTE RESOLUTION PROGRAM

Rep. Meredith stated we'll move on to our final agenda item for today, which is data on The No Surprises Act (NSA) balance billing independent dispute resolution (IDR) program. The Federal No Surprises Act, very importantly, set forth an IDR process to deal with balance bills, which can be incredibly harmful for consumers. As we will hear today, the law contains very important consumer protections, but there have been issues with the IDR program since it was enacted. This will be a great opportunity to hear about the data from the program and what we should know going forward.

Kennah Watts, Research Fellow at the Center on Health Insurance Reforms at the McCourt School of Public Policy at Georgetown University thanked the Committee and stated that I'm going to be talking to you about the NSA and in particular, I'm going to zoom in on the costs associated with the IDR process within the NSA. I'll also get into a little bit of detail about how states could potentially engage and hopefully reduce costs for consumers. So, before I dive into the data, I just wanted to refresh everyone on the NSA. When the law was enacted about 5 or 6 years ago, it had a dual purpose. The first purpose was to protect consumers from balance bills and reduce out of pocket costs associated with these surprise bills. The second objective was to more broadly contain costs in our health care system and with out-of-network costs in particular. What we've seen since the law's enactment is that this first purpose has been successful. Consumers have been successfully protected from surprise bills in the scenarios outlined in the law, and then when mistakes have happened, they have been rectified. So, that has been an incredible consumer protection over the last 5 years.

As far as the second objective to contain costs, the law has been slightly less successful. This has to do with the IDR process within the law. So, because the law prohibits providers from balance billing patients, which used to cover the costs that plans would not pay, the plans and providers now have to negotiate privately to find the ideal payment for those services covered. When these plans and providers cannot do this privately, they can go to the IDR process, which is a third-party arbitration process where a neutral party selects one of the payment offers from either party and binds them both to it. And this process was estimated to reduce premiums and overall health care costs as it would have incentivized providers to move in network and thus reduce rates. But early evidence has shown that this is not necessarily the case. In fact, our research shows that in over two and a half years of the IDR process's implementation, over $5 billion has been spent on this system alone. And these costs come from four main categories. The first two are merely administrative costs. So, the first are fees paid directly to the federal agencies to handle the portal associated with these disputes and just kind of keep the system running as intended.

The second contributor to costs is the fees paid directly to the arbiters or the IDR entities. The third and, the second biggest contributor to costs here are providers and plans internal costs to engage in this process. So, this really is just the mechanical process of filing the papers, engaging in negotiations, engaging in the dispute process. While this is quite a hefty sum, $1.9 billion across a two and a half year period, we expect that this also likely an underestimate because it does not include the parties' costs to engage in litigation surrounding these issues, which has been quite a litigated subject in the last few years. And finally, what we see is the major contributor to costs within this system are payment awards that exceed in-network rates. So, the IDR process included a Qualifying Payment Amount (QPA) which was meant to serve as a benchmark and indicator or proxy of sorts for plans' in-network rates for a given service and a given geography. And so, expecting that most disputes would come in around this QPA, that most disputes would be resolved around network rates, we would have expected this payment amount to be much lower. In fact, probably close to zero. But instead, because these awards are being paid out at such high amounts, this has incurred more than $2.25 billion in just a two and a half period alone.
And so there is a bit of lag in the data here. I'm talking about 2024 data. We're in 2026. Unfortunately, because there is this difference in when the data is released, the most up to date numbers we have are from quarter two of 2025. And so, while we haven't rerun that cost estimate to include the entirety of 2025 yet, what we can see from the first 6 months is quite shocking. And that's in this 6 month period alone, the fees spent just to administer this program and paid to the IDR entities are nearly equivalent to the same fees paid for the two and a half year period prior. So, I think for that reason, we were really expecting our $5 billion estimate to be a severe underestimate once we update for the 2025 data.

So, how did we get here? How did this system end up incurring billions of dollars of costs? I think it's because this process has not played out as the agencies or other stakeholders expected. Prior to the beginning of the IDR process, the agencies expected about 22,000 disputes to enter the IDR process per year. So, across kind of the three year period we're analyzing here, that would be about 72,000 disputes. But instead, the reality is far different. In fact, as of quarter two of 2025, more than 3.4 million disputes have been filed. And that is quite staggering. I think that's because the agencies and other stakeholders expected this to be a last resort for providers and plans when all else had failed in private negotiations. But instead, what we've seen is that providers have flooded the system and have found that it can be a successful way for them to win often and win big. And I'll dive into that in a bit more detail. We can see that providers really initiate the vast majority of disputes going into this process. So, looking at this graph, you can see that there's been a steady growth in disputes initiated in nearly every

quarter. Really the only exceptions we see here are when disputes were not being filed because there were pauses due to litigation. We can see that in the last two quarters alone, more than 1.2 million disputes were filed to the IDR portal. And this is more than double the volume from the same time period in the year prior. And not only are providers winning big, not only are they submitting often, but they're winning big and they're winning often as well. So, looking at this graph to the left, this is showing you the provider win rate in every quarter. While it averages out to about 84% across this two and a half year period, in the most recent quarter, providers won 88% of all disputes. So, they're not only initiating a majority of disputes, but they're also seeing they can win the majority as well. And when they win, they're winning at upwards of 4 and 5 times in-network rates. Looking at that graph to the right, you can see that the median prevailing provider offer in 2024 was 450% of the QPA. So, if we use the QPA as a proxy for in-network rates, this is more than four and a half times in-network rates.

And this is also 4.5 times more than plans win. So, when plans win, they're coming in at about 100% of QPA, which would make sense because that's their in-network rate, and that's what they're hoping to pay for the service. And while providers across the board are quite successful, I think this success is also highly concentrated to a few provider groups in particular. As you can see in this pie chart, 5 provider groups account for nearly two thirds of all the disputes going to IDR, and 4 out of 5 provider groups are backed by private equity. That includes Radiology Partners, Team Health, AGS Health, and SCP Health. And I make this call out to private equity, not only for the profit motive that is inherent to these actors but also because these are the same groups that fought tooth and nail against the passage of the NSA 5 years ago because balance billing was such a profitable scheme for these provider groups. So now they've just shifted their profit mechanism to the IDR rather than balance billing patients. And the fifth provider group here, I think is really the most interesting and that's Halo MD and while not backed by private equity, this provider group is really fascinating because they emerged after the IDR process was initiated solely to handle disputes on behalf of providers. So, this is essentially a middleman entity that makes a commission off of the awards that they can secure for providers by handling their dispute in IDR. In 2023, Halo MD accounted for less than 1% of all claims going to IDR. They were a minuscule player. But now you can see that as of quarter two, 2025, they are the leader in initiated disputes and account for nearly a quarter of all claims going to IDR.

In addition to being kind of the top initiator here, Halo MD is also among the most successful provider groups. So, in quarter two of 2025, Halo MD secured a medium prevailing offer of 820% of QPA. Again, that's 8 times in network rates. And this wasn't even their most successful quarter. There was one quarter in 2024, where Halo MD's median award was over 1,000 times QPA or 1,000% of QPA. So more than 10 times in network rates. And so, I just say this all to really underscore that there's a clear profit motive here. And the more that actors like Halo MD submit disputes and the more they continue to win they'll continue to win at higher award amounts. And I think this profit incentive holds true for the private equity backed groups too. As you can see on the slide, Radiology Partners secured a median award of 590% of QPA in quarter two of 2025 and was followed by SCP Health and Team Health at about 375% and 275% of QPA respectively. And what's also interesting about these private equity backed groups is not only are they winning larger awards than providers overall, but they're also winning more often. So, Radiology Partners, SCP Health and Team Health all won about 95% of disputes in quarter two of 2025. So, these providers know they can go to arbitration. They're most likely to win, and they will win a high award amount which is why we've seen the continued trends in volume and costs that we have.

I think while patients have been successfully protected and they are not receiving balance bills directly, I think there is real concern that these ever-growing trends and costs will eventually be passed down to consumers through higher premiums. In fact, we've heard from one private plan as well as one state employee health plan, that their premium increases this year are directly attributable to the costs incurred by the IDR process. And so, what can we do about this? How can we make sure that these costs are not continuing to be passed on to consumers? I think as we consider reforms, many state IDR systems might serve as a good starting point. So just as a reminder, while there is the federal IDR system, this only covers self-funded plans, whereas state IDR systems can cover fully funded and state-regulated plans. Because of this difference, states can also set different guardrails that the federal system might not have. We've seen in some states with public reports that because of these guardrails, they see far fewer cases, and they see more balanced outcomes than the federal system. For example, Virginia only had about 250 disputes enter its state system in a year period, and providers only won about half the time and we see similar trends in California, Colorado, and Washington. I think these states might serve as examples for how to adjust the federal system. And I think what else is really interesting is that some states, like Virginia and Washington, have created opt-in options for self-funded plans. These plans can choose to have disputes settled in the state system rather than the federal system. And so other states might consider this approach, too, as a means to kind of redirect the volume going to the federal system.

And while I say all this, I do also want to caution that while there are some promising states, there are some state systems that are inflationary as well. So, Texas and New York see very high volumes of disputes, very high provider win rates and very high award amounts and are more closely aligned with the federal system than these other state systems. I think as states look to take action here, a great first step might be to look to the state system and better understand what's going on and to really gauge whether or not the state system is inflationary. And if not, I think it might be worthwhile to consider opt-in options for self-funded plans in non-inflationary states. I know that was a lot to cover in about 15 minutes. I welcome any questions you might have. And for folks who are interested in reading more on the data or the litigation around this issue, please feel free to scan the QR code for our most recent publication.

Rep. Oliverson stated I enjoyed your presentation but I would challenge you a little bit in that I think your entire presentation rests on a fundamental assumption that I think is false, and that is that the QPA or the in-network rate is 100% accurate in terms of the fair market value of whatever that service is. And of course, 100% of these disputes are out-of-network situations where there is no agreement about what the value of the service is. So, if the in-network rate were adequate to begin with, I would submit to you that, that in and of itself would solve a lot of these problems in terms of the number of arbitrations because there wouldn't be a dispute because essentially the provider would have agreed to accept whatever the plan was offering as full payment for the services that were rendered. So, there's this fundamental disconnect, I think. And this is part of the problem that I think that was dealt with at the time in 2019 when we passed the Texas law and then that was taken to Washington and that became the NSA or at least the blueprint for it, is that the big question at that time was, should we just go to a single payer system and benchmark everybody to a standard rate and take away providers ability to negotiate in good faith completely? That's what IDR was designed to solve. It's no mystery why providers initiate so many of the arbitrations. If they were happy with the initial payment that was offered to them, they wouldn't go for arbitration. Essentially the health plan makes an offer, the provider says that's inadequate, they can't work it out, so they go to arbitration. If they just accepted what was initially offered, they wouldn't go to arbitration. If the rates were actually adequate, they wouldn't go to arbitration. So, that makes sense. It also makes sense that the providers would win more frequently if the rates were inadequate and the QPA by itself was not

a fair measure or benchmark for what I mean. All of these IDRs are done by an independent mediator who is not affiliated with a plan or provider, who's looking at a variety of data points and making a decision about what the actual fair market value of the service should be.

So, it's not a stacked deck for one side or the other. It's basically looking at the data that's available and trying to make an objective decision about what would be a fair market value for that service. The fact that providers are winning more frequently than plans tells me that the rate that's being offered in-network is inadequate. The hope was that over time, these providers and these plans would recognize that there's a happy medium there, and they would agree that this is what the fair market value is, hence this is what the in-network rate has been. But that hasn't happened. I'm wondering if you have thoughts on why it is that we haven't seen networks grow and why we haven't seen in-network rates increase. If plans are just getting their teeth kicked in an IDR, maybe they should increase their in-network rates.

Ms. Watts stated I think to your first point on the QPA, I agree that there have not been robust audits conducted by the agencies despite their authority to do so to see if plans are correctly calculating the QPA. Obviously, there's a lot of litigation about whether or not the QPA is a correct formula period or whether plans are calculating it correctly. Until we see those audits from the agencies, I can't speak to whether or not the QPAs are being accurately calculated. But I think as intended, they should ideally serve as a proxy for these in-network rates. Now to your question about network negotiations, I think this is another underlying point of the entirety of the NSA was whether or not it would bring providers in network. I believe there was a recent study either from the Government Accountability Office (GAO) or Assistant Secretary for Planning and Evaluation (ASPE) or both that did see some increase in networks and providers are coming in network and network rates are somewhat increasing I think to reflect that transition in network. So, I think to that extent, I do think this is working, and plans are realizing that to bring providers in, there does need to be a bit more negotiation there. But I think what's also really interesting is that when we kind of do more qualitative interviews with folks, we hear complete opposite sides of the story here. The plans say that the providers refuse to come in network because they're winning so high and so often in IDR. And the providers say the plans are pushing them out of network because it's cheaper for them to go through the IDR process than to pay the providers in-network rates. And so again, without kind of an objective data source there, there's no way for us to square these completely opposed stories. I do think that underscores that there is still a lot we don't know about this process. But I would say the early findings from either GAO or ASPE, and I'd be happy to share that report with you, show some indications of in-network movement.

Sen. Gossage asked has there been any effort that you're aware of to consider rather than the standard rates that they're using right now offered by carriers and instead a regional reasonable and customary amount as we do with some medical providers? Also, there's the Medicare plus rate. Has there been any movement in that direction? Ms. Watts stated not that I'm aware of. I think the QPA was intended to kind of be that benchmark of sorts for both offer submissions as well as for the IDR entities to kind of gauge where the offers were coming in. But I think it would be really helpful. I think to the earlier point, these IDR entities are these neutral third parties and don't necessarily have expertise on every service and every payment that is adequate for a certain service. And all they see is the information that's provided to them by both the plan and the provider in their submissions. I think to the extent that we could offer more data to the IDR entities to help them benchmark and understand where these offer amounts fall, say within Medicare rates, within broader state averages, within broader plan averages for a given service would be helpful to make sure that they are understanding both of the offers they're considering fully. I think anecdotally, we've heard that some providers are securing payment amounts

through IDR that even exceed billed charges, and I think there's no way we can even justify that. So, I think all this kind of comes back to my point that I think more information here would be helpful both to the arbiters as well as to folks outside of the system itself.

Rep. Stephen Meskers (CT) stated this is a two-part question. So am I understanding that private litigation is involved in this system and therefore that not only are we reimbursing the professionals, but we're reimbursing headhunters, if you will, or money hunters in the system right now. Is that correct? Ms. Watts stated I think that is fair. Yes, the costs that plans are using to litigate issues surrounding the IDR, those costs will ultimately be passed on to consumers by higher premiums. Is that the is that your question? Rep. Meskers stated that's exactly where I was headed. The second question is, do you have data on the nature of the procedures that are most showing up in terms of reimbursement? Because as Chair of Commerce and sitting on the Insurance Committee in my state, my problem is with the American Medical Association (AMA) and the limitation on the number of medical seats in the university system and the number of providers that we've scoped out. We don't have an adequate number of providers. And on the insurance side, we don't have an adequate or broad enough scope of service. So, the costs are just spiraling out of control. I'm not sure if we have procedures in the database as well? Does your report deal with where the concentration of disputes are?

Ms. Watts stated yes, we do have data on services and which services are most common. I think, as you would expect, because the NSA covers emergency services out of network, that's obviously a high proportion. But interestingly when we look at the award amounts for emergency services, they tend to be lower than the award amounts given to other kind of top services that come into IDR. So, what comes to top of mind to me is radiology, and that is a service that is paid out at very high amounts compared to emergency services and also occurs quite often in the IDR system. And I think that I want to call that out too, because we know radiologists were also pretty prevalent balance billers prior to the NSA. So to me, that just kind of is another data point that potentially these same providers that used to balance bill are now just shifting their kind of profit mechanism into the IDR system as well. But if you want to follow up with me afterwards, I can give you more specific data points on certain services and the outcomes we see.

ADJOURNMENT

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

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NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

Strengthening Transparency in the 340B Drug Pricing Program Model Act

Sponsored by Rep. Tom Oliverson, M.D. (TX).
****Co-sponsored by Sen. Paul Utke (MN) – NCOIL President.***

Draft as of June 16, 2026. To be discussed during the meeting of the Joint State-Federal Relations & International Insurance Issues Committee on July 16, 2026.

Table of Contents

Section 1. Title
Section 2. Purpose
Section 3. Definitions
Section 4. Reporting Requirements
Section 5. Penalties
Section 6. Rules
Section 7. Effective Date

Section 1. Title

This Act shall be known as the [State] Strengthening Transparency in the 340B Drug Pricing Program Act.

Section 2. Purpose

The purpose of this Act is to promote and strengthen transparency in the 340B Drug Pricing Program by way of implementing reporting requirements on 340B covered entities.

Section 3. Definitions

(a) "340B covered entity" means an entity described in 42 U.S.C. 256b(a)(4)(L) through 42 U.S.C. 256b(a)(4)(O) that is authorized to participate in the federal 340B Drug Pricing Program under Section 340B of the federal Public Health Service Act (42 U.S.C. 256b(a)(4)), and has a service address in [State] as of January 1 of the reporting year. The term includes any offsite outpatient facility affiliated under the 340B program with a covered entity.

(b) “340B program" refers to the federal 340B Drug Pricing Program established under 42 U.S.C. 256b.

(c) “State Department” refers to the [State] Department of Health.

Section 4. Reporting Requirements

(a) Before April 1 of each year, a 340B covered entity shall report the following information and transactions to the state department concerning the 340B covered entity's participation in or participation on behalf of the 340Bcovered entity in the federal 340B program for the previous calendar year:

(1) The 340B covered entity’s:

A. Name;

B. Service address;

C. 340B program identification number; and

D. Designation of entity type, as specific in 42 U.S.C. 256b(a)(4)

(2) The aggregate acquisition cost for all prescription drugs obtained under the 340B program and dispensed or administered to patients.

(3) The aggregate payment amount received for all drugs obtained under the 340B program and dispensed or administered to patients.

(4) The aggregate payment made to pharmacies under contract to dispense drugs obtained under the 340B program.

(5) The number of claims for prescription drugs described in subdivision (3).

(6) How the 340B covered entity uses any savings from participating in the 340B program, including the amount of savings used for the provision of charity care, community benefits, or a similar program of providing unreimbursed or subsidized health care.

(7) The aggregate payments made to any other entity that is not a 340B covered entity and is not a contract pharmacy as described in subdivision (4) for managing any aspect of the 340B covered entity's 340B program.

(8) The aggregate payment made for any other administering expense for the 340B program.

(9) The aggregate number of prescription drugs dispensed or administered to patients for which a payment was reported under subdivision (3).

(10) The percentage of the 340B covered entity's claims that were for prescription drugs obtained under the 340B program.

(11) The number and percentage of low income patients of the 340B covered entity that were served by a sliding fee scale for a prescription drug dispensed or administered under the 340B program.

(12) The 340B covered entity's total operating costs.

(13) The 340B covered entity's total costs for charity care.

(14) A copy of the 340B covered entity's financial assistance policy for the reporting year.

(b) The information required to be reported under subsection (a)(3) through (a)(5) must, to the extent feasible, be reported by payer type, including the following:

(1) Commercial.

(2) Medicaid.

(3) Medicare.

(4) Uninsured.

(c) The data submitted in the reports required under subsection (a) is confidential and is not available for public inspection.

(d) Before November 15 of each year, the state department shall prepare a report that aggregates the data submitted under subsection (a) and:

(1) submit the report to the [legislative council]; and

(2) post the report on the state department's website.

Section 5. Penalties

A 340B covered entity that fails to provide the information required under Section 4 of this Act by the date required shall pay to the state department a fine of [xxx] per day for which the information is past due.

Section 6. Rules

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

Section 7. Effective Date

This Act shall take effect xxxxxx.

FINANCIAL SERVICES & MULTI-LINES ISSUES COMMITTEE MATERIALS

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.

WORKERS' COMPENSATION INSURANCE COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
WORKERS' COMPENSATION INSURANCE COMMITTEE
2026 NCOIL SPRING MEETING – LOUISVILLE, KENTUCKY
APRIL 17, 2026
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Workers' Compensation Insurance Committee met at the Hyatt Regency in Louisville, Kentucky on Friday, April 17, 2026 at 9:45 a.m.

Ohio Representative Brian Lampton, Chair of the Committee, presided.

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Rep. Matt Lehman (IN)
Rep. Peggy Mayfield (IN)
Rep. Adrielle Camuel (KY)
Rep. Mike Clines (KY)
Rep. Michael Meredith (KY)
Rep. Michael Sarge Pollock (KY)
Del. Mike Rogers (MD)
Rep. Brenda Carter (MI)
Rep. Mike McFall (MI)
Sen. Lana Theis (MI)
Sen. Paul Utke (MN)
Sen. Jeff Barta (ND)
Sen. Jerry Klein (ND)
Rep. Tim Barhorst (OH)
Sen. George Lang (OH)
Rep. Tom Oliverson (TX)
Rep. Barbara Dittrich (WI)
Del. Walter Hall (WV)

Other legislators present were:

Sen. Jesse Bjorkman (AK)
Rep. Justin Wilmeth (AZ)
Rep. Stephen Meskers (CT)
Rep. Brett Barker (IA)
Sen. Beverly Gossage (KS)
Rep. Shaun Mena (LA)
Sen. Alonzo Washington (MD)
Sen. Mark Huizenga (MI)
Rep. Sarah Lightner (MI)
Sen. Keri Heintzman (MN)
Sen. Kristin Roers (ND)
Sen. Bill Gannon (NH)
Sen. Tim McGough (NH)
Rep. Julie Miles (NH)
Asw. Pamela Hunter (NY)
Rep. Kellie Deeter (OH)
Rep. Emily Gise (OK)
Rep. Ellyn Hefner (OK)
Rep. Chris Kannady (OK)
Sen. Mark Mann (OK)
Rep. Mark Tedford (OK)
Rep. Greg Scott (PA)
Rep. Perry Warren (PA)
Rep. Yusuf Hakeem (TN)
Rep. Calvin Callahan (WI)
Sen. Mary Felzkowski (WI)
Sen. Jamie Wall (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 Sen. Lana Theis (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. Barbara Dittrich (WI) and seconded by Del. Walter Hall (WV), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's November 13, 2025 meeting.

EVALUATING THE OHIO WORKERS' COMPENSATION SYSTEM

Rep. Brian Lampton (OH) stated we're going to start with a presentation on Ohio's workers' compensation system. As you know, Ohio is very unique in that we are one of four states that have basically monopolistic workers' comp coverage throughout the State. Since I'm from Ohio thought it would be a great idea to for the committee learn about the Ohio system.

Stephanie McCloud, CEO and Administrator of Ohio Bureau of Workers Compensation (BWC) thanked the Committee for the opportunity to speak and stated that BWC represents 6 million Ohioans, and we are responsible for the prevention and treatment of workplace injuries for them while they are in the workplace. As Rep. Lampton stated, we are only one of four states that by law is the exclusive provider for workers' compensation with the others being Washington, Wyoming and North Dakota. Our job is ensuring that workers injured on the job receive the medical treatment necessary, fair compensation during recovery, and support to return to work safely. We are dedicated to our mission of delivering consistently excellent experiences for each BWC customer each day. Our operations are funded by premiums that Ohio's 245,000 private and public employers pay for insurance coverage.

We have roughly 1,600 employees. We are serving about 200,000 workers comp claims. We have about $24 billion in assets to service those claims and we'll talk in a minute about our premiums, we have the fifth lowest premiums in the country, which we're very proud of. Under the leadership of Ohio Governor Mike DeWine, BWC has fostered a safety first mindset across Ohio and has been able to reduce rates by 50% and achieve the lowest rates in at least 65 years. When Governor DeWine was elected, he told his cabinet directors to listen to the needs of our customers and scrutinize our service offerings to improve them. And that's exactly what we have done at BWC. In fact, at Governor DeWine's request, the BWC Board has authorized $9.2 billion in dividends to Ohio's employers since 2019. Governor DeWine said in his State of the State that Ohio cannot reach its full potential unless every Ohioan is able to reach their full potential. At BWC, we believe every working Ohioan deserves the chance to go home to their families healthy and safe at the end of the day. Since the beginning of Governor DeWine's Administration in 2019, we've seen a reduction in workplace injuries from 2.6 injuries per 100 workers to just two. That's a pretty significant drop and that's a huge safety win for both employers and our workforce. These efforts reflect our state's and this Administration's ongoing commitment to maintaining fair and sustainable rates for employers, while ensuring continued support for workplace safety and claims management.

Last month, I had the privilege to speak before the U.S. House of Representatives Workforce Protection Subcommittee and highlight Ohio's success in workers' compensation. My testimony, similar to today, was focused on our growth as a state and how our workers' compensation has

worked for both employers and the workforce. Back in the 1990s, I worked for Governor Voinovich and for a period, I also worked for BWC as a staff attorney. BWC was referred to as the silent killer of jobs. Escalating costs, delays, inefficiencies in the workers' comp system were killing our economy. At the time, fewer than 1% of claims were processed within the first two weeks which is an essential window for supporting injured workers' recovery. Ohio's leaders responded with sweeping reforms that laid the groundwork for today's nationally recognized system and since then, BWC has achieved the fifth lowest premiums in the country. In 2008, we had the third highest. We've strengthened partnerships with managed care organizations that help injured workers receive timely, high-quality care and return workers safely to work. At BWC, everything we do starts with the customer. Their needs and expectations drive every decision we make. We see every interaction as an opportunity to deliver value. It's not just the big picture items, it's being there for our customers every day. As an example, our customer contact center has answered over 188,000 calls in 2025 with an average speed of 44 seconds. Also, the customer satisfaction rate in 2025 exceeded 97%.

One example of us working hand in hand with our employers is our Substance Use Prevention and Recovery Program. It provides incentives to support Ohio employers and continues goals of addressing substance use disorders affecting our workforce and communities throughout the state. As you know, Ohio was hit very hard, as were our neighboring states Kentucky and West Virginia, by the opioid crisis. This program merged three popular programs we have, but they were overlapping, so we merged them: the Drug-Free Safety Program, Drug-Free Safety Program Grants, and our Substance Use Recovery and Workplace Safety Program. The goal of this merger was to end employer confusion and let them better utilize this program and its offerings. Employers in this new program can receive reimbursement for testing, training, and rebates for completing program requirements. As you know, with the workforce challenges that our employers have seen over the years, for every Ohioan living up to their God-given potential, we need every able body in the workforce. Substance use disorders have been a huge damper on getting people and keeping people in the workforce. This is our attempt to help employers where we can and to help them ease some of the concerns that they have about hiring someone in recovery and help them move forward for a successful relationship.

As we move forward and continue to modernize our efforts, we are updating the way we interact with our staff and customers. We want to simplify our processes and create easier and excellent experiences for our customers. In 2025, we launched major improvements to our services, including the survivor portal specifically just for survivors and representatives when there's a decedent. If they don't have enough worry and sadness going on in their life, dealing with a bureaucracy is not something we want to see them have to do. So, we created a survivor portal just for them. Real-time, true-up, real-time cancellation of coverage.
We're also utilizing artificial intelligence to augment our staff, so they can be freed up to do what they do best, making decisions and providing the best service in the state. We're currently having a staffing shortage at our agency. It's hard to recruit young workers into government and insurance. I saw a study that said millennials have about a 4% interest in joining the insurance industry. You layer on top of that a really sexy name like Bureau of Workers' Compensation, and the challenges are exactly what you would expect them to be. So, we are using AI to supplement where we can.

When we outsourced our managed care, it was a fantastic thing. You heard the statistics that I gave you. It turned workers' comp around in Ohio but what it also did was we did a buyout of the pensions. That was a wonderful thing because it meant we didn't have to do layoffs, but it also meant a lot of people retired that we necessarily didn't need or want to retire. That was their right. I would have taken advantage of it if I hadn't literally been one year into the pension

system when we did it. But it also created a lot of hiring. That was great. If you're doing the math in your head, you are recognizing that was about 30 years ago, which means we are experiencing a very large number of retirements. Last year in 2025, voluntary turnover alone at an agency of over 1,600 people, I lost over 13% of my staff primarily to retirements. That is way out of the ordinary for us. That's okay, they're entitled to it, they've worked their time, they've earned their pension but that has put us in a position of hiring. Last year we hired over 200 people. We are hiring like crazy. You also know if you've had a 32-year employee retire, that that Full Time Equivalent (FTE) that retires is more like a 1.2, 1.3 FTE. and that person that you hire is about a 0.7, 0.8 FTE for quite some time.

So, we're using AI wherever we can to bridge that gap. We're using robotics to help our staff not be overwhelmed by the increased workload. The worst thing that can happen to me is that the folks who are picking up the slack from the retirements while we're hiring and bringing new people in, is that they don't see an end in sight and they begin to look for other work, which will only exacerbate my problem. So, we're working hard using AI trying to get rid of the tedious and repetitive tasks with the use of bots that can complete hundreds of claims documents overnight. AI is not a perfect system. We're not using it to replace people. We always have a human in the loop but we are using it when it comes to those repetitive tasks, but not for reviewing the work. We create more opportunities and better solutions for everyone when we do it this way. We want to focus on AI augmenting our staff, so they can be freed up to do what they do best, make those decisions and better service our customers. So, I hope everything I've shared with you today has been helpful and demonstrates our commitment to being a partner with the state's economic development and a force for workforce safety and health.

Rep. Lehman stated that I'm an insurance agent in Indiana, literally six miles from the Ohio line. We seem to at times have a conflict with what state pays what claim. If we have Indiana workers working in Ohio, you have something like 90 days you can work and questions like whether that's consecutive or non-consecutive days. But if it's an Ohio employer and they work in Indiana, you cover them regardless of the amount of time they're in Indiana. Is that correct? Ms. McCloud stated we have what's called other states coverage and we take out actually a private policy to cover other Ohio employees in other states. Rep. Lehman stated we have other state coverage as well, but it excludes the monopolistic states, which one of them is Ohio so I'm just curious down the road. I think there's some confusion sometimes among employers who being close to a border have a lot of people who are contractors who work in Ohio and they're always thinking they have coverage and they do but they might have to have Ohio coverage under certain circumstances like the employee might live in Ohio and things like that. So, have you had those kind of ongoing discussions with making sure we don't have barriers? Ms. McCloud stated we have not, to my knowledge at least, if we're having those problems, those haven't been raised to my level. But I'm going to make some notes here and dig into that.

Senator George Lang (OH) stated that depending on what ranking, Ohio is between the 5th and 15th most business friendly states in America and 10 years ago, we were amongst the 10 worst. And one of the big reasons that always comes up is our low workers comp cost. So, thank you very much for what you do. My question revolves around the recent legalization of recreational marijuana. Have you seen any increase in claims from people coming to work impaired and/or do your actuaries anticipate any increase in those claims? Ms. McCloud stated interestingly enough we have seen a slight uptick in claims. We haven't necessarily been able to assign those to the legalization of recreational marijuana in Ohio. We're digging into those. For quite a few years, we worked hard, employers worked hard, and we also had some shifts in our industry that caused our claims to slowly decline. We've always wondered where the bottom is. It's not zero. We think we may have hit that bottom, which is roughly about 70,000 new claims

filed a year. We're seeing a slight uptick. What we don't know is if that's going to start riding a wave. It's too early to tell. I'm having staff look into that, but we have not seen that necessarily tied to recreational marijuana.

Sen. Bill Gannon (NH) stated I run the Judiciary Committee in our Senate. I tend to be more of a punisher on fentanyl things and I look to punishing the suppliers and the dealers. I was very intrigued with your three part Drug Free Safety Program. Could you just go into that a little more for me because I tend to use a strong hammer for drug sales and I'm not always as nice and soft handed as I should be with people with problems. Ms. McCloud stated it's not a matter of not using the hammer. That's just not our job. Our job is, of course, preventing and dealing with workplace injuries. Certainly, our fine state legislators and our Governor, and our Attorney General are working hard to deal with the fentanyl dealers in our state. But as we have people who are in recovery looking for jobs, and we have a shortage in the workforce, certainly there has to be an opportunity to marry those two up. Where we have a shortage of workforce and employers may be reticent, rightfully so, to hire someone in recovery because maybe they've never done it before and they're nervous and they don't know what exposure that they have. We are offering resources to them, such as random drug testing that we will reimburse for and pre-employment drug testing. We will offer managers training and counseling in how to manage someone in recovery, what to look for if you're afraid of a relapse. And then we also offer some grant programs for that.

PRESENTATION ON INNOVATIONS IN TREATMENTS FOR MENTAL INJURIES

Rep. Lampton stated the next item on the agenda is a presentation on innovations in treatments for mental injuries. This topic is going to be very interesting, focusing on the emerging trend of using non-traditional types of medicine to treat injuries. It has obvious implications for the health care sector, but also for work comp, since treating mental injuries in the work comp marketplace has become an issue that states have wrestled with in the past several years. So this will be an interesting presentation to improve our knowledge on these things so we can properly address things as we move forward.

Gretchen Schaub, Director of Government Affairs at Definium Therapeutics thanked the Committee for the opportunity to speak and stated that we are currently facing a mental health crisis, and I'm here today to talk about why early dialogue is necessary to ensure system readiness and timely patient access to innovations in mental health treatment once they've gained Food & Drug Administration (FDA) approval and Drug Enforcement Administration (DEA) rescheduling. Mental illness costs the US over $282 billion each year, and suicide remains a leading cause of death particularly among our veterans and hometown heroes: police, first responders, firefighters, nurses, teachers. One life is lost to suicide every 11 minutes. After decades without new options, significant medical innovations for psychiatric conditions and substance use are finally emerging. Per workers' compensation policy research by the National Conference of State Legislatures (NCSL), untreated mental health issues cost employers significantly in the form of worker absences and lost productivity on the job. An already outdated 2007 study estimated that diagnosed depression alone among the workforce costs employers as much as $50 billion annually. It's 2026, we can assume it's much higher and that first responders suffer from post-traumatic stress disorder (PTSD) at a rate 50% higher than the national average. A 2021 survey of nurses revealed that nearly a third of all nurses planned to leave their current job by the end of 2022, again, outdated, citing stress and burnout as the top reason for leaving.

At the height of the pandemic, healthcare workers and first responders accounted for nearly 75% of all workers' compensation claims. In response, states have targeted much of their efforts to expand workers' compensation coverage for these workers. It is evident that untreated as well as inadequately treated mental health conditions are large drivers of cost burden to states and employers. As a reminder, one in five Americans suffer from a mental health condition. Fortunately, hope appears to be on the horizon when it comes to promising innovations in mental health. There are several drug sponsors developing new treatments working with schedule one substances for serious mental diagnoses by pursuing the existing regulatory pathway via large late-stage clinical trials, ultimately seeking FDA approval. As of 2026, the FDA has given eight clinical development programs in this space breakthrough therapy designation. This is important context as it shows the Agency's understanding of the grave unmet need in the treatment of serious mental illness like debilitating depression, anxiety, trauma, substance use disorder. This also indicates the Agency's understanding of the promise of clinical trial data illustrating potentially effective new treatment options.

Medical progress depends on innovation. Outdated state laws and regulations should not stand in the way of progress. While science advances, policy must advance as well. For patients who have tried existing remedies, new technologies and newly approved medicines are often the next and only step forward. Denying or delaying access to new tools does not preserve safety. It prolongs suffering. As an industry, we're using the opportunity to modernize policy at the federal and state levels to ensure access. As in most facets of life, timing is paramount. But in mental health, timing can be the difference between life and death. Weeks, months or years of unnecessary regulatory lag could bring about preventable tragedy. If a therapy has passed rigorous federal review for safety and efficacy, physicians should be able to use it as soon as it is legally available. In this context, it's why policy modernization is necessary. It provides a small policy change with great impact, particularly at the state level. Because timing matters. Before a medication in this class reaches a patient, it must demonstrate safety and efficacy through extensive clinical research and satisfy federal risk mitigation strategies. For controlled substances in development, following FDA approval, the DEA must determine the appropriate rescheduling for that medication based on medical use and abuse potential. These are two independent robust federal safeguards weighing the risk benefit ratio for a new treatment. Inconsistent scheduling frameworks at the individual state level create unintended barriers. Without the alignment of federal and state determinations, a medication could remain inaccessible for months or years while each state completes a separate legislative or administrative process. This creates legal uncertainty for licensed practitioners and continues suffering for patients.

By having conversations early and often, we can improve existing systems, setting the foundation for patient access. This includes system readiness by ensuring that once federal regulators determine a medication is safe and effective, states are ready to deliver new treatments without unnecessary delay. This is maintained oversight. This is not blanket deference or broad legalization of a drug class. These medications remain prescription only, dispensed and administered under licensed medical supervision and subject to state monitoring, licensing, and enforcement mechanisms. It provides regulatory clarity by aligning federal and state rescheduling timeframes. It allows certainty for practitioners, manufacturers, pharmacies, and insurers reducing compliance risks and confusion caused by inconsistent frameworks. And it's a very focused scope. The policy modernization that we're discussing only applies after FDA approval and DEA rescheduling at the federal level. In other words, no state is asked to make a decision or act until after federal action has been determined. Importantly, this modernization approach does not legalize any drug class or create a framework for recreational use of the drugs within this schedule. Instead, it's a narrow practical modernization of the Controlled

Substances Act state by state, providing regulatory clarity. It's about responsible technical updates so that our legal framework keeps pace with medical progress with the hope that a strong foundation will allow for meaningful discussions around access, coverage and reimbursement with state authorities when that time comes. We all deserve access to better tools if we're going to make a meaningful improvement in addressing the mental health crisis. And we all deserve better.

Rep. Mike McFall (MI) stated I appreciate you bringing this up. This is a very important conversation that we need to be having. In Michigan, I have introduced a bill that will decriminalize psilocybin use for people that are diagnosed with PTSD. As we know for our veterans, it's not just life changing. It's life saving for many because they're not getting high off from it. They're just microdosing it, but I don't want them to be in a world of hurt if they get pulled over and they happen to have some in their pocket for medications that they're using. So, I appreciate you bringing this forward and I appreciate this topic too. This is a very important topic. Is there something specific? Because I know there are others because I've had a veteran actually ask about something that was recommended by the Department of Veterans Affairs (VA). He reached out to me because he had seen that I had a bill on this and he had just gone to the VA that day and the doctor actually recommended he look into it. I know at the federal level there's a lot of discussions around rescheduling and doing all those things but are you talking about anything specific because I know there are other psychedelics and such as well. Could you expand on that?

Ms. Shaub stated yes. So, I use the analogy often to think about a large swimming pool, and we all have our individual lanes. I represent a company that is developing a drug and seeking FDA approval for a prescription product and there is a subset of companies that are developing drugs so that they can be options that are on formulary and integrated into the existing medical system. Then the other swim lanes are legalization or decriminalization. There are a variety of studies that are happening at local academic medical centers through the VA, etc. So, within the swim lane of FDA approved products. And those eight companies that I referenced, they're all in late-stage trials. So, it's a variety. You have MDMA for PTSD. There are multiple companies looking at synthetic pharmaceutical grade psilocybin for different mental health conditions. Really the focus here is about trigger legislation. Essentially, making sure that timelines are aligned once FDA approval occurs. Then DEA subsequently has to then move that approved drug down in scheduling so that it's prescribable. And then all 50 states have their own framework for handling alignment with DEA scheduling of those drugs so that they're available for practitioners. I say all of that because the umbrella is quite large in terms of the different companies focusing on different drug products and different diagnoses but the model is the same. And the industry at large is a complete innovation in the mental health space. So, it's kind of laying the foundation for access that's necessary on the industry side.

Rep. Yusuf Hakeem (TN) stated regarding PTSD, I believe there was a number you gave of $150 million of care that has been needed. Is it reasonable for leadership or advisors in those companies or within the military to have some idea of signs of problems for individuals? If you're looking at $150 million, we need to be finding a way to identify this early on. And I'm just wondering, is there any insight you have to give in regard to that? Ms. Shaub stated I think it's kind of a two level process in terms of the hope provided through the development right now and kind of the impetus for the research that's happening with this drug class. Because these are acute interventions. So, patients are coming to a clinic and it is a full day experience, but under medical supervision, much like being under anesthesia. I say that because it's also allowing psychiatry and mental health at large as a profession to get to the root cause of a lot of these conditions that for a long time, our best tools available have been to suppress symptoms.

When you think about PTSD or anxiety, there are physical, mental, and emotional symptoms that are quite difficult to manage and a lot of overlap and comorbid states for patients. I think for leaders to have the ability to have an additional tool in the toolbox for those really severe cases that it's a single treatment, one day is important. People are coming off of their medications, and it will be different certainly outside of clinical research in the real world. But that's also why I think these conversations are really necessary early so that we can all learn together and make sure that these are adopted and integrated into the medical system appropriately.

Rep. Julie Miles (NH) asked what are the top three drugs you have in your pipeline to come out first? Ms. Shaub stated right now we have two early-stage companies. One is DT120, and it is a derivative of LSD. And then we have an R-MDMA drug.

Rep. Miles stated my follow up is insurance companies are currently dropping many drugs off formularies that are already FDA cleared, have been on the formularies for years, and they're dropping them because of cost. How do you respond to the approach to getting these drugs on formulary once they're cleared through the FDA? And how do you see that path?
Ms. Shaub stated like any other drug, unfortunately we will be going through the process as every other company does for a new drug. I think the important context is that again, these are acute intervention, so it's going to look different. As an industry, we don't know yet because there hasn't been FDA approval. So, working with the Centers for Medicare & Medicaid Services (CMS) on pricing and understanding at the federal level what this means for Medicare and then commercial plans and Medicaid programs, we will certainly get there, and the conversation will continue to evolve. I want to put a fine point on the fact that it's a single administration. One time. Our phase three trials, speaking for Definium, we are following patients out over a year post that dose to really understand durability and retreatment, so that will also go into kind of where this sits on a formulary and all the additional kind of step therapy and prior authorization context, but again, we're looking as an industry at most of the clinical trials, I think by design, you end up getting the most acute patients. So, these are patients that have been very expensive to the system in terms of hospitalizations and on and off medications. So, all that to say, I would say think about it more like a specialty drug or infusion.

Rep. Stephen Meskers (CT) stated one of the issues we've faced with some persistent diseases, and I'll use multiple sclerosis (MS) as a case, is the adoption and use of formularies. I've had a number of constituents and a number of advocates talk to me about the change in medication and the dramatic effects in terms of reduction in efficacy or the reestablishment of a baseline of efficacy at a lower level. I don't know what we're considering here but when we talk about mental health issues, when we get to a proven track record, we're going to have to be very careful about the change in formularies. If people are using substances to prevent ideations of suicide, etc., we're going to have to watch formularies to make sure they're not changing medications, which could have material impact. I'm not sure how we handle that, but it's something I think you might want to address in the concerns going forward particularly with mental health, I don't know where the studies can give us the efficacy in the change in formularies and I'd be very concerned.

Ms. Shaub stated it's certainly something that I think keeps the industry up at night. Thinking about the next steps post approval and where this falls on formulary. We don't know yet. But your point is certainly taken. I think one of the opportunities with this new class of treatments is that it's a one-time thing, so think about it like getting an ACL repair versus being dependent on that drug to function every day. It's a really interesting trajectory to be able to follow the science right now. And the late-stage trials are following durability just as much as safety and efficacy. Because to your point, we don't know how long on average this will last. We followed patients

out to three months and the results were pretty incredible in terms of remission rates. At three months after a single dose, almost 50% of patients were still in complete remission with generalized anxiety disorder. Other studies are showing the same thing so I think discussions are going to be incredibly important in letting the data and the best information available when that time comes guide what insurance coverage looks like.

PRESENTATION ON TRENDS AND DEVELOPMENTS IN THE KENTUCKY WORK COMP MARKETPLACE

Rep. Lampton stated our final agenda item is a presentation on trends and developments in the Kentucky work comp marketplace. Scott Wilhoit, Commissioner of the Kentucky Department of Workers' Claims thanked the Committee for the opportunity to speak and stated that our system came about first in 1914. It went to the state supreme court at that time, saying it was unconstitutional. It was revamped, revised and came back in 1916, and we're now celebrating our 110th year of Kentucky workers comp. As a Kentuckian, we sometimes brag not only about our bourbon, not only about our basketball, but we also brag about our workers comp system because we have a very good system. We like to say that Kentucky tries to set the gold standard when it comes to workers comp. What I mean by that is maintaining that particular balance. It's all about balance. That means we have to take care of injured workers but you also have to make sure that costs are not so prohibitive that we cannot sustain that and we can't maintain and grow economically. I say my job as Commissioner, I'm sure you all know this as legislators, if I've got everybody unhappy with me, then I've done a good job because that is just what this is maintaining that balance.

I'll just say we are a private market. We are not a monopolized state. We are a private market like most of the states. And in that regard, I'm proud to say that Kentucky's rates continue to decline in the cost of workers' comp. I talked to my friends in the insurance industry, and they had told me that workers comp lines are probably some of the most profitable, meaning that it is an industry where the insurers are not running from the business but coming to the business. And that's a result you making sure we have legislation that maintains that balance. That balance also means staying hyper focused on getting that injured worker back to work and making sure that injured worker can receive the best medical care. One of the problems we're having is access to medical care. Back when I started in workers comp, it was kind of like my father who was an anesthesiologist, and he grew up in the very traditional way medicine was practiced. The old Marcus Welby days are gone. Most likely your constituents are not often seeing an MD or a DO. They're seeing a nurse practitioner or physician's assistant. And that's great, but we in the work comp field have to make sure to allow that access to those folks to get that medical care.

In Kentucky, we have a definition for "physician" and we have expanded that definition over the years to include psychologists, chiropractors and so forth. One of the things we realized in trying to keep our costs down is that in Kentucky, if you have a hearing loss, you must go to get an examination and get determined what that level of hearing loss actually is. Up until last year the hearing loss had to be signed off by an MD or a DO. We took a look at that and realized, okay, that's great but it's the audiologists who are actually performing the examination. And the physician comes in, takes a look at it and signs off. Usually, they agree with it. So, we expanded the definition to include doctors of audiology to reflect what is really happening out in the marketplace. In Kentucky, especially the rural areas of eastern Kentucky and in western Kentucky, we are lacking medical care in terms of doctors. So, we've got to expand and work on that. We need to look at that in order to expand out that definition to reflect what's actually happening out in the field. I became Commissioner four years ago and I made a promise that

I'm not going to be at my desk all the time in Frankfort, Kentucky. Four years later, I'm at my desk all the time in Frankfort but I try to get out and try to listen to others on what's going on out there. It's very easy to live in a vacuum and not see what's actually happening. That's what's great about these forums here today, to hear from others and know what's happening and what's going on.

I also will pick up a little bit where Ms. Shaub spoke a few moments ago. I think PTSD is a major issue. Kentucky, like many other states, back in the mid 1990s did a reform. And I understand that. I was a defense attorney. But with work comp, we try to get the goal making sure that injured worker gets back to work and the proper benefits are payable. I look at it that way. It is adversarial, but we all have that same goal. But back to the mid 1990s, we were part of that same trend where we eliminated pure mental claims. And by that, I mean there used to be, and I'm going to use an exaggeration here, you could file a claim if I don't like my boss or I'm stressed out by my boss and there were crazy examples. I defended a couple of those kind of cases. But for the most part, there was reaction to that to eliminate mental claims. I understand it but we also have to reflect again. Just as I talked about how the medical field has changed and progressed over the years, so has the medical science. We now realize that PTSD, as Rep. McFall stated, is a real thing. Back in the mid 1990s, we didn't have nearly the diagnostic tools we have today. Where today, they can look at a brain scan, and they can see anatomic physical changes to the brain, we know that happens. So, we need to look at PTSD.

Kentucky right now still is a mental state. In order to be covered for PTSD or any other mental trauma, you must first show a physical injury. Then you have a psychological overlay. Here's the problem, and here's an example that I'm concerned about that I hope that you as legislators might want to think about as well. I use tragically an example that happened in Kentucky a couple years ago. It just is truly tragic and it was workplace violence. We had a terrible situation where a fired disgruntled employee came into a local bank and opened fire. Several people were killed. It was mayhem. And here's the problem with PTSD coverage as it exists now. And this is hypothetical. Two employees walk out of that and both witness the carnage. One slips on the debris and it hurts her back and has PTSD because she saw what she did. The other employee manages to walk out. He gets no coverage. Now, it's hard to say why that is fair and equitable. And remember, workers' comp is designed to get those employees back to work. What do you do about the employee who didn't have a physical injury, who still has the trauma? What do you do about that employee? The studies have shown that if you get that employee therapeutic care, get the necessary medication, you're not talking about a lifelong treatment of family therapy - it is hyper focused on keeping that employee through that trauma and getting them back to work. That needs to be maintained as the goal. But we also have to watch the cost because it'd be great if we covered everything from a scratch on your hand but we have to be realistic about the cost. One of the things we're proposing is that we have strict criteria pursuant to the American Medical Association (AMA) guidelines, pursuant to the DSM-5 on what is PTSD. And there are those strict guidelines for those. I think one of the things we need to think about is where does that all fit in? How do we maintain that balance? Because again, we have to keep costs in mind. We have to get employees back to work.

One of the other areas that I'm concerned about is GLP-1s. They work. They are really expensive. When an individual sustains a knee injury or sustains a back injury, through the years I've seen the doctor before they'll do surgery or do anything to the patient say you have to lose weight. The problem is again that cost. I heard an insurance representative ask me if GLP-1's are going to become the statins of the future? Meaning that once you go on it, are you on it forever? And as far as workers' comp is concerned, does that mean the states, the workers' comp, the employers have to pay that forever? I don't know the answer to that. That's

something we have to figure out. We know they work, but I think the science is showing that once you stop taking it, guess what happens? And that could again affect the knee, the back, and so forth. And Kentucky's like many other states, we did have lifetime medicals. It now goes for 780 weeks plus renewable. So, we have someone with a back injury or knee injury that happened 10 years ago, and they're taking their GLP and so forth it is preventing them having to get another knee replaced here soon. That's a good question, and I don't know the answer. All of you are going to be faced with that with your legislatures on what do we do because we have to control those costs. We have to make it reasonable. We can't have a system that is so cost prohibitive that we drive business away.

Medical fee schedules are also important. Every two years, we update that medical fee schedule to make sure it's current. But we have to be careful too again in how much we increase that medical fee schedule? But we also want to make sure we have doctors and medical care specialists who are willing to take workers comp patients. In Kentucky, I say proudly with this administration, with Governor Beshear's Administration, we've added 68,000 jobs to the market. Kentucky is a smaller state. Ohio is a much bigger state. We are growing. We have to face those needs that we have as a rural state. Kentucky is one of those states as well that we still we have a lot of folks who still suffer from pneumoconiosis, black lung. Black lung is expensive. A lung transplant if someone suffers from pneumoconiosis is $1 million and sadly, it only has about a 50% success rate. I'm kind of talking about challenges here today as trends. Now I want to shift a little bit. I love workers comp because show me another social private government program that accomplishes as much as workers comp. We promote business, we take care of workers, and we do it in a way that has balance. As I often say, comp is pretty cool. We talk about the kids who don't want to go into workers' comp. It's really cool because we see the impact of what comp does. We get the worker back to work. For that worker too, who at the time is suffering from an injury and is healing, workers comp makes a difference making sure the lights stay on, the food stays on the table, and the kids are clothed as they recuperate, and they go forward and return to the workplace. That's what it's all about. Helping that injured worker when they can't get back to work, making sure they are taken care of.

Some of the things I think we are looking at in Kentucky as we're looking at those trends, is how we address those medical matters. We're also looking at artificial intelligence and what it's role is. I don't know but we have to look at it and as Ms. McCloud said a few moments ago, AI can be helpful, but we can never replace the human connection. Your constituents want to talk to a human. We always have to make sure that the judge is assigned to cases and not a robot. Those are the kind of things we need to look at. It's a tool that we can all use. It's there, it's going to be there. We have to move forward to it and adopt that in the best practice we can. We also in Kentucky have the Official Disability Guidelines (ODG). That's part of that process by which we try to make sure that the medical costs are proven, our medical procedures are proven effective procedures. We try to do that. We try to keep the best care, the appropriate care for those workers.

One of the things we're trying to work on is modernizing that access. One of the complaints I hear about workers comp because we still have some old-fashioned ways is that in Kentucky, when you have an injury, your insurance carrier provides you with a card. That you take that card that has your name on it, has your claim number on it and so forth. And you take it to your primary care provider, and they are supposed to do that whole process and then they send the records to the insurance carrier. They review it and go back and forth. Oftentimes what happens? Delay, delay, delay. Because waiting for medicals can go back and forth. The insurance carrier is not sure exactly where that claimant is getting treatment. The doctors aren't

getting paid. So, one of the things we're trying to do is come up with a system called Compass. I raised my phone mainly for the idea of a QR code. We're going to develop a QR code that that claimant can take and have it be assigned a QR code and take it to that doctor. The doctor will scan the QR code and it will have all the information on it. It will link up with the insurance carrier. The insurance carrier will have the information right away, have records right away, have medical bill and everything right away and communicate back and forth. Also too, at times comes litigation with a claim and we want to eliminate all that unknown there to make sure the provider gets paid fast and make sure the claimant gets the treatment as they should. Technology will help. But again, we don't want to lose that human connection with it all. There are so many really interesting things that comp does. Whether it's a monopolistic system or whether it's a free marketplace, private sector, we all share that same goal, helping those workers, keeping our costs contained and making sure we have a thriving economy.

Rep. Barbara Dittrich (WI) stated that I am Chair of the Assembly Committee on Insurance, but I've also done a lot of policy work on mental health and substance abuse. My question is really in regards to how you decide what you're going to cover with workers comp and mental health because I have real concerns about using things that are derived from psilocybin and LSD when you're trying to treat PTSD. I'm wondering if you consider any therapeutics like Eye movement desensitization and reprocessing (EMDR), Cognitive behavioral therapy (CBT) or Dialectical behaviour therapy (DBT) coverage for workers comp? Mr. Wilhoit stated I'll go back to the ODG we do. The legislature passed a few years ago kind of a universal guideline. Let me explain the ODG a bit more. Because we've had some pushback regarding the ODG, and ODG is a private company that produces it, and other states use it as well. What an ODG does, it makes it that we have one system of what the appropriate guidelines are for treatment guidelines, but I believe under ODG, it's not the final say so. It's a tool by which we can look at to see which way a medical procedure would be approved or not approved. When I hear people say, well, wait a minute, why the access to the ODG? Well, it's really no different than each insurance carrier had their own ODG or own system for saying, "Well, we'll approve this one. We won't approve that one." This tries to put everybody on the same level playing field, we all share the same rules.

With regard to the question on experimental drugs, it's a good question and I'm very much of the believer that we have to have proven science in order to determine that. As Commissioner, I don't adjudicate claims. I am an administrator. We have 17 administrative law judges who decide cases that come up on whether a medical care is reasonably necessary and is causally connected to the injury. But one of the factors they look at is that ODG and also what the doctors are saying. We also have a process in Kentucky where we have a university evaluator where we can get a person, not a doctor hired by the plaintiff or a doctor hired by the defense. We can go to one of the medical universities to try to get an impartial opinion on that and I think we need to utilize that more but to come back to your question about experimental drugs and so forth. I don't know. I'm not sure workers comp is a place to experiment because we have that obligation to keep costs down and to do that treatment for the claimants to get them back to work. So, I'm not exactly sure that we're there yet for that.

Rep. Mark Tedford (OK) stated I wonder if you could talk about additional types of work related claims to which GLP-1s would be used and and then also what guard rails need to be in place to make sure that the claimant is not incentivized just to use it as a personal weight loss treatment? Mr. Wilhoit stated that's a major concern because again, the problem then becomes as you just said, say someone needed a knee replacement and oftentimes the doctor will say, "You got to get a knee replacement, but you got to lose 50 pounds before you get that knee replacement." Let's assume that was a work-related injury. There's not a question of causation.

The patient goes on a GLP-1. They lose the weight. And it's a fair question. I don't know the answer to that because does that mean the insurance carrier has to pay for that forever? I don't know. Are we talking about a specific period until they lose a sufficient amount of weight? I think what's going to have to be is a combination. They're going to have to also learn that it's not just the pill you take, but you have to do some other steps because otherwise until those costs of those medicines come down that's going to be a cost driver. That is really a concern. Now, it's a great medicine, but it's a huge cost driver.

Rep. Tedford asked if you know of any states that are doing a good job with this that now that have any guardrails for this? Mr. Wilhoit stated I don't really know. We're looking at other states. I'm a member of an organization called the Southern Association of Workers Compensation Administrators as well as the International Association of Industrial Accidents. There are several big organizations and I can tell you the two topics that come up every conference is PTSD and GLP-1. I think we're all trying to figure out what we're supposed to do. We've had representatives in about these marvelous medications that are coming out. But it's a tough one. There's got to be some balance but where do you strike that?

Rep. Tim Barhorst (OH) stated I wanted to ask each commissioner a couple of questions because I think it'll be valuable for the group to see how we compare a monopolistic system to the Kentucky system. Obviously, the big issue is the risk pools and how you manage them. That's why we can't change a lot because once you've picked your lane, you pretty much have to stay in it as what I've been told and I agree with. Then can you also talk about the rural health challenges with providers and how you contract with them? I know Ohio has a reference based system that's based on Medicare Plus. I think those two things might be a little different or I'm just curious how that's managed in two different types of systems.

Mr. Wilhoit stated in Kentucky we don't have strict contracts with doctors. We have the medical fee schedule. Any doctor, any medical care provider that's defined as providing a service has to abide by the medical fee schedule on that. That's how we do that process and it's similar to what other states do as well with a medical fee schedule on it. As a medical care provider treats that claimant, they are consenting to abiding by the workers' compensation medical fee schedule. You're consenting through that process to be paid per that process. There's no balance billing allowed in Kentucky, as in other states, I don't think other states allow it. That's the other thing about Kentucky comp that is similar to all the other states. Zero cost for the employee, no out-of-pocket expense for the employee to get that medical care. But it is a challenge, and that's why we make sure that we sufficiently compensate the medical care provider, the hospital, the outpatient clinic so they are willing to accept comp claimants. I've got a good friend of mine from some of the other states in which they have difficulty attracting and maintaining providers into the system. We're doing okay. We are getting folks in by being competitive but not outrageous. I'm not sure if that exactly addresses all of it, but I think it all comes down to making sure that we adequately compensate those providers. And the good thing about comp is that the provider will get paid. They don't have to wait 9 months, 10 months, whatever it is to get the payment. They will get payment.

Ms. McCloud stated we struggle as well in our rural areas with getting providers in. We were spinning a lot of wheels with signing up providers around the state, certainly where we had provider deserts whether they were psychologists, dentists, things like that. And then we'd sign up these providers who said, "Yeah, I'll do that," and then they may not see a BWC patient for years. And then they eventually fall off the rolls. We decided that was kind of a waste of time and switched our efforts to moving toward kind of a concierge service. So, if we have an injured worker in southeast Ohio, they need a dentist. There's not a dentist certified around them. We

say, “what dentist do you use?“ And, then we go out and enroll that dentist if they’re willing to be enrolled. That we have found is a much better use of our time than signing up people who may never see BWC injured workers.

Rep. Oliverson stated to Cmsr. Wilhoit that you got my attention when you were talking about the definition of physician. Did I understand you correctly to say that you have redefined that term to include audiologists, chiropractors, and psychologists? Mr. Wilhoit stated that is correct because we refer to physician throughout our act as the medical care provider. We don’t use the term medical care provider per se as we use physician. So, we define physicians not only being an MD or DO, but also under all that as well a Psychologist, a Doctor of Psychology, a Doctor of Audiology, and Doctor of Chiropractic Medicine. All those we do include under that definition of what we mean by physician in terms of compensation and coverage on Kentucky workers’ comp. Rep. Oliverson stated I’m curious because I think your definition is now very inaccurate. I mean, the term “provider” is a very inclusive term. The term “physician” is a highly specific term to someone that either has an MD or a DO. Why not just change the statute to say provider, instead of creating a definition that’s inaccurate. I don’t know that anybody up here would agree with you that a psychologist is a physician. Mr. Wilhoit stated I agree with you. I think that is something that has been passed down over the years. I think it is something we need to look at, especially as we talk about medical care providers. I think it’s a really good point. As we all further broaden it out to reflect who’s providing that care, such as nurse practitioners. Such as Doctors of Physical Therapy. I agree with you on that. I think it is time we do need to look at that. It’s something that has been in our books since going back to the 1950s. Rep. Oliverson stated so you’re trapped by the statutory language basically. Mr. Wilhoit responded exactly.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Mike Clines (KY) and seconded by Rep. Peggy Mayfield (IN), the Committee adjourned at 11:00 a.m.

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TREASURER: Rep. Jim Dunnigan, UT
SECRETARY: Rep. Brenda Carter, MI

IMMEDIATE PAST PRESIDENT:
Asw. Pamela Hunter, NY

International Association of Industrial Accident Boards and Commissions Model Agreement Between Jurisdictions to Govern Coordination of Claims and Coverage
July 29, 2005

Supported by the NCOIL Executive Committee on July 22, 2006, July 17, 2011, July 14, 2016, and July 18, 2021.

To be considered for re-adoption during the Workers' Compensation Committee meeting on July 17, 2026.

Background and Uses

The purpose of this model is provide a useful overview of the experience of states in negotiating and administering reciprocal agreements to coordinate employer insurance requirements and claims in cases where "temporary" employment occurs in one of the states that are parties to a reciprocal agreement. The model presented here distills the structure and language commonly found in existing agreements.

Reciprocal agreements to coordinate interstate insurance requirements and claims handling are practiced by at least 10 states, dating back as early as 1968 (Washington). The benefits of such agreements are:

- For employers, they reduce requirements to purchase insurance coverage in multiple or numerous jurisdictions when an employer sends employees to work for short periods outside the state of hire and normal employment

- For workers, they eliminate any possible questions with regard to the employee's right to obtain workers' compensation benefits from the state of hire and normal employment, usually the home state of the worker with medical providers close to home.

- For state WC agencies, they ease the enforcement investigations and sanctions required to maintain the scope of workers' compensation coverage desired.

- For insurers/payers they reduce ambiguity in claims handling by insurance adjusters and minimize the need to deal with duplicate claims and offsets.

- For all parties, they reduce the costs of litigation for benefits when the applicable coverage by two states is ambiguous.

By way of background, it should be understood that most states do allow claims that occur in the course of temporary employment outside of the "home" state of operations to be processed under

the laws of the home state where the worker regularly works. However, employers are often exposed to the need to purchase multiple policies (especially when state-specific assigned risk plans are involved), which may result in them paying twice for the same workers' payroll. Disputes and litigation are most likely to arise when the claim is serious (major permanent injury or death) and the indemnity benefits are greatly different between states.

In addition to the requirements of law from each jurisdiction, agreements should be approached with a clear understanding of the consequences to employers and injured workers. Among the issues to consider are:

• If benefit levels are greatly different between the states, the state with the lower benefit level is constraining access to higher benefits for its workers that may be injured outside the state

• If one state has a much lower workers' compensation insurance rate (especially for mobile employment like construction trades), employers in the low rate state may have a competitive advantage in winning bids as compared to employers in the other party to the agreement (hence the common use of construction exceptions, given below).

[Note that the term "state" used below should be construed to include province, territory, or any sub-national jurisdiction having authority to govern workers' compensation.]

Model Reciprocal Agreement

The State of ___"A"____, acting by and through the Department of ________and the State of __"B"___, acting by and through its Department of ________, desiring to resolve jurisdictional issues that arise when workers from one state temporarily work in another, enter into the following agreement (the "Agreement"):

[Note: the signing authority in most of the existing laws is an agency head. As an exception, North Dakota agreements are signed by the Governor as well as agency representatives.]

Who Is Affected By This Agreement

This Agreement affects the rights of workers and the responsibilities of their employers when a contract of employment arises in "A" to work in "A" and the worker is temporarily working in B, or when the contract of employment arises in "B" to work in "B" and the worker is temporarily working in A. To be covered by this Agreement: 1) an employer must be considered an employer under both A's and B's workers' compensation laws, 2) an employer must have a workers' compensation insurance policy unless they are a licensed [insert the term that is appropriate under state law] self insurer, and 3) workers must be considered workers under both A's and B's workers' compensation laws. In the event that the employer or worker is not covered in one of the states that are signatories to this agreement, the existence of this agreement does not affect or alter the rights a worker may have against the employer under the laws of either state.

Note: If the employer is illegally uninsured, the employee may have the right of choice of venue to file the claim against an uninsured employer fund, assuming such funds exist in both states. You may want to make this explicit.

Basic Rule

When a worker employed in "A" and subject to "A" workers' compensation law is temporarily working in "B", or when a worker employed in "B" and subject to "B" workers' compensation law is temporarily working in "A":

1. Employers must secure the payment of workers' compensation benefits under the workers' compensation law of the worker's state of usual employment, and pay premiums or be self-insured in that state for the work performed while in the other state; and

2. Workers' compensation benefits for injuries and occupational diseases arising out of the temporary employment in the other state shall be payable under the workers' compensation law of the worker's state of usual employment, and that state's law provides the exclusive remedy available to the injured worker.

This agreement covers only employees whose place of usual employment is in one of the jurisdictions party to this agreement. In determining the place of usual employment, the jurisdiction in which the employee has spent the majority of paid work days over the past 12 months shall be the dominant factor in locating the nexus of employment. If there is no single jurisdiction with the majority of paid work days, the jurisdiction of hire will determine the place of usual employment for purposes of this agreement.

Note: If there is ambiguity about the nexus of employment, e.g., worker usually works in State B, but was hired in State C and occasionally reports for work in C, then this agreement may not apply even if the employment in A is temporary within the meaning of this agreement.

Drafting Note: States may wish to consider including language that would extend the definition of temporary employment to apply to emergency situations.

[Option 1 for determining Temporary employment]

In determining whether a worker is temporarily working in another state, "A" and "B" agree to consider:

1. The extent to which the worker's work within the state is of a temporary duration;

2. The intent of the employer in regard to the worker's employment status;

3. The understanding of the worker in regard to the employment status with the employer;

4. The permanent location of the employer and its permanent facilities;

5. The extent to which the employer's work in the state is of a temporary duration, established by a beginning date and expected ending date of the employer's work;

6. The circumstances and directives surrounding the worker's work assignment;

7. The state laws and regulations to which the employer is otherwise subject;

8. The residence of the worker;

9. The provisions of any contract, written policy manual or other written agreement concerning the terms and conditions of employment; and

10. Other information relevant to the determination.

[Drafting Note – Option 2 for determining "Temporary". The above open-ended criteria may lead to burdensome litigation and delays in determination and notice of extraterritorial coverage requirements. Thus, more objective triggers may be desirable.]

The employee's presence in the state of the temporary work assignment for purposes of conducting employment activities does not exceed any of the following periods:

(1) [ ] days in any 30-day period; or

(2) [ ] days in any 360-day period.

[Additional optional conditions on application of this agreement]

A. The employee was not hired to work specifically in the state of temporary work assignment;

B. The employer does not have a permanent place of business in the state of the temporary work assignment, and;

C. This Agreement does not apply to employees of an employer working in the State of the temporary work assignment [options: in construction, on public service contracts, or whatever other areas the law prescribes].

Within 30 days of the effective date of a law change, the parties agree to notify the other state in writing or via email of any changes to their statutory or decisional law that may affect this Agreement.

Exclusion From The Basic Rule

This Agreement does not apply to any "A" worker of a "B" employer while working in the State of "A" nor to any "B" worker of a "A" employer while working in the State of "B." It is understood that an employer from either "B" or "A" may have work in the other state where they may have both "B" and "A" workers not on temporary assignment. This circumstance would

require the employer to obtain coverage in both states to cover the subject workers of their respective states.

Certificates Of Coverage

Upon request, a duly authorized official of the workers' compensation board or similar agency in each state will issue certificates of extraterritorial coverage to the other when appropriate. It shall certify that an employer is insured in that other state for which extraterritorial coverage for the employer's subject workers while working within the state of temporary assignment on a temporary basis is being provided, as defined above. When issued, the certificate is prima facie evidence that the employer carries such compensation insurance.

Effective Date

This Agreement shall take effect immediately upon execution by both parties and public notification in compliance with the laws of "A" and "B". This agreement will remain in effect unless terminated, modified, amended or replaced in writing between the parties.

Termination

Either party may terminate the Agreement, without cause, by giving at least 60 days written notice to the other party to this agreement.

Notice

This Agreement creates no rights or remedies, causes of action, or claims on behalf of any third person or entity against "A" or "B", and is executed expressly and solely for the purpose of coordinating issues of workers' compensation coverage between the states

Drafting option: It would be useful to offer a specific dispute resolution process. In Canada, the Boards submit interjurisdictional disputes to a third Board for arbitration. In the US, it may be difficult to enlist a third-party state to arbitrate a dispute under this agreement. An alternative dispute resolution process might be to submit the claim dispute to the review body that normally receives appeals to hearings regarding disputed workers' compensation claims. It seems logical to submit the dispute to the jurisdiction in which the extraterritorial claim is being made, i.e., the jurisdiction of temporary employment.

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National Council of Insurance Legislators (NCOIL)

Trucking and Messenger Courier Industries Workers' Compensation Model Act

Adopted by the NCOIL Executive Committee on March 6, 2011, and the Workers' Compensation Insurance Committee on March 4, 2011. Readopted by NCOIL Executive Committee on July 17, 2016, and July 18, 2021. *Originally Sponsored by Rep. George Keiser (ND)

To be considered for re-adoption during the Workers' Compensation Committee meeting on July 17, 2026.

Section 1. Purpose

The purpose of this Act is to establish clear criteria to determine employee and independent contractor status for workers' compensation coverage purposes.

Section 2. Definitions

Definitions for this Section will track definitions in [Insert Workers' Compensation Statute].

Section 3. Independent Contractors in the Trucking and Messenger Courier Industries

In the trucking and messenger courier industries, an operator of a vehicle or vessel is an employee and subject to state workers' compensation laws unless each of the following factors is present, and if each factor is present the operator is an independent contractor:

1. the individual owns the equipment or holds it under a bona fide lease arrangement. Any lease arrangement, loan or loan guarantee cannot be with the hiring entity or any affiliate of the hiring entity. This would not apply in temporary replacement lease agreements;

2. the individual is responsible for substantially all of the principal operating costs of the vehicle or vessel and equipment, including maintenance, fuel, repairs, supplies, vehicle insurance, and personal expenses. The individual may be paid the carrier's fuel surcharge and incidental costs by the contracting entity, including, but not limited to, tolls, permits, and lumper fees;

3. the individual is responsible for supplying the necessary services to operate the equipment;

4. the individual's compensation is based on factors related to the work performed, such as mileage based rates or a percentage of any schedule of rates, and not solely on the basis of the hours or time expended;

5. the individual substantially controls the means and manner of performing services, in conformance with regulatory requirements and specifications of a shipper; and

6. there must be a certification statement affirming that the individual whose services are being acquired meets each of the factors in Section 3(1) through (5) and that the relationship is understood to be that of an independent contractor and not that of an employee. The statement must be signed and dated by the individual supplying the service and the hiring entity. The statement must be supplied on demand to an insurance premium auditor or [Insert Applicable State Agency].

Section 4. Penalties

Penalties for non-compliance will be levied in accordance with [Insert Workers' Compensation Statute].

Section 5. Enforcement

The [Insert Applicable State Agency] shall have enforcement authority as provided under [Insert Workers' Compensation Statute].

Section 6. Effective Date

This Act shall take effect immediately.

NCOIL – NAIC DIALOGUE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
NCOIL-NAIC DIALOGUE COMMITTEE
2026 NCOIL SPRING MEETING – LOUISVILLE, KENTUCKY
APRIL 17, 2026
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) NCOIL – NAIC Dialogue Committee met at the Hyatt Regency Hotel in Louisville, KY on Friday, April 17, 2026 at 1:45 p.m.

Louisiana Representative Edmond Jordan, NCOIL Vice President and Co-Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Stephen Meskers, CT
Rep. Matt Lehman, IN
Rep. Peggy Mayfield, IN
Sen. Beverly Gossage, KS
Sen. Donald Douglas, KY
Sen. Jason Howell, KY
Rep. Michael Sarge Pollock, KY
Rep. Brenda Carter, MI
Sen. Lana Theis, MI
Sen. Paul Utke, MN
Rep. Tim Barhorst, OH
Rep. Meredith Craig, OH
Sen. Mark Mann, OK
Rep. Ellyn Hefner, OK
Rep. Greg Scott, PA
Rep. Tom Oliverson, TX
Del. Walter Hall, WV

Other legislators present were:

Sen. Rob Yundt, AK
Sen. Jesse Bjorkman, AK
Rep. Justin Wilmeth, AZ
Rep. Brett Barker, IA
Rep. Elizabeth Wilson, IA
Rep. Wendy Dant Chesser, IN
Rep. Craig Snow, IN
Rep. Adrielle Camuel, KY
Rep. Mike Clines, KY
Rep. Mike Meredith, KY
Rep. Shaun Mena, LA
Del. Mike Rogers, MD
Sen. Mark Huizenga, MI
Sen. Jeff Barta, ND
Sen. Jeffrey Klein, ND
Sen. Kristin Roers, ND
Sen. William Gannon, NH
Sen. Tim McGough, NH
Rep. Julie Miles, NH
Rep. Kellie Deeter, OH
Rep. Derrick Hall, OH
Rep. Perry Warren, PA
Rep. Yusuf Hakeem, TN
Rep. Matt Morgan, TX
Rep. Trey Wharton, TX
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 Sen. Paul Utke (MN), NCOIL President, the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Sen. Utke and seconded by Rep. Tom Oliverson, M.D. (TX), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's November 14, 2025 meeting.

INTRODUCTORY REMARKS

Rep. Jordan thanked everyone for their participation and stated that I look forward to our organizations continuing to strengthen our relationship. When our organizations are able to work together, that ultimately benefits consumers and our state-based system of insurance regulation. I think last year was a great year in terms of our relationship improving and I look forward to another great year. He asked everyone to introduce themselves. Kentucky Commissioner Sharon Clarke; Washington Commissioner Patty Kuderer; Utah Commissioner and NAIC Vice President Jon Pike; and Oklahoma Commissioner Glen Mulready.

RECAP OF NAIC SPRING MEETING AND DISCUSSION ON NAIC 2026 PRIORITIES

Rep. Jordan stated that last month, the NAIC concluded its meeting in San Diego and as usual, there were many items discussed and actions taken that have a major impact on the insurance marketplace. We also understand that you set forth several priorities at both the state and federal level so we're going to ask you to touch on some of the highlights from your spring meeting and discuss your priorities for this year.

Cmsr. Pike stated that we appreciate the great collaboration that we have with NCOIL. It's a great relationship with great opportunities. The NAIC spring meeting was very productive. We focused on modernization, resilience, and consumer protection across the various insurance markets. We continue to prioritize strengthening market resilience, particularly around catastrophic risk, enhancing transparency and oversight of investments, data security, and artificial intelligence (AI). We also focused on protecting consumers while maintaining competitive markets. We know we need to be able to accomplish both. I will now share a few key developments in terms of market conduct and our what we call our market regulation and consumer affairs committee (D committee). The D Committee will be undertaking a holistic review of the market conduct framework to assess whether we have the appropriate data, tools, and supervisory approaches that are needed to oversee a rapidly evolving insurance marketplace. It's what we're calling our market conduct modernization effort.

The second big thing is the NAIC's homeowners market data call. The NAIC issued its nationwide homeowners market data call in March to better understand pricing, availability and coverage trends at the zip code level. This data will be the most comprehensive collection of homeowners insurance data to date. Regarding our strategic priorities for the year, capital and investment oversight is a big priority. Enhancing capital and investment frameworks to ensure insurer solvency to protect policyholders. This effort includes such things as modernizing our risk-based capital (RBC) framework, implementing asset adequacy testing for asset intensive reinsurance, strengthening oversight of complex investments and improving transparency and reporting. Beginning this year, insurers will be reporting more granular data on private credit holdings, and regulators will be expanding macro prudential monitoring and stress testing. As for data and analytics, we will be expanding NAIC's role as a data and analytics hub to improve early risk detection and market monitoring, as well as establishing more proactive regulatory oversight through data calls, dashboards and surveys. Then as to resilience and catastrophic risk, the NAIC will be strengthening its efforts to address growing disaster risks through improved modeling and risk mitigation and I'm sure we'll be doing a fair bit of coordination with NCOIL and with federal partners as well to close protection gaps. And then finally, another one of our priorities is AI innovation and cybersecurity.

The NAIC has a few federal priorities that I'd like to highlight and probably find some commonality there with you all on the concern about community resilience and market stability. First, we will be advocating for mitigation funding. In fact, there's even a bill currently on the federal docket that is bipartisan. We don't know if it's going to get legs this year, but we align with the federal bill and we'll be working with them so we're excited about that in terms of Federal mitigation and anything as it relates to that and we hope we can tie into tax issues as well to make sure there is tax parity for state funded mitigation grants as well. Then there is the goal of preventing federal overreach. There are a number of areas we hope to address, including the Treasury Department. We're hoping to replace the Federal Insurance Office (FIO) with a focused international insurance role within the Treasury Department. And in fact, the specific legislation for that is called the McCarran-Ferguson Restoration Act and I think we share a commonality there of really believing that we need to protect state sovereignty in this area. In fact, I love the phrase that I used to use when I was an elected mayor in Utah, which was "one size misfits all". We think that it's fantastic to have 56 U.S. jurisdictions acting as laboratories where we can get it right, hopefully at the local level, and learn from each other. You can't do that if it's all at the federal level. And I really do believe one size misfits all. And that's the beauty of McCarran-Ferguson and trying to keep it that way. We'll also be working to ensure that the FSOC (Financial Stability Oversight Council) consults with state regulators before implementing enhanced supervision and that's under what's called the Financial Stability Oversight Council Improvement Act. Another federal initiative relates to strengthening protections for policyholders and seniors, including prioritizing their claims in insurer insolvencies and that is behind the State Insurance Receivership Priority Act. The NAIC also supports federal support of state enforcement efforts to combat financial exploitation of seniors. Senior protection is behind the Empowering States to Protect Seniors from Bad Actors Act.

Now we will discuss some health insurance related Federal priorities. Extending enhanced ACA tax credits to stabilize premiums and protect access to coverage remains one of our priorities. Coordinating with state regulators on long term reforms to minimize market disruption is important. We keep working on authorizing state enforcement of Federal Medicare Advantage rules. We don't know how much control we are going to get, but we'd like to strengthen marketing practices, network adequacy, and information sharing requirements to improve accountability. Again, I think states are the boots on the ground and can more adequately be able to enforce those kinds of things. We'll see and continue to push for these changes. And we

think it is time to fully and timely fund State Health Insurance Assistant Programs (SHIPs) and mental health parity grants to support consumer assistance and program administration.

Rep. Tim Barhorst (OH) stated that I believe the basis of McCarran-Ferguson is solid with state rights as the top of the priority. Are there any other issues within McCarran-Ferguson that we could touch that would improve some of the current systems, particularly in the healthcare field? The Commerce Clause pretty much ruined a lot of things we could have improved on in our healthcare system and I think if we're going to look at McCarran-Ferguson, we should consider some items in that coverage line.

Cmsr. Mulready stated that I will highlight something more from a pushback standpoint. Cmsr. Pike talked about State enforcement of Federal Medicare Advantage plans. That's something that we've seen a lot of activity on at the NAIC and by that I mean there are some states, Idaho and Oklahoma specifically, who have taken a step many would say, including the Centers for Medicare and Medicaid Services (CMS), is a step beyond our authority. But that's been very purposeful. In that situation, Idaho got sued over it. Oklahoma has not yet been sued over that, but for us it was about let's generate more conversation and how can we give more authority to the states on Medicare Advantage plans. Because when there is a problem with Medicare Advantage, we get the call from consumers and we send the consumer to CMS where the issue goes into a black hole and it's super frustrating for every insurance department in the country. And so, we're pushing back on that inaction. And I will say this, although there's been no real changes right now, there has been a lot of substantive conversations. A couple weeks ago CMS took a call with five of the states that had been pushing back, and we had a productive conversation. Better yet, folks from CMS were at the NAIC's most recent national meeting. We've never seen CMS in that role just to interact and so the positive outcome of that is a lot more conversations and regular calls. And so, where we end up on that I'm not exactly sure, but that's been one particular focus point we have pushed on.

Rep. Brenda Carter (MI), NCOIL Secretary, stated as artificial intelligence (AI) continues to expand, where do you as regulators see the line between innovation and needed guardrails? Rep Jordan stated that AI is the next topic on the agenda so we will handle another question first.

Rep. Matt Lehman (IN) stated that you were talking about resiliency and I think the NAIC is looking at a model law similar to the NCOIL Strengthen Homes Program Model Law we adopted in 2024. Are those models going to be coordinated? I don't want to see conflicting models, and several states have already adopted the NCOIL model. Cmsr. Pike stated absolutely and I certainly have some affinity for that program because it was sponsored by Rep. Jim Dunnigan (UT), NCOIL Treasurer. Certainly we are looking to create a model law there, but we will absolutely be using the NCOIL model as a starting place and I think that's a good point. Cmsr. Mulready stated that as Vice Chair of the NAIC C Committee, the mitigation model act is something that we hope to, in NAIC terms, fast track. Because that model has already been set and has already been established in so many states and they are not very different. We're hoping to put out a draft for public comment, and we hope to vote on it by the end of the year. Cmsr. Pike stated that states are moving along on mitigation. In fact, my own state, we are looking at the model right now. I am hoping to talk about it in our interim legislative session and use Rep. Dunnigan's model for conversations.

Rep. Stephen Meskers (CT) asked just how comfortable are you with the guaranty funds currently as it relates to cybersecurity? Are we using the right measurements to reserve against those potential losses? Cmsr. Pike stated that the NAIC has other commissioners that are

experts on that issue but it certainly is a concern. Rep. Meskers stated that it just raises a lot of concerns about how we measure risk factors and I just don't know what liabilities we're measuring and I hope carriers can do it adequately. Cmsr. Pike stated that I don't know that we have all the answers yet on cyber, but it's definitely part of the discussion.

Cmsr. Mulready stated that going back to mitigation, something that the NAIC could use your help on is trying to push Congress on favorable tax treatment on mitigation efforts. So, there are some bills filed, but they really haven't gotten any traction. But in Oklahoma when we give out a $10,000 grant to a homeowner, that's taxable income to them. So, that tax relief issue would be super helpful to move these programs forward, and that's where we could really use your help. Rep. Jordan stated that we'll certainly discuss that topic during our DC fly-in.

DISCUSSION ON ARTIFICIAL INTELLIGENCE (AI) MATTERS

Rep. Jordan stated that AI continues to impact the insurance marketplace and in response to that, both state and federal policymakers have been very active in trying to respond with the policy measures that protect consumers but don't hinder innovation. From an NCOIL perspective, we had a model AI law that was discussed last year requiring human review of any AI claim denials or adjustments but that's on pause for now as we'll be considering a resolution on Sunday pushing back on federal activity in this area. And from my perspective, I'm interested in this because I've introduced an AI bill in my state and it's gotten some federal pushback. But first, we're interested in learning more about NAIC's AI systems evaluation tool. Can you please let us know where things stand in terms of implementation and state participation?

Cmsr. Clark stated that I think from a regulator perspective, none of us are against the use of technology if it is used appropriately, and it's use is still within the purview of the laws of our state. But this is a subject matter that crosses all lines of insurance. I will give you a couple of examples where it's even crossing into the policyholders' improper use of AI. But to the first point, the NAIC laid the groundwork for AI oversight, beginning with the AI principles in 2020, and the AI model bulletin in 2023. There are 25 states that have adopted that bulletin. I'm proud to say Kentucky is one of those states. The AI pilot project is in its very early infancy and I know that we will be able to give you a much better update later on this year but just the basics behind it, it's based on the work that the NAIC big data and AI working group developed to help regulators assess insurers' AI governance, risk management, and how they are using AI in the marketplace. And I appreciate your legislative concern in the NCOIL AI resolution. I'm kind of going off our talking points here, but I want to give you just one example of that human touch that needs to be in there with AI. There is a class action lawsuit now that involves a health insurer and they were using AI for authorization purposes and there was a senior lady who had some major surgery. She was allowed to go to a rehabilitation facility for four weeks. She was kicked out four days later and it was based on AI's review of her charts and that resulted in this class action lawsuit. So, that gives you just one example right now that we're dealing with of how AI is being used.

I mentioned the AI use by policyholders. Kentucky is investigating a fraud complaint right now where the policyholder has used AI to change pictures on an insurance claim and file false claims. So, it's not just the use of AI by insurers, we are now seeing that use for fraud. That fraud use would have never occurred to me but we have that challenge now. I'll give you another example of how we're dealing with AI. We have policyholders who are challenging the Departments of Insurance on interpretations of our laws and regulations. In fact, just this week, the Georgia Commissioner has been threatened with a lawsuit because the consumer alleges that "AI said that my claim's supposed to be paid". Forget what the Georgia Department of

Insurance says and the Georgia regulations and statutes. And that is just going to be the norm. We're hearing about AI produced arguments in multiple cases. Cmsr. Kuderer can talk about her department receiving AI generated complaints being filed with consumer complaint departments. So, AI is not just an issue with oversight of insurers. We're having to look at all of these other aspects of it. So it is a priority and to Rep. Carter's earlier question, the human touch needs to be involved and thank you NCOIL for your work on that resolution.

From my perspective, I have no problems with insurance companies using AI but they must be able to explain to me how that is being used, and in what capacity like claims payments, underwriting, and how it benefits their policyholders. Unfortunately, I had to have one difficult conversation with a company and I mentioned this type of process they were using, and I said, "How is it used?" They couldn't even tell me. That doesn't fly very well with regulators. So, it's a serious concern. I say sometimes we're running behind the car and holding on to the bumper of the car trying to keep up with all the changes in AI and how it's being used. I think another area that we do agree on is the role of the federal government and concern about federal activity here. We know that there was some activity back in December 2025 where there were some discussions about there should be a national AI policy framework and it would preempt state laws on this. All of us know that each state is its own marketplace and we all have our pluses and minuses and it needs to stay with the states. Congress has considered various proposals relating to AI governance but no comprehensive federal AI framework has been enacted.

The NAIC has raised concerns with federal efforts to preempt state authority, including the administration's executive orders on AI. We've submitted letters to congressional leadership. We have reiterated our opposition to a broad AI moratorium, emphasizing the potential disruption that it would cause in the marketplace and the confusion. The NCOIL resolution hopefully will have an impact. Maybe if our efforts have not been heeded, your legislative voices can be heard. Federal agencies are expected to continue to evaluate national approaches to AI and Congress may consider additional legislation. The NAIC and regulators will continue engaging with Congress and the administration to ensure any federal framework respects states. We strongly encourage states that have not yet done so to consider adopting the AI model bulletin and the NAIC Insurance Data Security Model Law. There have been 28 states that have adopted that so if you see that coming across your desk at any future sessions we'd like consideration of that. I'll turn the question back to you on AI. Have you all been considering any work on AI from a state perspective?

Rep. Jordan stated that before we get into that, after the NAIC's AI exercise is completed, what do you expect to do with the information? Will there be any new AI standards set forth as model bulletins, regulations or laws? Cmsr. Clark stated that I'm not sure I can answer that right now. I think we're going to have to see what information we can acquire from the pilot project and if there is an avenue to go forward, it remains to be seen.

Rep. Jordan stated that both of our organizations have pushed back on the proposed 10-year federal moratorium on state regulation of AI and on the Executive Order aiming to preempt the state abilities to regulate AI. And we're going to consider the NCOIL resolution on Sunday. I introduced a bill in Louisiana that would deal with the regulation of AI. And I think there are some things in the bill that can be worked on but what was shocking and disappointing to me is that I understood that my bill ended up coming on a Federal list from the administration. And when we inquired a little deeper into it, it was our understanding that right now Louisiana has hundreds of millions of dollars in broadband funding that should be coming from the federal government. And if any AI bill is passed, the word is that funding would be placed in jeopardy. I understand it's happened to some other states already, and that is tough leverage to exert over

a state. And if we succumb to that, in my personal opinion, and this is just me speaking, then I think we should just go ahead and federalize insurance because we're going down a slippery slope at that point where we're going to let the federal government dictate to us how the states operate. And to me, that violates every principle of McCarran-Ferguson and everything we've done. Today it's AI, tomorrow it could be some other issue. And it's not an issue of whether we agree or disagree on it. It's the principle of it all. And I think that is part of why we should move forward with the resolution. I think that's the correct thing to do.

Cmsr. Pike stated that I completely agree. I think that is a battle worth fighting. Rep. Jordan stated that I know some may not want to go to that extreme but if we give in on this issue, then I think you're going to start to see the federalization of insurance and then state regulation I think goes away. I do think this is a dangerous precedent that we are setting. Cmsr. Pike stated that I agree and I think it's another situation where currently the federal government really isn't doing it. The states are doing it and I think we're better positioned to do it like so many other things in this arena. Rep. Jordan stated that I've heard other states have experience similar things to what I did with my bill and one of those states was Utah and I don't know if you've been personally affected, or if you want to expound on that at all. Cmsr. Pike stated that we have some things underway and we have been cautioned and we had people reaching out to legislators in our state and saying, "don't do this, and don't do that." So there's some concern there. Our Governor is working hard to try to keep the communication open but that's about all I can say at this point.

Sen. Lana Theis (MI) stated that I think one of the things that is getting missed in the scope of this is what AI is, and a simple definition of AI is not easy to come by. Are we talking chat bots? Are we talking large language model search engines? Are we talking about smart AI? Are we talking about superintelligence? Some of this is directly related to national security. Some of this is specifically related to how someone's interacting with the website of their insurance company. Those are all very different things and very different scopes, and if we're trying to encompass AI and wrapping it all in that bundle, I think we do that at our own peril. We need to be very cautious as we approach an understanding of what specifically we're defining as we approach this topic, and as we try to legislate and regulate.

DISCUSSION ON INSURANCE AFFORDABILITY AND AVAILABILITY ISSUES

Rep. Jordan stated that the next topic is unfortunately still one of the most talked about issues when it comes to insurance and that is is affordability and availability. I'm sure that all of us here on some level have been dealing with the issues related to that and across different lines and I know there are headlines about insurance rates and insurers leaving markets that continue to appear in national news outlets. And I think we'll all be hard-pressed to say that things have improved a lot. I know that we've discussed this before, but I think that it's important to continue to maintain the dialogue about this and talk about what we're seeing in our states and within our organizations and what potential solutions to help us resolve these things are.

Cmsr. Kuderer stated that I think you articulated the issue really well. Cost and availability challenges continue to be a paramount concern for consumers and costs are being driven by increased catastrophe losses and volatility, rising reinsurance costs, and inflation. And this is felt most in the property markets, mainly in the homeowners insurance area as well as reinsurance. And at the NAIC, regulators are focused on understanding the drivers of these challenges and equipping states with the data and the tools and coordination needed to effectively respond. And our focus areas include catastrophe risk and resilience and through our NAIC's natural catastrophe risk and resilience task force, regulators are focused on improving catastrophe

modeling, supporting mitigation efforts, and better understanding how catastrophe exposure impacts pricing and availability in property markets. Next, the NAIC is focused on healthcare work streams. The health insurance and managed care committee continues to address access and cost drivers, monitor health insurance markets and engage with Congress and federal agencies on ACA tax credits, Medicare Advantage oversight, and funding for consumer assistance programs. You heard Cmsr. Mulready talk about the need to have more oversight of Medicare Advantage. One of the largest complaints we get at my office in Washington is about Medicare Advantage plans and deceptive marketing practices. We've brought up to Congress that we'd like to have more oversight over Medicare Advantage. Another issue is market conduct modernization and underwriting oversight through the NAIC's D Committee. Regulators are reviewing the market conduct framework to ensure they have the tools and data needed to monitor underwriting practices, pricing trends, and market impacts.

Another issue that we're focused on is something that I think is universally felt across the country, and that is the issue of insurance for childcare organizations. Regulators and legislators alike are increasingly hearing concerns about the cost and availability of coverage for foster care providers and childcare organizations, particularly in the liability market. And in Washington state, my office has met with many childcare providers, agency heads, the insurance industry, and other stakeholders about this issue. And there is a real sense of urgency around this. We're talking about the increased liability exposure, litigation trends, expanded statutes of limitations for child abuse claims, reduced insurer participation and changes in coverage terms. In our state these issues led to a study that documented past child sexual abuse claims and what we are referring to as a coverage gap as the single most significant driver of challenges for these organizations. And in response to these concerns, the NAIC's, Property and Casualty Insurance Committee formed a new working group that I will chair to further study these challenges and provide recommendations to regulators and legislators to help address this urgent cost and availability issue for child placement agencies and group foster homes. State regulators are closest to the market conditions and are best positioned to help develop these solutions. And as with all these focus areas, we welcome NCOIL collaboration especially with the issue of insurance for childcare organizations as I know that you're also hearing about this issue as well and it's really important that we help solve this very critical issue.

Sen. Beverly Gossage (KS) stated that as a health insurance agent for 22 years, I also write Medicare programs. Medicare Advantage is a completely different animal in that all its structures must be approved through Medicare and even though I believe that in state control of health insurance, I'm very reluctant to support any bill that would say Medicare Advantage should fall under the states. So, I'd like to hear more about that. Cmsr. Kuderer stated that I appreciate that and giving me the opportunity to clarify because I think what we're talking about is oversight of the advertising of Medicare Advantage plans. We have a program in Washington State that we call Community Connect. And we go around the state and we talk to folks about insurance issues and healthcare, of course, is the number one issue that we hear about. And of that, about 50% of the complaints we hear are about Medicare Advantage and feeling like what's being represented on the commercial is not the same as what they're actually getting, and that's really what we've been asking Congress.

Sen. Gossage that I definitely support that and I appreciate that clarification about false advertising.   Cmsr. Mulready stated that my push in my case is trying to have Oklahomans taking care of Oklahomans and at the federal level we just want to be able to enter into collaborative agreements. We don't have to mandate anything really big, just allow us to enter into collaborative agreements with states that want to do that. And with marketing efforts, the problem is at enrollment where someone has signed up and then they realize there's a smaller

number of physicians than they thought and then they are trapped. And then a second situation that comes up and we had one very recently where it did resolve itself, but it involved a contract negotiation with a big health system. And I think we have a much better feel on the ground of what the impact of that would be if someone goes out of network and the ability to then dictate a special open enrollment period versus from DC, declaring the impact on that market and and declaring a special open enrollment. So, those are a couple examples of what we would like to see have some more authority on. Sen. Gossage stated that I'd be happy to talk about that and about how we could work together on what would make the most sense.

Rep. Meskers stated that one of the issues that strikes us in Connecticut is related to the statute of limitation on sexual abuse. We have a large percentage of our nonprofits who are providing services to the state and I think the issue needs to be addressed as to whether or not we look at capping payouts that are for claims that are 20 or 30 years old, or providing some commonality of a guaranty fund. Or looking at how we can address the issue because the state is going to be left with no providers if we can't do something about this. I don't know how much is affected by federal statute of limitations and how much of state statute of limitations sits with the state but probably guidance from both sides is needed, and how do we move forward with capping those either in a humane way or changing the regulatory framework because it's unworkable. I think when we set this up, we were looking at hitting well established organizations with long term patterns of abuse and now we're hitting people who are doing the work for us. Who are inadvertently caught up and swept up in claims that are hard to adjudicate. So, I'd love your thoughts on what we can do.

Cmsr. Kuderer stated that it's a real challenging issue to say the least. I will say that in Washington state we actually lifted the statute of limitations and our study found that really did not impact the number of claims. What was more impactful was the direct solicitation of plaintiffs, and the entrance of private equity into this area. And so we are taking a strong look in the Working Group about all issues that play in this area. And like you said, maybe a guaranty fund, that sort of thing, is appropriate. We want to balance how do we be fair to child sex abuse victims and how do we also be fair to the organizations that are providing care today? They're completely different organizations today than they were 40 years ago, which is where we're seeing a lot of this. And the insurance industry already changed its approach to this. Insurers used to have occurrence based policies, and then they went to claims-made policies in order to address the lengthened statute of limitations. So, the current issue and all the other insurance risks are really not an issue for these organizations. It really is just the gap, these past child sexual abuse claims. Every state has a different statute of limitations. Many have probably done what Washington did and lifted it. But our goal is to provide a set of recommendations that individual states can look at and pick and choose what works best for them in their situation.

Cmsr. Mulready stated that just to add a little color to that too, something that you all addressed I know fairly recently is third party litigation funding by private equity. We have addressed it in Oklahoma. We passed legislation addressing disclosure of funding from private entities and adversarial nations. But the next big hurdle in that space is addressing the tax issue. And so something for you all to be thinking about is at the federal level, there was a bill addressing the tax issues within third party litigation funding.

UPDATE ON NAIC PROPERTY & CASUALTY INSURANCE MARKET INTELLIGENCE DATA CALL

Rep. Jordan stated that next, I understand that NAIC recently announced a data call relating to homeowners insurance. Can you provide us with some background as to what led to the data

call and what the NAIC intends to do with the data in terms of potential model laws or regulations?

Cmsr. Mulready stated that last month, the NAIC sent out that nationwide homeowners data call. This really is the second data call. The first one went out and covered up to 2022 to establish a baseline for us. We tweaked a second data call to see what would be most helpful for folks so this will now cover eight years, from 2018 to 2025. We're going to be looking at premiums, coverage, deductibles, claims and losses, mitigation discounts, cancellations, non-renewals, down to the zip code level, that will really be helpful for us in the departments of insurance to really have a much better feel of the market and what is happening there. Now, when we first were going to roll this out, I spoke with Colorado Commissioner Mike Conway, chair of the C committee, because we thought it was important that there be some sort of public facing document and data that comes out of this. As you can imagine, there's a lot of concern about proprietary information and that type thing but the decision was made to produce a separate report. The deadline to respond is June 15th. There'll be a lot of slicing and dicing after that, but then we recently formed a Homeowners Market Report Working Group to establish what will exactly that public facing documented data look like. So there will be a significant amount of information for us, and we expect to release a public report in 2027. We really want to identify availability gaps and affordability gaps and understand the rate and underwriting and claim trends and then understand mitigation and evaluate the effectiveness of mitigation and interventions. So, we have a multi-state-wide-led effort that hopefully will be help bring us some more answers and give us a good finger on the pulse of what's happening in the marketplace down to the zip code level.

Rep. Jordan asked if this relates to the data call with FIO from a couple of years ago? Cmsr. Mulready stated that yes, that was the first one we did and then this is now the second phase where we'll have the full eight years of data available to us. FIO was not involved in this.

DISCUSSION ON U.S. TREASURY MEETINGS WITH INSURANCE REGULATORS ON PRIVATE CREDIT MARKETS

Rep. Jordan stated that we understand a couple of weeks ago the US Treasury announced that it would be meeting with insurance regulators regarding the growth of private credit in the insurance marketplace. Something that certainly caught our eye in the announcement was that the Treasury has no direct regulatory authority over the insurance industry but stated that its goal is to have Treasury be a convening authority for all 50 US state insurance regulators. So, we're certainly curious if there are any concerns from the NAIC here about any type of federal encroachment. And if you would provide us with any information you could about the scheduled meetings and what the NAIC's views are on this issue and how it relates to the private credit rating provider due diligence framework, that would be great.

Cmsr. Pike stated that we do have concerns. We certainly recognize the U.S. Treasury's statutory authority to convene meetings, and we're happy to meet and we will be doing that. Soon, we anticipate at least a high level meeting with NAIC President and Virginia Commissioner Scott White and the Treasury Department. We anticipate sometime in May that there will be a broader discussion with a larger group of commissioners. I think that mostly what the secretary wants to do is convene and to discuss and to share concerns and we'll hopefully be able to help him understand what is happening in the states. This issue is not new to us. It's been an issue, but it's becoming more of an issue, as you know. Private credit has predominantly been an issue in the life insurance and annuities arenas, but it's getting into other lines and we believe it has its place and we'll communicate that. But there are also a lot of

concerns and we want to try to get up-to-speed. And as Cmsr. Clark mentioned when it comes to AI, the same thing applies when it comes to private credit - we don't want to have it be the tail wagging the dog. We'd like to try to get ahead of it a bit and be able to properly regulate insurers and exposure to these emerging kinds of investment and private credit markets. Some of the concerns are limited transparency and pricing clarity and less liquidity and being harder to sell, especially in a market downturn. Complex structures may mask risk. Also, affiliated investments where interdependence of pricing and risk assessment may be less clear is a concern. Another concern is oversight of valuation. It's hard kind of by definition to value these kinds of assets. But capital rules are keeping up, and we need to make sure they are keeping up with market growth. We also don't know how yet these assets will perform through a full credit cycle which remains largely untested and the current scale that that we're seeing is concerning. We're proactively monitoring exposures through NAIC analysis and coordinated state oversight, including work being done by the Capital Markets Bureau and Macro Prudential Working Group within the NAIC. We're beginning at the end of this year financial filings to require insurers to disclose more granular reporting on private credit holdings, including valuation details, classifications, and their use of private ratings. Regulators will use this data to identify concentrations and emerging risks and engage directly with insurers when warranted.

We do believe private credit can play a legitimate role in insurance portfolios when properly managed and we are focused as regulators on ensuring that transparency, valuation discipline and capital requirements keep pace with market innovation so it's not the tail wagging the dog. And the priority remains to protect policyholders and maintain insurer solvency with regulators actively supervising these risks through coordinated state-based oversight. And I can speak with a little bit of experience on this in the last few years. It is extremely complex and it's difficult sometimes to convince some insurers about how important it is. We wish to recognize market trends, but we also again, have to always make sure insurance carriers remain solvent and that we protect ultimately the policyholder. And while we should have the same goal in mind and insurers always say they do, ultimately we are tasked with liquidity and we need to make sure solvency is preserved in the event of a downturn. Like I said, new assets types are not fully tested, and we just don't want to have a disaster because of not truly understanding complex valuations because. And in this case, it's just very difficult. And so I think all those things are things we will communicate that we're on top of and monitoring very closely.

Cmsr. Clark stated that from the financial solvency perspective, states have long had investment language in our statutes prohibiting things like junk bond purchases and there's limitations on various categories of investments. As Cmsr. Pike said, we did that for a reason. We want to protect the assets of that company so that claims can be paid. And with this issue, it is fast-moving. Sometimes they cannot explain the investment to us, and that makes us nervous so it's going to have heightened scrutiny. And I can promise you we'll be on top of it because I know the financial analysts in my department and I use the expression, "they scrub things with a wire brush". So I feel like all of the departments are going to be looking at this very closely and asking for information that will be forthcoming.

Cmsr. Mulready stated that I'd just like to take a minute to acknowledge the work that NCOIL did with us as we were trying to move forward in the not so distant past on private credit ratings and how we might challenge those when we see a large differentiation. And there was a lot of work done and we got a lot of feedback from you. It culminated in leadership from NCOIL and NAIC visiting the Securities Valuation Office (SVO) to see exactly what was happening. I wanted to applaud your efforts on that because I think, ultimately, we came out with a better product because of that.

Rep. Jordan asked if the NAIC is concerned with the increased growth of private credit in the insurance marketplace? Cmsr. Pike stated yes. I can answer for myself with some of my own experience. We would typically look and hope for a pretty low percentage of assets being in these kinds of investments of at total of 15%, or maybe 20%. But we're starting to see some insurers with much more than that. I was reading an article saying some insurer investment concentrations were reaching 50% or 60%, and that is greatly concerning. I won't speak for my fellow commissioners, but that concerns me at that point because there is so much at risk there, so much unknown. And again, in my experience, the difficulty is placing a valuation on those assets, and we don't really know quite what we have. And while I am not an investment expert, I do have some investment experts in my department and it makes them nervous and if it makes them nervous, I'm nervous.

Cmsr. Kuderer stated that we definitely have concerns in Washington, and we're also concerned with some of the rating agencies that might be inflating the value of these investments and that's also an issue that we're monitoring very closely.

Rep. Meskers stated that you're having trouble valuing private credit probably because it is private credit and it has no public market. And I think that maybe the easiest application is an overall limit on private equity and fixed income. They will then gravitate towards equity presumably because it's a potential higher return and a loss. But the idea that we're putting fixed income into credit that we can't figure out if it's got a liquidation value. You're going to face two risks, insolvency or simple illiquidity. And the claims on the system could be catastrophic. It's really a cap on the overall non-public markets and the reason this stuff is created in the non-public market is because there is no transparency and I won't say the word investment public benefit manager too often, but when I can't figure out the diagram of a cash flow, it's because maybe there is no cash flow, and that's the problem. Cmsr. Pike stated I agree. That is the biggest problem - illiquidity. And again, in a potential downturn market. And to quote one of my former insurance commissioner friends, "insurance companies need to be a solvent every day. Not just the good days." Cmsr. Mulready reiterated that in year-end filings at the end of this yea, we will begin receiving from insurers granular data on the credit holdings and their valuation detail.

UPDATE ON RENEWAL OF TERRORISM RISK INSURANCE ACT (TRIA)

Rep. Jordan noted that the committee was out of time and couldn't discuss the last scheduled topic, the renewal TRIA. Cmsr. Mulready stated that the NAIC is in favor of a renewal of TRIA. Cmsr. Pike stated that we hope it can be renewed long term like for a minimum of seven years so that it doesn't disrupt the market.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Lehman and seconded by Sen. Theis, the Committee adjourned at 3:00 p.m.

HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
2026 NCOIL SPRING MEETING – LOUISVILLE, KENTUCKY
APRIL 17, 2026
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee met at the Hyatt Regency Hotel in Louisville, KY on Friday, April 17, 2026 at 11:00 a.m.

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

Other members of the Committee present were:

Rep. Stephen Meskers, CT
Rep. Brett Barker, IA
Rep. Peggy Mayfield, IN
Rep. Adrielle Camuel, KY
Rep. Deanna Gordon, KY
Sen. Beverly Gossage, KS
Sen. Jason Howell, KY
Rep. Edmond Jordan, LA
Rep. David LeBoeuf, MA
Rep. Brenda Carter, MI
Sen. Mark Huizenga, MI
Rep. Mike McFall, MI
Sen. Lana Theis, MI
Sen. Paul Utke, MN
Sen. Tim McGough, NH
Sen. Jeff Barta, ND
Sen. Jerry Klein, ND
Asm. Jarett Gandolfo, NY
Asw. Pamela Hunter, NY
Rep. Tim Barhorst, OH
Rep. Meredith Craig, OH
Rep. Brian Lampton, OH
Sen. George Lang, OH
Rep. Ellyn Hefner, OK
Rep. Gregory Scott, PA
Rep. Tom Oliverson, M.D. TX
Rep. Calvin Callahan, WI
Sen. Mary Felzkowski, WI
Rep. Barbara Dittrich, WI
Del. Walter K. Hall, WV

Other legislators present were:

Sen. Jesse Bjorkman, AK
Sen. Robert Yundt, AK
Rep. Justin Wilmeth, AZ
Rep. Wendy Dant Chesser, IN
Rep. Michael Meredith, KY
Rep. Mike Clines, KY
Rep. Shaun Mena, LA
Rep. Yusuf Hakeem, TN
Rep. Mike Rogers, MD
Sen. Alonzo Washington, MD
Sen. Keri Heintzman, MN
Sen. Bill Gannon, NH
Rep. Julie Miles, NH
Sen. Kristin Roers, ND
Rep. Kellie Deeter, OH
Rep. Derrick Hall, OH
Rep. Emily Gise, OK
Rep. Christopher Kannady, OK
Sen. Mark Mann, OK
Rep. Mark Tedford, OK
Rep. Perry Warren, PA
Rep. Matt Morgan, TX
Sen. Jamie Wall, 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. Matthew Gambill (GA) and seconded by Sen. Beverly Gossage (KS), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Sen. Gossage and seconded by Rep. Tom Oliverson, M.D. (TX), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's November 13, 2025 meeting.

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. Pollock stated first up in our agenda, is an introduction and discussion of the NCOIL Model Act Ensuring Access to Eye Care Services and Materials for Patients Through Transparent and Fair Business Practices by Vision Benefit Plans (model). I look forward to the committee learning more about these issues. We had a really good introduction and educational session on this at the Annual meeting in November. I'll note recognize the model's sponsor, Rep. Deanna Gordon (KY).

Rep. Gordon stated that I'm very proud to sponsor this model, which you can view on the website, app, and in your binders on page 23. I would also like to thank Sen. Justin Boyd (AR) for carrying this torch in my absence at the last meeting. My main goal in bringing this model forward is to address concerns regarding vertical integration and preserving the doctor-patient relationship. This model is patient-driven and is meant to improve transparency, fairness, and competition for our constituents. And it's important to note that this Model is not a one-off type of situation. There has been a trend across the country the past several years in terms of states passing laws like this one that you see before you today. In fact, many of the model's provisions come from those state laws. I am passionate about this proposed model, because I face these same issues in my private practice every day where I work as an audiologist. These what I call third party or vertical integration plans essentially turn doctors into contractors. They control all aspects of patient care from scheduling, examining, selecting, ordering, manufacturing, delivering and servicing, while I am the one that's paying staff, rent and overhead to essentially be the face of their plan. I look forward to the discussion today, and hopefully we can have something ready to

finalize at a future meeting. I hope to earn your vote on this important matter facing our patients and our constituents.

David Parker, O.D. of the Mississippi Optometric Association thanked the Committee for the opportunity to speak and stated that I have practiced as an optometrist in Mississippi for over 30 years. I picked optometry because I had a family member who is an optometrist who loved his patients, and I decided to follow in his footsteps. In addition to my clinical work, I've held numerous leadership positions within my profession, both at the state and national level and my passion has always been caring for and protecting the patients and the people in my community. This passion led me to run for the Mississippi State Senate in 2013. I was fortunate enough to be elected at that time and served until January of this year when I retired. During that service, I chaired the veteran and military affairs committee, the economic development committee, and the accountability, efficiency and transparency committee. That experience has allowed me to analyze issues both from a doctor perspective and from your perspective as policymakers. And over time, I've learned to recognize patterns and try to prevent history from repeating itself. The problem that we are facing right now as optometrists is that vision benefit managers or administrators are increasingly consolidating their power and oversight over the profession of optometry. They're acting simultaneously as insurer, retailer, supplier, practice owner and marketer. And that level of vertical integration creates clear conflicts of interest, in my opinion to the detriment of patients.

I want to give you a real-world example of one of those, as certain plans sometimes have provisions that you agree upon and that you sign up to when you select to be a participant doctor on the plan. But this year, for example, one of the vision plans that we accept in my practice has mailed us five different new subgroups within that, that have totally different provisions from what the one that we signed up had. Our plans mainly allow us to do what we call in-office finishing. In-office finishing means that if a young child comes in and has never worn glasses and has a very high need for glasses, we then on that day can cut lenses for the child, provide them with the glasses and let them leave the office that day with the product. Some of the new plans that I've seen pop up this year will not allow us to do in-office finishing at all. And it's not a term that something in our practice has agreed to, it's just been something that's been added on by vision plans. The problem is that we can't opt out of new imposed terms because to opt out would jeopardize our ability to remain with the parent plan which covers a number of the patients in the office. I don't see that as negotiation. I see that more as a coercive type of tactic. Your doctor should be able to choose the best lab or supplier based on what is best for the patient. Certain restrictions interfere with clinical judgment and limit patient-centered care. To give a historical parallel for myself, I've worked very diligently over the last 13 years on pharmacy benefit manager (PBM) legislation as both author and co-author of certain issues that have come up in our state. I think this issue very closely mirrors what we're dealing with in the PBM world, which I know you're all familiar with.

In my location about 20 years ago, I had a large pharmacy in the area come to me. We had just built a new building. They asked to buy my building and I said, "It's not for sale." They said, "Everything's for sale." I didn't sell it to them but they said, "This is the location we've determined that we need to be in." And I didn't sell to them so they bought the bank

next door, built a pharmacy there, and then about four years ago they closed it and moved out and it was an empty building for about three years because what they did was they got in, they created what they needed, and then unfortunately, they left the community. They are not sponsors of sports teams in the community and not supporting community activities that we do as a practice. And it's a loss to the community. I don't want to see us make that mistake again in vision care because I think the PBM situation has gotten into a situation of desperation for pharmacists. So, the purpose of this Model is it creates clear definitions and applies consistent standards across all entities involved. It strengthens transparency through disclosure and oversight. It ensures fair reimbursement so that providers are not forced to deliver care at a loss. It prohibits coercive practices like steering and manipulation. It protects provider independence, ensuring that clinical decisions remain with the doctor, and it provides meaningful enforcement so that these protections actually matter. In short, it creates a fair, transparent framework that protects patients, supports providers and ensures accountability. This model draws clear lines. Patients come first, not profits. It restores trust, transparency, and balance to a system that has tilted too far towards corporate interests. That was my goal as chairman to promote accountability, efficiency and transparency in my past work in the Senate, and it continues to be what I strive for, and why I'm here today.

Matt Burchett, O.D. of the Kentucky Optometric Association thanked the Committee for the opportunity to speak and stated that I have been a practicing optometrist here in Kentucky for 24 years and this Model speaks to the care that we give to our patients. As we're all aware, there's a growing and significant concern regarding the practices of the vision benefit managers (VBMs). The concerns are evident in how they structure their benefits for employers, as well in their lack of transparency regarding covered lives and the true scope of benefits that they provide to these lives. Additionally, their practices directly impact the doctors who deliver the care and the materials to the patients covered under these plans. Currently, there are numerous VBM's operating in the marketplace, collectively covering approximately two-thirds of Americans with vision benefits. Of those, the two largest VBMs control over 80% of the covered lives. In many communities, this creates a disproportional level of market control, limiting competition and effectively reducing provider autonomy. When multiple employers in a region rely on the same VBM, local providers often have little leverage to advocate for appropriate patient care, being forced instead to adhere to restrictions dictated by these entities.

The dynamic results in a de facto monopoly, eliminating meaningful negotiation and restricting both clinical decision-making and patient choice. A major contributing factor is the vertical integrated business model employed by the VBM's. Over time, these organizations have used substantial profits to acquire, not only competitors, but also eyeglass frame manufacturers, lens producers and optical laboratories. As a result, the coverage is often limited to products manufactured within their own corporate structure. Even when those products may not meet a patient's specific clinical needs. In many cases, providers are also required to utilize the VBM-owned laboratories, further reducing oversight and quality control. This consolidation ultimately restricts providers' ability to deliver optimal patient care. My own practice has been directly impacted by these practices. We were forced to make some difficult decisions in the last few years to discontinue participation with certain VBM plans due to several ongoing concerns, thus

leaving some of our patients without the care they need. Some of these things were the limited coverage options. Patients frequently express frustration with the narrow selection of materials covered and the inability to access alternatives better suited to their needs. Before a patient was covered by VBMs, we had the choice of using any lab that will provide the materials that the patient needs. Costs were kept low through competition. But when patients are covered by a VBM, the vertical integration imposed have doesn't always allow patients to get the materials they need, and the cost is now fixed by the VBM for their own materials.

Quality concerns. We experienced repeated issues with eyewear quality from VBM-owned laboratories, including frequent remakes from lab error, and extended turnaround times for four-to-six weeks and more. That's not acceptable for good quality patient care and there is also inadequate reimbursement. Reimbursement for comprehensive eye exams have often failed to cover even half of the costs of the doctor that provides the eye care. As we all know, as business owners, there's a cost to doing business and there is a baseline cost to keeping the lights on. And most plans that we see in our area will reimburse $40 to $60, while the cost of in my office to see a patient is at least $110. So, we're making about half of what it costs to actually see the patient before any profits are realized on our end. And reimbursement has not changed in the 24 years that I've been in practice and that has most certainly hurt our ability to continue to provide the quality care that patients need, and ability to hire and retain good staff members by paying them what they deserve. Our challenges are not isolated. They reflect systemic issues within the VBM model. VBMs are multimillion dollar corporations which continue to expand through acquisition, yet these profits are not reinvested in the patient care or provider support. Instead, they're used to consolidate market control, reduce competition and limit both provider and patient choice. While VBMs will claim a willingness to collaborate with states and providers, the reality suggests otherwise. As an example, if meaningful reform were occurring voluntarily, we would not see multiple states pursuing and passing this legislation to address these concerns.

And furthermore, states like Illinois, who in 2023 passed a compromise bill with vision benefit administrators, have already found it necessary to revisit and revise prior agreements due to the language not being abided by VBMs. Another common argument they have is that legislation will increase costs for employers and patients. However, evidence from other states that have passed this legislation suggest otherwise. Ongoing investigations by the U.S. Congress, the Federal Trade Commission (FTC), the Department of Justice (DOJ) and the Government Accountability Office (GAO) indicate that the rising plan costs are not associated with increased patient value. It is important to recognize that premiums are determined by the VBM's themselves. They are engaged in a competitive race to secure covered lives, often at the expense of quality and sustainability. Any increase in premiums is a corporate pricing decision, not a direct consequence of this legislation. Ultimately, the system places the burden on employers, patients and providers alike. This legislation speaks to correct these imbalances by ensuring transparency in coverage, access for patients to needed services and materials and establishing a fair reimbursement for providers providing the care. These are the fundamental requirements for maintaining access, quality, and integrity within the vision care system.

Julian Roberts, Executive Director for the National Association of Vision Care Plans (NAVCP), thanked the Committee for the opportunity to speak and stated that NAVCP membership consists of 14 managed vision care organizations across the country who provide vision insurance to over 220 million Americans and they do this in partnership with over 100 carriers, both national and regional across the country. If you're not familiar with vision insurance, it tends to be a voluntary benefit which means that consumers and employees can make the choice themselves as to whether vision benefits are important and valuable to them. If you're like me, and I see a few of you in the room happen to wear lenses and require correction, it is a very valuable benefit because I will need this for the rest of my life, and I want to be able to manage my out-of-pocket cost as I continue through this. So, as we look at the model that is before you today, it is not a consensus model from that perspective. Where it does borrow a few concepts from various states, the model goes much further and would fundamentally change the way vision care plans contract with providers. It would impose a sweeping framework that has not been totally or broadly tested in the marketplace and there's no documented consumer harm that justifies this level of intervention. For those reasons, we believe that this is a radical departure from collaborative policymaking and we'll dive a little bit further in some of the provisions.

JP Wieske, on behalf of NAVCP, stated the idea this is consumer bill is just not correct. For example, if you look at section 4(F) and 4(G), which allow providers to charge a higher rate to insured consumers. They're not required under contract to include a usual and customary rate. There are provisions in here that intend to control steerage, and I understand their concerns. But there are provisions here that require the insurers to hide lower-cost providers in their provider networks from consumers. That is not a pro-consumer bill. In addition, some of this language is functionally unclear. So maybe we're misinterpreting it, but it is certainly imprecise in the way I'm used to dealing with insurance code language. When we look at the pricing, it's interesting to look at the definitions such as the definition of "nominal". I was always told nominal is a small amount. Wisconsin statutes allow you to take a nominal item in certain cases subject to ethics laws. This is not nominal. This would open up those numbers. The Model nominal charge includes provider cost plus including profit. And so, we're looking at something that creates a provider price floor across the market which will lead to significantly less provider price competition. It requires, in fact, that every single provider has to be accepted inside a network at their rate. So, this is a problematic approach. This means that consumer costs are going to go up.

And it doesn't just mean that the insurance costs are going to go up. It means that when you're looking at co-pays, deductibles and other pieces that consumers are going to be paying more for their services and that's a concern. And then we take a look at consumer choice and maybe the language is imprecise but it doesn't just allow the providers to choose which insurer they want to operate and it's not even some of the sub insurers, they're allowed to pick plan by plan, based on the imprecise language in this model. So, in other words, two employees who purchased two different plans from the same employer may have an entirely different network of providers. This creates huge problems from the standpoint of administration and from predictability and their ability to be able to to operate.

In addition, these price floors will result in less competition in the market further creating the problems that they're intending to fix with this legislation.

And as a former regulator, I have strong concerns with this idea that you can have three layers of oversight over vision plans. This approach is untried across the country and it's untried in insurance generally. And so, you would be allowed under this legislation to have both an insurance regulator, which is perfectly appropriate, to regulate these plans. Then also Attorney General oversight which creates a competing effort and allows a $10,000 potential profit making lawsuit which is unprecedented. And as a former regulator, it also creates a large problem for you to have consistent regulation of the plans because now you're subject lawsuit to lawsuit, and judge to judge, to figure out what in fact the law means structurally. So, there's strong concerns from from that section as well. There's also significant statutory micromanagement of the plans. The 90-day timeframe is a problem. We understand that they've got offices, and they've got timeframes. We don't have any concerns with creating a more reasonable timeframe for them to be able to review. And again, when you look at reimbursement floors, fee schedules, and the lack of differentiation between plans, this creates a significant issue in the market. And as Mr. Roberts emphasized, this is insurance that is voluntary. So, it's a limited benefit that's offered to employees. They voluntarily pick it and in a number of cases or individuals purchase it separately. So, the cost and value is a significant issue.

Mr. Roberts stated that consumers and employers expect affordability and access when it comes to their vision care and vision insurance. This model ultimately harms the people that it claims to help with mandated cost increases that will drive up premiums pushing employers to scale back their coverage, cut access to preventative eye care, restrict plan operations, and force carriers potentially out of the market, which will be limiting the choice that employers and consumers have in the market. And when participation becomes economically unattractive, price-sensitive consumers are not going to get a better deal. They'll simply lose access. So, in closing, access to vision care is a critical health care need. I think we all agree to that. Employers and employees overwhelmingly see value in vision care insurance. In fact, if you check with your departments of insurance, you'll see that there are very few, if any, complaints from consumers in regards to their vision benefits. Vision insurance definitely saves out-of-pocket costs for consumers and vision care premiums have remained somewhat constant and consistent, slightly increasing, but nowhere close to what you've seen in regards to medical care. We as an organization are definitely supportive of collaborative legislation as long as it preserves access and choice and quality for the consumer and also allows for free market solutions.

Asw. Pam Hunter (NY), NCOIL Immediate Past President, stated that Dr. Parker mentioned what the model includes, and some of those are clear definitions and transparency provisions and it prohibits coercive practices. As I read through this Model, it seems pretty comprehensive but then I'm hearing conversation of price wars so specifically, does this model dictate the terms and conditions of the contract? Because if you look in section four, covered and non-covered services and material provisions, there seems to be some flexibility in pricing. Relative to pricing, there shall be no limitation on the ability of an individual eye care provider or a group of eye care providers who practice to have conversations relative to fees. And this is just one example. So I'm just trying to

get to an understanding of does the model dictate terms and conditions of the contract? Because it seems like you should be able to get to the middle based on both sides of what you all are talking about on the panel. Can anyone answer that question? Dr. Burchett stated that the language in there speaks to that criteria, but it also still allows for negotiations between the provider and the VBM.

Dr. Parker stated that the model does not dictate terms. As a practitioner, I think everyone should have the right to look at a contract and accept it or not accept it. But I have some contracts that I've signed up for maybe 15-to-20 years ago, and I don't know that I've gotten any correspondence back in many years on them. It would be good to receive an update on what changes may have occurred other than a new program that came along. But this is not about setting prices. This is not about the expense. It's about transparency and practitioners protecting their patients and their practices so that we don't become contractors and our patients don't just become consumers. My biggest fear is that everyone is a consumer and then you miss the patient aspect. There are patients that I treat and then diagnose for glaucoma, diabetic retinopathy and retinal detachments that are then treated with lasers that I do and all the other procedures. Detecting and treating ocular disease that are detected during the comprehensive exam is important. I'm going to keep seeing my patients whether you pass this legislation or not. But I don't want to see practices in the future close because they weren't able to remain the small town kind of eye care providers, and they were swallowed up by the bigger fish in the end.

Mr. Wieske stated first, read the bill and look at the definition of "nominal" and look at the requirement that you have the same payment rate that goes to other providers. We had a similar bill in Wisconsin when I was a regulator, and so we were looking at how to operationalize that. It would have required significant reporting across the state and the model does in fact set those and the definition of nominal is in there. It sets a floor. And we fully agree that a contract should be both sides. The Model turns this discussion into a one-sided contracting effort. We disagree with their sort of characterization that this is a two-sided contract. It now becomes a one-sided contract. I understand what their concerns are and we've got legislation that as a group we've supported in other states around this. But this one turns it the other way.

Mr. Roberts stated that I will also add that I have 14 vision care plans that are members of our organization. I can also tell you that all 14 have different business models in that regard. All of their contracts are somewhat different. With the structuring of this legislation, this would basically make all of these plans basically look alike in regards to their contracting with providers and that is at the time that you create a situation I talked briefly about potentially some players getting out of the marketplace. Once you all look alike and you all start commoditizing the product at this point in time, the strongest survives, the weaker ones tend to not. And so I think that also creates an issue of having new, smaller, up-and-coming organizations grow within our industry.

Sen. Mary Felzkowski (WI), Vice Chair of the Committee, stated that I'm going to direct this towards Mr. Roberts and Mr. Wieske. These are limited benefit plans. I always struggle calling these insurance, but that's what we decided to do a long time ago. So, let's say you have a $1,500 cap, and then you're going to have caps inside. So you painted a pretty

harsh picture that this is going to drive up costs and drive up co-pays but if I have a $1,500 cap and that's all you're ever going to pay out, I need you to elaborate on that a little bit more. How are you totally harming employers and constituents and people inside of these plans that actually took them?

Mr. Roberts stated that I don't know that there's necessarily a $1,500 cap. In vision, there's two aspects to the benefit. There is the coverage for the exam, and then there is an allocation toward your first set of frames and lenses. As it relates to the exam, there is a fee schedule in place. And when we're talking about premiums for vision on an individual basis, you could be looking anywhere between $7 and $12 a month so the premiums that exist there are not that high. If you increase potentially the fees that are being paid by the plan for the eye care exam significantly, there will have to be increases in premiums. Someone that may not utilize their benefits on a regular basis will potentially decide, well is it worth it? Do I want to pay that added premium when I only go to the optometrist every two years? In fact, I was having lunch today and somebody says, "I buy vision insurance every other year because I'm not going to go every year to an optometrist." It's a heavily selected benefit to where you're not going to buy it unless you're going to utilize it in that regard. So, that's why there are some very underwriting sensitive numbers that we have to look at in that regard from a vision care plan perspective.

Mr. Wieske stated that maybe the language is imprecise because the word "health plan" and "plan" is used interchangeably throughout the model but it does appear that there is specific approval by the optometrists of what specific plan they're willing to participate in inside a specific insurance company based on the language. That creates an issue where maybe they only want to operate in those. And then when you set floors and you set other requirements, it ends up being more expensive for the consumer, either premium wise or from their out of pocket so that's sort of where the concern lands.

Rep. Adrielle Camuel (KY) stated just for clarification, I'm hearing the words "patient" and "consumer" used differently in this discussion. Could someone clarify what the difference is between the two? Rep. Gordon stated that as an audiologist I think the word "patient" infers relationship, and "consumer" is more transactional. We are here to preserve the patient-doctor relationship. Dr. Parker stated I think that's where a lot of the confusion lies here. To have an example of where I'm going to just use my vision insurance every other year, that's a patient who doesn't understand what an eye exam is about. That's someone who thinks they're going to get just a pair of glasses and not an exam and in our practice we've detected so many things early, everything from brain tumors, to chronic disease to dry eye just because a patient comes in annually. Patients become your family. Consumers are just looking for a price.

Rep. Stephen Meskers (CT) stated that I think this highlights why NCOIL and what we do is so important. I think what we're framing here is a conversation about two things - about quality of care and level of care and cost of care, and a community issue that we're facing in all of our committees and across each of our states. We've got Amazon who does everything remotely. We've got Tesla who sends all of their profits to the great state of Texas or California. So, we've got a business model where we have local providers with potentially an increased cost, but providing cost and care with local offices and paying

taxes locally, not part of a chain. And I'm not attacking the chain model. I think when we ask about the issue, it's a model of where we want to go in each community. In reference, in Connecticut we have a liquor law where the supermarket can't sell liquor. So Connecticut has what they call a package store that sells alcohol. The package store are managed and owned individually or in small groups, but the profits stay in the local community. They invest in the little leagues, they pay to the community. The same thing with our car dealerships versus a Tesla model. I think there are two pieces here: it's a quality of care, the consistency of care and the business model. I'm not sure where I fall on this, because my glasses are from Amazon and they are readers but I think the question becomes, what do we do about the model and what potential changes are because I think the Model does address a concern that we're x-ing out the individual providers over time. And I think it has to be acknowledged that if we don't provide some steps, the local optometrist will disappear and that's a question on policy that may not fit with insurance, but as I sit as Chair of the Commerce Committee in Connecticut, it sits with me there too. If you could both comment about the model and what it means to both of you. I understand there's a cost issue, But I would challenge you on whether we're getting the best competitive model if we aggregate all the business into larger providers.

Mr. Wieske stated that I would just say that from a model standpoint, this is not that. This turns it into something different. And there are consensus things but this is not a consensus model. If you ask ChatGPT or Claude, they will tell you less than one third of this specific model has even been looked at across the across the country. And the model is pulling from the American Optometric Association (AOA) website. And there are things that are consensus that can protect local aspects and we would be happy to work on a consensus.

Asm. Jarett Gandolfo (NY) stated to Dr. Parker that in your testimony you had mentioned coercion and coercive practices. What exactly do you mean by that? Can you expand a little bit? Dr. Parker stated that there's so much integration now where if a company owns the practice management software and they own the practice and own the lab and own the frame suppliers, they have the ability to, while the patient is scheduling an appointment to recommend certain things be done. One of my colleagues mentioned that she had a patient while she was in the exam room that got a text from her vision insurance that said, "At the end of your exam, go to such and such business, and get your contact lenses." That is a direction that has turned patients into consumers and is what I think is the danger to our smaller towns. I'll give this example. We had a terrible ice storm this winter, and we closed office for a week. I had a patient who lives about a half a mile from me, whose son accidentally shot her in the eye with a Nerf gun. So my son, who's also studying to be an optometrist, we got on our coats and we walked across the snow and ice to the house and we saw that young lady in her home. And that's what we do as optometrists. We go to the homes; we take care of the people. And if we lose that, much like I've seen that lost in the pharmacy world without me fighting for it, then I missed an opportunity to to express my concern.

Rep. Gordon stated that to put it in plain terms, it's self-dealing. They're referring the patient to your office and then they're dictating care. And they often own the very labs that they're telling you you have to purchase the product from. I think Sen. Felzkowski kind of

hit the nail on the head. If you have a benefit amount, I can operate within that benefit amount but don't tell me how I have to to use that benefit. That's the crux of the problem.

Rep. Pollock thanked everyone for their comments and stated that here at NCOIL, I'm proud that what we do here is to create and make a good model for us legislators to take back to our states. And obviously this is the start of this situation here and I'm not sure that we've ever had any of this type of legislation, maybe bits and pieces, so this is the start of this conversation. If anyone has any questions or comments on this in advance of our next meeting, please reach out to Rep. Gordon, myself or NCOIL staff.

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

Rep. Pollock stated that next on our agenda is a continued discussion on the NCOIL Charity Medical Care and Medical Debt Reform Model Act (model). We've had great discussions on this at our previous two meetings, and it looks like we're getting closer to where this model could be voted on. The model is in your binders on page 17 and on the website and app. Before we go any further, I want to recognize the sponsor of the model, Rep. Tom Oliverson, M.D. (TX).

Rep. Oliverson thanked everybody who's reached out to me on this model. It sounds like this model has generated a lot of interest around the country. I think it's definitely timely and needed. As we mentioned back in November, this model is based on legislation that I had filed in Texas and essentially, it all began with a report that I received that we had tax-exempt hospitals and systems in our state that were sending patients, who would have been eligible for charity under the hospital's own definition of charity, to third party debt collectors and just destroying them financially, rather than taking the time to screen them for the charity that they would have undoubtedly qualified for. And so that prompted this whole discussion. So generally what the model does is it prevents hospitals from pursuing debt collections on patients until after they have verified whether a patient is eligible for charity under the guidelines that they promulgate and are compliant with the IRS tax code. And you can see that in section four of the model. I have received some very positive feedback from a variety of stakeholders. I'd like to just say that I have I have found Ascension to be a a very good working partner, and Ascension has come forward with some very good suggestions and we've tried to incorporate those that made sense to us.

I'm not going to go through every single change that we made to the model, but I do want to highlight a couple of them. We clarify that this bill does not apply to for profit hospitals since they're not claiming a tax exemption and we wanted to be clear about that. There was some discussion of whether it should apply to all hospitals, but again, only a hospital that has a tax-exempt status designation is actually supposed to be providing charity in exchange for tax benefits. Although for-profit hospitals do provide charity, and in some cases, they provide the same amount of charity as a tax exempt hospital might, they are not getting any benefit from state government or federal or local tax benefits in exchange for doing so. They're just doing that from the goodness of their heart. We did provide some pretty strong clarifications in response to conversations with the hospitals with regards to what constitutes a violation and providing the Attorney General some discretion

as to whether he or she wishes to bring an action against a hospital to revoke a tax-exempt status as opposed to mandating that they do so. We also included a section that may require some clarification and that has to do with that this is not meant to be a requirement on a hospital to essentially provide charity for cosmetic or non-elective care. Although I do think that we probably need to go back to the drawing board a little bit and define what we mean by “elective”, because essentially, I’ll give you a good example of this. A hernia may at some point be elective. However, if it remains untreated, it could become a life-threatening emergency. So, I think there is some continuum there on some of these things and I think we need to be clear about when we say “non-elective” versus “elective”, what do we actually mean by “elective”?

I’m happy to continue to work with the stakeholders to define the term “elective”. There are some unresolved questions that I am going to put to you, the committee members, that need to be resolved. So, I’m going to invite you to study this model and get back to me with your ideas. But these are the questions: should the model apply only to uninsured and self-pay patients, or should it apply to all patients? And I bring that up because as we live in the era of increasingly high deductibles and patient responsibilities, somebody may technically have coverage, but still essentially not be able to completely afford care in the event of of some type of emergency situation which they could not foresee. Should the screening process apply to non-medically necessary care? This gets back to the question I just brought up regarding elective care. I don’t think we should be considering facelifts and breast augmentations and dental restorations and various cosmetic things to be subject to charity requirements, but maybe you do and I’d love to get your feedback on that. I would ask you to look at section 4(G) with the reimbursement process and I’m just going to ask the committee to consider whether they believe that is appropriate or would it potentially encourage bad attorney behavior? The last thing I ever want to do is adopt a model that creates a new form of lawsuit abuse. And finally, should the model require hospitals to issue an annual report to state departments regarding how their charity program is being implemented. In other words, how much of a tax break are you getting? How much charity are you actually doing? What are you defining as community benefit? You may recall we talked about this in November that there was a hospital that very famously put a drinking fountain in the lobby of the hospital and said that was a community benefit and claimed that was charity. Obviously, that’s abusive, and I’m not trying to suggest that everybody does things like that but I think it’s important as state lawmakers that if we’re going to provide these exemptions and these tax breaks that we’re keeping some oversight. We don’t want this to turn into another sort of fraud event where it’s all over the news. Also, if anybody wants to be added as a co-sponsor on this model, I would be honored to have your support.

Rep. Pollock thanked Rep. Oliverson and stated that he would like to be added as a co-sponsor to the model.

Eli Rushbanks, General Counsel and Policy Director for Dollar For thanked the Committee for the opportunity to speak and stated that Dollar For is a nonprofit that helps patients nationwide access hospital financial assistance programs. We want these programs to be known, easy, and fair to patients. One such patient is to my right, Katie Smith, who lives here in Kentuck and I’m going to let you hear directly from her about her experience.

Ms. Smith thanked the Committee for the opportunity to speak and stated that in August of 2024, I had surgery and it was supposed to be a relatively short-term turnaround to becoming well but it became more complicated to the point where I had to have home health services. While I was in the process of trying to heal and recover, bills were coming in and that was making me very depressed. So, I contacted the hospital to say, “do you guys have a plan?” Because I couldn’t go to work. And I asked whether they have a plan to help people that have financial difficulties? And they said “yes” and I was given paperwork to fill out. And I kept calling to see if any decision had been made and nobody ever said they lost my application, but he just kept saying that I need to fill out another application. And then I had a case manager who contacted me and I was just talking about how I’m frustrated with all these bills that are coming in and she said I’m going to find a referral for you. So she did call back and referred me to Dollar for, and they contacted me and said “Fill out the paperwork and we’ll take it from here.” And I did and I think it was probably only in about a matter of two months that I got a call that it was taken care of. And I’m just so appreciative because not only was I still trying to recover, but I was not at work, and of course I had all my other bills to pay so I’m appreciative and I don’t mind sharing my experience.

Lucy Culp, VP of Government Affairs for Blood Cancer United thanked the Committee for the opportunity to speak and stated that if you’re thinking who in the world are we are, it’s a recent name change from the Leukemia Lymphoma Society. So a new name, but the same mission to help cure blood cancers and serve folks with blood cancers. So, just as a refresher, blood cancers are extraordinarily complicated to treat and extraordinarily expensive to treat. In the first year, on average, for a leukemia patient it costs about $500,000. So it’s not shocking that about 42% of cancer patients report exhausting their entire life savings within two years of a diagnosis. And what happens then? They begin to accumulate medical debt. And I will say, Katie’s experience and struggle plus the time it takes, and the process, we hear that a lot. And that’s for the folks who even know to ask because many don’t. And so many patients never get financially screened or don’t get screened until well after the fact when they have a mountain of bills that they can’t pay, and they call an organization like ours and we go through the process of applying for financial assistance. All of that is to say we’re we’re really pleased to support the model. We would support it as written. I will try to off-the-cuff answer some of those questions that you posed Rep. Oliverson because I think you’re asking really great questions about how the model can be strengthened. We did some polling with some partners at the American Cancer Society, and Undue Medical Debt, and I think you probably all know that reforms in this area are extremely popular. When we polled on financial assistance screening in particular, we saw really overwhelming support across party lines, over 85% support from voters across the country.

So, just a couple of thoughts that I think could help strengthen the model as it exists or maybe worth considering for drafting notes. As you know, different states have different needs and some things may be more applicable than in other places. I will say that the terms “charity care” and “financial assistance” do get used somewhat interchangeably and you may want to consider the term “financial assistance” in part because that is the term that the IRS uses. It’s also a little bit more understood by patients to be assistance that

they are eligible for versus the term charity can sometimes come with a sense of shame or stigma in having to ask for charity when in fact this is financial assistance people are eligible for and they should know about and they should be screened for it. I think the other thoughts we had of hinge on the idea that for the most part, patients don't have a lot of choice in where they're treated. If the hospital that is closest to them has the service that they need, whether it's a for-profit or a non-profit, if it's in their state versus out of their state, if it's a state facility versus not a state facility, they don't have a lot of options. They're going to the place that can serve them closest to their home for the most part. So, we just offer that as you think about whether this should apply to all hospitals. Certainly, for-profit hospitals don't have to, but they can and many do. There is a study out of Harvard and the Lown Institute Hospital Index found there really isn't a significant difference in charity care spending as a share of expenses between non-profits and for-profit hospitals. So I think that's something to consider, if not for the model, then as you think about adopting this model in your states. Also, the model only applies to residents of the state where the hospital sits. And particularly in rural communities, people do have to go across state lines to get care. So, you may want to consider who is eligible and who should be screened in that section. We would really encourage you to have this apply to all patients. At my organization, with our medical debt case management program, about 95% are insured so it's very much a problem for folks who do have insurance.

Joe Burchfield, National Director of State Policy for Ascension, thanked the Committee for the opportunity to speak and stated that I also want to express our sincere appreciation for Rep. Oliverson and his work on this issue and his willingness to work with us and other hospital stakeholders on the model. We're a Catholic health system with a mission to deliver compassionate, personalized care to all with a special focus on the vulnerable. Our network spans 15 states and the District of Columbia with approximately 97,000 associates, more than 23,000 aligned providers, and 91 wholly owned or consolidated hospitals. We also operate 26 senior living facilities and a variety of other care sites, offering a wide range of services. Consistent with our mission, we approach financial assistance and charity care with a unique perspective and significant experience. In fiscal year 2025, Ascension provided $1.7 billion in care to persons living in poverty and other community benefit programs. That's in addition to $1.8 billion in unreimbursed Medicare costs across our system. This level of patient support is guided by our compassionate, patient-centered financial assistance billing and collections policies which I'd like to share with you today. Patients with incomes less than or equal to 250% of the federal poverty level, which for reference is about $39,000 for an individual and about $80,000 a year for a family of four are eligible for 100% charity care. So, if you fall within that range your debt is completely resolved. Patients with incomes above that and below 400% receive a sliding scale discount based on the patient's portion of the charges between 95% and 85%. And for reference, 400% of the federal poverty level is going to be about $62,000 a year for an individual, $129,000 for a family of four.

Patients who have incomes greater than 400% of the federal poverty level may also be eligible for financial assistance, echoing some of what we've heard earlier due to excessive total medical debt. When that can be proven to be greater than the household's gross income, the 400% sliding scale would apply for that patient. And we would define that medical debt to be inclusive of anything owed to Ascension and other providers. So it

is comprehensive, not just what's on the books with us. In addition to that, all patients regardless of their eligibility for medical assistance are eligible for zero interest payment plans. To inform patients of this very important policy, all of our billing statements on the front page include a callout box with notice of our financial assistance policy. We provide a link, a phone number and a QR code so patients can access that information and begin the process. Moreover, in close alignment with the model, we perform presumptive financial assistance eligibility screenings for uninsured patients. Between the first and second billing cycle, we work with a third-party vendor to use publicly available data based on patient demographics and information to determine their likelihood of eligibility for our financial assistance program. For patients who qualify, assistance is provided automatically in accordance with the categories I've just discussed. From a billing and collections standpoint, our policy is not to report medical debt to credit bureaus or to use extraordinary collection actions, except in extreme circumstances. An extreme circumstance would apply to an unpaid balance for elective, non-emergency, non-medically necessary care where a patient has been determined to have substantial resources and refused to pay the amount due. We do not pursue extraordinary collection actions for any account that has qualified for financial assistance.

We recognize the impact of medical debt on patients, whether that's due to being uninsured or as a result of health coverage that carries a high out-of-pocket cost. And we strive to maintain a program that supports patients' financial stability. In terms of the Model, we support applying the presumptive screening requirement to uninsured or self-pay patients. We believe that this approach supports the most vulnerable, while our clear plain language notice on financial assistance on all of our billing statements provides additional guidance and access to assistance for all patients. And while we support the proposed screening requirement in the model, the potential for penalties associated with non-compliance does remain an area of concern. Given the scope of the model to require presumptive screening before sending a bill, the threat of removing nonprofit status when there is no adverse action taken against a patient is concerning. Hospital billing is both a manual and automated process. It's high volume where tens of thousands of bills are sent each month in a given area. And as a result, there is legitimate potential for a bill to be inadvertently sent before a presumptive screening even though no adverse action is taken against that patient. So, with that in mind, we would recommend adding language that clarifies a violation of the act only occurs when a patient is sent to collections or reported to a credit bureau without first being presumptively screened for financial eligibility. Further authorizing the Attorney General to act when there's a clear pattern of behavior by a hospital would help reduce the risk to good actors in this space. Lastly, in terms of adding state level reporting data, Rep. Oliverson was spot on that many of those points are already reported to the IRS on an annual basis and we would recommend that any state level reporting mirror those reporting requirements to minimize the administrative burden and avoid any additional administrative costs. We truly believe this model can serve to establish standards across the health system that benefit all patients.

Rep. Emily Gise (OK) stated that in section six of the model regarding credit reporting and debt collection for debt related to life saving and emergency care, it was an effort that we tried to do in Oklahoma this session, but we saw some things coming from the federal government that barred state measures from exempting medical debt. Have you

experienced any challenges with that? And how do you recommend we proceed forward? Ms. Culp stated that the Consumer Financial Protection Bureau (CFPB) issued a non-legally binding opinion that the federal Fair Credit Reporting Act preempts states from exactly this type of policy. I think there's been a lot of question about what that means, particularly for the 15 states who already have this kind of language on the books. In the comments that my organization put forward, we recommended a slightly different variation of approaching the issue and that's really to look at the contracts entered into between the provider and the debt collection agencies. That seems to be a space where there doesn't seem to be a preemption question. So it's another way to I think achieve the same goal of helping to protect folks without the potential for litigation that we're seeing pop up in a couple of states.

Mr. Rushbanks stated that I was having a conversation with the folks at the National Consumer Law Center and they were talking about this issue and they also said one strategy, sort of a belt and suspenders approach, would be to prohibit the use of medical debt from credit reports if medical debt makes its way onto them for certain sensitive screening scenarios, like tenant screenings or something like that. Prohibit that specific behavior instead or maybe in addition to the actual reporting itself, in case this preemption issue becomes a problem.

Sen. George Lang (OH) stated that this is obviously a very noble cause and I think Rep. Oliverson has put a few safeguards in there that I'm mostly comfortable with the model. My only concern though is that we are the National Council of Insurance Legislators and I just don't see how this has any direct impact on insurance markets or insurance consumers. I see some indirect impact, but making sure you brush your teeth daily or eat a healthy meal has those same indirect impacts and I just I wonder if this legislation isn't better for one of the statewide models that aren't focused on insurance. Mr. Rushbanks stated that one nexus is to basically make this model apply to insured patients. There's an accounting firm, Crowe, that does studies on who has medical debt and their most recent one that I've seen shows that almost 60% of medical debt is held by insured patients, which is up from about 11% in 2013. And the federal law that makes nonprofit hospitals have to have financial assistance policies requires that those policies apply to all patients. There isn't an exception for insured patients and so we think that it's important for this model to apply to insured patients, which would kind of be the nexus to NCOIL.

Rep. Oliverson stated that just in summary, I thought it would be helpful to throw a couple of stats at you: 15% of the families living in your districts have past due medical debt, and two-thirds of those folks are below 200% of the federal poverty level; 62% of bankruptcies in America are due to medical debt and 29% of patients nationally who qualify for charity currently get it. So, that's the delta we're working with. Now on the hospital side, we're only talking about the out-of-pocket portion of hospital revenue, which is less than 2.5% of total revenue for hospitals. Which means that if everybody who qualified for charity across the country actually got the full measure of the charity they were required to get under this tax-exempt agreement, we are only talking about 0.7% of hospital revenue. So, I just want you to have those statistics. I'm happy to keep working on this.

Rep. Pollock thanked everyone and stated that this is a timely and important issue for NCOIL to explore. There's some time between now and Boston to answer some of the questions and the comments that were mentioned today. Hopefully we can consider voting on this model in Boston, but we'll see how that goes.

DISCUSSION AND POTENTIAL CONSIDERATION OF NCOIL RESOLUTION IN SUPPORT OF PUBLIC POLICY IMPROVING MATERNAL HEALTH

Rep. Pollock stated that next on our agenda is a discussion and potential consideration of the NCOIL resolution in support of public policy improving maternal health. We did have a great discussion on this topic in November, and now we have a resolution before us. I think it's great that NCOIL is discussing such an important topic and I'll turn it over to the sponsors of this resolution, Rep. Brenda Carter (MI), NCOIL Secretary, and Rep. Greg Scott (PA).

Rep. Greg Scott (PA) stated that I am proud to co-sponsor this resolution and I appreciate the opportunity to continue the conversation that we began in November. The resolution is available on the website, the app and in your binders on page 39. Before I begin my formal remarks, let me acknowledge Rep. Perry Warren (PA) sitting next to me, Chair of the Pennsylvania House Insurance Committee. Also, in my chamber we have three dynamic, substantive women who lead the Pennsylvania Black Maternal Health Caucus, and they are the thought leaders in our chamber on this issue and have helped me extensively. I want to lift up their names. They are Rep. Morgan Cephas, Rep. Gina Curry, and Rep. La'Tasha D. Mayes, and also the Caucus's Chief of Staff Angelica Sanders. Women are dying during what should be the best days of their lives. It almost happened to my sister when healthcare professionals initially ignored her symptoms, only later to be diagnosed with preeclampsia. As a father of a daughter born eight months ago after a high-risk pregnancy, I've seen this danger up close, firsthand. National data continues to show troubling trends. More than 80% of pregnancy-related deaths are preventable and for every one of those deaths, there are roughly 70 severe maternal morbidity events, which are unexpected complications that have long-term health consequences. Maternal mortality events in the U.S. have risen over the past several decades, spiked during the pandemic, and even with recent declines remain higher than pre-pandemic levels. Access to and quality of care before, during, and after pregnancy directly affects outcomes for mothers and infants. Yet only a small share of mothers receive adequate prenatal care and conditions like hypertensive disorders remain strongly associated with severe maternal mortality or morbidity. We also know postpartum depression affects one in eight women and ensuring access to timely, evidence-based, and fast-acting treatment is essential. Insurance coverage plays a major role here, especially as rising premiums are causing some consumers to drop coverage altogether. I'm proud of the work we've done in Pennsylvania, including expanding Medicaid coverage for doulas, expanding a doula advisory board, and introducing the Pennsylvania Momnibus, which is a comprehensive legislative package crafted to directly confront the staggering rate of maternal mortality and morbidity in our Commonwealth addressing critical disparities in maternal health care, including measures that would improve access to essential services and eliminate maternal health deserts.

I'm glad that NCOIL is continuing to elevate these issues. At its core, this resolution recognizes that there are concrete, actionable steps policymakers can take to improve maternal health outcomes. We know the challenges are significant, but we also know that they are solvable. This resolution should serve as a starting point for conversations with stakeholders in your respective bodies. The resolution outlines several policy levers or buckets that should act as headers in proposed legislation and help guide those deliberative conversations. They include strengthening maternal mortality review committees (MMRCs), improving data collection, and expanding access to maternal support services. The resolution also calls for increased investments to expand doula services across Medicaid as a starting point but in your state, you could expand that to include others as well. I also want to highlight additional opportunities for states to lead, ensuring postpartum depression is identified and treated appropriately, expanding access to prenatal, inter-pregnancy, labor and postnatal care. Ensuring access to blood pressure monitors for pregnant and postpartum individuals, supporting innovative care and payment models that expand access to doula, midwives, and donor milk. Encouraging insurers to eliminate barriers to fast-acting treatments for postpartum depression. And I'll close with this, if history is precedent, we have future insurance commissioners and maybe even a Governor or two sitting in this room. Our Governor Josh Shapiro created a maternal health strategic action plan, the first of its kind from a state administration that challenges state departments, including our Department of Insurance, to cross collaborate and coordinate as they work to address maternal health from a state level. Together, the Pennsylvania Departments of Health, Human Services, and Drug and Alcohol Programs, and Insurance work to create a strategic action plan with clear work being done to address the needs of those with lived experience and those delivering care, and the steps we can take together to change the trajectory of poor maternal health outcomes and persistent disparities in Pennsylvania. So, as you can see, there are many levers that you can pull in states and this resolution reflects a thoughtful starting point that you can use to improve maternal health outcomes nationwide. I encourage the committee to support the resolution.

Rep. Carter thanked Rep. Scott for sponsoring this important resolution with her and stated that I don't have much to add to what Rep. Scott said. I'm very pleased that NCOIL is discussing this issue. I think the resolution contains valuable steps that states can consider taking to improve maternal health. Importantly, this resolution isn't serving as any type of mandate on states. Rather, it simply sets forth policy states that states can consider implementing in an overall effort to support maternal health. I do have a very minor amendment to offer and I have discussed this with Rep. Scott and it is printed out before you and it's in the online materials. On page 41 in your binders, under the section titled "Improving Data Collection and Infrastructure", language is proposed to be added to ensure that as a part of data collection efforts, definitions should aim to align with existing state and federal data collection efforts to minimize duplication. Obviously, duplication of efforts benefits no one, and that's certainly not the intent of this resolution. That's all I have, and I encourage the committee to support the resolution.

Sarah Duggan Goldstein, DrPH, MPH, Managing Director of Legislation and Regulatory Policy, Health Equity Policy, at the Blue Cross Blue Shield Association (BCBSA), thanked the committee for the opportunity to speak and stated that we are so grateful to Rep. Scott

and Rep. Carter and to the committee for consideration of this resolution. Maternal health is really not just a medical issue. It's a reflection of how well our systems function, how effectively our policies respond to real needs and how committed we are to protecting the well-being of women and infants. States play a critical role in this work. They shape the policies that determine access to care, quality of services, and the strength of the public health infrastructure that supports families before, during and after pregnancy. This is why strong, reliable data matters. States rely on accurate information to understand where gaps exist and how to close them. MMRCs and multidisciplinary bodies that examine maternal deaths are uniquely positioned to identify preventable factors and recommend solutions. But for these committees to be effective, they need consistent funding, independence and the ability to collect and analyze data in a centralized and standardized way. This resolution emphasizes several pathways for states to strengthen maternal health outcomes. First, by supporting and expanding the work of MMRCs, States can ensure that lessons learned from each case translate into meaningful policy and practice improvements. Second, by improving data collection, especially around severe maternal morbidity, states can better identify where interventions are needed most. Standardizing race and ethnicity data is also essential for understanding and addressing disparities. Expanding access to maternal support services is another critical step. Doula care, for example, has been associated with improved outcomes. Yet many women lack access. Investing in doula workforce development and ensuring hospitals integrate doulas into care teams can help bridge this gap. Maternal mental health also requires a coordinated response. Integrated care models that bring together obstetric providers, pediatricians, nurses and community-based support workers can help ensure that mental health needs are recognized and addressed early.

Finally, the resolution encourages hospitals to adopt evidence based clinical practices such as the Alliance for Innovation in Maternal Health Hypertension Bundle, which has been shown to improve the management of hypertensive disorders during pregnancy. Taken together, these measures reflect a comprehensive approach, one that recognizes the complexity of maternal health and the need for coordinated action across systems. States are key partners in this work. By strengthening data systems, expanding access to care, supporting maternal mental health, and promoting evidence-based practices, States can help ensure that every mother has the chance for a safe and healthy pregnancy. Improving maternal health is not only a matter of public policy. It is a commitment to the well-being of families and communities. The steps outlined in this resolution highlight the essential role states play in creating a future where maternal deaths are rare, preventable complications are addressed and every mother receives care that she needs.

Sen. Bill Gannon (NH) stated that we're getting a lot of money from the Rural Health Transformation Program. For us, it's $1 billion over the next five years. We're using it mostly on our northern cities and towns where we have a poorer population and they get less healthcare. So we're hoping that it's going to be huge on maternal health and it will be one of the areas that the money goes to. Is this the same in all the states? Are they all getting a big share? And will a lot of it go towards maternal health? Ms. Duggan Goldstein stated that a lot of the states are using a significant portion of their funds to address maternal health in some way. Of course, all states are doing it a little bit differently. And

some states got a little less, some states got a little bit more, but most states got about $1 billion over five years.

Sen. Beverly Gossage (KS) stated that as a health insurance agent for the last 22 years, I've seen rates that have gone up partially because of the accumulator. Correct me if I'm wrong, but when an actuary determines how are we going to price this plan, if you choose the exact same benefits, but you have a $250 deductible or you choose the exact same plan and you have a $5,000 deductible, the premium's going to be vastly different because they know that you are participating in this cost sharing and know that you're probably going to be a better consumer, watch how you spend, and how you use your medical care. And therefore, it's called consumer-driven health care. When you choose a $5,000 deductible and you have a lower premium, but somebody else is helping you to pay the balance of that deductible, it vastly changes the mindset of the individual and the consumer. Can you address what you've seen with the accumulator and how that has affected premiums? And might I just add the caveat, an insurance carrier doesn't know oftentimes that grandma's going to help pay for this or uncle is going to help pay for this but if it's an insurance carrier themselves or a provider themselves, they want that individual to get to the hospital and I would like for them to get to where they've met their deductible as soon as possible, because the insurance company is then going to start paying at 100%. Could you address that for us, please?

Rep. Pollock stated to Sen. Gossage that I think you may be talking about the accumulator adjustment program model which will be discussed later. This is the maternal health resolution discussion. Sen. Gossage stated that she will wait for her question.

Rep. Peggy Mayfield (IN) stated that I wanted to add to Rep. Carter's comments about having good, accurate data. I sit on our state's Commission for Women and the Commission for Latino and Hispanic Affairs. These are obviously two groups that are directly impacted by maternal care. I also sit on the insurance committee and I've been one of the premier pro-life legislators for the state of Indiana and yes, the pro-life movement is also very concerned about maternal health care. But one of the interesting facts I've seen is that it's usually flipping back and forth, the number one and number two causes of maternal mortality are homicide and suicide. When you say maternal mortality, you tend to think access to medical care. So, those two items, I think we need to not pull out. Their lives are very valuable too, but we need to separate the data for medical reasons versus environmental reasons and many of those deaths in the homicide are intimate partners and family members, which are very disturbing numbers. But I think if we are going to address this issue on the medical side, we need the medical data. If we're going to address it on the social side, we need that, and we might have to take different approaches. So, I just wanted to say regarding Rep. Carter's comments, we do need very detailed breakdowns of the numbers in maternal mortality. Ms. Duggan Goldstein stated that yes, and the MMRCs do collect all deaths regardless of cause so intimate partner violence is absolutely one of those. And suicide and mental health conditions are also obviously a big chunk of that as well. So, those are definitely collected so that every death can be analyzed appropriately.

Rep. Scott stated that I would just add that we all agree. If you look at the actual maternal health data that the committees are pumping out, they extract it. I'll be more than happy to provide Rep. Mayfield a copy of Pennsylvania's data. I think the data is incredibly important. We can't make decisions based upon emotions. We've got to make them based upon the data. So, thank you for that comment. Rep. Carter stated that I want to end thanking the state of Michigan for the incredible work that they've been doing. We recently passed a black maternal health resolution where black women are dying four times the rate of any other population. And therefore, I want to thank Blue Cross Blue Shield of Michigan, the Michigan Department of Insurance and Financial Services and the entire Michigan Legislature for standing behind this work.

Rep. Pollock thanked everyone for their comments and stated that as a reminder, per NCOIL bylaws, all NCOIL votes are voice votes, except that a roll call vote shall be taken at the direction of the chair or upon the request of a committee member in instances where there are dissenting votes. Hearing no questions or comments, upon a Motion made by Rep. Scott and seconded by Rep. Barbara Dittrich (WI), the Committee voted without objection via a voice vote to adopt the amendment Rep. Carter offered to the resolution. Then, upon a Motion made by Asw. Pam Hunter (NY), NCOIL Immediate Past President, and seconded by Rep. Scott, the Committee voted without objection via a voice vote to adopt the resolution as amended.

DISCUSSION AND CONSIDERATION OF RE-ADOPTION OF MODEL LAWS

Rep. Pollock stated that last on our agenda is a consideration of re-adoption of model laws. As a reminder, per NCOIL bylaws, all NCOIL models are scheduled to be considered for re-adoption every five years and if it's not re-adopted, it sunsets. First, we will hear comments on the NCOIL Telemedicine Authorization and Reimbursement Model Act. The model is available on the website and the app and in your binders on page 51. We'll hear from Erin Hiley, Chief Legal Officer at American Specialty Health (ASH), who has some comments on the model and some potential suggested changes.

Ms. Hiley thanked the Committee for the opportunity to speak and stated that this is my first time presenting here so I thought I would take one moment just to introduce ASH. We've been in business for 39 years. We started with chiropractic networks in California 39 years ago and since then became the first restricted health plan in California. We moved nationally, and other than growing geographically, we grew our specialties from chiropractic to include acupuncture, naturopathy, podiatry, and more importantly physical therapy as well as some others. We also have other business units, but we work with health plans, employer groups, and direct-to-consumer in the healthcare and in the fitness and wellness space. I mentioned physical therapy being important because it's a rapidly growing specialty in healthcare. And ASH currently has 82,000 physical therapists and occupational therapists across the country, 81,000 of those provide services on a home-based or mobile service basis. And ASH also has 350 physical therapists and occupational therapists working in the telemedicine space. We are asking that this model remain open for consideration of a few changes. I want to thank Asw. Hunter for her foresight and innovation in getting this model passed. It addressed important pandemic needs, and it remains relevant today and requires very little edits to modernize it to make it less about

the need to address COVID needs and more about utilizing telemedicine so that patients in all of these settings can have choice. I just want to highlight here that we're recommending very minimal change and ASH requests that the Model stay open for consideration of possible changes.

Asw. Hunter thanked Ms. Hiley for her comments and stated that as the original sponsor of this model, I do think it's worth having some discussions as to whether any changes to the model should be made. This model was adopted during the COVID pandemic, and such a tremendous amount has changed in the telemedicine landscape in the past five years. I'm not committing to making any specific changes but I think it's worth at least having some discussion around the current telemedicine landscape and how it may impact the model. That stated, I would recommend that the model be re-adopted until the summer meeting rather than for the full five years, so that we're afforded the opportunity to discuss and consider any potential changes.

Rep. Pollock agreed with Asw. Hunter. Hearing no further questions or comments, upon a motion made by Rep. Carter and seconded by Sen. Felzkowski, the committee voted without objection via a voice vote to re-adopt the model until the summer meeting in July.

Rep. Pollock stated that we will now entertain the remaining three model laws for re-adoption: the NCOIL Model Act Regarding Air Ambulance Protections, the NCOIL Accumulator Adjustment Program Model Act, and the NCOIL Employer Sponsored Group Disability Income Protection Model Act. Rep. Pollock stated to Sen. Gossage that regarding the accumulator adjustment program model, staff is going to work to provide you information on that. Rep. Pollock then stated that the models scheduled for re-adoption are on the website and app and appear in your binders starting on page 42. Neither NCOIL staff nor I have received any comments on these models.

Sen. Lang stated that he has some serious concerns with the accumulator model. The model goes against many things that insurance is built on. Insurance is built on good risk and if you look at a health insurance plan right now, you all know Pareto's law, the 80/20 rule, and in health insurance it's even worse. About 4% to 6% of your participants in a plan make up about 60% of your claims. So, the insurance pricing model is designed to get young people to participate in the plan because young people for the most part, their only significant risk of a catastrophic cost is an accident or pregnancy. And the risk for catastrophic cost is real, but it's infinitesimal. So, they price these plans to create a plan that has a high deductible and a low premium to get our young friends to participate to pay for folks like me. I'm battling stage four colorectal cancer right now and my wife and I sit down and we choose to take the high premium but the low out of pocket, low deductible cost for that. That's the way insurance works. We incentivize the young to participate to offset the cost for those of us that are aging. With this plan there is nothing stopping me from going into the plan designed for the young people, getting the high deductible plan, having the insurance companies pay my deductible, so my out of pocket cost now goes to zero, and I can scam the system and participate in the lower premium plan. Every single pharmaceutical company that I've met with I say if this plan is so vital, why don't you just lower your total cost for your drugs to benefit the entire market rather than trying to take a portion of the market and build it in so that you can have a higher overall cost? This does

add cost. And keep in mind, the only people we are impacting with this cost are those that we control. Specifically, the small market risk pools. And in Ohio, we can regulate Medicaid and the state plan and some state university plans as well.

You cannot even do this in the Medicaid and the Medicare plans because it is illegal. It is considered a kickback. All of the universities have come to us because there's a bill right now being considered asking for a carve out so they do not have to participate in this plan. I've got a list of about a dozen other reasons why this is a bad idea, but for the sake of time, I would rather see pharmaceutical companies lower their costs and benefit everybody rather than lowering the cost and they will modify the coupon based on your deductible. If it's a $5,000 deductible, you'll get a $5,000 coupon for one month. If it's a $20,000 deductible, you'll get four $5,000 coupons. And I'll finish with this. Ten years ago, we controlled about 20% of the market in Ohio as it fell under our regulations. Every time we had an unfunded mandate, the most recent one being hearing aids for kids which is a noble cause but I fought against that. If it's a noble cause, let the state pay for it. Don't force the small businesses to pay for it. Our percentage of people that we control just in Ohio went from about 20% of the market to today down to 10%. The Farm Bureau just came out with their own Medishare program, similar to the ones that the health ministries have. I believe we're going to see other organizations coming out with similar programs, all designed to help the little business guy get out from under our thumb. The small business has figured out how to go partially self-funded. How to join a consortium. How to get out of everything that we do to raise the cost because we only impact the little guys. And the little guys are competing against the big guy's of the world for talent, but we're asking them to compete with handcuffs and shackles on. I've got a whole bunch of other reasons to oppose this but for the purpose of time, I would just urge us to give serious consideration to this model and I would ask that we don't consider all three models at the same time for re-adoption.

Asw. Hunter stated that I just want to just briefly say I support the re-adoption of this model. It's been a very successful model adopted by several states. This is just a re-adoption, and we're not obviously forcing any state to adopt this model. I would like to move for re-adoption.

Kevin McKechnie, Executive Director of the American Banker's Association (ABA) Health Savings Account (HSA) Council, thanked the committee for the opportunity to speak and stated that the grand question of whether copay accumulators are a good or a bad idea is not part of my brief. But I want to raise the point that in the model law in section 4(C) that there is a compromise between the pharmaceutical industry and the HSA industry so that States that wish to legislate in this space can do so without impeding the contribution eligibility of people with high deductible health plans. In other words, it preserves the fully insured market for HSA-qualified insurance in your state. I am making a general comment in support of renewal because it's an important tool for us in these debates in states and it works. I'm not addressing the question or the concerns you brought up Sen. Lang. What I'm suggesting is right now it's working for us because when we enter these debates, we have to find a way to coordinate federal IRS rules with state rules and preserve your ability to legislate in the places you would wish to legislate, which is what section 4(C) does.

Sen. Lang stated that it may be working for you, but every unfunded mandate that we put in is not working for the small business employers in the state of Ohio. Mr. McKechnie stated that I was only referring to the coordination language in section 4(C). The grand question is something else; something you'll have to manage.

Rep. Pollock thanked everyone for their comments and stated that today is only about re-adoption and substantive comments are something that we can continue on discussing at a later time if necessary, but for today it's only about re-adoption. is the re-adoption of this model. Hearing no further questions or comments, upon a motion made by Asw. Hunter and seconded by Rep. Ellyn Hefner (OK), the committee voted by way of a voice vote to re-adopt the model with Rep. Pollock determining that the yes votes clearly outnumbered the no votes.

Then, upon a motion made by Rep. Oliverson and seconded by Rep. Mayfield, the committee voted without objection via a voice vote to re-adopt the NCOIL Model Act Regarding Air Ambulance Protections and the NCOIL Employer Sponsored Group Disability Income Protection Model Act.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Gossage and seconded by Sen. Lang, the Committee adjourned at 12:45 p.m.

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IMMEDIATE PAST PRESIDENT:
Asw. Pamela Hunter, NY

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 discussed during the Health Insurance & Long Term Issues Committee on July 17, 2026.

Table of Contents

Section 1. **Title**
Section 2. **Definitions**
Section 3. **Transparency and Disclosure Requirements for Insurers and Vision Benefit Managers**
Section 4. **Covered and Non-Covered Services and Materials Provisions**
Section 5. **Prohibiting Coercive Tactics by Insurers and Vision Benefit Managers; Providing Reimbursement Parity for Optometrists and Ophthalmologists; Requiring Affiliates to Comply with Statute**
Section 6. **Acceptance as Participating Eye Care Provider**
Section 7. **Permitting Eye Care Providers to Use any Lab or Supplier**
Section 8. **Private Right of Action for Eye Care Providers**
Section 9. **Relationship to Other Laws**
Section 10. **Enforcement**
Section 11. **Severability**
Section 12. **Rules**

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

4. 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.

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

PRESIDENT: Sen. Paul Utke, MN
VICE PRESIDENT: Rep. Edmond Jordan, LA
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SECRETARY: Rep. Brenda Carter, MI

IMMEDIATE PAST PRESIDENT:
Asw. Pamela Hunter, NY

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. Re-adopted by the Health Insurance & Long Term Care Issues Committee on April 17, 2026 and the Executive Committee on April 19, 2026 until the 2026 Summer Meeting while proposed amendments are developed.

Draft as of June 16, 2026. To be discussed by the NCOIL Health Insurance & Long Term Care Issues Committee on July 17, 2026. Proposed Amendments sponsored by Asw. Pam Hunter (NY).

Table of Contents

Section 1. Title
Section 2. Purpose
Section 3. Definitions
Section 4. Coverage of Telemedicine Services
~~Section 5. Limited Telemedicine License~~
Section 5~~6~~. Network Adequacy and Limitation
Section 6~~7~~ Rules
Section 7~~8~~. Effective Date
Section 8~~9~~. Severability

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.~~

(D~~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 where such provider also provides services at a brick and mortar location; but where the provider provides healthcare services only via telemedicine (or within a telemedicine only network), the provider may accept lower rates, as negotiated. Insurers, corporations or

health maintenance organizations may not mandate patients utilize telemedicine only providers.

(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 5~~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 6~~7~~. Rules

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

Section 7~~8~~. Effective Date

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

Section 8~~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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SECRETARY: Rep. Brenda Carter, MI

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Asw. Pamela Hunter, NY

National Council of Insurance Legislators (NCOIL)

Charity Medical Care and Medical Debt Reform Model Act

Sponsored by Rep. Tom Oliverson (TX).
****Co-sponsored by Sen. Paul Utke (MN), NCOIL President, and Rep. Brenda Carter (MI), NCOIL Secretary.***

Draft as of June 16, 2026~~October 14, 2025~~. To be discussed and considered during the meeting of the NCOIL Health Insurance & Long Term Care Issues Committee on July 17, 2026.

Table of Contents

Section 1. **Title**
Section 2. **Purpose**
Section 3. **Definitions**
Section 4. **Charity Care Screening**
Section 5. **Calculation of Net Patient Revenue**
Section 6. **Credit Reporting and Debt Collection for Debt Related to Lifesaving and Emergency Care**
Section 7. **Rules**
Section 8. **Effective Date**

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.

(K~~J~~) "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.

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

(M~~L~~) "[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.

(NM) "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.

(O) "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.

> *Drafting Note: States may wish to consider having the screening process requirements apply only to uninsured or self-pay patients.*

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

> (1) perform a presumptive screening process when billing for 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).

(CB) 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.

Drafting Note: States may also wish to consider requiring hospitals that are subject to the provisions of this Act to submit annual reports to the appropriate state agency containing information such as the amount of charity care provided and the amount of net patient revenue.

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 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 xxxxxx

PROPERTY & CASUALTY INSURANCE COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
PROPERTY & CASUALTY INSURANCE COMMITTEE
2026 NCOIL SPRING MEETING – LOUISVILLE, KENTUCKY
APRIL 18, 2026
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Property & Casualty Insurance Committee met at the Hyatt Regency Hotel in Louisville, KY on Saturday, April 18, 2026 at 9:00 a.m.

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

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Rep. Stephen Meskers (CT)
Rep. Matt Lehman (IN)
Rep. Peggy Mayfield (IN)
Rep. Adrielle Camuel (KY)
Rep. Mike Clines (KY)
Rep. Deanna Gordon (KY)
Rep. Erika Hancock (KY)
Sen. Jason Howell (KY)
Rep. Mike Meredith (KY)
Rep. Sarge Pollock (KY)
Rep. Edmond Jordan (LA)
Rep. David LeBoeuf (MA)
Rep. Brenda Carter (MI)
Sen. Mark Huizenga (MI)
Rep. Mike McFall (MI)
Sen. Paul Utke (MN)
Sen. Jeff Barta (ND)
Sen. Jerry Klein (ND)
Sen. Tim McGough (NH)
Asm. Jarett Gandolfo (NY)
Rep. Tim Barhorst (OH)
Rep. Meredith Craig (OH)
Rep. Brian Lampton (OH)
Sen. George Lang (OH)
Rep. Tom Oliverson, M.D. (TX)
Rep. Trey Wharton (TX)
Rep. Calvin Callahan (WI)
Rep. Barbara Dittrich (WI)
Sen. Mary Felzkowski (WI)

Other legislators present were:

Sen. Jesse Bjorkman (AK)
Rep. Justin Wilmeth (AZ)
Rep. Brett Barker (IA)
Rep. Elizabeth Wilson (IA)
Rep. Wendy Dant Chesser (IN)
Sen. Beverly Gossage (KS)
Rep. Shaun Mena (LA)
Del. Mike Rogers (MD)
Rep. Sara Lightner (MI)
Sen. Bill Gannon (NH)
Rep. Julie Miles (NH)
Rep. Kellie Deeter (OH)
Rep. Ellyn Hefner (OK)
Sen. Mark Mann (OK)
Rep. Greg Scott (PA)
Rep. Yusuf Hakeem (TN)
Rep. Matt Morgan (TX)
Sen. Jamie Wall (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 Asm. Jarett Gandolfo (NY), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Asm. Gandolfo and seconded by Rep. Tom Oliverson, M.D. (TX), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's November 15, 2025 meeting.

PRESENTATION ON DEVELOPMENTS IN THE PARAMETRIC INSURANCE MARKETPLACE

Sen. Theis stated that first on our agenda is a presentation on developments in the parametric insurance marketplace. Parametric insurance is very helpful in insuring against things such as extreme weather events or occurrences like earthquakes. It pays a pre-established amount based on the occurrence of a physical event with certain characteristics. For example, with an earthquake, the product would pay out when an earthquake hits 4.0 on the Richter scale. In certain states like New York, the insurance statutes did not allow insurers to issue this coverage so New York is one of a handful of states that have taken active steps to define and regulate parametric insurance. The New York law is in the online materials. Today, Dan Rabinowitz of Herbert, Smith, Freehills, Kramer LLP will brief us on developments in the parametric insurance marketplace.

Mr. Rabinowitz thanked the committee for the opportunity to speak and stated that parametric coverage is a type of recovery that pays out a pre-agreed amount when a predefined event occurs using a predefined index or parameter. So, instead of having to show actual loss, the policyholder gets a recovery when an event occurs beyond a certain trigger or threshold. There's no loss adjustment process. This is intended to result in a faster payout of claims. By way of example, you could have a parametric contract that says that if an earthquake of magnitude of X amount occurs in a defined geographic area, the contract will pay a certain amount, say $10 million. Or there could be a sliding scale where if the magnitude is seven, it pays $10 million. Or if it's nine, it pays $30 million, regardless of how much loss the policyholder actually has suffered. Who might use parametric coverage? What areas might it be attractive in? Well, digital infrastructure and artificial intelligence data centers are a big ones because their size and unique characteristics expose them to extreme weather events and power grid related events like outages. So, you could have a parametric contract based on events affecting the power grid.

Similarly, the travel industry is exposed to weather and other kinds of events that might make parametric coverage appropriate. Not just weather, but you could have a parametric coverage based on the number of arriving flights at a particular airport or the number of passengers transiting through a particular airport. So, if that number dips below a certain amount, the contract would pay out X amount. And in the retail business, you could have parametric coverage that's triggered by decreased foot traffic in stores. Some other areas where parametric coverage might be attractive are agriculture, renewable energy and construction because these sectors are also affected by extreme weather and other sorts of natural events. It's difficult to get reliable information about the exact size and scale of parametric coverage but one study that came out that was cited by the Society of Actuaries reported that in 2025, the global market size of the parametric sector was about $19 billion. Now, that's a very small fragment of the global insurance market as a whole, six-tenths of a percent. But this is expected to grow. And the U.S. accounts for about a quarter of that. By 2035, this study forecasts that the parametric market will be about $63 billion. That's an annual growth rate projected for the next 10 years of about 12% with the largest market being North America, but the fastest growing region being Asia Pacific.

Parametric contracts are nothing new in the area of third-party capital insurance-linked securities such as catastrophe bonds or cat bonds. And just briefly, if you are not familiar with these, cat bonds are investment products. They're capital markets products that are issued to investors by a sponsoring insurance company where the sponsoring insurance company wants a sort of substitute for reinsurance. The proceeds of the bonds are segregated and put in an investment account or in a trust. And they act as a sort of recovery, a source of recovery when the sponsoring company is exposed to the particular risk. So, an earthquake exceeds a certain trigger, the bond pays the insurance company. The hurricane exceeds the trigger, the bond pays the insurance company. Because it's based on a parametric trigger and not actual loss this is expected to result in quicker settlement for the investors. The investors don't want to wait months or years to get their principal back and the parametric character of the coverage makes settlement quicker. It's also worth pointing out here that the contract, without getting into too much detail, between the sponsoring insurance company and the issuing entity might be a traditional reinsurance contract, or it might be a swap written on what's known as an ISDA master which is the traditional form on which swaps and other kinds of derivatives are written. So, the form of the contract might be insurance, or it might be a swap, but either way, the risk that it's protecting against is parametric in nature.

So, where does parametric coverage fit into the statutory State scheme having to do with insurance law and definitions of insurance. Let's focus a little bit on the New York definition of insurance contract and I focus on New York because it has a well known and traditional definition of insurance and one that has been developed and opined on by the New York Insurance Regulators in guidance over the years. And generally speaking, in New York, an insurance contract is an agreement whereby the insurer is obligated to confer benefit of pecuniary value upon the beneficiary dependent upon the happening of a fortuitous event. And a fortuitous event is defined as an event beyond the control of either party. The fortuitous event must be one in which the insured is expected

to have a material interest that will be adversely affected. So, the New York Department of Financial Services and its predecessor, the New York Insurance Department, over the years issued guidance saying that the two main characteristics of an insurance contract are insurable interest, that is having a material interest in the property that's exposed, and having to show proof of loss when the event happens.

Are these factors present in parametric coverage? Well, insurable interest you might say could be if you only issue the product to someone who owns property in the particular region and is exposed to the particular risk. It might not necessarily be the case if you sell the product to someone else, but if you sell the product to someone with the insurable interest, then the factor of insurable interest could be present. But clearly, the whole point of parametric coverage is to do away with proof of loss so that characteristic of insurance is not present in parametric coverage. Nevertheless, as we heard, the New York legislature introduced a new line of insurance coverage called parametric insurance in 2025. It limited it to weather-related events like windstorm, flood, snow, etc, and it said that parametric insurance is insurance. So again, it's defining it as insurance with those characteristics regardless of whether they're there, based on the proximity and magnitude of an event. New York goes on to say that if you issue parametric coverage, you have to disclose to the policyholder that it's not a substitute for property or flood insurance which may be more comprehensive, and a lender might not accept the parametric policy.

Let's compare New York's approach with a couple of other states. Vermont, as you may know, is a major captive domicile and has a very robust captive insurance statute. And in 2022, Vermont amended its statute to specifically permit parametric coverage for captive insurance companies. They also went on to say what a parametric contract is. It's a contract to make a payment upon the occurrence of a specified triggering event without proof of loss and they specifically said a parametric contract is not an insurance contract. But then in 2024, they amended the statute to delete that language. So, they deleted the sentence that said, "A parametric contract is not an insurance contract." And in a legislative summary memo accompanying the bill, the legislature said it has become apparent that parametric contracts can be structured as insurance contracts. So, Vermont seems to be taking a somewhat agnostic view on whether or not a parametric contract could be insurance after initially saying categorically that it could not. Tennessee also has a robust captive statute, and it changed its statute in 2021 to allow for parametric coverage. Tennessee specifically says in its statute parametric contracts are considered contracts of insurance.

Let's look at Connecticut, which also has a captive statute. And again, these statutes applying to captive insurance companies are not yet in effect for regular insurance companies, just for captives. Connecticut seemed to be circumspect in its definition of captive. It said that a captive insurance company can accept or transfer risk by means of a parametric contract and that if a captive does so, it has to comply with all federal and state laws. That's similar to what Vermont said in its statute. And, then it defines parametric contract again with the definition that we've seen in other states but it doesn't characterize it as insurance or non-insurance. Puerto Rico has introduced laws on micro insurance. So, these are low premium, low coverage policies for the retail market

responding to hurricane coverage because of their exposure to hurricanes in Puerto Rico. The contracts covered by microinsurance are parametric contracts, according to the Puerto Rico regulation. And Puerto Rico specifically defines parametric coverage as an insurance contract and it goes on to specifically say in its regulation that the insurable interest is verified at the time of executing the contract and consists in the fact that the insured has a reasonable expectation that he will incur an economic loss in the event that the predetermined adverse effect occurs. So not only is Puerto Rico saying that parametric coverage is insurance, but they are specifically saying that insurable interest is present.

As we've seen before, the boundary between insurance contract and swap in this context can be blurry. And as we saw in the cat bond context, risk transfer can be accomplished by means of an insurance contract, a reinsurance contract or a swap on an ISDA master where the coverage is the same. And just to focus a bit on the federal definition of swap. This comes from the Commodities Exchange Act. It's an agreement that provides for any purchase that is dependent on the occurrence, non-occurrence, I'm paraphrasing, or the extent of the occurrence of an event or contingency associated with a potential financial, economic, or commercial consequence or of one or more payments based on the value or level of one or more indices and that transfers between the parties the financial risk associated with a future change in any such value or level. Again, a definition not much different than what we've seen in the parametric insurance context. The definition of swap also lists out a number of contracts that are categorically defined as swaps, including weather swaps.

So, where does that leave us in terms of regulating parametric coverage as more states enter this space in their statutory codes? It's tempting to want to say I would suggest that we should regulate the substance rather than the form of a contract and that we should look at any commercial transaction and see what is the substance of it rather than what it's called and if the substance is insurance, it should be regulated by the states and if it's a swap, it should be regulated by the federal government. But I would suggest that may be an elusive ambition, because as we've seen the boundary between insurance and swap, if it was ever robust in the first place, is kind of eroding because of the falling away of the proof of loss requirement and the questionable presence of insurable interest. So, does that leave us with more of a functional or pragmatic approach where we say that something is an insurance contract if it covers the kinds of risks or perils that are historically associated with insurance or that are written by an insurance company or that are historically associated with the regulation of insurance. And that something is a swap if it contains those risk parameters that are associated with things traditionally known as swaps or regulated as swaps. There's something kind of unsatisfying about that because that does sort of elevate form over substance a little bit. But in an area that's as fluid and changing as this area of parametric coverage that may be where we're heading and only time will tell as developments increase in the future on this.

Rep. Mike Meredith (KY) stated that your form over substance discussion is very interesting to me and especially in this space it's something I think all of us as legislators need to be thinking about because of the blurred lines of parametric insurance now versus the swap. We're already seeing that in regards to sports wagering and the blur in

the lines of swaps playing out at a national level right now. I can see this being the next step by a lot of these exchanges related to their Commodity Futures Trading Commission (CFTC) exclusive jurisdiction. Mr. Rabinowitz stated that this is very much similar to the controversies over predictive markets. I agree, and it just underscores what you're saying that the line between swaps and other kinds of products, including gambling contracts. It's very interesting and it's something that's playing out before our very eyes.

Rep. Stephen Meskers (CT) stated that I would be more concerned as a representative in Connecticut about the implications for parametric insurance which is basically event-based insurance or a payout you can swap - the linguistics are not relevant to me. I think the question becomes is it the appropriate level of coverage? If I think about the banking industry which has loans out to the entire commercial and residential property market, if someone's covering their insurance on an event-based parametric insurance and the event is somehow poorly defined or the flood happens not because of rainfall but some other act, is the coverage even adequate? And in parametric insurance, you're carving out an event that may not have 100% correlation to what you were trying to insure against and therefore you might want to regulate it as insurance but the scope of whether it's adequate coverage for a loss puts me at I'd be very concerned.

Mr. Rabinowitz stated that I think what you are referring to is what's known as basis risk, which is what they call the potential mismatch between the expected payout that I have as a property owner and the loss that I might incur and the actual payout that I get because the parametric coverage is based on a predefined amount. Those two things may be different. I might come out ahead, I might come out behind. You're right. And minimizing basis risk I think is a major focus of the industry right now trying to align those two things so that there's not a mismatch. But I agree that if one of the points of insurance regulation is to assure that payouts are adequate and adequately compensate consumers for the risks that they incur, the functionality of parametric coverage has to be looked at in that context. And I agree, it's a very important point. It's intended to help the consumer by not having a loss adjustment process, by just being an automatic payout and therefore paying out more quickly, but you have to balance that against the basis risk. I agree, and that's something that will continue to develop.

Sen. George Lang (OH) stated that due to what I kind of perceived on your presentation of the lack of a reinsurance market and the dependence on the cat bonds, are the capital requirements for a captive playing in this field typically higher than in the rest of the industry? Mr. Rabinowitz stated that for a captive insurance company to write parametric coverage my understanding in the states that have adopted parametric coverage for captive insurance, I don't think the capital requirements are very different. They haven't introduced additional capital requirements for captive insurance companies. For cat bonds, it's a slightly different kind of analysis because for cat bonds, you're talking about sort of a capital market substitute to reinsurance so the companies that are issuing cat bonds or that are relying on cat bonds are using a substitute for reinsurance and those companies that they're buying the coverage from are basically look through entities for investors so there are no specific capital requirements associated with those. Those are funded, those are funded 100% by the investors.

Sen. Theis stated that I'd be interested in the regulator's approach to that question and asked are you finding that individuals would be purchasing a baseline, minimal insurance and then the parametric in addition to it? Or are they just doing parametric? Mr. Rabinowitz stated that I think that the way that it's evolved to date is that it's intended to be supplemental. That is, I think that the companies writing parametric coverage to the extent that they're writing it in retail markets, and New York reflects this in its disclosure requirement as we noted that you tell consumers that this is not comprehensive, is that it's intended to be additive. Although I do note that in Puerto Rico, they do seem to intend that the micro insurance, because of the population and the exposure that they're dealing with, seems to be a substitute for regular insurance.

Sen. Theis stated that regarding the payout timeline, we know there are delays with traditional insurance. Can you do a compare and contrast with traditional insurance payouts versus parametric? Mr. Rabinowitz stated that I don't know if there's any specific empirical data on that. The intent is that parametric coverage pays out in days or weeks rather than months. The idea is that the event occurs, it occurs at a certain level, it's reported, it's verifiable, and then the company is obligated to make payouts to the policyholder. The policyholder does not have to report that it's suffered a loss. The policyholder doesn't have to quantify their loss. It's intended to be automatic, so theoretically it could be immediate. But as a practical matter, my understanding is that it takes days or weeks. Sen. Theis stated that I'm assuming that the parametric contracts traditionally determine who it is that is the authoritative entity on determination. Mr. Rabinowitz stated correct, they identify a federal or state government agency whose reports are considered to be dispositive for that purpose.

Sen. Justin Boyd (AR) stated that I realize we're in an insurance committee, but with this, you talked about basis and mismatch - do you find that states maybe need to look at their tax code on this to make them more efficient and business friendly to use? Mr. Rabinowitz stated that for tax or accounting purposes the tax code does need to respond to this. I think that parametric coverage would probably be considered insurance. I'm no tax lawyer, so I don't want to get out ahead of my skis. But I would think that a parametric contract would be considered insurance for tax purposes. For accounting purposes, I would point out that if something is considered a derivative or if it's considered a swap functionally, you treat it with fair value accounting rather than as a risk transfer contract. So, that's something that you would have to navigate depending on what kind of contract it is.

Sen. Theis thanked everyone and stated that I think this topic is a good opportunity for NCOIL to further discuss and potentially offer some guidance down the road. If anyone has any interest in it, please reach out to me or the NCOIL staff.

UPDATE ON POTENTIAL NCOIL MODEL ACT REGARDING INSURERS' USE OF AERIAL IMAGES

Sen. Theis stated that next up is an update on a potential NCOIL model act regarding insurers use of aerial images. As a reminder, this committee discussed this topic

extensively for over a year and ultimately, the model that we were working on was narrowly voted down. However, after that happening, several legislators expressed interest in taking another go at this issue, and it's a very important one and one that's not going away. Bills continue to be introduced across the country and two of them were recently signed into law. One of those bills is from Indiana and we're going to hear about that from our colleague and past NCOIL president, Rep. Matt Lehman (IN).

Rep. Lehman stated that the Indiana law is on page 99 is your binders. We did recently pass this there. First I want to thank Rep. Brian Lampton (OH) and Rep. David LeBoeuf (MA) for sponsoring the prior version of the Model. I know we've worked on this for over a year and I really felt we had taken a pretty straightforward look at this. But I felt it was necessary to get something passed and out there because this is an issue that has to have some consumer protections around it so we made a few changes in Indiana. And people ask did you create the perfect law and even though I was the author, it was not the perfect law. And my philosophy at NCOIL has always been our role here is to build the foundation. We put a foundational place and then we let the states finish it off. And so I think what we did in Indiana was we built that good foundation and we can always tweak that moving forward but I think the guardrails are there. And I think NCOIL needs to pick this back up. I think it's an important issue moving forward and you can use Indiana's model as a start. I do think that by our summer meeting in July, I would like to see us having something out there that we can sit down with the industry, with the consumer groups and with us as the legislators to try to put some things together. I know Georgia recently passed a law as well, and so I think we've got to get to where NCOIL, as we do so well, can create a model and I look forward to that. I think there's a lot on the table when it comes to these technologies, and this is just one of those pieces of the puzzle. I look forward to working again with Rep. Lampton and Re. LeBeouf and hopefully have something in the summer we can work on.

Sen. Theis thanked Rep. Lehman and stated that my only commentary with respect to it is has to do with timelines. And you mentioned that in your language, ensuring that they're aligned with state timelines and then also timelines to correct the insufficiencies. For example, a roof in Michigan, if it's identified at midwinter, it's going to be really hard to correct within the 60-day window. Rep. Lehman stated that I think that we have to have again the discussion around the time to cure. We did use this as our template to then move our non renewal notices on homeowners to 60 days so I think that's a win for consumers. Also, this being the "sole" purpose of the non-renewal, that's a hard one to define sometimes so I do think there is some work to do and I look forward to working on it.

Sen. Theis stated that I agree that taking up this issue is absolutely necessary and I think the Indiana law is is a good baseline for us and and something that we can launch off from. Please don't hesitate to reach out to me, Rep. Lehmann, prior sponsors, or NCOIL staff with any questions.

CONTINUED DISCUSSION AND POTENTIAL CONSIDERATION OF PROPOSED AMENDMENTS TO NCOIL TRANSPORTATION NETWORK COMPANY (TNC) MODEL ACT

Sen. Theis stated that next up is a continued discussion of proposed amendments to the NCOIL TNC model act. You can view the model in your binders on page 89. It's also on the NCOIL website and app. As a reminder, we've had a vigorous discussion on this at our last meeting in November, and it seems that while progress has been made, we're not ready to vote yet. Unfortunately, the sponsor of the amendments, Sen. Walter Michel (MS) couldn't be with us today as a special session was called right before he was about to get on the plane to come here but he did ask me to relay to the committee that he's pleased to sponsor these amendments, which serve an important purpose to modernize the NCOIL TNC model. It has been one of NCOIL's most successful models, but there has been a significant amount of change in the TNC landscape in the ten years since that model was adopted. You're also beginning to see bills pop up in states that are similar to these amendments so he thinks it's important that NCOIL offer some guidance to states that are considering this. He acknowledges that there is some disagreement among some folks about the intent of some of these amendments and what effect they would have which is why he's comfortable having some more discussion before offering the amendments up for a vote. He assures the committee that the amendments are offered up to respond to changes in the marketplace in the past ten years. There's nothing nefarious about them, but that said, there's no need to rush this, and he wants to make sure we get as close as possible to a consensus before moving forward.

Megan Sirjane-Samples, Director of Public Policy at Lyft, thanked the committee for the opportunity to speak in support of modernizing the liability insurance framework governing TNCs and the independent drivers who use their platforms. 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 governing this sector were largely established more than a decade ago when the rideshare industry was still in its infancy and little claims data existed. These outdated requirements now impose disproportionate costs on riders and drivers alike without delivering commensurate benefits to consumers or claimants. Today, TNCs maintain robust ultra liability coverage typically $1 million or more per incident whenever a driver is engaged in a trip. These high coverage levels were adopted before reliable data existed to guide risk assessment. The data now tells a clear story that the period 2 (P2) risk profile is fundamentally different than P3. Based on our own data, more than 90% of bodily injury claims are resolved or valued at less than $100,000. Over 85% are resolved or valued at below $50,000. Period two, the time after a ride is accepted but before the passenger enters the vehicle, accounts for roughly 12% of bodily injury claims counts only and the claim volume is far closer to P1, app on no ride accepted, than P3 passenger in the vehicle.

Despite this, P2 insurance limits can reach up to 12 times P1 limits as high as $1.5 million in bodily injury and property damage compared to the $50,000/$125,000 levels for P1. These requirements are not defensible based on data. P2 carries no passenger yet is subject to coverage levels equivalent to or exceeding P3. The result is that TNC carriers are targets for outsized litigation, inflated claims, and adverse selection costs ultimately borne by drivers in reduced earnings and by riders in higher fares. On average, 15% of ride fare goes to mandated insurance-related expenses, and many

markets far exceed that 15%. Aligning P2 insurance requirements with actual risk exposure by applying requirements proportional to P1 rather than P3 right sizes coverage without eliminating any consumer protections. It stabilizes the TNC insurance market, reduces litigation incentives and supports the long term affordability and sustainability of rideshare for the communities that depend on it. Equally important is the legislative clarity on vicarious liability. Without an explicit statutory exemption, plaintiffs' attorneys increasingly name TNCs as defendants in auto liability actions, not because TNC liability is well-founded, but because high insurance limits make TNCs attractive litigation targets. To date, courts ruling on dispositive motions have overwhelmingly found that TNCs are not vicariously liable for the alleged acts of drivers. Yet, TNCs still expend significant resources defending these claims before achieving dismissal. This burdens companies, clogs court dockets, and delays compensation for injured parties, even when that compensation is already fully available through the mandated insurance policies. This reform is consistent with the Graves Amendment, the federal law shielding rental and leasing companies from vicarious liability absent direct negligence.

Just as Hertz is not liable for a renter's negligent driving, a TNC shouldn't be liable for a driver's actions by virtue of providing the platform unless the TNC itself has failed to meet its legal obligations. A couple clarifications. This does not eliminate consumer protections. The statutorily mandated $1 million or more insurance policy remains intact. Injured parties can recover without suing the TNC directly. This does not shield criminal conduct. The model expressly allows state and federal criminal charges to be brought against a TNC or driver. Protections apply where the TNC has failed to fulfill its obligations under a state's TNC code. This does not bar legitimate direct claims. If a TNC is independently negligent, it remains fully exposed to liability. These reforms are not abstract policy questions, they have direct consequences for the people rideshares serves. A significant share of rides begin or end in low income communities where access to affordable transportation is critical. The vast majority of rideshare drivers use the platform part-time, balancing other jobs or educational commitments. Insurance cost inflation directly reduces their take-home earnings. Rising insurance costs, if left unaddressed, risk making rideshare unaffordable for everyday riders, the very population companies like Lyft were built to serve. Taken together, these reforms represent a balanced, data-driven approach to modernizing the rideshare regulatory framework. They would reduce litigation costs, streamline claims resolution, maintain strong consumer protections and ultimately make rides more affordable for riders and more sustainable for drivers. We respectfully urge the committee to advance the amendments and encourage states to adopt these common sense updates to their TNC insurance and liability frameworks.

Bob Passmore, Department Vice President, of Personal Lines at the American Property Casualty Insurance Association (APCIA), thanked the committee for the opportunity to speak and stated that APCIA and others were key stakeholders in the development of the NCOIL TNC model and have worked closely with the TNC industry to see legislation based on the model adopted in 49 states. We have no objection to the proposals that revise the definition of digital network, TNC driver, or the clarification of application to allow for the way the drivers submit such information electronically today. But we do have some concerns about the proposed changes to the activity periods and the limits

that apply. Our association has historically been agnostic on the question of what limits should be, considering that a public policy issue for the states. However, we support the NCOIL model and find that the limits that it requires are reasonable.

The number one goal of the TNC model was to provide a clear set of insurance requirements that separate the commercial exposure of carrying passengers for hire from those typically on a personalized policy and to avoid gaps in coverage that could result in disputes. And the model's been very successful at doing that. But our members have expressed concern that the change in the period definition and the limits that apply could result in disputes that we've been trying to successfully avoid for the last ten years on the roughly 12% of the TNC claims that occurred during that period. There's a significant difference between how drivers behave when they're engaged in heading to pick up a passenger who could cancel that ride within those first five minutes. Companies also offer endorsements for these drivers now. They're commonly wraparound endorsements that complement the coverage that's provided by the platforms. Those products would need to be completely revised and refiled and rewritten for a risk that we really haven't been able to measure separately from the rest of the TNC risk so that presents a significant upheaval for those kinds of products as well. That being said, we understand the reasons for these proposed changes. The TNCs have been a prime target for legal system abuse, and we've worked closely with Uber and Lyft on reform efforts. We have talked with Uber and Lyft to better understand the exposure for this period, and we'll continue to do so.

Sarah Collins, Attorney at Sam Aguiar Injury Lawyers, thanked the committee for the opportunity to speak and stated how many times growing up, did your parents tell you and then later you tell your children, "Never get in the car with a stranger." Victims' advocates, personal safety experts and police warn always avoid getting in the car with a stranger. If someone has a knife, and tries to rob you, you give them your purse. But if they have a knife and are trying to force you in the car, you fight with everything you have to avoid getting in that car. Because we know there are dangers associated with being in an enclosed moving space with a stranger. The risks are obvious and we all know them. We don't trust strangers. Boasting over 400 million rides in 2025 alone a client of mine trusted Lyft. To her, Lyft wasn't a stranger. Lyft had driven her friends. She sees Lyft commercials. From TV, to Facebook, to Twitter, Lyft and Uber are all around her, providing, and I believe it was just quoted a "reliable source of transportation." So, she trusted Lyft. She had trusted Lyft many times. And so do your college-aged daughters on the way to a fraternity party. We hope they take a Lyft or Uber. I tell my son, do not get in the car with a drunk driver. Never drive drunk. Always get a ride. Your wife going to the airport trusts Lyft or Uber. Your husband going to a business meeting out of town trusts Lyft and Uber. They are a national brand. And they have changed the way we think about or don't think about getting in the car with a stranger.

What my client didn't stop to realize is that the moment she confirmed her ride she gave up every ounce of ability to protect herself and she handed that power completely over to Lyft. My client is a young mother of four living in Louisville, KY. She's a very petite, small woman and she has used Lyft on various occasions. Most recently, she began using Lyft several times a week after she was in a serious car accident at the beginning

of the year and had to get transportation to and from a chiropractor's office multiple times a week. She hadn't had a problem until the afternoon of February 4th. She was picked up by her Lyft driver, Jordan Diaz Vera. She didn't choose him. She had never met him. She knew nothing about him. All she knew was that someone by that name would be picking her up in a car. She didn't know if he had previously been reported for inappropriate comments, inappropriate touches. She didn't know how often passengers requested never to ride with him again. She did not know how often he had pulled off route with female passengers. All she knew was her Lyft had arrived and she got in the back seat. She told him that she was having a bad day and asked if he would turn on some music. Shortly after in broad daylight, he pulled off the route of the trip into a church parking lot and opened his glove compartment, revealing and brandishing a firearm. He got in the back seat with my client as she desperately tried to open the doors that had been locked. He took off his clothes, forced his penis in her mouth and forced her to perform oral sex on him until he finished. She was terrified and cried the whole time. And after nine minutes, he exited the back of the car and got in the front seat and drove her a short distance to her chiropractor appointment where he just let her out of the car. She went inside and was able to call the police as he circled the block multiple times.

She was immediately hysterical. Weeks later when I met her, she is the most traumatized victim I have ever been in contact with. She does not want to leave her house. She can't stand to be alone. She has therapists that are coming to her house, and she prefers women because she is terrified of men, especially those that she does not know. I have learned from law enforcement that five separate DNA test samples were found from bodily fluids in the back of his car. Not hair samples, bodily fluid samples, and those are being tested. And if that's not terrifying enough, he had only had that car for two weeks. One thing we've been learning is that there is an ability to switch cars with these services. It is estimated that a rape survivor will pay over $120,000 across her lifetime for being raped and the effect of these amendments is saying, "That's where those costs belong." Every eight minutes Uber receives a report of sexual assault and misconduct. Over 400,000 reports of sexual misconduct were reviewed by the New York Times for Uber rides that occurred over six years. Overwhelmingly, these reports came from women who were alone at night. The vast majority of the alleged perpetrators are men. It's my understanding that Uber is quick to say three fourths of these claims weren't rape. They include things like flirting, commenting inappropriately on appearance. I'm glad Uber has that information because they don't tell that to the consumer. They don't tell the passengers who see reliability and safety in a national brand that they do not see with a stranger or a small local company.

Sen. Theis asked Ms. Collins to comment directly on the proposed amendments. We feel terribly about your clients' experience, obviously, but you're taking an extended period of time and you haven't specifically discussed the amendments.

Ms. Collins stated that accountability drives standards that keep passengers safe. Every other transportation company plays by these rules. Had my client taken a taxi and the same thing happened, the taxi would be fully liable. The same with the limousine company, the same with bus companies. Uber wants complete immunity, allowing them

to cut corners, allowing them to undercut competitors. And with the amendments, what incentives would there be to keep passengers as safe as possible? What incentive would there be for Uber and Lyft to have increased background checks? At the moment she confirmed the ride, my client's power was gone, and in the hands of a company that she believed. She did not choose the driver as no passenger does. She chose Lyft and Uber and Lyft and Uber must be accountable for what happens to their passengers. They are not special. They are not being targeted. Their victims are.

Brad Nail, on behalf of Uber, thanked the committee for the opportunity to speak and stated that Ms. Sirjane-Samples laid out the basis for the amendments and did a good job with that and I don't want to repeat that in the interest of time. I do want to say that it has been over a decade since the TNC model was adopted and by any measure, it has been probably the most successful model that NCOIL has passed. Our cooperation with the insurance industry on this I think set a standard for how these models can be deployed. And what we've seen in the interim period of time as Ms. Sirjane-Samples described is realizations of how the litigation environment has evolved to pursue Uber and Lyft specifically and we're already seeing legislation in your states to try to enact some of these same changes and we have seen some of these changes enacted in some of your states. These amendments specifically, three of them really fall into what I would call litigation reform and then one of them is around the insurance limits that Mr. Passmore addressed.

The ones that address litigation reform, I think Ms. Collins was speaking most directly to the vicarious liability piece and without knowing the facts of that particular case, but based on the description we just heard, it sounds like there would be a cause of action even after the amendments that we're proposing. We are not proposing language changes that would reduce or eliminate liability of Uber or Lyft in scenarios where they did something wrong. What we've seen that we're trying to address are innumerable lawsuits where there is no cause of action stated against Uber or Lyft. It's that we operated the digital network upon which the driver connected and was simply negligent in an auto accident. We get named as an additional defendant and therefore, we have to hire counsel and go through an extended process to be dismissed from that lawsuit that we never should've been named in. We are not trying to in any way identify or get out of any lawsuits where there is a credible claim of negligence against the TNC. It's only scenarios where there is no real allegation of negligence, the negligence lies with the driver and we already have insurance, $1 dollars in insurance, to cover that driver's negligence. That's the scenario.

The other pieces of litigation reform are around product liability and common carrier status, which I think are consistent with the existing law, but need to be clarified in that they apply to TNCs. And then the final piece is the insurance piece that Mr. Passmore was speaking to, the limits in P2. I know a lot of you, including Rep. Lehman and Sen. Jerry Klein (ND) were at NCOIL at the time of the model's original adoption and have been dealing with this for a long time. Some of you probably weren't in the legislature when these bills were passed the first time through and the whole period concept is not as clear to you as to all of us who speak this language every day. But we divided the TNC activity into three periods. The period when they turn the app on and are available

but have not received a ride request, and we set an insurance limit amount for that. The period when they have accepted the ride request, P2, and are on the way to pick someone up but they don't have any rider in the car and we set a limit for that, $1 million in the model. And P3, when there are riders in the car, and we set the limit for that at $1 million. And what we're saying is that P2, without any rider in the car, the risk profile matches up more closely with P1 at the lower limit than P3 at the higher limit when there are riders in the car. I appreciate Mr. Passmore's concerns and the industry's concerns. We think that the impact to the insurance industry will be minimal but we're going to keep working with them to see if we can supply them with some more data and get them to a comfort level and move forward with that.

Rep. Lehman stated the discussion I think we're missing maybe a little bit here is, in P1, we're still telling the industry, I'm in my personal automobile. It's my personal auto policy who's going to respond. We set limits on that in state statute, minimum limits, and then people can choose what they want. Once I accept that ride, I've moved into a commercial space because most of those auto policies will say once you've engaged in a commercial activity, you lose that coverage. So now we say, well now you've moved from a personal auto to a commercial auto and we over time have always held commercial autos to a much higher standard. So if you make P2 like P1, I think we're actually going to cloud the waters a little bit into am I commercial or am I not? And I think you said there's only 12% of the claims were in that P2 but if I'm going to pick someone up, I'm in the course of my business even though nobody's in the car. So I think you're going to have a gray area where the insured, the consumer, is going to be in a position of I don't know if my personal auto policy will respond or Lyft's or Uber's will. So I disagree with you on that part of this. I agree with you on the vicarious liability.

Rep. Oliverson stated that I have some questions regarding the independent contractor status things because that's the one that raises an eyebrow for me. Does Uber or Lyft currently conduct a background check on every person that signs up? Mr. Nail replied yes. Rep. Oliverson asked if that changes if they become an independent contractor? Mr. Nail replied no. Rep. Oliverson asked if Uber and Lyft verify legal immigration status for a driver and eligibility to work? Ms. Sirjane-Samples stated yes, eligibility to work is determined at onboarding through the background check. Rep. Oliverson stated so everybody that's driving for Uber and Lyft is here lawfully, eligible to work, and has done an I- 9? Ms. Sirjane-Samples replied yes.

Rep. Oliverson asked if Uber or Lyft do any type of criminal background checking or what are the exclusion criteria and how would that change if they went to an independent contractor status? Ms. Sirjane-Samples stated to be clear, they're independent contractors today. The proposed amendment is just codifying in the model what is already in state statute across the country. Rep. Oliverson stated walk me through what does your criminal background check look like? I'm trying to understand how a guy like the one Ms. Collins described ends up working for one of your companies. Ms. Sirjane-Samples stated that I'm happy to offline go through the entire background process that we have. We use a third-party validator called Checkr, so it's a continuous background check on them. If this was the first time that he was an offender, obviously that wouldn't have shown up on the background check with him, but we do

take sexual assault very seriously on the platform. I will tell you as soon as an allegation is made that comes through, there is immediately a hold on that driver's account until an investigation is done and completed, and they are not allowed to drive on the platform. So, we have continuous monitoring on this situation. Unfortunately, sexual assault is a problem in this country and in this world, and TNCs are not excluded from that.

Rep. Oliverson stated that I understand but I think they need a higher level of scrutiny just given the fact that you've put somebody in a very vulnerable position when they're in your car. I'm looking at this I'm not totally opposed to what you're trying to do, but the last thing I want is more headlines like this. And I need you to convince us that this is not going to open the door to sloppy background check stuff. It's not going to remove your liability in a situation where somebody commits a criminal act against another person. And I'm not convinced right now. Mr. Nail stated that just to clarify, I think the process that Ms. Sirjane-Samples described for Lyft is consistent with Uber's as well. The background checks are codified in your statutes. They are extensive background checks. We can show you examples of them. And again, the language that we're proposing around vicarious liability is not intended, and I believe that the language is correct right now, it would not in any way reduce our liability for either our actions or our inaction. Ms. Sirjane-Samples stated that nor does it reduce our requirements to complete those background checks to the full extent that we are doing today. It does not touch that process. Rep. Oliverson stated that I think that's the rub here. I think if you want to get these amendments passed, I think that's the bar you need to make sure we're all comfortable with is that we're not opening the door to more stories like this.

Sen. Jesse Bjorkman (AK) stated that just for some clarity, across the country there's not a uniform standard of whether TNC or delivery network company (DNC) drivers are employees or independent contractors. That is a point of significant debate across the country. Full disclosure, I've been running a bill in Alaska for Uber. They just pulled support for my bill yesterday. As we look at this issue generally, my concern is we had an accident over the summer in Alaska where somehow a driver was able to waive uninsured and underinsured motorist coverage with a passenger in the back seat. So, there's an accident, Uber gets hit by a drunk driver. Significant loss, very high medical bills. The uninsured motorist is at fault. You have no payer. I don't read in the model where it contemplates uninsured or underinsured motorist coverage, which is a problem. So I'm interested in seeing the model deal with that. The limit that had been proposed by a colleague of mine was very similar to the limit in the model at $1 million, but somehow that was unacceptable to Uber. So as we look at the things that get said in forums like this and then the things that get done across the country, I think we're all not naive enough to realize that those things don't necessarily match up. But as we look at this, I think we need to be careful at changes we make, as Rep. Lehman said, to the P2 period as that has a significant implication on the DNC model act and how companies function under that as well. But I'm concerned with the underinsured and uninsured motorist coverage, and apparently Uber's opposition to that and it might be something to add to the model.

Rep. Meredith asked Mr. Passmore what would be the difference in the risk profile during the P2 part of a TNC versus the DNC coverage model? Mr. Passmore stated for

TNC, you've got a driver who's accepted the ride and trying to get to the customer and if he doesn't get there on time, he could lose the ride. In the DNC model, that delivery doesn't usually get canceled based on when you get there and things like that. So we think that the risk profile or the activity is definitely different in that period. Your typical auto policy has an exclusion for what's called a livery exclusion for holding yourself out for hire and in most cases that policy language is going to be triggered when you hold yourself out for hire, which is when you actually make yourself available to accept a ride on the app. Now, being available means a lot of things. You could be driving around or going to some places where there is a sporting event or near hotels to get a ride but once you've engaged, you are trying to get to a certain place. You have an objective to pick up your customer, and we think that's a difference because you're trying to get there before that cancels.

Rep. Meredith stated that I understand what you're saying related to that, but they're also engaged when they're in delivery phase. There's usually a time that they have said they're going to be there and have that delivered by. They're trying to meet that time or they're going to get bad reviews or or whatever. I think you have that same problem in both pieces of that. Mr. Passmore stated that there are some similarities there. We think it's a little bit different because you actually have a person sitting on the other end who could say, enough of this, I'm going to the other application. I'm going to do something else.

Rep. Sarge Pollock (KY) asked Mr. Nail to elaborate on Sen. Bjorkman's comments on uninsured and underinsured coverage because that's obviously an important segment. Mr. Nail stated that I can tell you what the model contemplated on that coverage which is that it should follow whatever the state law is for personal autos. If the state requires uninsured coverage, it should be carried by the TNC as well at the same state limits. If it's rejectable under your statutes, it's rejectable. That's what the model contemplated and that's what most of the states did. There were a handful of states that imposed a TNC specific much higher uninsured coverage limit and we did see very substantial costs associated with that. So we have worked over the last few years to try to bring those uninsured limits down to reflect more the model limits.

PRESENTATION ON PATHS TO AFFORDABILITY AND AVAILABILITY IN HOMEOWNERS INSURANCE

Sen. Theis stated that last on our agenda is a presentation on paths to affordability and availability in homeowners insurance. This issue is unfortunately one of the most talked about issues in the insurance marketplaces as several state insurance markets have been experiencing significant issues with their homeowners' insurance markets. As we can see in states like California and Alabama, there are measures that states can take to improve things. Today, we'll hear from our speakers who can offer up some solutions that states can take to better their homeowners markets and perhaps equally as important, offer up some things that states shouldn't do as well.

Fox Parker, Senior Director at the US Chamber of Commerce, thanked the Committee for the opportunity to speak and stated that I am delighted to be here to discuss a few

high-level points from our white paper we published last November titled, The Path to Affordability and Availability in Homeowners Insurance. The chamber represents over 3 million businesses across the country and I can tell you that the stability of the homeowners insurance market is a top concern we hear from our members. Not just from our insurers, but from builders, realtors, lenders and small business owners whose livelihoods depend on a healthy housing market so this issue truly cuts across the entire economy. Across the country, constituents are feeling the pinch of rising premiums and in some regions, the lack of available coverage. This a dual crisis of affordability and availability and I want to acknowledge that this personal for people. We're talking about families who are seeing rising premiums or getting non-renewal notices and scrambling to find coverage. That's real and it is urgent.

But as our white paper outlines, the solution isn't artificially capping rates. We cannot regulate our way to lower premiums. History has shown us that when we try, insurers exit markets, consumers are left with fewer options and often end up in state residual markets that provide less coverage at a higher cost. True affordability and availability can only be achieved by reducing the underlying risk itself. If we reduce the risk, we stabilize markets. Carriers compete and consumers benefit. Let's look at what's driving up the baseline cost of that risk. Even before a storm hits, the economics of rebuilding have changed drastically. Inflation and the cost of materials are massive drivers of affordability issues. Post-COVID, we saw costs of construction materials like lumber double at times, alongside severe skilled labor shortages. And it just wasn't lumber. Concrete, roofing materials, electrical and electrical components, virtually every input in the construction supply chain saw significant price increases. On top of that, the labor market tightened considerably. Skilled tradespeople were already in short supply before the pandemic, and that gap has only widened, driving up the cost and timeline of repairs and rebuilds.

Insurance is a lagging indicator, and years after historic inflation, it has become clear that rate increases in some areas were necessary. The graph here illustrates how inflation disproportionately impacts the insurance industry. As you can see, the consumer price index for all items from 2020 to 2023 was just over 19%. We all hear about the rising cost of eggs, milk, beef. But look at how much higher construction services and materials are compared to the average cost of all items. Double and nearly double. That gap is critical to understanding why premiums have moved the way they have. When the cost to repair a home jumps by 30 to 40%, insurance premiums eventually have to reflect those economic realities to ensure claims can be paid. An insurer that doesn't adjust for those costs simply cannot fulfill its promises to policyholders when disaster strikes. While economic inflation is national, the physical drivers of costs are highly regional. A policy that works for mitigating wildfire risk in the West is fundamentally different from addressing convective storms in the Midwest or hurricanes in the Southeast. And we are seeing risk patterns emerge as well. States that historically didn't worry about certain perils are now facing them with increased frequency and severity. Because costs are driven regionally, it will take different tailored solutions for different states.

This is exactly why state-based regulation and the work you all do here at NCOIL is so vital. A one size fits all federal approach simply cannot account for the diverse risk across the country. As you can see from this map of Florida, populations are moving into higher risk areas where people were not living 20, 30, 40, 50 years ago. Coastal development has exploded and with it concentration of insured value in catastrophic zones. Parts of Oklahoma have always experienced significant hail. The difference now is that people are living in those areas and roofs are now in the path of those hailstorms. More people in harm's way means more exposure, more claims, and ultimately higher costs for everyone in the market. While we need to address the physical and economic risks, we also have to recognize regulatory burdens are real. When rate adjustments are artificially delayed during inflationary periods, insurers mathematically are forced to pull back, hurting consumers in the long run. When an insurer withdraws from a market, it means fewer choices for homeowners, less competition, and often migration for policyholders to state-run plans of last resort, which typically offer narrower coverage.

However, this challenge presents an opportunity. States have the power to carefully evaluate their specific risk profiles and institute smart policy frameworks. By modernizing rate approval processes and allowing for accurate risk-based pricing, states can attract insurers back to their markets. We've seen this work and states have taken proactive steps to streamline their regulatory processes. Those states have seen increased carrier participation, and more competitive offerings for consumers. The goal should be encouraging consumers towards the private market because the private market is well positioned to understand and accurately manage complex risk. Private insurers invest heavily on data modeling and underwriting expertise when they're allowed to operate in a fair regulatory environment and consumers in turn get better products, better service and more options. One of the most effective ways to lower the underlying risk is through physical mitigation. Stronger homes equal fewer claims, which equals stabilized premiums. When we build stronger homes, homes survive. Look at Alabama and Kentucky as prime examples. Alabama's program to retrofit homes with fortified roofs has proven incredibly successful at mitigating damage from severe weather and actively reducing claims costs and stabilizing the local market.

We've seen homes with fortified roofs standing virtually untouched next to homes that were severely damaged by the same storm, and that is powerful evidence.
Kentucky has similarly embraced enhanced building codes and partnerships to combat tornado and wind risk. These states are proving that resiliency pays off not just in saved lives, but in real economic terms. The Chamber and the US Chamber Foundation have done significant work on resiliency. Our research paper, The Preparedness Payoff, finds that for every $1 spent on pre disaster mitigation, a community will save $13 in economic costs, damages and cleanups. Think about that return: 13 to 1. Any person would take that that type of payback. While initial costs of mitigation and resiliency may seem high, the money saved on recovery and the preservation of economic activity will more than pay for those investments. Beyond the dollar figure, resilient communities recover faster, keep businesses open and keep families in their homes. I want to commend NCOIL's leadership on this point. The NCOIL Strengthen Homes Model Law is exactly the kind of forward-thinking policy the Chamber supports. By establishing a model framework for state grant programs to help homeowners retrofit their properties, NCOIL is handing

states a blueprint to directly reduce risk. These grant programs are especially important for lower and middle income homeowners who want to protect their homes but may not have the upfront capital to invest in retrofits on their own. If broadly adopted, this model act can help stabilize insurance markets across the country. The chamber also supports building more resilient communities alongside home retrofits to compound the protections for homeowners and businesses. When we pair stronger individual homes with resilient infrastructure, better drainage, hardened utilities, updated community building codes, the cumulative effect on risk reduction is substantial.

Finally, we cannot talk about cost drivers without talking about legal system abuse. Excessive litigation is a man made disaster that drives up premiums for everyone. Unlike a hurricane or wildfire, this cost driver is entirely within our power to fix. We have seen how tort reform benefits the marketplace, most notably in Florida. After facing a truly dire market crisis fueled by litigation, where Florida accounted for a disproportionate share of the nation's homeowners insurance lawsuits despite having a fraction of its total claims, Florida legislators passed comprehensive reforms targeting fee multipliers and assignment of benefit abuse. Today we are seeing insurers re-enter the Florida market and premium rates decrease. This is a direct result of the legislative action and is a model worth studying. The chamber is also incredibly optimistic that we will see similar market improvements in Georgia following their recent and ongoing tort reform efforts.

The chamber spends a considerable amount of time on legal-related cost drivers. The cost of lawsuits, specifically tort cases, are massive and rising. According to the latest research from my colleagues at the Chamber's Institute of Legal Reform, costs and compensation in the tort system amounted to $529 billion in 2022. That's the equivalent of 2.1% of GDP and equates to $4,200 per American household. That is a hidden tax on every American family and if current trends continue, overall tort costs will rise to $900 billion by 2030. That trajectory is simply unsustainable, and it underscores why meaningful tort reform must be part of every conversation in every state. In conclusion, everyone here knows that the challenges in property and casualty insurance are complex but there are common sense solutions available to your respective states. The three pillars we discussed today, physical resilience, sensible regulatory flexibility, and meaningful tort reform are not theoretical. They are proven strategies that are already working across the country. By championing these approaches, legislatures can promote affordability and availability for their constituents. The US Chamber looks forward to partnering with you in upcoming legislative sessions to build stronger, more resilient state insurance markets and we are ready to bring our resources, research and national network to support your efforts. I have a QR code and you can scan that and dive deeper into the white paper including additional data case studies and policy principles.

Mr. Passmore thanked the committee for the opportunity to talk about some trends and cost drivers that impact homeowners insurance as well as some solutions. The good news is that homeowners rate increases are significantly slowing. The chart on the left shows that homeowners insurance rate increases spiked following the record inflation of 2022, slowed slightly in 2024 but still remained at double digit levels, then dropped back down to an average of 6% last year. The early data that we're hearing for 2026 suggests that rate increases may slow even further, although probably still at a slightly higher level

than inflation or median wage increases. The right graph is the cost of replacing buildings in the U.S. which is the primary cost driver for homeowners. You can see that it spiked in the early 2020s, but the increases are flattening somewhat in 2023 and 2024, and probably even more in 2025. But stability doesn't mean highly profitable. Over the long term, homeowners insurance has generated relatively modest returns, often below the cost of capital. Capital levels are rebuilding, reinsurance capacity is improving, and pricing has become more competitive which means availability pressures are easing, but affordability remains the longer-term challenge for consumers and policymakers. Weather risk remains the biggest single source of uncertainty, including discussion around a potential super El Nino. That doesn't necessarily mean more losses, but it does mean shifting risks across regions as we see different kinds of events in different areas.

And the takeaway is that the industry is moving towards stability, but volatility driven by extreme weather isn't going away. If we narrow the view to just the last 10 years, we see that insurers had a cumulative underwriting loss of just a little bit more than $47 billion. The industry experienced a profit in 2024, though not enough to offset steeper losses in those immediate prior years. This has led to an average return on net worth for the industry that's much lower than for the broader economy, and the results are even worse for homeowners insurance, raising red flags for investors. And then the chart on the right, you'll see green is the Fortune All Industry Average, which is a little bit over 14%. You can see that yellow is the countrywide property casualty insurance average, which is around 6%, and then the homeowners countrywide is on the red. But that kind of return on capital is what's causing market availability imbalances. There are three tiers of cost drivers for homeowners insurance. First is macroeconomic pressures. Economic growth and inflation are our primary cost drivers, both of which have slowed although have not started to decline. Tariffs, labor supply impacts, oil prices, all those things affect the cost of building materials and labor. The second bucket is our demographic shifts into hurricane and fire-prone areas. Those continue but are slowing somewhat. Climate change continues, although we were fortunate to avoid catastrophic hurricanes this year. The third bucket can be what we could categorize as government risk. That includes coverage mandates and regulatory rate suppression, but legal system abuse is the flashing danger signal, as you heard from the chamber, with contractor liability losses also directly impacting building costs.

Drilling down a little bit on the cost trends, the left graph shows the natural catastrophe losses roughly doubling over the last decade. The right graph shows the cost of replacing structures in use in the US, also more than doubling. While the weather events are more severe, the biggest driver is homes are becoming larger and far more expensive to replace. Inflation escalated to 9.1% in 2022. That was a 40-year record. Building material and labor costs escalated far more than inflation, roughly 39% over the last five years, and those costs feed directly into homeowners insurance rates. California experienced some of the most severe weather events this year, actually over the last 10 years, ranking only behind Texas and Florida for losses from wildfires, storms, droughts and floods. And even excluding the most recent wildfire, losses have increased dramatically due to inflation, as population shifts into more risky areas and the effects of climate change are felt. This slide is from Verisk, and it illustrates what they call habitational, which is homeowners and commercial property insurance premiums

per location and that's expected to grow approximately 9% between 2025 and 2028. You can see the growth projections vary widely by state, with the highest increases in green.

Contractors liability also varies significantly across the states, with the highest severity in states such as California, New York and Florida. Loss ratios for contractor-related liability lines are running significantly higher than historical norms and are a major drag on housing affordability. Availability pressures are driven by a simple supply and demand imbalance. Demand is increasing due to higher rebuilding values, demographic growth, inflation, worsening weather and legal system abuse. Supplies are decreasing because losses have been outpacing rates and capital has contracted, and the returns have been too low to attract new investment.

The best long-term solution to reduce homeowners insurance costs is stronger mitigation and resiliency and insurers have been working with policymakers, supporting infrastructure investments and stronger building codes, funding research, and advocating for financial support to improve resilience. Property casualty insurers fund the Insurance Institute for Business and Home Safety (IBHS), which developed the Fortified building standards. Those programs strengthen buildings through improved roofing, load paths and construction practices, and early results are showing meaningful loss reduction. As Mr. Parker mentioned, Alabama has led the nation in fortified homes. The Alabama Insurance Department did a study following Hurricane Sally and found that homes built to fortified standards experienced between 66% and 71% lower losses than those that did not and homes with fortified roofs performed over 50% better compared to non-designated homes. These results are a powerful testament to the benefits of mitigation.

You heard Mr. Parker talk about legal system abuse. Florida took steps to address legal system abuse head on through their tort reform that they passed recently. Claims that reform harmed consumers are contradicted by improved rate stability, affordability, and market availability. Since the passage of Florida's legal reforms, insurers have reduced rates, litigation filings are down sharply, and new insurers have entered the marketplace. And Citizens, which is the state-run insurer of last resort in Florida, has been depopulating. So, these reforms are producing real consumer benefits. Florida has seen some of the strongest homeowner insurance rates improvements in the nation following reforms. Litigation has declined, rates have stabilized and turned negative, and affordability has improved meaningfully. On, this chart, you'll see the homeowners rate increase slide that I showed you in the beginning with the red is the countrywide average, and the blue is Florida. You can see the dramatic improvement in the reduced number of rate changes that have occurred since those reforms took place.

Paul Martin, VP of State and Policy Affairs at the National Association of Mutual Insurance Companies (NAMIC) thanked the committee for the opportunity to speak and stated that I'm going to hit on some very high level points as we've had two excellent presentations ahead of mine. This is the chart. When we talk about loss ratios, this what we talk about. The loss ratios for the last 25 years have averaged one and 2.7. That means for every $1 of premium that has come in nationwide for homeowners insurance, companies have paid out almost $1.30. So, this a challenging market, challenging line of

business to do in the U.S. Why roof age matters. We saw some legislation from a number of states this year regarding the ability of insurance companies to use roof age in underwriting. Our friends at IBHS have done some research, and they determined once the asphalt shingle roof hits somewhere between eight and 10 years old, it becomes much more susceptible to damage and because the roof-related damage accounts for somewhere between 70% and 90% of insured losses, an aging roof stock in the country will drive higher claims costs. If your 40-year warranty on your roof performs like a 10-year-old roof, the warranty is a marketing document. The warranty is about the workmanship creating the shingle. It is not a guarantee that the roof will last those number of years. So I think policymakers need to remember that as we go through and discuss this.

We all know what a 100-year event is. It's an event that has a 1% chance of happening in any given year but there is this thing called cumulative probabilities that we need to keep in mind. Because if the 100 year event doesn't happen this year, it just means there is a greater chance next year it will happen. So, let's look at this slide a little bit more. This is from our friends at the National Weather Service in New Orleans, it talks about flood risk. It doesn't matter what the peril is, the math is the same. What we hear from you when we have conversations is, "We want insurance companies to devote capital long-term to our state." So, what does that look like? Well, the 30-year risk: if you take a 30-year mortgage, there is a 26% chance that home during the life of the 30-year mortgage will have a 100 year event. That is what the insurance company is signing up for when they agree to start insuring a home. And hopefully, that policyholder stays with the insurance company for 30 years. Add to that the volatility that we're seeing in these 100 year events. In the last 25 years, the North Carolina coast has had nine 100 or 1,000-year events. According to ABC News, in wildfire-prone states, the 100 year, particularly in states like Colorado and New Mexico, are now happening every five years.

Every day that passes without one of these events just means the odds that event will occur increase every single day. I want to draw your attention to the far left side of the slide. That's garden variety inflation over the last five years. Look at asphalt shingles. Asphalt shingles is almost twice garden variety inflation. These insurance companies sitting behind me that write property, they spent a lot of money on shingles, and that price has gone up dramatically since the pandemic. One of the challenges we see and one of the challenges we hear about is the fact that median household incomes are not growing as fast as homeowners premiums. That is absolutely true. Part of it is because wages just don't grow as fast. Part of it is because asphalt shingles now cost 44% more than they did five years ago. These are the real drivers and the real things that are impacting homeowners. What is not the problem? We've seen a number of bills across the country this year for states that want to regulate rates more than they already are. We've seen legislation that gives Attorney Generals the ability to intervene in rate filings and rate discussions and rate hearings with regulators. We've seen more restrictions on underwriting freedom and tools. We've seen legislation that would require flood coverage under homeowners policies. Making it harder and more expensive to write insurance in your state will not make insurance more affordable, nor more available.

Now, I know you're not federal legislators, but sometimes they listen to you more than they listen to us. That is why it's so critical when you talk to your federal colleagues about why we need to fund the Federal Emergency Management Agency (FEMA) and why we need to fund the Weather Service. A lot of insurance companies use data to calculate premiums, and when that data is not available, it is much more difficult to get an actuarially precise rate set. When you defund the weather service today, you expand the disaster relief budget tomorrow. That is the message we are giving federal legislators. You heard yesterday about the big National Association Insurance Commissioners (NAIC) data call coming up. I'm going to tell you what that report's going to say. Homeowners' insurers are not making money year over year. They are working to stay ahead of a more dangerous, more expensive world. And we're now seeing more billion dollar events than we have in the years prior.

The three R's that this report will generate. The story is about roofs, rebuilding cost and raging weather. That is what we think this report is going to show. So, over the last 25 years, insurers have paid out basically every dollar they've taken in in premium for homeowners. More government regulation does not mean more affordability and availability. Roof age matters. Shingles don't last as long as we'd like. Each day is a day closer to the next 100 year event we'll have this decade. And when the NAIC data call comes out and supports what we've been saying, what happens then? What are we going to do with that information? I think those are the conversations we need to be having.

The challenge in two sentences. Frequency of storms, rising claim costs, inflation drive premiums and premiums are outpacing real wage growth. At some point, these problems stop being insurance problems and they start being societal problems. Folks, we can't fix the societal problems. We can't fix inflation. We can't fix the weather. These are problems that are beyond our control. We have to work on the things we can control. So, what are those things? Well, at the federal level, we need FEMA funding for pre-disaster mitigation. We need the Department of Interior to work, particularly west of the Rockies, in our forest to make sure that we're doing everything we can to prevent these large wildfires. We need to be utilizing the tax code and HUD regulations to build better, and we need to be promoting more innovative research on building materials. And at the state level, what can we do? Same thing we've been telling you. Better building codes, better land use codes and enforcement. Identifying the cost drivers, especially within property insurance litigation, and identifying the rate underwriting and regulatory friction points and addressing those as well.

Rep. Matt Morgan (TX) stated that I heard a lot about the increased cost of building materials which I see when I go to Home Depot, but that doesn't actually translate into claims. And I say that because I've been in claims for 25 years in this industry, so I've written estimates forever. And if you use the Xactimate software, which people use for writing homeowners' claims damages for roofs and stuff, and I have actually done this and took the exact same home wrote the exact same estimate and changed the pricing model from a decade ago to today on a standard home, the estimate has changed very little in a decade on what the insurance company would pay a decade ago to what they'll pay today. So, I do agree that materials are going up and I do agree that shingles are

going up and I 100% agree that after about eight to ten years, asphalt shingle roofs become significantly more susceptible to losses, and we need to work on fortifying things. But I think some of you that are doing research on this are skipping that point and should look at Xactimate data sets when you're actually making your analysis on what's driving the cost of insurance because I don't think your data is actually encompassing what you're trying to encompass. You're just looking at raw numbers of information not actually what's being paid for claims, and that's what would drive the cost.

Mr. Passmore stated that it sounds like you might be more familiar with the Xactimate tool than I am, but my understanding is that the pricing comes from the marketplace and that's updated as we go. So I need to do a little bit more research myself to see why that would be the case, and I don't know whether it's a matter of updating the software. Structurally, you still have to replace shingles. You still have to replace, in some cases, underlayment roof material sheathing all that kind of stuff. So, the number of steps and things you have to do are there but the cost of those different elements has clearly gone up and I guess I'm not understanding why it shouldn't be reflected in the Xactimate pricing. Rep. Morgan stated that I literally wrote the exact same estimate and just changed the pricing because you can change what month, what year of the pricing system in Xactimate and it literally went up a de minimis amount over a decade. So, I suggest you guys look at that when you're actually making analysis.

Rep. Brian Lampton (OH) stated that I am an insurance agent and kind of tired of delivering huge rate increases on homeowners. One of the emphasis points from my carriers are insurance to value. It seems like it's a never-ending battle. Are they making progress in that area? Mr. Martin stated I think the short answer is yes. Invariably, what happens is that when companies are attempting to calculate the insured to value, the quote process is 15, 30 minutes. The claims process is hours if not days and so the more time you spend in getting the insured to value right on the front end, the more accurate it will be. What we find is that consumers oftentimes don't want to spend the time. Understandably so. I'm not being critical of the consumer. It's just the reality and that's what we're trying to fix. I think what we're seeing is that as these claims become more frequent and more severe, good news, bad news is we get more data and when we get more data, I think the industry is getting better at calculating that more rapidly than perhaps we were years ago.

Sen. Bjorkman stated that I think one of the big drivers of more legislation and mandates from insurance really stems from a lack of clear communication from insurers to consumers about what they should expect from their policy and how it will perform. We saw significant angst when we have flooding events and insureds need a denial in order to apply for FEMA funding and then they make a claim and get a denial and then they're dropped by their insurer. That creates an outcry from the public because of what many people would see as a negative or bad business practice from. Also, when we have insurers increasing to non-renew policies due to X, Y, or Z reason, then you have outcry from the public saying, government, we want you to regulate business because we believe that business is treating us unfairly. I'm not sure how to balance that as a policymaker. If I have a constituent coming to me saying, "Hey, my garage burned down with all my stuff in it a year ago, and my insurance company still hasn't paid." As

policymakers, what would you like us to do? If insurance companies aren't following the laws and we need tighter guidelines and better sideboards for insurance policies and insurers to provide a benefit that people have paid for. It's not going to result in better outcomes if you have homeowners who pay for a policy for decades and then they make two claims in three years and their insurance company drops their coverage. And oh, by the way, the claims that they made might have been worth maybe 50% of what they paid in premiums over that same period of time. That type of activity by insurance companies begets more legislative oversight and more laws that are going to negatively impact your market. So, there has to be a balance there somewhere.

Mr. Parker stated that I would just say on the consumer education piece of it, I completely agree with you. I think consumers need to understand how these policies work and the chamber is starting to think about how we can kind of be the leading financial education voice around insurance. But I think a lot of the frustration comes from consumers not fully understanding their insurance products. So, I fully agree with that.

Sen. Beverly Gossage (KS) stated that this is regarding proximity to a fire station. I've been in my home for 44 years. The first 41 years I had the same carrier, no issues. Bad hailstorm, used the policy one time and to my surprise I received my statement from my mortgage company. And I'm like, what has happened? And they said you need to talk to your insurance company. Your rate more than doubled for your homeowners. And this was years after the hailstorm. When I called, they said, "Oh, I don't know why. Let me look it up." "Oh, it's because you're now in zone 10." Okay, well my house hasn't moved. So, what does that mean I'm in zone 10? Yeah, I don't know. We have this system that we use. When I went to the fire station, they said, Senator, it looks to me like you should be in zone three. I don't know what they're talking about. I live in the country three miles from two small towns. Three different fire stations would respond to my home if I called and said "I have a fire." And what I was told was this - all of these insurance companies use the same system, and so now this insurance company has moved over to that system. The only one that doesn't is State Farm. You may want to call them. I called State Farm and saved a lot of money. This is not a State Farm commercial. But I'm just saying, what is this system? And I think it would help lower rates, we're talking about affordability, instead of just looking at a system or some artificial intelligence program, to actually look at a house hasn't changed and still has three fire departments that can go there.

Mr. Martin stated that the system you're referring to is the ISO system. Fire departments are rated generally on a scale of one to ten, depending on whether or not they're volunteers or full or part volunteers or full time paid and what type of equipment they have. That is because those things factor in response times. Those things factor in terms of how much damage would be done to a home after a fire. It sounds like what you did was you shopped around and you save money when you shop around and the industry spends lots of money encouraging people to shop around to get a better deal. That is why we think a strong marketplace is so necessary, so that people can, as their life situation changes and as other things change, they can go out and get the coverage they need, maybe from a different company than they do business with right now.

Sen. Gossage stated that I was only able to shop one other carrier. If everybody else is using this same program, that's a problem, right? Doesn't that become a monopoly on this particular system? Mr. Martin stated that I don't know that we'd call it a monopoly because there's no reason why other vendors couldn't do the same thing. Somebody else could also set it up. But that is a system that, you know, you spend a lot of money to figure out what the risks are associated with any given house in any given jurisdiction because of whatever fire department they have. I will tell you from personal experience that just because you improve your fire rating, I live in Austin Texas. I live directly across the street from my fire station. That's how close my house is. We went from ISO two to ISO one. Number one is the best. And the city council people were like, well, why didn't my homeowner's premiums go down? Because there's not a rate delta associated from going from ISO two to ISO one.

ADJOURNMENT

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

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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. Re-adopted by the Property & Casualty Insurance Committee on April 18, 2026 and Executive Committee on April 19, 2026 until the 2026 Summer Meeting.**

***To be considered for re-adoption by the Property & Casualty Insurance Committee during Summer Meeting in July, 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.

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NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

Model Act Regarding Insurers' Use of Aerial Images

Sponsored by Rep. Matt Lehman (IN) and Rep. Brian Lampton (OH).
****Co-sponsored by Rep. Matt Morgan (TX)***

Draft as of May 18, 2026. To be discussed during the meeting of the Property & Casualty Insurance Committee on July 18, 2026.

Table of Contents

Section 1. Title
Section 2. Purpose
Section 3. Scope
Section 4. Definitions
Section 5. Insurers' Use of Aerial Images
Section 6. Rules
Section 7. Effective Date

Section 1. Title

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

Section 2. Purpose

The purpose of this Act is to honor consumer's traditional rights with regard to property insurance in the face of advancing aerial technologies.

Section 3. Scope

This Act applies to personal insurance and not to commercial insurance or excess and surplus insurance.

Section 4. Definitions

(d) "Aerial image" means an image of a named insured's property captured from an airborne platform.

(e) “Non-renewal” means a termination of property insurance coverage that occurs at the end of the policy term.

(f) “Renewal” means:

(1) the issuance and delivery by an insurer at the end of a policy period of a policy superseding a policy previously issued and delivered by the same insurer; or

(2) the issuance and delivery of a certificate or notice extending the term of an existing policy beyond its policy period or term.

Section 5. Insurers’ Use of Aerial Images

When utilizing aerial images as the sole reason for non-renewing a policy, an insurer shall:

(a) Ensure that the non-renewal notice sent to the named insured include information about how the named insured can request to review copies of the images of the property that were used to make the decision. Photos must have been taken within the past twenty-four (24) months.

(b) Establish a point of contact and a process for the name insured to use to provide documentation of completion of the required work that the insurer communicates to the insured in subsection (a). This documentation must be used by the insurer in considering whether to uphold or reverse the non-renewal.

(c) Establish an appeal process that allows the named insured to correct any errors or misunderstandings related to the non-renewal.

(d) Provide the named insured a time period consistent with notice requirements of this state to cure the defects or conditions underlying a non-renewal after the date the insurer identifies the specific conditions under subsection (a). An insurer shall have the right to assess the work used to cure the defects or conditions to ensure they have been corrected in a manner that meets the standards originally communicated by the insurer in subsection (a).

Drafting Note: States are encouraged to amend their non-renewal notice laws to ensure that the non-renewal notice period is at least 60 days.

(e) Offer a renewal policy to the named insured who submits proof that they have cured the defects or conditions identified in subsection (a). However, an insurer may non-renew the policy only for a reason unrelated to the defects or conditions identified under subsection (a).

Section 6. Rules

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

> *Drafting note: As part of the rules adopted to effectuate the provisions of this Act, States may wish to include rules that set forth the minimum and maximum sizes of the photos referenced in subsection 5(a).*

Section 7. Effective Date

This Act shall take effect xxxxxx.

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National Council of Insurance Legislators (NCOIL)

Distracted Driving Model Act

Sponsored by Sen. Bob Hackett (OH) and Asm. Ken Cooley (CA)

Adopted by the Property & Casualty Insurance Committee and Executive Committee on April 18, 2021.

To be considered for re-adoption during the meeting of the Property & Casualty Insurance Committee on July 18, 2026.

Table of Contents

Section 1. Title
Section 2. Purpose
Section 3. Definitions
Section 4. Operation
Section 5. Penalties
Section 6. Enforcement and Reporting
Section 7. Effective Date

Section 1. Title

This Act shall be known and may be cited as the “[State] Distracted Driving Act.”

Section 2. Purpose

This Model provides a structure to strengthen distracted driving laws across the country by establishing a comprehensive hands-free law to curb driver distraction, including manual, visual and cognitive distraction, to reduce highway fatalities, save lives, reduce auto crashes and make roads safer. The Model enables law enforcement to ticket drivers for holding a mobile device and limits use of a mounted or “hands-free” device while operating a motor vehicle, including texting, viewing videos or images, entering data, and talking or broadcasting content. Exceptions are provided for emergencies, for certain voice-activated technology, for navigation, and for “single swipe” activation as long as the device is not held by the driver or used to engage in viewing distracting content. The increased prevalence of smartphone technology and expansion of its capability and potential for use has exacerbated distraction behind the wheel. Along with heightened public awareness, targeted research, and the development of technology to mitigate risks,

the enactment of primary enforcement laws is an important part of the strategy to reduce traffic deaths and life altering crashes.

Section 3. Definitions

'Stand-alone electronic device' means a portable device other than a wireless telecommunications device which stores audio or video data files to be retrieved on demand by a user.

'Utility services' means and includes electric, natural gas, water, waste-water, cable, telephone, or telecommunications services or the repair, location, relocation, improvement, or maintenance of utility poles, transmission structures, pipes, wires, fibers, cables, easements, rights of way, or associated infrastructure.

'Wireless telecommunications device' means one of the following portable devices:

(1) a cellular telephone;
(2) a portable telephone;
(3) a text-messaging device;
(4) a personal digital assistant;
(5) a stand-alone computer, including but not limited to a tablet, laptop or notebook computer;
(6) a global positioning system receiver;
(7) a device capable of displaying a video, movie, broadcast television image, or visual image; or
(8) Any substantially similar portable wireless device that is used to initiate or receive communication, information or data.

Such term shall not include a radio, citizens band radio, citizens band radio hybrid, commercial two-way radio communication device or its functional equivalent, subscription-based emergency communication device, prescribed medical device, amateur or ham radio device, or in-vehicle security, navigation, communications or remote diagnostics system.

"**Voice-operated or hands-free feature or function**" means a feature or function that allows a person to use an electronic wireless communications device without the use of either hand, except to activate, deactivate, or initiate the feature or function with a single touch or single swipe.

Section 4. Operation

(A) The driver of a school bus shall not use or operate a wireless telecommunications device, as such as term is defined in Section 3 of this Act, or two-way radio while loading or unloading passengers.

(B) The driver of a school bus shall not use or operate a wireless telecommunications device, as such term is defined in Section 3 of this Act, while the bus is in motion, unless it is being used in a similar manner as a two-way radio to allow live communication between the driver and school officials or public safety officials.

(C) A driver shall exercise due care in operating a motor vehicle on the highways of this state and shall not engage in any actions which shall distract such driver from the safe operation of such vehicle.

(D) While operating a motor vehicle on any street, highway, or property open to the public for vehicular traffic in this state, no individual shall:

> (1) Physically hold or support, with any part of his or her body a:
>
> > (a) Wireless telecommunications device; or
> >
> > (b) Stand-alone electronic device;
>
> (2) Write, send, or read any text-based communication, including but not limited to a text message, instant message, e-mail, or social media interaction on a wireless telecommunications device or stand-alone electronic device; provided, however, that such prohibition shall not apply to a voice-operated or hands-free communication feature which is automatically converted by such device to be sent as a message in a written form; or
>
> (3) Make any communication, including a phone call, voice message, or one-way voice communication; provided, however, that such prohibition shall not apply to a voice-operated or hands-free communication feature or function
>
> (4) Engage in any form of electronic data retrieval or electronic data communication on a wireless telecommunications device or stand-alone electronic device;
>
> (5) Manually enter letters, numbers, or symbols into any website, search engine, or application on a wireless telecommunications device or stand-alone electronic device;

(6) Watch a video or movie on a wireless telecommunications device or standalone electronic device other than watching data related to the navigation of such vehicle; or

(7) Record, post, send, or broadcast video, including a video conference on a wireless telecommunications device or stand-alone electronic device; provided that such prohibition shall not apply to electronic devices used for the sole purpose of continuously recording or broadcasting video within or outside of the motor vehicle.

(E) While operating a commercial motor vehicle on any highway of this state, no individual shall:

(1) Use more than a single button on a wireless telecommunications device to initiate or terminate a voice communication; or

(2) Reach for a wireless telecommunications device or stand-alone electronic device in such a manner that requires the driver to no longer be:

(a) In a seated driving position; or

(b) Properly restrained by a safety belt.

(F) Each violation of this Code section shall constitute a separate offense.

Section 5. Penalties

(A) Except as provide for in paragraph (B) of this section, any person convicted of violating this Act shall be guilty of an unclassified misdemeanor which shall be punished as follows:

(1) For a first conviction with no conviction of and no plea of no contest accepted to a charge of violating this Act within the previous 24 month period of time, as measured from the dates any previous convictions were obtained or pleas of no contest were accepted to the date the current conviction is obtained or plea of no contest is accepted, a fine of not more than $150.00 and charged two (2) points.

(2) For a second conviction within a 24-month period of time, as measured from the dates any previous convictions were obtained or pleas of no contest were accepted to the date the current conviction is obtained or plea of no contest is accepted, a fine of not more than $250.00 and charged three (3) points.

(3) For a third or subsequent conviction within a 24-month period of time, as measured from the dates any previous convictions were obtained or pleas of no contest were accepted to the date the current conviction is obtained or plea of no contest is accepted, a fine of not more than $500.00, charged four (4) points, and at the court's discretion, suspension of the offender's driver's license for a period of 90 days.

(B) Any person appearing before a court for a first charge of violating Section 4 (D)(1) of this Act who produces in court a device or proof of purchase of such device that would allow such person to comply with such paragraph in the future shall not be guilty of such offense. The court shall require the person to affirm that they have not previously utilized the privilege under this paragraph.

(C) Any person convicted of a violation of any law or ordinance pertaining to speed when the offender also was distracted, as defined in this Act, shall be charged points as follows:

(1) when the speed exceeds the lawful limit by thirty miles per hour or more, six (6) points

(2) When the speed exceeds the lawful speed limit of fifty-five miles per hour or more by more than ten miles per hour, four (4) points

(3) When the speed exceeds the lawful speed limit of less than fifty-five miles per hour by more than five miles per hour, four (4) points

(D) Any person who causes physical harm to property as the proximate result of committing a violation of this Act is guilty of a misdemeanor of the first degree. In addition to any other authorized penalty, the court shall impose upon the offender a fine not less than five hundred dollars and not more than one thousand dollars.

(E) Any person who causes serious physical harm to another person as the proximate result of committing a violation of this Act is guilty of aggravated vehicular assault and shall be punished according to this STATE's CRIMINAL CODE.

(F) Any person who causes the death of another as the proximate result of committing a violation of this Act is guilty of aggravated vehicular homicide and shall be punished according to this STATE'S CRIMINAL CODE.

DRAFTING NOTE: States should consider aligning property damage, injury, and/or death with equivalent driver intoxication offenses and penalties.

(G) Section 4 (D) and (E) of this Act shall not apply when the prohibited conduct occurred:

(1) While reporting to state, county or local authorities a traffic accident, medical emergency, fire, an actual or potential criminal or delinquent act, or road condition that causes an immediate and serious traffic or safety hazard;

(2) By an employee or contractor of a utility services provider acting within the scope of his or her employment while responding to a utility emergency.

(3) A person operating a commercial truck while using a mobile data terminal that transmits and receives data;

(4) By a law enforcement officer, firefighter, emergency medical services personnel, ambulance driver, or other similarly employed public safety first responder during the performance of his or her official duties; or

(5) While in a motor vehicle which is lawfully parked.

Section 6. Enforcement and Reporting

(A) When a law enforcement officer issues a citation for a violation of this Act, the law enforcement officer must record the race and ethnicity of the violator. All law enforcement agencies must maintain such information and report the information to the [State Agency] in a form and manner determined by the [State Agency]. Beginning one year after enactment, the [State Agency] shall annually report the data collected under this Act to the Governor, the President of the Senate, and the Speaker of the House of Representatives. The data collected must be reported at least by statewide totals for local law enforcement agencies, state law enforcement agencies, and state university law enforcement agencies. The statewide total for local law enforcement agencies shall combine the data for the county sheriffs and the municipal law enforcement agencies.

(B) A law enforcement officer who stops a motor vehicle for a violation of this Act must inform the motor vehicle operator of his or her right to decline a search of his or her wireless communications device and may not:

(1) Access the wireless communications device without a warrant.

(2) Confiscate the wireless communications device while awaiting issuance of a warrant to access such device.

(3) Obtain consent from the motor vehicle operator to search his or her wireless communications device through coercion or other improper method. Consent to search a motor vehicle operator's wireless communications device must be voluntary and unequivocal.

Section 7. Effective Date

This Act shall become effective________________.

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National Council of Insurance Legislators (NCOIL)

COVID-19 Limited Immunity Model Act

Sponsored by Rep. Bart Rowland (KY) *Co-Sponsored by Rep. Matt Lehman (IN)

Adopted by the Property & Casualty Insurance Committee on February 19, 2021, and the Executive Committee on April 18, 2021.

To be considered for re-adoption during the meeting of the Property & Casualty Insurance Committee on July 18, 2026.

Section 1. Title

This Act shall be known and may be cited as the "[State] COVID-19 Limited Immunity Act."

Section 2. Definitions

(A) "Arising from COVID-19" means an injury or harm caused by or resulting from:

(1) the actual, alleged, or possible exposure to or contraction of COVID-19; or

(2) services, treatment, or other actions performed, not performed, or delayed in response to COVID-19.

(3) The term "arising from COVID-19" includes:

(a) the implementation of policies and procedures to prevent or minimize the spread of COVID-19;

(b) testing;

(c) monitoring, collecting, reporting, tracking, tracing, disclosing, or investigating COVID-19 exposure or other COVID-19 related information;

(d) using, designing, manufacturing, providing, donating, or servicing precautionary, diagnostic, collection, or other health equipment or supplies, including personal protective equipment;

(e) closing or partially closing to prevent or minimize the spread of COVID-19;

(f) delaying or modifying the schedule or performance of any medical procedure; and

(g) providing services or products in response to government appeal of repurposing operations to address an urgent need for personal protective equipment, sanitation products, or other products necessary to protect the public.

(B) "COVID-19" refers to any of the following:

(1) The novel coronavirus known as SARS-CoV-2;

(2) Any mutation of SARS-CoV-2;

(3) The coronavirus disease 2019.

(C) "Person" means any entity recognized in this state and shall include but not be limited to an individual, corporation, limited liability company, partnership, trust, association, church or religious organization, city, county, public or private school district, college, university or other institution of higher education, or other unit of local government.

Section 3. Limited Immunity from Liability

(A) Notwithstanding any other statute to the contrary, any person who acts in good faith in the course of or through the performance or provision of the person's business operations or on the premises owned or operated by the person shall be immune from civil liability for ordinary negligence for any personal injury or death arising from COVID-19, if the person acts as an ordinary, reasonable, and prudent person would have acted under the same or similar circumstances. For purposes of this subsection, ordinary, reasonable, and prudent shall include the adoption of safety measures as set forth in subsection (B) of this Section.

(B) Notwithstanding any other statute to the contrary, there shall be a rebuttable presumption that the safety measures adopted by any person, as defined in Section 2(C) of this Act, are reasonable, as used in subsection (A) of this Section, if those measures conform to the Centers for Disease Control and Prevention guidelines in existence at the

time of the alleged exposure. For purposes of this Section, the rebuttable presumption does not alter the applicable standard of care for medical, legal, or other negligence cases.

(C) Immunity as described in this section shall not apply to acts or omissions that constitute an intentional tort or willful or reckless misconduct as defined in [State Tort Code].

(D) Nothing in this Act shall be construed to modify the application of [State] worker's compensation laws.

(E) The immunity provided in this section is in addition to any other immunity protection that may apply in state or federal law.

Section 4. Effective Date

An emergency existing therefor, which emergency is hereby declared to exist, this Act shall be in full force and effect on and after its passage and approval.

Section 5. Sunset Date

The provisions of Section 3 of this Act shall be null, void, and of no force and effect on and after [ ].

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National Council of Insurance Legislators (NCOIL)

Peer-to-Peer Car Sharing Program Model Act

Sponsored by Rep. Bart Rowland (KY)

Adopted by the Property & Casualty Insurance Committee and Executive Committee on December 13th, 2019. Amended on April 18, 2021.

To be considered for re-adoption during the meeting of the Property & Casualty Insurance Committee on July 18, 2026.

Table of Contents

Chapter 1. Short Title
Chapter 2. Scope
Chapter 3. Definitions
Chapter 4. Insurance
Chapter 5. Consumer Protection Disclosures
Chapter 6. Regulations
Chapter 7. Effective Date

AN ACT concerning transportation.

Be it enacted by the Legislature of the State of X:

[(New Act) / or / (The statutes of the jurisdiction are hereby amended as follows)]:

Chapter 1. Short Title

This Act may be cited as the Peer-to-Peer Car Sharing Program Act.

Chapter 2. Scope

This Act is intended to govern the intersection of peer-to-peer car services and the state-regulated business of insurance. Nothing in this Act shall be construed to extend beyond insurance or have any implications for other provisions of the code of this state, including but not limited to, those related to motor vehicle regulation, airport regulation, or taxation.

Chapter 3. Definitions

Drafting Note: These definitions need to be read, interpreted and implemented within the limitations placed upon this Act by its scope set forth in Chapter 2.

Application of definitions

Sec. 1. Except as otherwise provided, the definitions in this chapter apply throughout this article.

"Peer-to-Peer Car Sharing"

Sec. 2. "Peer-to-Peer Car Sharing" means the authorized use of a vehicle by an individual other than the vehicle's owner through a peer-to-peer car sharing program. "Peer-to-Peer Car Sharing" does not mean rental car or rental activity as defined in _______.

"Peer-to-Peer Car Sharing Program"

Sec. 3. "Peer-to-Peer Car Sharing Program" means a business platform that connects vehicle owners with drivers to enable the sharing of vehicles for financial consideration. "Peer-to-Peer Car Sharing Program" does not mean rental car company as defined in _______.

"Car Sharing Program Agreement"

Sec. 4. "Car Sharing Program Agreement" means the terms and conditions applicable to a shared vehicle owner and a shared vehicle driver that govern the use of a shared vehicle through a peer-to-peer car sharing program. "Car Sharing Program Agreement" does not mean rental car agreement, as defined in _______.

"Shared Vehicle"

Sec. 5. "Shared vehicle" means a vehicle that is available for sharing through a peer-to-peer car sharing program. "Shared vehicle" does not mean rental car or rental vehicle as defined in [insert citation to the State's statutory definition of "rental car" or the equivalent term in that State's laws].

"Shared Vehicle Driver"

Sec. 6. "Shared Vehicle Driver" means an individual who has been authorized to drive the shared vehicle by the shared vehicle owner under a car sharing program agreement.

"Shared Vehicle Owner"

Sec. 7. “Shared Vehicle Owner” means the registered owner, or a person or entity designated by the registered owner, of a vehicle made available for sharing to shared vehicle drivers through a peer-to-peer car sharing program.

“Car Sharing Delivery Period”

Sec. 8. “Car Sharing Delivery Period” means the period of time during which a shared vehicle is being delivered to the location of the car sharing start time, if applicable, as documented by the governing car sharing program agreement.

“Car Sharing Period”

Sec. 9. “Car Sharing Period” means the period of time that commences with the car sharing delivery period or, if there is no car sharing delivery period, that commences with the car sharing start time and in either case ends at the car sharing termination time.

“Car Sharing Start Time”

Sec. 10. “Car Sharing Start Time” means the time when the shared vehicle becomes subject to the control of the shared vehicle driver at or after the time the reservation of a shared vehicle is scheduled to begin as documented in the records of a peer–to–peer car sharing program.

“Car Sharing Termination Time”

Sec. 11. “Car Sharing Termination Time” means the earliest of the following events:

> (1) The expiration of the agreed upon period of time established for the use of a shared vehicle according to the terms of the car sharing program agreement if the shared vehicle is delivered to the location agreed upon in the car sharing program agreement;
>
> (2) When the shared vehicle is returned to a location as alternatively agreed upon by the shared vehicle owner and shared vehicle driver as communicated through a peer-to-peer car sharing program, which alternatively agreed upon location shall be incorporated into the car sharing program agreement; or
>
> (3) When the shared vehicle owner or the shared vehicle owner’s authorized designee, takes possession and control of the shared vehicle.

Chapter 4. Insurance

Insurance Coverage During Car Sharing Period

Sec. 1.(a) A peer-to-peer car sharing program shall assume liability, except as provided in subsection (b) of this chapter, of a shared vehicle owner for bodily injury or property damage to third parties or uninsured and underinsured motorist or personal injury protection losses during the car sharing period in an amount stated in the peer-to-peer car sharing program agreement which amount may not be less than those set forth in (State's financial responsibility law).

(b) Notwithstanding the definition of "car sharing termination time" as set forth in Chapter 3 or 4 of this Act, the assumption of liability under subsection (a) of this subsection does not apply to any shared vehicle owner when:

(1) A shared vehicle owner makes an intentional or fraudulent material misrepresentation or omission to the peer-to-peer car sharing program before the car sharing period in which the loss occurred, or

(2) Acting in concert with a shared vehicle driver who fails to return the shared vehicle pursuant to the terms of car sharing program agreement.

(c) Notwithstanding the definition of "car sharing termination time" as set forth in Chapter 3 or Chapter 4 of this Act, the assumption of liability under subsection (a) of this section would apply to bodily injury, property damage, uninsured and underinsured motorist or personal injury protection losses by damaged third parties required by *[insert citation to the applicable state financial responsibility law]*

(d) A peer-to-peer car sharing program shall ensure that, during each car sharing period, the shared vehicle owner and the shared vehicle driver are insured under a motor vehicle liability insurance policy that provides insurance coverage in amounts no less than the minimum amounts set forth in *[insert citation to applicable statute establishing state minimum coverage],* and:

(1) Recognizes that the shared vehicle insured under the policy is made available and used through a peer-to-peer car sharing program; or

(2) Does not exclude use of a shared vehicle by a shared vehicle driver.

(e) The insurance described under subsection (d) may be satisfied by motor vehicle liability insurance maintained by:

(1) A shared vehicle owner;
(2) A shared vehicle driver;

(3) A peer-to-peer car sharing program; or
(4) Both a shared vehicle owner, a shared vehicle driver, and a peer-to-peer car sharing program.

(f) The insurance described in subsection (e) that is satisfying the insurance requirement of subsection (d) shall be primary during each car sharing period and in the event that a claim occurs in another state with minimum financial responsibility limits higher than [insert minimum limits citation], during the car sharing period, the coverage maintained under subsection (e) shall satisfy the difference in minimum coverage amounts, up to the applicable policy limits.

(g) The insurer, insurers, or peer-to-peer car sharing program providing coverage under (d) or (e) shall assume primary liability for a claim when:

(1) a dispute exists as to who was in control of the shared motor vehicle at the time of the loss and the peer-to-peer car sharing program does not have available, did not retain, or fails to provide the information required by Section 4 of this Chapter 4; or

(2) a dispute exists as to whether the shared vehicle was returned to the alternatively agreed upon location as required under Section 11(2) of Chapter 3.

(h) If insurance maintained by a shared vehicle owner or shared vehicle driver in accordance with subsection (e) has lapsed or does not provide the required coverage, insurance maintained by a peer-to-peer car sharing program shall provide the coverage required by subsection (d) beginning with the first dollar of a claim and have the duty to defend such claim except under circumstances as set forth in Chapter 4 Section (1)(b).

(i) Coverage under an automobile insurance policy maintained by the peer-to-peer car sharing program shall not be dependent on another automobile insurer first denying a claim nor shall another automobile insurance policy be required to first deny a claim. (j)

Nothing in this Chapter:

(1) Limits the liability of the peer-to-peer car sharing program for any act or omission of the peer-to-peer car sharing program itself that results in injury to any person as a result of the use of a shared vehicle through a peer-to-peer car sharing program; or

(2) Limits the ability of the peer-to-peer car sharing program to, by contract, seek indemnification from the shared vehicle owner or the shared vehicle driver for economic

loss sustained by the peer-to-peer car sharing program resulting from a breach of the terms and conditions of the car sharing program agreement.

Notification of Implications of Lien

Sec. 2. At the time when a vehicle owner registers as a shared vehicle owner on a peer-to-peer car sharing program and prior to the time when the shared vehicle owner makes a shared vehicle available for car sharing on the peer-to-peer car sharing program, the peer-to-peer car sharing program shall notify the shared vehicle owner that, if the shared vehicle has a lien against it, the use of the shared vehicle through a peer-to-peer car sharing program, including use without physical damage coverage, may violate the terms of the contract with the lienholder.

Exclusions in Motor Vehicle Liability Insurance Policies

Sec. 3. (a) An authorized insurer that writes motor vehicle liability insurance in the State may exclude any and all coverage and the duty to defend or indemnify for any claim afforded under a shared vehicle owner's motor vehicle liability insurance policy, including but not limited to:

(1) liability coverage for bodily injury and property damage;

(2) personal injury protection coverage as defined in [CITE STATUTE];

(3) uninsured and underinsured motorist coverage;

(4) medical payments coverage;

(5) comprehensive physical damage coverage; and

(6) collision physical damage coverage

(b) Nothing in this Article invalidates or limits an exclusion contained in a motor vehicle liability insurance policy, including any insurance policy in use or approved for use that excludes coverage for motor vehicles made available for rent, sharing, or hire or for any business use.

(c) Nothing in this Article invalidates, limits or restricts an insurer's ability under existing law to underwrite any insurance policy. Nothing in this Article invalidates, limits or restricts an insurer's ability under existing law to cancel and non-renew policies.

Recordkeeping; Use of Vehicle in Car Sharing

Sec. 4. A peer-to-peer car sharing program shall collect and verify records pertaining to the use of a vehicle, including, but not limited to, times used, car sharing period pick up and drop off locations, fees paid by the shared vehicle driver, and revenues received by the shared vehicle owner and provide that information upon request to the shared vehicle owner, the shared vehicle owner's insurer, or the shared vehicle driver's insurer to facilitate a claim coverage investigation, settlement, negotiation, or litigation. The peer-to-peer car sharing program shall retain the records for a time period not less than the applicable personal injury statute of limitations.

Exemption; Vicarious Liability

Sec. 5. A peer-to-peer car sharing program and a shared vehicle owner shall be exempt from vicarious liability in accordance with 49 U.S.C. § 30106 and under any state or local law that imposes liability solely based on vehicle ownership.

Contribution against Indemnification

Sec. 6. A motor vehicle insurer that defends or indemnifies a claim against a shared vehicle that is excluded under the terms of its policy shall have the right to seek recovery against the motor vehicle insurer of the peer-topeer car sharing program if the claim is: (1) made against the shared vehicle owner or the shared vehicle driver for loss or injury that occurs during the car sharing period; and (2) excluded under the terms of its policy.

Insurable Interest

Sec. 7. (a) Notwithstanding any other law, statute, rule or regulation to the contrary, a peer-to-peer car sharing program shall have an insurable interest in a shared vehicle during the car sharing period.

(b) Nothing in this section creates liability on a Peer-to-Peer Car Sharing Program to maintain the coverage mandated by this Chapter 4, Sec. 1.

(c) A peer–to–peer car sharing program may own and maintain as the named insured one or more policies of motor vehicle liability insurance that provides coverage for:

(1) liabilities assumed by the peer–to–peer car sharing program under a peer–to–peer car sharing program agreement; or

(2) any liability of the shared vehicle owner; or

(3) damage or loss to the shared motor vehicle; or any liability of the shared vehicle driver.

Chapter 5. Consumer Protections Disclosures

Sec. 1. Each car sharing program agreement made in the State shall disclose to the shared vehicle owner and the shared vehicle driver:

(a) Any right of the peer-to-peer car sharing program to seek indemnification from the shared vehicle owner or the shared vehicle driver for economic loss sustained by the peer-to-peer car sharing program resulting from a breach of the terms and conditions of the car sharing program agreement;

(b) That a motor vehicle liability insurance policy issued to the shared vehicle owner for the shared vehicle or to the shared vehicle driver does not provide a defense or indemnification for any claim asserted by the peer-to-peer car sharing program;

(c) That the peer-to-peer car sharing program's insurance coverage on the shared vehicle owner and the shared vehicle driver is in effect only during each car sharing period and that, for any use of the shared vehicle by the shared vehicle driver after the car sharing termination time, the shared vehicle driver and the shared vehicle owner may not have insurance coverage;

(d) The daily rate, fees, and if applicable, any insurance or protection package costs that are charged to the shared vehicle owner or the shared vehicle driver.

(e) That the shared vehicle owner's motor vehicle liability insurance may not provide coverage for a shared vehicle.

(f) An emergency telephone number to personnel capable of fielding roadside assistance and other customer service inquiries.

(g) If there are conditions under which a shared vehicle driver must maintain a personal automobile insurance policy with certain applicable coverage limits on a primary basis in order to book a shared motor vehicle.

Driver's License Verification and Data Retention

Sec. 2. (a) A peer-to-peer car sharing program may not enter into a peer-to-peer car sharing program agreement with a driver unless the driver who will operate the shared vehicle:

(1) Holds a driver's license issued under _________ that authorizes the driver to operate vehicles of the class of the shared vehicle; or

(2) Is a nonresident who:

(i) Has a driver's license issued by the state or country of the driver's residence that authorizes the driver in that state or country to drive vehicles of the class of the shared vehicle; and

(ii) Is at least the same age as that required of a resident to drive; or

(3) Otherwise is specifically authorized by ________ to drive vehicles of the class of the shared vehicle.

(b) A peer-to-peer car sharing program shall keep a record of:

(1) The name and address of the shared vehicle driver;

(2) The number of the driver's license of the shared vehicle driver and each other person, if any, who will operate the shared vehicle; and

(3) The place of issuance of the driver's license.

Responsibility for Equipment

Sec. 3. A peer-to-peer car sharing program shall have sole responsibility for any equipment, such as a GPS system or other special equipment that is put in or on the vehicle to monitor or facilitate the car sharing transaction, and shall agree to indemnify and hold harmless the vehicle owner for any damage to or theft of such equipment during the sharing period not caused by the vehicle owner. The peer-to-peer car sharing program has the right to seek indemnity from the shared vehicle driver for any loss or damage to such equipment that occurs during the sharing period.

Automobile Safety Recalls

Sec. 4. (a) At the time when a vehicle owner registers as a shared vehicle owner on a peer-to-peer car sharing program and prior to the time when the shared vehicle owner makes a shared vehicle available for car sharing on the peer-to-peer car sharing program, the peer-to-peer car sharing program shall:

(1) Verify that the shared vehicle does not have any safety recalls on the vehicle for which the repairs have not been made; and

(2) Notify the shared vehicle owner of the requirements under subsection (b) of this section.

(b) (1) If the shared vehicle owner has received an actual notice of a safety recall on the vehicle, a shared vehicle owner may not make a vehicle available as a shared vehicle on a peer-to-peer car sharing program until the safety recall repair has been made.

(2) If a shared vehicle owner receives an actual notice of a safety recall on a shared vehicle while the shared vehicle is made available on the peer-to-peer car sharing program, the shared vehicle owner shall remove the shared vehicle as available on the peer-to-peer car sharing program, as soon as practicably possible after receiving the notice of the safety recall and until the safety recall repair has been made.

(3) If a shared vehicle owner receives an actual notice of a safety recall while the shared vehicle is being used in the possession of a shared vehicle driver, as soon as practicably possible after receiving the notice of the safety recall, the shared vehicle owner shall notify the peer-to-peer car sharing program about the safety recall so that the shared vehicle owner may address the safety recall repair.

Chapter 6. Regulations

The Insurance Commissioner shall have the authority to promulgate rules that are not inconsistent with and necessary to administer and enforce the provisions of this Act.

Chapter 7. Effective Date.

Sec. 1. This Act shall take effect on the day that occurs *[the effective date should be at least nine (9) months after the Act becomes law—insert date here]* after the date on which the Act becomes law.

Drafting Note – The effective date should be a minimum of 9 months from the date the Governor signs the legislation.

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NATIONAL COUNCIL OF INSURANCE LEGISLATORS

PROPERTY/CASUALTY INSURANCE MODERNIZATION ACT

**Adopted by the NCOIL Executive Committee on July 13, 2001.*
Amended by the NCOIL Executive Committee on November 16, 2001, and March 1, 2002. Reviewed and amended by the NCOIL Executive Committee on November 21, 2003. Readopted by the NCOIL Executive Committee on July 22, 2006.
Re-adopted by the NCOIL Property & Casualty Insurance Committee on July 12, 2018 and the NCOIL Executive Committee on July 15, 2018
Amendments sponsored by Sen. Neil Breslin (NY) and Rep. Matt Lehman (IN), NCOIL President, adopted by the Special Committee on Race in Insurance Underwriting on March 5, 2021, and the Executive Committee on April 18, 2021.

To be considered for re-adoption during the meeting of the Property & Casualty Insurance Committee on July 18, 2026.

Summary
This model bill establishes a use-and-file rate regulatory system for personal lines of insurance, a no-file system for commercial lines, and allows policies sold to large, sophisticated commercial insurance providers to be exempt from rate and regulatory requirements. This creates a more competitive and less onerous regulatory industry. This model is intended for consideration in insurance regulatory jurisdictions with a more restrictive rate filing and review system than outlined in the bill. Additionally, this model defines proxy discrimination and makes clear that proxy discrimination is unfairly discriminatory in all kinds of insurance.

Section 1. {Short Title}

This act shall be known as the Property/Casualty Insurance Modernization Act.

Section 2. {Legislative Declaration}

This legislature finds and declares that a modernized and competitive procedure be employed

A. To recognize and enhance the role well-informed consumers play in the competitive marketplace

B. To promote price competition among insurers

C. To protect policyholders and the public against adverse effects of excessive, inadequate, or unfairly discriminatory rates

D. To prohibit unlawful price fixing agreements by or among insurers

E. To authorize essential cooperative activities among insurers in the ratemaking process and to regulate such activities to prohibit practices that tend to substantially lessen competition or create monopolies

F. To provide necessary regulatory authority in the absence of a competitive Marketplace

G. To prevent unfair discrimination, including proxy discrimination.

Drafting Note: This model is intended for consideration in insurance regulatory jurisdictions with a more restrictive rate filing and review system than outlined in this bill. States may also wish to consider implementing a competitive rating law that eliminates the regulatory rate filing process for all lines of insurance that are competitive.

Section 3. {Definitions}

A. For the purpose of this Act, "Advisory organization" means any person or organization, which has five (5) unrelated members and which assists insurers as authorized by Section 11. It does not include joint underwriting organizations, actuarial or legal consultants, single insurers, any employees of an insurer, or insurers under common control or management of their employees or managers.

B. For the purpose of this Act, "Classification system" or "classification" means the process of grouping risks with similar risk characteristics so that differences in costs may be recognized.

C. For the purpose of this Act, "Commercial risk" means any kind of risk, which is not a personal risk.

D. For the purpose of this Act, "Commissioner" means the Commissioner or Director or Superintendent of Insurance of this state.

E. For the purpose of this Act, "Competitive market" means any market except those which have been found to be non-competitive pursuant to Section 5.

F. For the purpose of this Act, "Developed losses" means losses (including loss adjustment expenses) adjusted, using standard actuarial techniques, to eliminate the effect of differences between current payment or reserve estimates and those which are anticipated to provide actual ultimate loss (including loss adjustment expense) payments.

G. For the purpose of this Act, "Expenses" means that portion of a rate attributable to acquisition, field supervision, collection expenses, general expenses, taxes, licenses, and fees.

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

I. For the purpose of this Act, "Joint underwriting" means an arrangement established to provide insurance coverage for a risk, pursuant to which two or more insurers contract with the insured for a price and policy terms agreed upon between or among the insurers.

J. For the purpose of this Act, "Large Commercial Policyholder" is a commercial policyholder with the size, sophistication, and insurance-buying expertise to negotiate with insurers in a largely unregulated environment and which meets at least two of the following criteria: (1) aggregate premium on commercial policies held by the insured, including workers' compensation, (2) number of employees, (3) annual net revenues or sales, (4) net worth, (5) annual budgeted expenditures for not-for profit organizations or a public body or agencies, or (6) population for municipalities.

Drafting Note: Specific criteria may require a large commercial policyholder to generate annual net revenues or sales in excess of $50,000,000; employ more than 50 employees; procure insurance through a full-time risk manager or retained qualified insurance consultant; possess net worth in excess of $25,000,000; or, if a nonprofit organization or public body/agency, generate annual budgeted expenditures of at least $25,000,000.

K. For the purpose of this Act, "Loss adjustment expense" means the expenses incurred by the insurer in the course of settling claims.

L. For the purpose of this Act, "Market" is the statewide interaction between buyers and sellers in the procurement of a line of insurance coverage pursuant to the provisions of this Act.

Drafting Note: A state may wish to consider a geographic area smaller than the statewide market to be tested, keeping in mind the state's particular insurance market environment.

M. For the purpose of this Act, "Non-competitive market" means a market, which is subject to a ruling pursuant to Section 5 that a reasonable degree of competition does not exist, and, for the purposes of this Act, residual markets, and pools are non-competitive markets.

N. For the purpose of this Act, "Personal risk" means homeowners, tenants, nonfleet private passenger automobiles, mobile homes, and other property and casualty insurance for person, family, or household needs. This includes any property and casualty insurance that is otherwise intended for non-commercial coverage.

O. For the purpose of this Act, "Pool" means an arrangement pursuant to which two or more insurers participate in the sharing of risks on a predetermined basis. A pool may operate as an association, syndicate, or in any other generally recognized manner.

P. For the purpose of this Act, "Prospective loss cost" means that portion of a rate that does not include provisions for expenses (other than loss adjustment expenses) or profit, and are based on historical aggregate losses and loss adjustment expenses adjusted through development to their ultimate value and projected through trending to a future point in time.

Q. For purposes of this Act, as well as for the purpose of any regulatory material adopted by this State, or incorporated by reference into the laws or regulations of this State, or regulatory guidance documents used by any official in or of this State, "Proxy Discrimination" means the intentional substitution of a neutral factor for a factor based on race, color, creed, national origin, or sexual orientation for the purpose of discriminating against a consumer to prevent that consumer from obtaining insurance or obtaining a preferred or more advantageous rate due to that consumer's race, color, creed, national origin, or sexual orientation.

R. For the purpose of this Act, "Rate" means that cost of insurance per exposure unit whether expressed as a single number or as a prospective loss cost with an adjustment to account for the treatment of expenses, profit, and individual insurer variation in loss experience, prior to any application of individual risk variations based on loss or expense considerations, and does not include minimum premiums.

S. For the purpose of this Act, "Residual market mechanism" means an arrangement, either voluntary or mandated by law, involving participation by insurers in the equitable apportionment of risks among insurers for insurance which may be afforded applicants who are unable to obtain insurance through ordinary methods.

T. For the purpose of this Act, “Special assessments” means guaranty fund assessments, Special Indemnity Fund assessments, Vocational Rehabilitation Fund assessments, and other similar assessments. Special assessments shall not be considered as either expenses or losses.

U. For the purpose of this Act, “Supplementary rate information” means any manual or plan of rates, classification, rating schedule, minimum premium, policy fee, rating rule, and any other similar information needed to determine an applicable rate in effect or to be in effect.

V. For the purpose of this Act, “Supporting information” means (1) the experience and judgment of the filer and the experience or data of other insurers or organizations relied upon by the filer, (2) the interpretation of any statistical data relied upon by the filer, (3) a description of methods used in making the rates, and (4) other similar information relied upon by the filer.

W. For the purpose of this Act, “Trending” means any procedure for projecting losses to the average date of loss, or premiums or exposures to the average date of writing, for the period during which the policies are to be effective.

Section 4. {Scope}

A. Section 6(A)(3)(a) of this Act applies to all kinds of insurance written on risks in this state by any insurer authorized to do business in this state.

B. All remaining sections of this Act apply to all such kinds of insurance written on risks in this state by any insurer authorized to do business in this state except:

1. Life insurance
2. Annuities
3. Accident and health insurance
4. Ocean marine insurance
5. Aircraft liability and aircraft hull insurance
6. Reinsurance
7. Surplus Lines
8. Workers Compensation Insurance

Section 5. {Competitive Market}

A. A competitive market for a line of insurance is presumed to exist unless the commissioner, after notice and hearing, determines that a reasonable degree of competition does not exist within a market and issues a ruling to that effect. The burden

of proof in any hearing shall be placed on the party or parties advocating the position that competition does not exist. Any ruling that a market is not competitive shall identify the factors causing the market not to be competitive. Such ruling shall expire one year after issue unless rescinded earlier by the commissioner or unless the commissioner renews the ruling after a hearing and a finding as to the continued lack of a reasonable degree of competition. Any ruling that renews the finding that competition does not exist shall also identify the factors that cause the market to continue not to be competitive.

B. The following factors shall be considered by the commissioner for purposes of determining if a reasonable degree of competition does not exist in a particular line of insurance:

1. The number of insurers or groups of affiliated insurers providing coverage in the market
2. Measures of market concentration and changes of market concentration over time
3. Ease of entry and the existence of financial or economic barriers that could prevent new firms from entering the market
4. The extent to which any insurer or group of affiliated insurers controls all or a portion of the market
5. Whether the total number of companies writing the line of insurance in this state is sufficient to provide multiple options
6. The availability of insurance coverage to consumers in the markets
7. The opportunities available to consumers in the market to acquire pricing and other consumer information

C. The commissioner shall monitor the degree and continued existence of competition in this State on an on-going basis. In doing so, the commissioner may utilize existing relevant information, analytical systems, and other sources; or rely on some combination thereof. Such activities may be conducted internally within the insurance department, in cooperation with other state insurance departments, through outside contractors, and/or in any other appropriate manner.

Section 6. {Rating Standards and Methods}

A. Rates shall not be excessive, inadequate, or unfairly discriminatory.

1. For the purpose of this Act, “Excessive” means a rate that is likely to produce a long-term profit that is unreasonably high for the insurance provided. No rate in a competitive market shall be considered excessive.

Drafting Note: Reflecting the well-accepted economic principle that costs and prices are driven downward by competition, insurance laws in seventeen (17) states do not allow a

finding of excessiveness in a competitive market. Those seventeen (17) states are: Arkansas, Connecticut, Delaware, Georgia, Idaho, Illinois, Indiana, Kentucky, Michigan, Missouri, Montana, Nevada, Oklahoma, Oregon, Vermont, Virginia, and Wyoming. Insurance laws in five (5) other states say that rates are "presumed" not to be excessive if there is a reasonable degree of competition. Those five (5) states are: Arizona, Kansas, Minnesota, New Mexico, and Wisconsin.

2. For the purpose of this Act, "Inadequate" means a rate which is unreasonably low for the insurance provided and a. the continued use of which endangers the solvency of the insurers using it, or b. will have the effect of substantially lessening competition or creating a monopoly in any market

3. a. For the purpose of this Act, "Unfairly discriminatory" refers either to rates that cannot be actuarially justified, or to rates that can be actuarially justified but are based on proxy discrimination. It does not refer to rates that produce differences in premiums for policyholders with like loss exposures, so long as the rate reflects such differences with reasonable accuracy. A rate is not unfairly discriminatory if it averages broadly among persons insured under a group, franchise or blanket policy, or a mass marketing plan.

b. No rate in a competitive market shall be considered unfairly discriminatory unless it violates the provisions of section 6(B) in that it classifies risk, on the basis of race, color creed, or national origin. Risks may be classified in any way except that no risk may be classified on the basis of race, color, creed, or national origin.

B. In determining whether rates in a non-competitive market are excessive, inadequate, or unfairly discriminatory, consideration may be given to the following elements:

1. Basic Rate Factors. Due consideration shall be given to past and prospective loss and expense experience within and outside of this state; to catastrophe hazards and contingencies; to events or trends within and outside of this state; to dividends or savings to policyholders, members, or subscribers; and to all other factors and judgments deemed relevant by the insurer.

2. Classification. Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified for individual risks in accordance with rating plans or schedules which establish standards for measuring probable variations in hazards or expenses, or both.

3. Expenses. The expense provision shall reflect the operating methods of the insurer and its own past expense experience and anticipated future expenses.

4. Contingencies and Profits. The rates shall contain a provision for contingencies and a provision for a reasonable underwriting profit, and reflect investment income directly attributable to unearned premium and loss reserves.

5. Other relevant factors. Any other factors available at the time of hearing.

Section 7. {Rate Regulation in a Market Determined to be Non-Competitive}

A. If the commissioner determines that competition does not exist in a market and issues a ruling to that effect pursuant to Section 5, the rates applicable to insurance sold in that market shall be regulated in accordance with the provisions of Section 6 through 9 applicable to non-competitive markets.

B. Any rate filing in effect at the time the commissioner determines that competition does not exist pursuant to Section 5 shall be deemed to be in compliance with the laws of this state unless disapproved pursuant to the procedures and rating standards contained in Section 6 through 9 applicable to non-competitive markets.

C. Any insurer having a rate filing in effect at the time the commissioner determines that competition does not exist pursuant to Section 5 may be required to furnish supporting information within 30 days of a written request by the commissioner.

Section 8. {Filing of Rates, Supplementary Rate Information, and Supporting Information}

A. Filings in Competitive Markets. For personal lines, every insurer shall file with the commissioner all rates and supplementary rate information to be used in this state no later than 30 days after the effective date; provided, that such rates and supplementary rate information need not be filed for inland marine risks, which by general custom are not written according to manual rules or rating plans. Rates in a competitive market for commercial insurance need not be filed.

B. Filings in Non-Competitive Markets.

1. Every insurer shall file with the commissioner all rates, supplementary rate information, and supporting information for non-competitive markets at least 30 days before the proposed effective date. The commissioner may give written notice, within 30 days of the receipt of the filing, that the commissioner needs additional time, not to exceed 30 days from the date of such notice to consider the filing. Upon written application of the insurer, the commissioner may authorize rates to be effective before the expiration of the waiting period or an extension thereof. A filing shall be deemed to meet the requirements of this Act and to

become effective unless disapproved pursuant to Section 9 by the commissioner before the expiration of the waiting period or an extension thereof. Residual market mechanisms or advisory organizations may file residual market rates.

2. The filing shall be deemed in compliance with the filing provisions of this section unless the commissioner informs the insurer within 10 days after receipt of the filing as to what supplementary rate information or supporting information is required to complete the filing.

C. Reference Filings. An insurer may file its rates by either filing its final rates or by filing a multiplier and, if applicable, an expense constant adjustment to be applied to prospective loss costs that have been filed by an advisory organization on behalf of the insurer as permitted by Section 11.

D. Filings Open to Inspection. All rates, supplementary rate information, and any supporting information filed under this Act shall be open to public inspection once they have been filed, except information marked confidential, Trade Secret, or proprietary by the insurer or filer. Copies may be obtained from the commissioner upon request and upon payment of a reasonable fee.

E. Consent to Rate. Notwithstanding any other provisions of this section, upon written application of the insured, stating the reason therefore, a rate in excess of or below that otherwise applicable may be used on any specific risk.

Section 9. (Disapproval of Rates)

A. Bases for Disapproval

1. The commissioner shall disapprove a rate in a competitive market only if the commissioner finds pursuant to subsection (B) of this section that the rate is inadequate under Section (6)(A)(2) or unfairly discriminatory under Section 6(A)(3)(b).

2. The commissioner may disapprove a rate for use in a non-competitive market only if the commissioner finds pursuant to subsection (B) of this section that the rate is excessive, inadequate, or unfairly discriminatory under Section 6A.

B. Procedures for Disapproval

1. Prior to the expiration of the waiting period or an extension thereof of a filing made pursuant to Section 8, subsection (B), the commissioner may disapprove by written order rates filed pursuant to Section 8, subsection (B), without a hearing. The order shall specify in what respects such filing fails to meet the requirements

of this Act. Any insurer whose rates are disapproved under this section shall be given a hearing upon written request made within 30 days of disapproval.

2. If, at any time, the commissioner finds that a rate applicable to insurance sold in a non-competitive market does not comply with the standards set forth in Section 6, the commissioner may, after a hearing held upon not less than 20 days written notice, issue an order pursuant to subsection 9I disapproving such rate. The Hearing notice shall be sent to every insurer and advisory organization that adopted the rate and shall specify the matters to be considered at the hearing. The disapproval order shall not affect any contract or policy made or issued prior to the effective date set forth in said order.

3. If, at any time, the commissioner finds that a rate applicable to insurance sold in a competitive market is inadequate under Section 6(A)(3)(a) or unfairly discriminatory under Section 6(A)(3)(b), the commissioner may issue an order pursuant to subsection 9(C) disapproving the rate. Said order shall not affect any contract or policy made or issued prior to the effective date set forth in said order.

C. Order of Disapproval. If the commissioner disapproves a rate pursuant to subsection (B) of this section, the commissioner shall issue an order within 30 days of the close of the hearing specifying in what respects such rate fails to meet the requirements of this Act. The order shall state an effective date no sooner than 30 business days after the date of the order when the use of such rate shall be discontinued. This order shall not affect any policy made before the effective date of the order.

D. Appeal of Orders; Establishment of Reserves. If an order of disapproval is appealed pursuant to Section 20 the insurer may implement the disapproved rate upon notification to the court, in which case any excess of the disapproved rate over a rate previously in effect shall be placed in a reserve established by the insurer. The court shall have control over the disbursement of funds from such reserve. Such funds shall be distributed as determined by the court in its final order except that de minimus refunds to policyholders shall not be required.

Section 10. {Large Commercial Policyholder}

A. A policy of insurance sold to a "Large Commercial Policyholder," as defined in Section 3(J), shall not be subject to the requirements of this chapter, including but not limited to, Sections 5, 6, 7, 8, and 9. The forms and endorsements for any policy sold to a "Large Commercial Policyholder" shall not be subject to filing and approval requirements of (reference form filing and approval provisions plus other applicable provisions).

B. All policies issued pursuant to the provisions of this section shall contain a conspicuous disclaimer printed in at least ten-point, bold-faced type that states that the policy applied for (including the rates, rating plans, resulting premiums, and the policy forms) is not subject to the rate and form requirements of this state and other provisions of the insurance law that apply to other commercial products and may contain significant differences from a policy that is subject to all provisions of the insurance law. Such notice shall set forth possible differences in policy conditions, forms, and endorsements, as compared to a policy that is subject to all of the provisions of the insurance law. The format and provisions of such notice shall be prescribed by the commissioner. The disclosure notice will also include a policyholder's acknowledgment statement, to be signed and dated prior to the effective date of the coverage, and shall remain on file with the insurer.

C. In procuring insurance, a "Large Commercial Policyholder" shall certify on a form approved by the department of insurance that it meets the eligibility requirements set out in Section 10(A) and specify the requirements that the policyholder has met. This certification is to be completed annually and remain on file with the insurer.

D. A surplus lines broker seeking to obtain or provide insurance for a "Large Commercial Policyholder" is authorized to purchase insurance from any eligible unauthorized insurer without making a diligent search of authorized insurers as required by (applicable surplus lines law).

Section 11. {Records and Reports: Exchange of Information}

A. In only those markets found to be non-competitive pursuant to Section 5, insurers and advisory organizations shall file with the commissioner, and the commissioner shall review, reasonable rules and plans for recording and reporting of loss and expense experience. The commissioner may designate one or more advisory organizations to assist in gathering such experience and making compilations thereof. No insurer shall be required to record or report its experience in a manner inconsistent with its own rating system.

B. The commissioner and every insurer and advisory organization may exchange rates and rate information and experience data with insurance regulatory officials, insurers, and advisory organizations in this and other states and may consult with them with respect to the collection of statistical data and the application of rating systems.

Section 12. {Joint Underwriting, Pools, and Residual Market Activities}

A. Acting in Concert. Notwithstanding the provisions of Section 13, insurers participating in joint underwriting, pools, or residual market mechanisms may act in cooperation with each other in the making of rates, rating systems, supplementary rate information, policy

or bond forms, underwriting rules, surveys, inspections and investigations; in the furnishing of loss and expense statistics or other information; and in conducting research. Joint underwriting, pools, and residual market mechanisms shall not be deemed advisory organizations.

B. Regulation

1. If, after notice and hearing, the commissioner finds that any activity or practice of an insurer participating in a joint underwriting or pooling mechanism is unfair, unreasonable, will tend to substantially lessen competition in any market, or is otherwise inconsistent with the provisions or purposes of this Act and all other applicable statutes, the commissioner may issue a written order specifying in what respects such activity or practice is unfair, unreasonable, anti-competitive, or otherwise inconsistent with the provisions of this Act and all other applicable statutes, and require the discontinuance of such activity or practice.

2. Every pool shall file with the commissioner a copy of its constitution, articles of incorporation, agreement, or association bylaws; rules and regulations governing activities; its members; the name and address of a resident of this state upon whom notices, process, and orders of the commissioner may be served; and any changes or modifications thereof.

3. Any residual market mechanism, plan, or agreement to implement such a mechanism, and any changes or amendments thereto, shall be submitted in writing to the commissioner for approval, together with such information as may be reasonably required. The commissioner shall approve such agreements if they foster (i) the use of rates which meet the standards prescribed by this Act and all other applicable statutes and (ii) activities and practices not inconsistent with the provisions of this Act and all other applicable statutes.

4. The commissioner may review the operations of all residual market mechanisms to determine compliance with the provisions of this Act and all other applicable statutes. If after a notice of hearing, the commissioner finds that such mechanisms are violating the provisions of this Act and all other applicable statutes, the commissioner may issue a written order to the parties involved specifying in what respects such operations violate the provisions of this Act and all other applicable statutes. The commissioner may further order the discontinuance or elimination of any such operation.

Section 13. {Assigned Risks}

A. Agreements may be made among insurers with respect to the equitable apportionment among them of insurance that may be afforded applicants who are in good faith entitled

to, but who are unable to, procure such insurance through ordinary methods, and such insurers may agree among themselves on the use of reasonable rate modifications for such insurance, such agreements, and rate modifications to be subject to the approval of the commissioner.

Drafting Note: This section is to be included if the current provision authorizing agreements for the assigned risk or other residual market is repealed as part of the current rating law. You may wish to pick up current state provisions.

Section 14. {Examinations}

A. The commissioner may examine any insurer, pool, advisory organization, or residual market mechanism to ascertain compliance with this Act.

B. Every insurer, pool, advisory organization, and residual market mechanism shall maintain adequate records from which commissioner may determine compliance with the provisions of this Act. Such records shall contain the experience, data, statistics, and other information collected or used and shall be available to the commissioner for examination or inspection upon reasonable notice.

C. The reasonable cost of an examination made pursuant to this section shall be paid by the examined party upon presentation to it of a detailed account of such costs.

D. The commissioner may accept the report of an examination made by the insurance supervisory official of another state in lieu of an examination under this section.

Section 15. {Exemptions}

The commissioner may, after public notice and hearing, exempt any line of insurance from any or all of the provisions of this Act for the purpose of relieving such line of insurance from filing or any otherwise applicable provisions of this Act.

Section 16. {Consumer Information}

The Commissioner shall utilize, develop, or cause to be developed a consumer information system(s) which will provide and disseminate price and other relevant information on a readily available basis to purchasers of homeowners, private passenger non-fleet automobile, or property insurance for personal, family, or household needs. The commissioner may utilize, develop, or cause to be developed a consumer information system(s) which will provide and disseminate price and other relevant information on a readily available basis to purchasers of insurance for commercial risks and personal risks not otherwise specified herein. Such activity may be conducted internally within the insurance department, in cooperation with other state insurance departments, through

outside contractors, and/or in any other appropriate manner. To the extent deemed necessary and appropriate by the commissioner, insurers, advisory organizations, statistical agents, and other persons or organizations involved in conducting the business of insurance in this State, to which this section applies, shall cooperate in the development and utilization of a consumer information system(s).

Drafting Note: For jurisdictions that need a separate and distinct means of funding a consumer information system the following provision may be added to Section 16:

The cost of complying with this section shall be assessed against insurers subject to this Act and authorized to write types of business subject to a consumer information system. The assessments shall be made on an equitable and practicable basis established, after hearing, in a rule promulgated by the commissioner. This activity shall be conducted in a reasonably economical manner consistent with the purposes of this Act.

Section 17. {Dividends}

Nothing in this Act shall be construed to prohibit or regulate the payment of dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers. A plan for the payment of dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers shall not be deemed a rating plan or system.

Section 18. {Penalties}

A. The commissioner may impose after notice and hearing a penalty determined in accordance with (refer to appropriate penalties provision).

B. Technical violations arising from systems or computer errors of the same type shall be treated as a single violation. In the event of an overcharge, if the insurer makes restitution including payment of interest, no penalty shall be imposed.

C. The commissioner may suspend or revoke the license of any insurer, advisory organization, or statistical agent which fails to comply with an order of the commissioner within the time prescribed by such order, or any extension thereof which the commissioner may grant.

D. The commissioner may determine when a suspension of license shall become effective and the period of such suspension, which the commissioner may modify or rescind in any reasonable manner.

E. No penalty shall be imposed and no license shall be suspended or revoked except upon a written order of the commissioner stating his or her findings, made after notice and hearing.

Section 19. {Judicial Review}

A. Any order, ruling, finding, decision, or other act of the commissioner made pursuant to this Act shall be subject to judicial review in accordance with (cite applicable provisions of state civil practice act).

Section 20. {Notice and Hearing}

A. Notice Requirements. All notices rendered pursuant to the provisions of this Act shall be in writing and shall state clearly the nature and purpose of the hearing. All relevant facts, statutes, and rules shall be specified so that respondent(s) are fully informed of the scope of the hearing, including specific allegations, if any. If a hearing is required, all notices shall designate a hearing date at least 14 days from the date of the notice, unless such minimum notice period is waived by respondents.

B. Hearings. All hearings pursuant to the provisions of this Act shall be conducted in accordance with (cite applicable provisions of Administrative Procedures Act) to the extent such provisions are consistent with the procedural requirements contained in this Act.

Section 21. {Severability}

If any provision or item of this Act, or the application thereof, is held invalid, such invalidity shall not affect other provisions, items, or applications of the Act that can be given effect without the invalid provision, item, or application.

Section 22. {Effective Date}

The provisions of this Act become effective _______________ months after the enactment.

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

PRESIDENT: Sen. Paul Utke, MN
VICE PRESIDENT: Rep. Edmond Jordan, LA
TREASURER: Rep. Jim Dunnigan, UT
SECRETARY: Rep. Brenda Carter, MI

IMMEDIATE PAST PRESIDENT:
Asw. Pamela Hunter, NY

National Council of Insurance Legislators (NCOIL)

Property/Casualty Flex-Rating Regulatory Improvement Model Act

Adopted by the NCOIL Executive Committee on February 27, 2004 and re-adopted on November 20, 2011, July 17, 2016, and July 17, 2021.

To be considered for re-adoption during the meeting of the Property & Casualty Insurance Committee on July 18, 2026.

Drafting Note: This model is intended for consideration in jurisdictions with a more restrictive rate-filing and review system than outlined in this bill. The model is intended to serve as an interim approach to enactment of an open competition–based system, as endorsed by the National Conference of Insurance Legislators (NCOIL) Property/Casualty Insurance Modernization Act.

Section 1. Short Title

This Act shall be known as the Property/Casualty Flex-Rating Regulatory Improvement Model Act.

Section 2. Scope

This Act applies to personal lines insurance written on risks in this state by any insurer authorized to do business in this state.

Section 3. Flex-Rating Provisions

A. Notwithstanding the requirements of [insert citations of state laws providing for the filing, review, approval, and/or disapproval of rates for property and casualty insurance], a filing made by an insurer under this section that provides for an overall statewide rate increase or decrease of no more than twelve (12) percent in the aggregate for all coverages that are subject to the filing may take effect the date it is filed. The twelve (12) percent limitation does not apply on an individual insured basis. No more than one rate filing may be made by an insurer pursuant to the expedited process provided in this subsection during any twelvemonth period, unless a rate filing, when combined with any other rate filing or filings made by an insurer within the preceding twelve (12) months, does not result in an overall statewide increase or decrease of more than twelve (12) percent in the aggregate for all coverages that are subject to the filing.

B. Rate filings falling outside of the limitation provided for in subsection (A) of this section shall be subject to [insert citations to the appropriate filing and review provisions of the insurance code], unless those filings are otherwise exempt from those provisions pursuant to another section of the insurance code.

C. A filing submitted pursuant to subsection (A) of this section is considered to comply with state law. However, if the Commissioner of Insurance determines that the filing is inadequate or unfairly discriminatory, he/she shall issue a written order specifying in detail the provisions of the insurance code the insurer has violated and the reasons the filing is inadequate or unfairly discriminatory and stating a reasonable future date on which the filing is to be considered no longer effective. An order by the Commissioner pursuant to this subsection that is issued more than thirty (30) days from the date on which the Commissioner received the rate filing is prospective only and does not affect any contract 2 issued or made before the effective date of the order. For purposes of this Act, "unfairly discriminatory" means a rate for a risk that is classified in whole or in part on the basis of race, color, creed, or national origin.

D. No rate increase within the limitation specified in subsection (A) of this section may be implemented with regard to an individual existing policy, unless the increase is applied at the time of a renewal or conditional renewal of an existing policy and the insurer, at least thirty (30) days in advance of the end of the insured's policy period, mails or delivers to the named insured, at the address shown in the policy, a written notice that clearly and conspicuously discloses its intention to change the rate. A notice of renewal or conditional renewal that clearly and conspicuously discloses the renewal premium applicable to the policy shall be deemed to be in compliance with this subsection.

Section 4. Effective Date

This Act shall take effect thirty (30) days after its approval by the Governor.

616 Fifth Avenue, Unit 106
Belmar, NJ 07719
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CHIEF EXECUTIVE OFFICER: Will Melofchik

PRESIDENT: Sen. Paul Utke, MN
VICE PRESIDENT: Rep. Edmond Jordan, LA
TREASURER: Rep. Jim Dunnigan, UT
SECRETARY: Rep. Brenda Carter, MI

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Asw. Pamela Hunter, NY

National Council of Insurance Legislators (NCOIL)

POST-ASSESSMENT PROPERTY AND LIABILITY INSURANCE GUARANTY ASSOCIATION MODEL ACT

Adopted by the Property-Casualty Insurance Committee on November 16, 2007, and Executive Committee on November 17, 2007. Amended by both Committees on March 1, 2015. Readopted by the Property & Casualty Insurance Committee on September 24, 2020 and the Executive Committee on September 26, 2020. Amendments, sponsored by Asm. Ken Cooley (CA), adopted on April 18, 2021.

To be considered for re-adoption at the 2026 Summer Meeting in July. Proposed amendments sponsored by Rep. Matt Lehman (IN).

Summary

This model provides a comprehensive scheme for the protection of certain policy claimants when a property- casualty insurance company becomes insolvent and is ordered liquidated. The model calls for payment of covered policy claims that the now insolvent insurance company would not be able to pay on a timely basis and most likely would not be able to pay in full. While the model provides for claims payment, it is intended as a statutory remedy and not replacement insurance coverage. Hence, coverage will not always mirror that called for under the insurance policy. Reasonable limits are placed on coverage in order to strike a balance between the need to protect policy claimants when an insurance company becomes insolvent and the need to keep costs to the public, for providing this remedy, at a rational level.

Table of Contents

Section 1. Title
Section 2. Scope
Section 3. Definitions
Section 4. Creation of the Association
Section 5. Board of Directors
Section 6. Powers and Duties of the Association
Section 7. Plan of Operation
Section 8. Duties and Powers of the Commissioner
Section 9. Effect of Paid Claims
Section 10. Exhaustion of Other Coverage

Section 11. Prevention of Insolvencies
Section 12. Examination of the Association
Section 13. Tax Exemption
Section 14. Recognition of Assessments in Rates
Section 15. Immunity
Section 16. Stay of Proceedings

Section 1. Title

This Act shall be known as the [insert state name] Insurance Guaranty Association Act.

Section 2. Scope

This Act shall apply to all kinds of direct insurance, but shall not be applicable to the following:

A. life, annuity, health, or disability insurance

B. mortgage guaranty, financial guaranty, or other forms of insurance offering protection against investment risks

C. fidelity or surety bonds, or any other bonding obligations

D. credit insurance, vendors' single interest insurance, or collateral protection insurance or any similar insurance protecting the interests of a creditor arising out of a creditor debtor transaction

E. Other than coverages that may be set forth in a Cybersecurity insurance policy, insurance of warranties or service contracts, including insurance that provides for the repair, replacement, or service of goods or property, or indemnification for repair, replacement or service, for the operational or structural failure of the goods or property due to a defect in materials, workmanship or normal wear and tear, or provides reimbursement for the liability incurred by the issuer of agreements or service contracts that provide such benefits

F. title insurance

G. ocean marine insurance

H. any transaction or combination of transactions between a person (including affiliates of such person) and an insurer (including affiliates of such insurer) that involves the transfer of investment or credit risk unaccompanied by transfer of insurance risk or

I. any insurance provided by or guaranteed by government

Drafting Note: In states where the insurance code does not adequately define "ocean marine insurance," the following may be added to Section 3. Definitions: "Ocean marine insurance" includes any form of insurance, regardless of the name, label, or marketing designation of the insurance policy, that insures against maritime perils or risks and other related perils or risks that are usually insured against by traditional marine insurance, such as hull and machinery, marine builders risk, and marine protection and indemnity. Such perils and risks insured against include, without limitation, loss, damage, or expense or legal liability of the insured for loss, damage, or expense arising out of or incident to ownership, operation, chartering, maintenance, use, repair, or construction of any vessel, craft, or instrumentality in use in ocean or inland waterways for commercial purposes, including liability of the insured for personal injury, illness, or death or for loss or damage to the property of the insured or another person.

Section 3. Definitions

As used in this Act:

A. "Account" means any one of the three (3) accounts created by Section 6.

B. "Affiliate" means a person who directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with another person.

C. "Affiliate of the insolvent insurer" means a person who directly, or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with an insolvent insurer on December 31 of the year prior to the date the insurer becomes an insolvent insurer.

D. "Association" means the [insert name of state] Insurance Guaranty Association created under Section 4.

E. "Association similar to the Association" means any guaranty association, security fund, or other insolvency mechanism that affords protection similar to that provided by the Association. The term also shall include any property-casualty insolvency mechanism that obtains assessments or other contributions from insurers on a pre-insolvency basis.

F. "Claimant" means any insured making a first-party claim or any person instituting a liability claim, provided that no person who is an affiliate of the insolvent insurer may be a claimant.

G. "Commissioner" means the Commissioner of Insurance of this State.

Drafting Note: States that use the term "Director" or "Superintendent" rather than "Commissioner" should substitute that term in paragraph G and as used elsewhere in this Act.

H. "Control" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing ten (10) percent or more of the voting securities of any other person. This presumption may be rebutted by a showing that control does not exist in fact.

I. 1. "Covered claim" means an unpaid claim, including one for unearned premiums, submitted by a claimant, that arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this Act applies issued by an insurer, if such insurer becomes an insolvent insurer after the effective date of this Act and

a. the claimant or insured is a resident of this state at the time of the insured event provided that for entities other than an individual, the residence of a claimant, insured or policyholder is the state in which its principal place of business is located at the time of the insured event or

b. the claim is a first-party claim for damage to property with a permanent location in this state.

2. "Covered claim" shall not include:

a. any amount awarded as punitive or exemplary damages

b. any amount sought as a return of premium under any retrospective rating plan

c. any amount due any reinsurer, insurer, insurance pool, underwriting association, health maintenance organization, hospital plan corporation, professional health service corporation, or self-insurer as subrogation recoveries, reinsurance recoveries, contribution, indemnification, or otherwise. No such claim for any amount due any reinsurer, insurer, insurance pool, underwriting association, health maintenance organization, hospital plan corporation, or self-insurer may be asserted against a person insured under a policy issued by an insolvent insurer other than to the

extent such claim exceeds the Association obligation limitations set forth in Section 6 of this Act.

Drafting Note: Express exclusions set out in (c) above for health maintenance organizations, hospital plan corporations, professional health service corporations, and self-insurers may not be included in many current state laws. Fund counsel should review applicable case law in their states to determine if it is necessary or advisable to add them as part of an amendment package. Funds may want to consider characterizing such an amendment, if adopted, as "clarifying" or "technical."

<u>Option A approach for net worth limitations–Exclude only first-party claims (Note: Amounts paid to third parties may be recovered by Association pursuant to section 9.B of this Act.)</u>

d. any first-party claim by an insured whose net worth exceeds $10 million on December 31 of the year prior to the date the insurer becomes an insolvent insurer provided that an insured's net worth on such date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis

<u>Option B approach for net worth limitation–Exclude both first and third-party claims</u>

d. any first-party claim by an insured whose net worth exceeds $10 million on December 31 of the year prior to the date the insurer becomes an insolvent insurer; provided that an insured's net worth on such date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis;

e. any third-party claim relating to a policy of an insured whose net worth exceeds $25 million on December 31 of the year prior to the date the insurer becomes an insolvent insurer, provided that an insured's net worth on such date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis. This exclusion shall not apply to third-party claims against the insured where the insured has applied for or consented to the appointment of a receiver, trustee, or liquidator for all or a substantial part of its assets, filed a voluntary petition in bankruptcy, filed a petition or an answer seeking a reorganization or arrangement with creditors or to take advantage of any insolvency law, or if an order, judgment, or decree is entered by a court of competent jurisdiction, on the application of a creditor, adjudicating the insured bankrupt or insolvent or approving a petition seeking reorganization of the insured or of all or substantial part of its assets.

Drafting Note: If Option B for net worth is chosen, drafters may want to consider whether jurisdictional circumstances warrant a carve out from subparagraph e. for workers' compensation claims, personal injury protection (PIP) claims, no-fault claims, and any other claims for ongoing medical payments to third parties. If administrative considerations suggest that an unacceptable interruption in claims payments would occur, such a carve out may be warranted.

f. any claim that would otherwise be a covered claim, but is an obligation to or on behalf of a person who has a net worth greater than that allowed by the insurance guaranty association law of the state of residence of the claimant at the time specified by such law, and which association has denied coverage to that claimant on that basis.

g. any first-party claims by an insured that is an affiliate of the insolvent insurer

h. any fee or other amount relating to goods or services sought by or on behalf of any attorney or other provider of goods or services retained by the insolvent insurer or an insured prior to the date it was determined to be insolvent

i. any fee or other amount sought by or on behalf of any attorney or other provider of goods or services retained by any insured or claimant in connection with the assertion or prosecution of any claim, covered or otherwise, against the Association

j. any claims for interest

k. any claim filed with the Association or a liquidator for protection afforded under the insured's policy for incurred-but-not-reported losses

3. Notwithstanding any other provision in this Act

a. an insurance policy issued by a member insurer and later allocated, transferred, assumed by or otherwise made the sole responsibility of another insurer, pursuant to a state statute providing for the division of an insurance company or the statutory assumption or transfer of designated policies and under which there is no remaining obligation to the transferring entity (commonly known as "Division" or "Insurance Business Transfer" statutes), shall be considered to have been issued by a member insurer which is an Insolvent Insurer for the purposes of this Act in the event that the insurer to which the policy has been allocated,

transferred, assumed or otherwise made the sole responsibility of is placed in liquidation.

b. insurance policy that was issued by a non-member insurer and later allocated, transferred, assumed by or otherwise made the sole responsibility of a member insurer under a state statute described in subsection shall not be considered to have been issued by a member insurer for the purposes of this Act.

J. "Cybersecurity insurance," for purposes of this Act, includes first- and third-party coverage, in a policy or endorsement, written on a direct, admitted basis for losses and loss mitigation arising out of or relating to data privacy breaches, unauthorized information network security intrusions, computer viruses, ransomware, cyber extortion, identity theft, and similar exposures.

K. "Insolvent insurer" means an insurer licensed to transact insurance in this state, either at the time the policy was issued or when the insured event occurred, and against whom a final order of liquidation has been entered after the effective date of this Act with a finding of insolvency by a court of competent jurisdiction in the insurer's state of domicile.

Drafting Note: "Final order" as used in this section means an order that has not been stayed. States in which the "final order" language does not accurately reflect whether or not the order is subject to a stay should substitute appropriate language consistent with the statutes or rules of the state to convey the intended meaning.

L. "Insured" means any name insured, any additional insured, any vendor, lessor, or any other party identified as an insured under the policy.

M. 1. "Member insurer" means any person who:

a. writes any kind of insurance to which this Act applies under Section 2, including the exchange of reciprocal or inter-insurance contracts; and

b. is licensed to transact insurance in this state (except at option of state).

2. An insurer shall cease to be a member insurer effective on the day following the termination or expiration of its license to transact the kinds of insurance to which this Act applies; however, the insurer shall remain liable as a member insurer for any and all obligations, including obligations for assessments levied prior to the termination or expiration of the insurer's license and assessments levied after the termination or expiration, which relate to any insurer that became

an insolvent insurer prior to the termination or expiration of such insurer's license.

N. "Net direct written premiums" means direct gross premiums written in this state on insurance policies to which this Act applies, less return premiums thereon and dividends paid or credit to policyholders on such direct business. "Net direct written premiums" does not include premiums on contracts between insurers or reinsurers.

O. "Person" means any individual or legal entity, including governmental entities.

Drafting Note: In determining whether this definition of person is appropriate in a particular jurisdiction, fund managers and counsel should consider other applicable definitions of "person" embodied in state codes and case history interpreting existing definitions as applied to the guaranty association.

P. "Self-insurer" means a person that covers its liability through a qualified individual or group self-insurance program or any other formal program created for the specific purpose of covering liabilities typically covered by insurance.

Section 4. Creation of the Association

There is created a nonprofit unincorporated legal entity to be known as the [insert state name] Insurance Guaranty Association. All insurers defined as member insurers in Section 3 shall be and remain members of the Association as a condition of their authority to transact insurance in this state. The Association shall perform its functions under a plan of operation established and approved under Section 7 and shall exercise its powers through a board of directors established under Section 5. For purposes of administration and assessment, the Association shall be divided into three (3) separate accounts: the account for workers' compensation, the account for auto, and the account for all other claims covered by the Association.

Drafting Note: While the three accounts set out above are typical, states may divide guaranty fund liabilities into other account structures as they deem appropriate.

Section 5. Board of Directors

A. The Board of Directors of the Association shall consist of not less than ( ) nor more than ( ) persons serving terms as established in the plan of operation. The members of the Board shall be selected by member insurers subject to the approval of the Commissioner. Vacancies on the Board shall be filled for the remaining period of the term by a majority vote of the remaining Board members subject to the approval of the Commissioner. If no members are selected within sixty (60) days after the effective date of this Act, the Commissioner may appoint the initial members of the Board of Directors.

B. In approving selections to the Board, the Commissioner shall consider, among other things, whether all member insurers are fairly represented.

C. Members of the Board of Directors may be reimbursed from the assets of the Association for expenses incurred by them as members of the Board.

Section 6. Powers and Duties of the Association

A. The Association shall:

1. be obligated to pay covered claims existing prior to the order of liquidation, that arise within thirty (30) days after the order of liquidation or before the policy expiration date if such expiration date is less than thirty (30) days after the order of liquidation, or that arise before the insured replaces the policy or causes its cancellation, if he does so within thirty (30) days of the order of liquidation. Such obligation shall be satisfied by paying to the claimant an amount as follows:

a. the full amount of a covered claim for benefits under a workers' compensation insurance coverage

b. an amount not exceeding $10,000 per policy for a covered claim for the return of unearned premium

c. an amount not exceeding $300,000 per claim for all other covered claims; provided, that for purposes of this limitation, all claims of any kind whatsoever arising out of, or related to, bodily injury or death to any one person shall constitute a single claim, regardless of the number of claims made, or the number of claimants

d. In no event shall the Association be obligated to pay an amount in excess of $300,000 for all first- and third-party claims under a policy or endorsement providing or that is found to provide Cybersecurity insurance coverage and arising out of or related to a single insured event, regardless of the number of claims made or the number of Claimants;

Drafting Note: A state may wish to enact a higher claim limit depending on cost- of-living issues in the state.

In no event shall the Association be obligated to pay a claimant an amount in excess of the obligation of the insolvent insurer under the policy or coverage from which the claim arises. Notwithstanding any other provisions of this Act, a covered claim shall not include a claim filed with the Association after the earlier of: (a) twenty-five (25) months

after the date of the order of liquidation, or (b) the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer.

Drafting Note: Optional language concerning workers' compensation benefits is included below for consideration in jurisdictions where the use of a 25-month bar date may be inappropriate in view of the latent nature of some occupational diseases that do not manifest themselves within this shortened period. This language is as follows:

The requirement of filing within twenty-five (25) months after the date of the order of liquidation shall not apply to claims by injured employees for workers compensation benefits where the basis for the claim is an occupational illness that does not manifest itself within the 25-month period.

Drafting Note: We recommend that the bar date provision set out above be applied only to claims related to liquidations occurring after the effective date of the amendment.

Any obligation of the Association to defend an insured on a covered claim shall cease upon the Association's (i) payment, either by settlement releasing the insured or on a judgment, of an amount equal to the lesser of the Association's covered claim obligation limit or the applicable policy limit or (ii) tender of such amount.

2. be deemed the insurer only to the extent of its obligation on the covered claims and to such extent, subject to the limitations provided in this article, shall have all rights, duties and obligations of the insolvent insurer as if the insurer had not become insolvent, including but not limited to, the right to pursue and retain salvage and subrogation recoverable on paid covered claim obligations. The Association shall not be deemed the insolvent insurer for any purpose relating to the issue of whether the Association is amenable to the personal jurisdiction of the courts of any state.

Drafting Note: The provision set out in this subsection 6. A. 2. is intended to be a clarification of the existing law in this state of the extent to which an association shall be deemed the insurer and concerning the nature of the contacts of the association outside of [designate state].

3. allocate claims paid and expenses incurred among the three (3) accounts separately, and assess member insurers separately for each account, amounts necessary to pay the obligations of the Association under this Act subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the calendar year prior to the assessment on the kinds of insurance in the account bears to the net direct written premiums of all member

insurers for the calendar year prior to the assessment on the kinds of insurance in the account. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. No member insurer may be assessed in any one year on any account an amount greater than two (2) percent of that member insurer's net direct written premiums for the calendar year preceding the assessment on the kinds of insurance in the account. Subject to this stated assessment limit, insurers may be subject to a minimum assessment determined by the Board, not to exceed $XX in any one year. If the maximum assessment, together with the other assets of the Association in any account, does not provide in any one year in any account an amount sufficient to make all necessary payments from that account, the funds available shall be pro-rated and the unpaid portion shall be paid as soon thereafter as funds become available. The Association shall pay claims in any order that it deems reasonable, including the payment of claims as such are received from the claimants or in groups or categories of claims. The Association may exempt or defer, in whole or in part, the assessment of any member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance; provided, however, that during the period of deferment, no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when such payment will not reduce capital or surplus below required minimums. Such payments shall be refunded to those companies receiving larger assessments by virtue of such deferment, or at the election of any such company, credited against future assessments. Each member insurer may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of such claims by the member insurer if they are chargeable to the account for which the assessment is made.

4. investigate claims brought against the Association and adjust, compromise, settle, and pay covered claims to the extent of the Association's obligation and deny all other claims. The Association shall have the right to appoint and to direct legal counsel retained under liability insurance policies for the defense of covered claims.

5. not be bound by any settlement, release, compromise, waiver, or judgment executed or entered within twelve (12) months prior to an order of liquidation and shall have the right to assert all defenses available to the Association including, but not limited to, defenses applicable to determining and enforcing its statutory rights and obligations to any such claim. The Association shall be bound by any settlement, release, compromise, waiver, or judgment executed or entered into more than one year prior to an order of liquidation; provided, however, such claim is a covered claim and such settlement or judgment was not a result of fraud,

collusion, default, or failure to defend. Further, as to any covered claims arising from a judgment under any decision, verdict, or finding based on the default of the insolvent insurer or its failure to defend, the Association either on its own behalf or on behalf of an insured may apply to have such judgment, order, decision, verdict, or finding set aside by the same court or administrator that made such judgment, order, decision, verdict, or finding and shall be permitted to defend such claim on the merits.

6. handle claims through its employees or through one or more insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the Commissioner, but such designation may be declined by a member insurer.

7. reimburse each servicing facility for obligations of the Association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the Association and shall pay the other expenses of the Association authorized by this Act.

8. establish procedures for requesting financial information from insureds and claimants on a confidential basis for purposes of applying sections of this Act concerning the net worth of first and third-party claimants, subject to such information being shared with any other Association similar to the Association and the Liquidator for the insolvent company on the same confidential basis. If the insured or claimant refuses to provide the requested financial information and an auditor’s certification of the same where requested and available, the Association may deem the net worth of the insured or claimant to be in excess of [insert proper amount] at the relevant time.

B. The Association may:

1. employ or retain such persons as are necessary to handle claims and perform other duties of the Association

2. borrow funds necessary to effect the purposes of this Act in accord with the plan of operation

3. sue or be sued, and such power to sue includes the power and right to intervene as a party as a matter of right before any court in this state that has jurisdiction over an insolvent insurer as defined by this Act.

4. negotiate and become a party to such contracts as are necessary to carry out the purpose of this Act

5. perform such other acts as are necessary or proper to effectuate the purpose of this Act

6. refund to the member insurers in proportion to the contribution of each member insurer to that account that amount by which the assets of the account exceed the liabilities, if at the end of any calendar year, the board of directors finds that the assets of the Association in any account exceed the liabilities of that account as estimated by the board of directors for the coming year

7. bring an action against any third-party administrator, agent, attorney, or other representative of the insolvent insurer to obtain custody and control of all files, records, and electronic data ("claims information") related to an insolvent company that are appropriate or necessary for the Association, or a similar association in other states, to carry out its duties under this Act. In such a suit, the Association shall have the absolute right through emergency equitable relief to obtain custody and control of all such claims information in the custody or control of such third-party administrator, agent, attorney, or other representative of the insolvent insurer, regardless of where such claims information may be physically located. In bringing such an action, the Association shall not be subject to any defense, lien (possessory or otherwise) or other legal or equitable ground whatsoever for refusal to surrender such claims information that might be asserted against the Liquidator of the insolvent insurers. To the extent that litigation is required for the Association to obtain custody of the claims information requested and it results in the relinquishment of claims information to the Association after refusal to provide the same in response to a written demand, the court shall award the Association its costs, expenses, and reasonable attorneys' fees incurred in bringing the action. The provisions of this section shall have no affect on the rights and remedies that the custodian of such claims information may have against the insolvent insurers, so long as such rights and remedies do not conflict with the rights of the Association to custody and control of the claims information under this Act.

C. Suits Involving the Association

1. Except for actions by member insurers aggrieved by final actions or decisions of the Association pursuant to Section 6.A.3., all actions relating to or arising out of this Act against the Association must be brought in the courts in this state. Such courts shall have exclusive jurisdiction over all actions relating to or arising out of this Act against the Association.

2. Exclusive venue in any action by or against the Association is in [designate appropriate court]. The Association may, at the option of the Association, waive such venue as to specific actions.

3. In any lawsuit contesting the applicability of Sections 3.I.2.d. and e. or 9.B.1. where the insured or claimant has declined to provide financial information under the procedure provided pursuant to Section 6 of this Act, the insured or claimant shall bear the burden of proof concerning its net worth at the relevant time. If the insured or claimant fails to prove that its net worth at the relevant time was less than the applicable amount, the court shall award the Association its full costs, expenses, and reasonable attorneys' fees in contesting its claim.

Drafting Note: Because of the potential impact on guaranty association coverage, it is recommended that the legislation include an appropriate provision clearly stating that the any newly enacted net worth provision applies only to legislation estates commencing after its effective date. If only the new administrative provisions are being added to a preexisting net worth exemption, it would be possible to apply them to all outstanding claims.

Section 7. Plan of Operation

A. 1. The Association shall submit to the Commissioner a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the Association. The plan of operation and any amendments thereto shall become effective upon approval in writing by the Commissioner.

2. If the Association fails to submit a suitable plan of operation within ninety (90) days following the effective date of this Act, or if at any time thereafter the Association fails to submit suitable amendments to the plan, the Commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this Act. Such rules shall continue in force until modified by the Commissioner or superseded by a plan submitted by the Association and approved by the Commissioner.

B. All member insurers shall comply with the plan of operation.

C. The plan of operation shall:

1. establish the procedures whereby all the powers and duties of the Association under Section 6 will be performed

2. establish procedures for handling assets of the Association

3. mandate that procedures be established for the disposition of liquidating dividends or other monies received from the estate of the insolvent insurer

4. mandate that procedures be established to designate the amount and method of reimbursing members of the board of directors under Section 5.C

5. establish procedures by which claims may be filed with the Association and establish acceptable forms of proof of covered claims. Notice of claims to the receiver or liquidator of the insolvent insurer shall be deemed notice to the Association or its agent and a list of claims shall be periodically submitted to the Association or Association similar to the Association in another state by the receiver or liquidator

6. establish regular places and times for meetings of the board of directors

7. mandate that procedures be established for records to be kept of all financial transactions of the Association, its agents, and the board of directors

8. provide that any member insurer aggrieved by any final action or decision of the Association may appeal to the Commissioner within thirty (30) days after the action or decision

9. establish the procedures whereby selections for the board of directors will be submitted to the Commissioner

10. contain additional provisions necessary or proper for the execution of the powers and duties of the Association

D. The plan of operation may provide that any or all powers and duties of the Association, except those under Section 6.A.3. and 6.B.2., are delegated to a corporation, Association similar to the Association, or other organization that performs or will perform functions similar to those of this Association or its equivalent in two or more states. Such a corporation, association, or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of any other functions of the Association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the Commissioner, and may be made only to a corporation, association, or organization that extends protection not substantially less favorable and effective than that provided by this Act.

Section 8. Duties and Powers of the Commissioner

A. The Commissioner shall:

1. notify the Association of the existence of an insolvent insurer not later than three (3) days after he receives notice of the determination of the insolvency. The Association shall be entitled to a copy of any complaint seeking an order of

liquidation with a finding of insolvency against a member company at the same time that such complaint is filed with a court of competent jurisdiction

2. upon request of the board of directors, provide the Association with a statement of the net direct written premiums of each member insurer

B. The Commissioner may:

1. suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer that fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the Commissioner may levy a fine on any member insurer that fails to pay an assessment when due. Such fine shall not exceed five (5) percent of the unpaid assessment per month, except that no fine shall be less than $100 per month.

2. revoke the designation of any servicing facility if he finds claims are being handled unsatisfactorily

C. Any final action or order of the Commissioner under this Act shall be subject to judicial review in a court of competent jurisdiction.

Section 9. Effect of Paid Claims

A. Any person recovering under this Act shall be deemed to have assigned his rights under the policy to the Association to the extent of his recovery from the Association. Every insured or claimant seeking the protection of this Act shall cooperate with the Association to the same extent as such person would have been required to cooperate with the insolvent insurer. The Association shall have no cause of action against the insured of the insolvent insurer for any sums it has paid out except such causes of action as the insolvent insurer would have had if such sums had been paid by the insolvent insurer and except as provided in Subsection B. below. In the case of an insolvent insurer operating on a plan with assessment liability, payments of claims of the Association shall not operate to reduce the liability of the insureds to the receiver, liquidator, or statutory successor for unpaid assessments.

B. The Association shall have the right to recover from the following persons all amounts paid by the Association on behalf of such person, whether for indemnity or defense or otherwise:

1. any insured whose net worth on December 31 of the year immediately preceding the date the insurer becomes an insolvent insurer exceeds $25 million; provided that an insured's net worth on such date shall be deemed to include the

aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis; and

2. The Association may also, at its sole discretion and without assumption of any ongoing duty to do so, pay any workers compensation claims or any third-party claims or Cybersecurity insurance obligations covered by a policy or endorsement of an insolvent company on behalf of a high net worth insured as defined in Section 3 I.2.d. & e. In that case, the Association shall recover from the high net worth insured under this Section all amounts paid on its behalf, all allocated claim adjusted expensed related to such claims, the Association's attorney's fees, and all court costs in any action necessary to collect the fill amount to the Association's reimbursements under this Section.

3. any person who is an affiliate of the insolvent insurer.

C. The Association and any Association similar to the Association in another state shall be recognized as claimants in the liquidation of an insolvent insurer for any amounts paid by them on covered claims obligations as determined under this Act or similar laws in other states and shall receive dividends and any other distributions at the priority set forth in [Liquidation Act reference]. The receiver, liquidator, or statutory successor of an insolvent insurer shall be bound by determinations of covered claim eligibility under this Act and by settlements of claims made by the Association or a similar organization in another state. The court having jurisdiction shall grant such claims priority equal to that which the claimant would have been entitled in the absence of this Act against the assets of the insolvent insurer. The expenses of the Association or similar organization in handling claims shall be accorded the same priority as the liquidator's expenses.

D. The Association shall periodically file with the receiver or liquidator of the insolvent insurer statements of the covered claims paid by the Association and estimates of anticipated claims on the Association. Such filing shall preserve the rights of the Association against the assets of the insolvent insurer.

Section 10. Exhaustion of Other Coverage

A. Any person having a claim under an insurance policy, whether or not it is a policy issued by a member insurer, and the claim under such other policy arises from the same facts, injury, or loss that gave rise to the covered claim against the Association, shall be required first to exhaust all coverage provided by any such policy. Any amount payable on a covered claim under this Act shall be reduced by the full applicable limits stated in such other insurance policy and the Association shall receive a full credit for such stated limits, or, where there are no applicable stated limits, the claim shall be reduced by the total recovery. Notwithstanding the foregoing, no person shall be required to exhaust any right under the policy of an insolvent insurer.

1. A claim under a policy providing liability coverage to a person who may be jointly and severally liable with or a joint tortfeasor with the person covered under the policy of the insolvent insurer that gives rise to the covered claim shall be considered to be a claim arising from the same facts, injury, or loss that gave rise to the covered claim against the Association.

2. A claim under an insurance policy shall also include, for purposes of this section:

a. a claim against a health maintenance organization, a hospital plan corporation, or a professional health service corporation; and

b. any amount payable by or on behalf of a self-insurer

c. To the extent that the Association's obligation is reduced by the application of this section, the liability of the person insured by the insolvent insurer's policy for the claim shall be reduced in the same amount.

B. Any person having a claim that may be recovered under more than one insurance guaranty association or its equivalent shall seek recovery first, from the Association of the place of residence of the insured except that if it is a first-party claim for damage to property with a permanent location, he shall seek recovery first from the Association of the location of the property, and if it is a workers' compensation claim, he shall seek recovery first from the Association of the residence of the claimant. Any recovery under this Act shall be reduced by the amount of recovery from any other insurance guaranty association or its equivalent.

Section 11. Prevention of Insolvencies

To aid in the detection and prevention of insurer insolvencies:

A. The board of directors may, upon majority vote, make recommendations to the Commissioner for the detection and prevention of insurer insolvencies.

B. The board of directors may, upon majority vote, make recommendations to the Commissioner on matters generally related to improving or enhancing regulation for solvency.

C. The board of directors may, at the conclusion of any domestic insurer insolvency in which the Association was obligated to pay covered claims, prepare a report on the

history and causes of such insolvency, based on the information available to the Association, and submit such report to the Commissioner.

Section 12. Examination of the Association

The Association shall be subject to examination and regulation by the Commissioner. The board of directors shall submit, not later than March 30 of each year, a financial report for the preceding calendar year in a form approved by the Commissioner.

Section 13. Tax Exemption

The Association shall be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions except taxes levied on real or personal property.

Section 14. Recognition of Assessments in Rates

Drafting Note: Insurance companies that are "members" of the guaranty associations provide funds through assessments, as needed, for the guaranty associations' claim payment obligations. A method to recoup such assessments needs to be established in each state. Mechanisms currently employed include 1) permitting member insurers to surcharge policyholders, 2) permitting a premium tax offset for assessments paid by insurers, and 3) permitting premium increases to recoup assessment costs. This Section is left blank so that local authorities may determine the most appropriate mechanism for their states.

Section 15. Immunity

There shall be no liability on the part of, and no cause of action of any nature shall arise against any member insurer, the Association or its agents or employees, the board of directors, or any person serving as a representative of any director, or the Commissioner or his representatives for any action taken or any failure to act by them in the performance of their powers and duties under this Act.

Section 16. Stay of Proceedings

All proceedings in which the insolvent insurer is a party or is obligated to defend a party in any court in this state shall, subject to waiver by the Association in specific cases involving covered claims, be stayed until the last day fixed by the court for the filing of claims and such additional time thereafter as may be determined by the court from the date the insolvency is determined or an ancillary proceeding is instituted in the state, whichever is later, to permit proper defense by the Association of all pending causes of action.

The liquidator, receiver, or statutory successor of an insolvent insurer covered by this Act shall permit access by the board or its authorized representative to such of the insolvent insurer's records that are necessary for the board in carrying out its functions under this Act with regard to covered claims. In addition, the liquidator, receiver or statutory successor shall provide the board or its representative with copies of such records upon the request by the board and at the expense of the board.

<u>EXECUTIVE COMMITTEE MATERIALS</u>

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
EXECUTIVE COMMITTEE
2026 NCOIL SPRING MEETING – LOUISVILLE, KY
APRIL 19, 2026
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Executive Committee met at the Hyatt Regency in Louisville, KY on Sunday April 19, 2026 at 10:45 AM (EST).

NCOIL President, Senator Paul Utke (MN), Chair of the Committee, presided.

Other members of the committee present:

Sen. Jesse Bjorkman (AK)
Rep. Matt Lehman (IN)
Rep. Peggy Mayfield (IN)
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. Jeff Barta (ND)
Asm. Jarett Gandolfo (NY)
Rep. Brian Lampton (OH)
Sen. George Lang (OH)
Rep. Tom Oliverson, M.D. (TX)
Rep. Barbara Dittrich (WI)
Sen. Mary Felzkowski (WI)
Del. Walter Hall (WV)

Other legislators present were:

Rep. Justin Wilmeth (AZ)
Rep. Shaun Mena (LA)
Sen. Keri Heintzeman (MN)
Rep. Meredith Craig (OH)
Rep. Kellie Deter (OH)
Sen. Cale Case (WY)

Also in attendance were:

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

QUORUM

Upon a motion made by Rep. Sarge Pollock (KY) and seconded by Del. Walter Hall (WV), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a motion made by Rep. Edmond Jordan (LA), NCOIL Vice President, and seconded by Rep. Brian Lampton (OH) the Committee voted without objection by way of a voice vote to approve the minutes of the Committee's November 15, 2025 meeting in Atlanta, GA.

FUTURE MEETING LOCATIONS

Sen. Paul Utke (MN), NCOIL President stated that looking ahead to the rest of 2026, the Summer Meeting will be in Boston, MA from July 15th-18th and the Annual Meeting will be in Sanibel, FL from November 19th – 22nd. The Annual Meeting will also start with the 5th Annual NCOIL Open Insurance Legislators Foundation (ILF) Golf Outing.

Rep. Brenda Carter (MI), NCOIL Secretary stated I did want to make a proposal for the Committee to consider and that is to book the 2029 Annual Meeting in Detroit, MI.

Sen. Utke said we certainly have Michigan on the agenda for consideration and a Summer Meeting might be best for a Detroit Meeting.

ADMINISTRATION

Will Melofchik, NCOIL CEO stated we ended up with 399 total registrants including 75 legislators from 27 states and of that number there were 11 first time attendee legislators from 9 states. Additionally, 5 Insurance Commissioners participated with 13 total insurance departments represented. These are tremendous attendance numbers and we can't thank everyone enough.

Mr. Melofchik gave the 2026 unaudited financials through March 31st showing revenue of $468,814.20 and expenses of $271,639.04 for an excess of $197,175.16.

CONSENT CALENDAR

Sen. Utke noted that the consent calendar includes committee reports including resolutions and model laws adopted and re-adopted therein, as well as ratification of decisions made and actions taken by the NCOIL Officers and staff in the time between Executive Committee Meetings.

The Consent Calendar included:

- The Health Insurance & Long Term Care Issues Committee adopted a Resolution in Support of Public Policy Improving Maternal Health and readopted: the NCOIL Telemedicine Authorization and Reimbursement Model Act (until Summer Meeting in July); the NCOIL Model Act Regarding Air Ambulance Patient Protections; the NCOIL Accumulator Adjustment Program Model Act; and the NCOIL Employer-Sponsored Group Disability Income Protection Model Act.

- The Life Insurance & Financial Planning Committee adopted the NCOIL Model Act Regarding Life Insurers' Use of Genetic Information and readopted: the NCOIL Beneficiaries' Bill of Rights; the NCOIL Life Insurance Consumer Disclosure Model Act; and the NCOIL Long Term Care Tax Credit Model Act.

- The Property & Casualty Insurance Committee readopted the NCOIL Transportation Network Company (TNC) Model Act until the Summer Meeting in July.

- The Joint State-Federal Relations & International Insurance Issues Committee adopted the NCOIL Individual Coverage Health Reimbursement Arrangements Model Act.

- The Financial Services & Multi-Lines Issues Committee adopted a Resolution Affirming U.S. State-Based Regulation of Artificial Intelligence in Insurance Consistent with the McCarran-Ferguson Act.

Sen. Utke 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 Asm. Jarett Gandolfo (NY) and seconded by Sen. Lana Theis (MI), the Committee voted to adopt the consent calendar without objection by way of a voice vote.

OTHER SESSIONS

Sen. Utke stated that there were two great General Sessions including "Developments in Rural Health Improvement Policies and the Rural Health Transformation Program" and "Network Leasing in Healthcare – What Policymakers Need to know." We also had a great featured speaker with Scott Jennings, CNN Contributing and Former Presidential Advisor speaking at the Keynote Luncheon. We also held a great special Thunder Over Louisville Reception last night.

NEW EXECUTIVE COMMITTEE MEMBERS

Sen. Utke stated that pursuant to their status as Chair of their state's committee with jurisdiction over insurance issues, legislators from Contributing States attending the Executive Committee are recognized as new Executive Committee members. Accordingly, Sen. Cale Case (WY) should be added to the Executive Committee.

Hearing no questions or comments, upon a Motion made by Sen. Jeff Barta (ND) and seconded by Rep. Matt Lehman (IN), the Committee voted without objection by way of a voice vote to add Sen. Case to the Executive Committee.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Lampton and seconded by Sen. Jesse Bjorkman (AK), the Committee adjourned at 11:15 a.m.