30 DAY MATERIALS AND GENERAL SCHEDULE
NCOIL ANNUAL MEETING
NOVEMBER 19 - 22, 2026

As of November 10, 2026, and Subject to Change



The Marriot Sanibel Harbour Hotel
Sanibel, Florida



NCOIL ANNUAL MEETING
Sanibel, Florida --- November 19 - 22, 2026

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

THURSDAY, NOVEMBER 19TH

NCOIL Open Insurance Legislators Foundation (ILF) Golf Outing	1:00 p.m.		
Welcome Reception	6:30 p.m.	-	7:30 p.m.

FRIDAY, NOVEMBER 20TH

Registration *Exhibits Open: 8:00 a.m. – 5:00 p.m.*	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.
Health Insurance & Long Term Care Issues Committee	10:00 a.m.	-	11:45 a.m.
General Session Examining the Data Surrounding Claims Closed Without Payment	11:45 a.m.	-	12:45 p.m.
The Institutes Griffith Foundation Legislator Luncheon Understanding Fraud as a Driver of Insurance Costs ***Open to Public Policymakers and Staff Only***	12:45 p.m.	-	2:00 p.m.

Workers' Compensation Insurance Committee	2:00 p.m.	-	3:30 p.m.
Networking Break **Sponsored by Aflac**	3:30 p.m.	-	3:45 p.m.
Life Insurance & Financial Planning Committee	3:45 p.m.	-	5:00 p.m.
Budget Committee	5:00 p.m.	-	5:30 p.m.
Adjournment	5:30 p.m.		
CIP Member & Sponsor Reception ***Open to Public Policymakers, CIP Members, and Annual Meeting Sponsors***	6:00 p.m.	-	7:00 p.m.

SATURDAY, NOVEMBER 21st

Registration *Exhibits Open: 8:00 a.m. – 5:00 p.m.*	8:00 a.m.	-	5:00 p.m.
Financial Services & Multi-Lines Issues Committee	9:00 a.m.	-	10:45 a.m.
NCOIL – NAIC Dialogue	10:45 a.m.	-	12:00 p.m.
Luncheon with Keynote Address	12:00 p.m.	-	1:30 p.m.
General Session Perspectives on Healthcare Affordability and Key Cost Drivers	1:30 p.m.	-	3:00 p.m.
Networking Break	3:00 p.m.	-	3:15 p.m.
Joint State-Federal Relations & International Insurance Issues Committee	3:15 p.m.	-	5:00 p.m.
Adjournment	5:00 p.m.		
Nominating Committee (Members Only)	5:00 p.m.		
Women's Caucus Reception ***Open to all Women Attendees***	6:15 p.m.	-	7:15 p.m.

Please reach out to Pat Gilbert at pgilbert@ncoil.org with any questions.

SUNDAY, NOVEMBER 22nd

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 Annuities: A Primer for Public Policymakers ***Open to Public Policymakers and Staff Only***	7:45 a.m.	-	8:45 a.m.
General Session Insurance for Child Care Providers: Is Coverage Accessible and Affordable?	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 November 10, 2026. There will be modifications between now and the start of the Meeting.******

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

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

Thursday, November 19, 2026

NCOIL Open Insurance Legislators Foundation (ILF) Golf Outing
Thursday, November 19, 2026
1:00 p.m.

Welcome Reception
Thursday, November 19, 2026
6:30 p.m. – 7:30 p.m.

Friday, November 20, 2026

Welcome Breakfast
Friday, November 20, 2026
8:15 a.m. – 9:45 a.m.

1.) **The Hon. Mike Yaworsky – Florida Insurance Commissioner**
    -Welcome to Florida
2.) **Will Melofchik**
    -Introductory Comments from NCOIL CEO
3.) **Sen. Paul Utke (MN)**
    a.) President's Welcome
    b.) New Member Welcome and Introduction
4.) Any Other Business
5.) Adjournment

Networking Break
Friday, November 20, 2026
9:45 a.m. – 10:00 a.m.

First Time Attendee Legislator & Staff Meeting
Friday, November 20, 2026
9:45 a.m. – 10:00 a.m.

Health Insurance & Long Term Care Issues Committee
Friday, November 20, 2026
10:00 a.m. – 11:45 a.m.

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

1.) Call to Order/Roll Call/Approval of July 17, 2026 Cmte. Mtg. Minutes
2.) Introduction and Discussion on Legislation Improving Access to Prostheses and Orthoses
Rep. Brenda Carter (MI), NCOIL Secretary; Sen. Bill Gannon (NH) – Sponsors
Nicole Ver Kuilen and Maggie Baumer - So Every BODY Can Move
3.) Discussion on Legislation Relating to Coverage for the Treatment of Stuttering
Michael Kidd-Gilchrist, Founder – Change & Impact; Rep. Michael Sarge Pollock (KY); Sen. Willie Preston (IL)
4.) Continued Discussion and Potential Consideration of Proposed Amendments to NCOIL Telemedicine Authorization and Reimbursement Model Act
Asw. Pam Hunter (NY), NCOIL Immediate Past President – Sponsor
Maxwell Treu, American Specialty Health
5.) Continued Discussion and Potential Consideration of 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
National Ass'n of Vision Care Plans (NAVCP) Representative
American Optometric Ass'n (AOA) Representative
6.) Any Other Business
7.) Adjournment

General Session
Examining the Data Surrounding Claims Closed Without Payment
Friday, November 20, 2026
11:45 a.m. – 12:45 p.m.

Moderator: Sen. Cale Case (WY)

Robert P. Hartwig, PhD, CPCU
Clinical Associate Professor, Finance Department and Director, Center for Risk and Uncertainty Management
Darla Moore School of Business
University of South Carolina

Jay Feinman
Distinguished Professor Emeritus
Rutgers Law School

The Institutes Griffith Foundation Legislator Luncheon
Understanding Fraud as a Driver of Insurance Costs
Friday, November 20, 2026
12:45 p.m. – 2:00 p.m.
*****Open to Public Policymakers and Staff Only*****

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

Workers' Compensation Insurance Committee
Friday, November 20, 2026
2:00 p.m. - 3:30 p.m.

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

1.) Call to Order/Roll Call/Approval of July 17, 2026 Cmte. Mtg. Minutes
2.) Presentation on Demographic Forces Shaping Workplace Risk
    Patrick Coate, PhD, Senior Economist, National Council on Compensation Insurance (NCCI)
3.) Presentation on Pharmacy Benefit Managers (PBMs) and their Role in Work Comp

Lisa Anne Hurt-Forsythe, VP of Gov't Affairs – American Ass'n of Payers, Administrators and Networks (AAPAN)

4.) Discussion on Trends and Developments in the Florida Work Comp Marketplace

The Hon. David Langham, Deputy Chief Judge of Compensation Claims – Florida Office of Judges of Compensation Claims

5.) Any Other Business

6.) Adjournment

Networking Break
Sponsored by Aflac
Friday, November 20, 2026
3:30 p.m. – 3:45 p.m.

Life Insurance & Financial Planning Committee
Friday, November 20, 2026
3:45 p.m. – 5:00 p.m.

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

1.) Call to Order/Roll Call/Approval of July 16, 2026 Cmte. Mtg. Minutes

2.) Presentation on Artificial Intelligence Use Cases in Life Insurance

Cara St. Martin, Chief Compliance and Ethics Officer – Ladder Life Insurance Company

3.) GLP-1s – Insurance and Mortality Risk Developments

Kimberly Ferrero, Ph.D., M.Sc., Assistant Director, Research - American Academy of Actuaries

4.) Discussion on Federal and State Retirement Security Initiatives

Jill Rickard, Regional VP, State Relations - American Council of Life Insurers (ACLI)

5.) Any Other Business

6.) Adjournment

Budget Committee
Friday, November 20, 2026
5:00 p.m. – 5:30 p.m.

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

1.) Call to Order/Roll Call/Approval of July 15, 2026 Cmte. Mtg. Minutes

2.) Consideration of 2027 Budget
3.) Any Other Business
4.) Adjournment

CIP Member & Sponsor Reception
Friday, November 20, 2026
6:00 p.m. – 7:00 p.m.
*****Open to Public Policymakers, CIP Members, and Annual Meeting Sponsors*****

Saturday, November 21, 2026

Financial Services & Multi-Lines Issues Committee
Saturday, November 21, 2026
9:00 a.m. – 10:45 a.m.

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

1.) Call to Order/Roll Call/Approval of July 16, 2026 Cmte. Mtg. Minutes
2.) Presentation on Artificial Intelligence Developments in Insurance
Joe Wodark, Senior VP – Verisk
3.) Discussion on Health Savings Account (HSA) Developments Involving Bankruptcy Protection and Unclaimed Property Laws
Kevin McKechnie, Executive Director, HSA Council – American Bankers Ass'n (ABA)
4.) Presentation on Reinsurance Trends and Developments
The Hon. John Huff, CEO - Association of Bermuda Insurers & Reinsurers (ABIR)
5.) Introduction and Discussion on Legislation Relating to Insurer Service of Process Requirements
Rep. Brian Lampton (OH) – Sponsor
Matt Overturf, Assistant VP, State Affairs – National Ass'n of Mutual Insurance Companies (NAMIC)
6.) Consideration of Re-adoption of Model Laws
a.) Identity Theft Protection Model Act – Originally Adopted 11/21/03
b.) Uniform Captive Insurer Model Act – Originally Adopted 11/20/21
c.) Insurer Division Model Act – Originally Adopted 4/18/21
d.) Remote Notarization Model Act --- Originally Adopted 11/20/21
7.) Any Other Business
8.) Adjournment

NCOIL – NAIC Dialogue
Saturday, November 21, 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 July 17, 2026 Meeting Minutes
2.) Discussion on NAIC Communications with Congress on Private Credit and Insurance
3.) Update on NAIC's Development of Residential Mitigation Grant Program Model Act
4.) Discussion on NAIC's Analysis of Homeowners Insurance Market Trends
5.) Discussion on Development of NAIC's Privacy of Consumer Information Model Act
6.) Update on Work of NAIC's Big Data and Artificial Intelligence (H) Working Group
7.) Follow-up Discussion on NAIC's Security Incident
8.) Any Other Business
9.) Adjournment

Luncheon with Keynote Address
Saturday, November 21, 2026
12:00 p.m. – 1:30 p.m.

Steve McMahon
Co-founder & CEO
Purple Strategies

General Session
Perspectives on Healthcare Affordability and Key Cost Drivers
Saturday, November 21, 2026
1:30 p.m. – 3:00 p.m.

Moderator: Sen. Mary Felzkowski (WI)

Miranda Motter
Senior VP, State Affairs & Policy
America's Health Insurance Plans (AHIP)

Eric Waskowicz
Senior Policy Manager
United States of Care

Sharon Lamberton
Deputy VP
PhRMA

Terry Cunningham
Senior Director, Administrative Simplification Policy
American Hospital Association (AHA)

Jonathan Buxton
Senior Director – State Affairs
PCMA

Networking Break
Saturday, November 21, 2026
3:00 p.m. – 3:15 p.m.

Joint State-Federal Relations & International Insurance Issues Committee
Saturday, November 21, 2026
3:15 p.m. – 5:00 p.m.

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

1.) Call to Order/Roll Call/Approval of July 16, 2026 and September 25, 2026 Cmte Mtg Minutes
2.) Continued Discussion and Consideration of NCOIL Strengthening Transparency in the 340B Drug Pricing Program Model Act
Rep. Tom Oliverson, M.D. (TX) – Sponsor; Sen. Paul Utke (MN), NCOIL President; Rep. Brenda Carter (MI), NCOIL Secretary – Co-sponsors
3.) Presentation on U.S. Departments of Labor, Treasury and Health and Human Services Proposed Rule Relating to Fertility Care Coverage
Jodi Neuhauser - Fertility Providers Alliance
Joseph Letourneau, M.D. – IVIRMA Medical
4.) Discussion on Center for Consumer Information & Insurance Oversight (CCIIO) Priorities
Peter Nelson, Deputy Administrator & Director – CCIIO, Centers for Medicare & Medicaid Services (CMS)
5.) Consideration of Re-adoption of Model Laws
a.) Resilient Revolving Loan Fund Model Act – Originally Adopted 11/20/21
b.) Company Licensing Modernization Model Act – Originally Adopted 7/12/02
6.) Any Other Business
7.) Adjournment

Nominating Committee (Members Only)
Saturday, November 21, 2026
5:00 p.m.

Women's Caucus Reception
Saturday, November 21, 2026
6:15 p.m. – 7:15 p.m.
*****Open to all Women Attendees*****
*****Please reach out to Pat Gilbert at pgilbert@ncoil.org with any questions.*****

Sunday, November 22, 2026

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

The Institutes Griffith Foundation Legislator Breakfast
Annuities: A Primer for Public Policymakers
Sunday, November 22, 2026
7:45 a.m. – 8:45 a.m.
*****Open to Public Policymakers and Staff Only*****

David McCarthy, Ph.D.
Professor of Risk Management & Insurance
Terry College of Business
University of Georgia

General Session
Insurance for Child Care Providers: Is Coverage Accessible and Affordable?
Sunday, November 22, 2026
9:00 a.m. – 10:30 a.m.

Moderator: Sen. Pam Helming (NY)

Chandra Kwaske
Chief Underwriting Officer
Nonprofits Insurance Alliance

Chris Reed
Chief Risk Officer and General Counsel
Nonprofits Insurance Alliance

Rachel Gwaltney
Executive Director
Children's League of Massachusetts

Charles Malone
Chief Deputy Commissioner
Washington Insurance Dep't

Andrea Durbin
CEO
Illinois Collaboration on Youth

Eric Goldberg
Dep't VP and Counsel, Commercial Lines
American Property Casualty Insurance Ass'n (APCIA)

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

Networking Break
Sunday, November 22, 2026
10:30 a.m. – 10:45 a.m.

Property & Casualty Insurance Committee
Sunday, November 22, 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 July 18, 2026 Cmte Mtg Minutes
2.) Continued Discussion and Consideration of Proposed Amendments to NCOIL Model Act to Regulate Insurance Requirements for Transportation Network Companies and Transportation Network Drivers
Sen. Walter Michel (MS) – Sponsor
Bob Passmore, Department VP, Personal Lines – American Property Casualty Insurance Ass'n (APCIA)
3.) Continued Discussion and Consideration of NCOIL Model Act Regarding Insurers' Use of Aerial Images
Rep. Matt Lehman (IN); Rep. Brian Lampton (OH) – Sponsors; Rep. Matt Morgan (TX) – Co-sponsor
Matt Overturf – NAMIC
Joe Roth, Ass't VP, State Gov't Relations - APCIA
Wes Bissett, Senior Counsel – Independent Insurance Agents and Brokers of America (IIABA)
4.) Discussion on Potential Development of Model Legislation Regarding Autonomous Vehicles
Brad Nail – On behalf of Waymo
Mike Nelson, Chairman – QuantivRisk
Bob Passmore – APCIA
Matt Overturf – NAMIC
5.) Discussion on Proposed Amendments to NCOIL Peer-to-Peer Car Sharing Program Model Act

Rep. Meredith Craig (OH) – Sponsor
Sean Vinck, Global Lead Counsel for Legislation & Policy - Turo
Brian Rothery, VP of Gov't & Public Affairs - Enterprise Mobility
Don Lefeve, President & CEO – American Car Rental Ass'n (ACRA)
Bob Passmore – APCIA

6.) Introduction of NCOIL Wildfire Prepared Program Model Act
Rep. Jim Dunnigan (UT), NCOIL Treasurer – Sponsor
Matt Overturf – NAMIC

7.) Any Other Business
8.) Adjournment

Executive Committee
Sunday, November 22, 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 July 18, 2026 Cmte Mtg Minutes
2.) Future Meeting Locations
3.) Administration
a.) Meeting Report
b.) Receipt of Financials
4.) Consent Calendar
5.) Other Sessions
a.) General Sessions
b.) Featured Speakers
6.) Nominating Cmte Report/Election of Officers
7.) Any Other Business
8.) Adjournment

HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
2026 NCOIL SUMMER MEETING – BOSTON, MASSACHUSETTS
JULY 17, 2026
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee met at The Westin Copley Place Hotel in Boston, MA on Friday, July 17, 2026.

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

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Sen. Tim Grayson (CA)
Rep. Stephen Meskers (CT)
Rep. Rita Mayfield (IL)
Rep. Peggy Mayfield (IN)
Rep. Adrielle Camuel (KY)
Rep. Deanna Frazier Gordon (KY)
Rep. Edmond Jordan (LA)
Rep. David LeBoeuf (MA)
Rep. Robert Foley (ME)
Rep. Brenda Carter (MI)
Sen. Mark Huizenga (MI)
Sen. Lana Theis (MI)
Sen. Paul Utke (MN)
Sen. Tim McGough (NH)
Asm. Erik Dilan (NY)
Asm. Jarett Gandolfo (NY)
Asw. Pamela Hunter (NY)
Rep. Brian Lampton (OH)
Sen. George Lang (OH)
Rep. Ellyn Hefner (OK)
Rep. Carl Anderson (SC)
Rep. Matt Morgan (TX)
Rep. Tom Oliverson, MD (TX)
Rep. Dennis Paul (TX)
Rep. Calvin Callahan (WI)
Del. Walter Hall (WV)

Other legislators present were:

Rep Kerry Wood (CT)
Rep. Ben Fuhrman (ID)
Sen. Willie Preston (IL)
Rep. Daniel Grossberg (KY)
Rep. Michael Meredith (KY)
Rep. Poppy Arford (ME)
Rep. Michelle Boyer (ME)
Del. Pam Guzzone (MD)
Sen. Bill Gannon (NH)
Rep. Julie Miles (NH)
Rep. Kevin Norwood (OK)
Rep. Trey Wharton (TX)
Sen. Cale Case (WY)
Rep. Pepper Ottman (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. Brenda Carter (MI), NCOIL Secretary, and seconded by Rep. Dennis Paul (TX), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Peggy Mayfield (IN) and seconded by Rep. Rita Mayfield (IL), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's April 17, 2026 meeting.

PRESENTATION ON IMPROVING ACCESS AND AFFORDABILITY IN THE HEALTHCARE MARKETPLACE

Rep. Pollock stated that in keeping with NCOIL's focus on healthcare affordability, first on our agenda is a presentation from a health insurer that has a unique business model which aims to promote access and affordability in the healthcare marketplace.

Natalie Leino, General Counsel and Chief Compliance Officer at Sidecar Health thanked the Committee for the opportunity to speak and stated that affordability has certainly been a central theme throughout this conference so it's great to be able to share what we are doing because we do believe that the current system as it is, is broken, and something more than just minor tweaks needs to happen for it to improve. Prior to joining Sidecar two years ago, I've worked in other large health insurance companies, both at a Fortune 20 national insurer and also at a regional nonprofit so I have seen companies try to address challenges associated with rising costs through a number of different forms. Sidecar is a mission driven organization who aims to make quality health care affordable and accessible for everyone. Our first major medical product was introduced in 2021. We started offering products to large group employers 2022. And now we're focused on continuing to expand to new markets. So, what do we do? We lower costs by making healthcare shoppable. Almost all other things that people get in this country are shoppable, and healthcare is a huge exception to that today. What's the status quo? There's no transparency into cost and quality of care. There's little motivation for patients to consider cost in decisions.

And even when patients do have that motivation now because they're in high-deductible health plans or otherwise have high cost sharing, they can't do it because they don't have that transparency into cost in order to make those decisions. What traditional health plans have done in light of rising costs is they've begun to restrict care with things like smaller networks, prior authorizations, step therapy, and formularies. Sidecar believes we have to approach it in a fundamentally different way. We provide our members with complete transparency by providing cost and quality data upfront. We align incentives so we reward smart decisions when our members make good choices and begin to treat healthcare dollars like their own, and that leads to lower costs for everybody. We have found that aligning incentives does change behavior. Our members have higher rates of primary care utilization, 50% higher mental health utilization. This translates into 40% lower emergency room costs. They access prescriptions at lower cost pharmacies 75% of the time, 60% of colonoscopies are performed at lower cost facilities, and perhaps mostly uniquely, the average family on our plan earns $1,000 a year for making good

decisions. So, just to give a very simple example. If you look at any given drug, there's a wide variation in how much that drug will cost when you go to different places. So here, Lipitor, about 30% of people age 40 and above are on a statin. A 90day supply varies from $11 to $32 in a particular geography. An annual cost for an employer when you add a number of people on, it can be quite significant. If you then translate this to every drug and every service, the amount of savings that can add up when members are making smart decisions is huge.

So, we have found that this approach does lower medical costs, an average total savings of 20%. The average member savings per member is $2,000 a year and this translates into 20% lower premiums for employer groups that pick Sidecar. So how does this work? All care has a transparent budget. We refer to this as the benefit amount, and it's an amount the plan pays for any given service or drug. The key is this is not just a reference price. It is set to the typical cost where that member lives. There's a large number of inputs that go into it, and so it's very regionalized and specific in terms of how the benefit amount is set. Members then can understand what the benefit amount for any service is and then the cost at different providers in their area. And when they choose to go to lower-cost care, they keep half the savings. Sometimes members choose to go to a provider above the benefit amount, and they pay the difference. So, you can see here, a little visual, and we do have an app that will very clearly show you. Members can search by provider, or search by service. You'll see what you will pay or earn as a consumer. You pay for your care with a Sidecar Visa card. This is not a credit card, it's a benefit card that when you swipe the card, the provider gets paid at the point of service. But those funds come directly out of our Sidecar claims account. So there's no element of the member kind of having credit the way a traditional credit card works.

Then, when they make good choices, they earn money. So, the app will always show them how much they have earned. They can use those earnings for future medical care, and if they haven't used them by the end of the year, it is paid out in cash through their employer, and it is taxed at that point. Now I will quickly show some examples. This is an example of an MRI. The cost varies greatly for the exact same MRI. You can see that a member can decide where to go. They can either pay a significant amount out of pocket, pay zero, or in this case, they can earn $227 for getting that MRI at a lower cost provider. Another quick example for a colonoscopy, same thing, they can earn $1,100, pay zero or pay $1,400. And these are real examples of specific situations from our claims data. So, probably a question all of you are asking is do the lower cost providers equate to lower quality? Study after study shows that that is not true. There is no correlation between cost and quality. We include quality data on our app for members. After looking at various options, we decided to include something called GAM, Global Appropriateness Measures. It's done out of Johns Hopkins University. When you look at our data, 91% of claims by our members are at or below the benefit amount so where the member paid nothing or earned money were with four or five star providers. So, once you align incentives and members understand prices up front and make good choices, you don't need to restrict care in the ways that traditional insurers have been restricting care.

So, perhaps one of the most defining features of our plan is we do not have a provider network. Networks effectively are a tool through which traditional insurers try to reduce costs by having members see providers that they have contracts with. Our members can see any provider and that same benefit amount is available to any licensed provider. Likewise, we don't have prior authorization. That's another tool that has been used more widely by insurers to try to reduce costs. Formularies and step therapies again, we don't have those on our plan. So, I want to end just by saying that we are subject to the Affordable Care Act (ACA) and all state laws so we have all of the standard consumer protections that other commercial insurance plans have. And we also guarantee you can always have choices at or below the benefit amount. We have unplanned

events protection, so if you thought costs would be a certain amount, and additional services are performed than were unexpected, we cover those at cost. In emergencies, our plan acts exactly as it does with traditional insurance. We never want anyone to have to think about shopping for care in an emergency. And we have additional programs in place that apply for higher complexity services. So, I'll just end by sharing on a personal note. I am a member of Sidecar. I've been one since I started. I have worked in health insurance for a long time, and I have learned far more about how our health system works, and how much services cost by being a member these past two years than I have in all my years working in insurance. Our members, the word we hear over and over again is that they feel empowered, they feel in control of their care and they would never want to return to the status quo.

Sen. George Lang (OH) stated what an amazing concept this is and I've not seen this before. Is there a mechanism in your system whereby the employer can take a portion of the savings of the employee? Ms. Leino stated we have thought about different models. I think one of the things that's core to our model is incentivizing consumers to make decisions and we found that retaining half of the savings is a way to do that. Our employers do save a lot and the premiums are 20% lower than what they would have with regular insurance. So, the way we think about it is that the employers save through the premium reductions and the employees save through choices. Employers do talk about traditional cost sharing, but we do have different plan options that have deductibles when employers want it. So, employers do have additional levers to lower their premiums by choosing things like what the amount of cost sharing will be.

Rep. Pollock asked how many different states are participating in this program? Ms. Leino stated that technically we have members in 48 states but in terms of where we are licensed as an insurer and can sell fully insured products, we're currently in Ohio, Florida, Georgia and Texas. We've just gotten our certificates of authority in a few different states and are filing in others. We just are launching in Texas in August so that's our most recent and most exciting launch. We want to expand, but we want to do so thoughtfully. I am not sure if you are all aware, but the federal government just updated regulations to allow for non-network plans on the exchanges so that's a very exciting change that we were really glad to see, and we're evaluating whether it makes sense for us to also offer individual plans on the exchanges.

Rep. Pollock asked if there are any hurdles from hospitals and doctors accepting your plan? Ms. Leino stated that the biggest hurdle for us is change and change is hard so there's definitely a change curve for our members. For providers, we do find different degrees in how quickly providers adapt and how excited they are. In general, smaller or independent providers get it right away. They're used to accepting cash. They love the idea of not having to wait weeks or sometimes months to get paid because they get paid on the spot. For larger hospitals, we have ones who have been really excited by it. In fact, in certain places where we do have a concentration of members, we've seen hospitals actually say, "Hey, what do I need to lower my prices to in order to have your members make us be the one that members want to see?" There are other providers that, unfortunately, genuinely don't know how much services cost. They have a tricky time being able to help our members understand a lot of the transparency laws that have come out of health. So, the requirement that providers give good faith estimates makes it so that providers do a better job of helping our members understand costs up front. But it's a very complex system and it is definitely a bit of a change for people that some are adapting to faster than others.

Rep. Tom Oliverson, M.D. (TX) stated I'm a huge fan of Sidecar and this has sort of been a dream for me to get a health plan where we're actually incentivizing patients to actually function like consumers and I think you've done that very nicely. You actually have unlocked a huge amount of savings with labs - can you talk a little bit about that? Ms. Leino stated labs are something that

probably everyone in this room has had. When I would go to my appointments, they would give you the slip, you'd walk down the hall and you'd get your labs, and you never thought about how much those cost. Even though in recent years, I was on plans where that all went to a deductible and I ended up paying dollar for dollar for those costs. Our members know that there are facilities that are devoted entirely to labs that often are located a mile or less down the road from larger providers. Our members instead simply ask for the lab request form, walk down the street and to give potential numbers, something that might cost $100 in one setting will cost $10 at somewhere like LabCorp or Quest. In general, the same thing can be said about having a surgery at an ambulatory surgery center versus in a hospital. So, there's a number of items for which the site of care, or where you get it makes a huge difference, and that's something that our members can shop for and understand and is a huge source of savings.

Rep. Stephen Meskers (CT) stated I want to understand the business model better. Ms. Leino stated we are an insurance company so we underwrite the policies and this aspect works very similarly to traditional insurance. So often working with brokers who sell the insurance policies to large employers. We provide to our members what we refer to as the benefit amounts and we have price information listed. We get that information both for the setting of benefit amounts and for sharing prices with our members from a variety of sources. As you all may know, there are transparency requirements that require providers to post information including on what their cash prices are and we have vendors and that we pay to obtain that data and bring it to us and then we make it available to our members.

Rep. Meskers stated, and then the members, if they find a lower price, do members enjoy a price sharing with the members on that procedure? Ms. Leino stated, correct, and they can find those lower prices on our app. So, our app will tell them when the provider's cost is below our benefit amount and tell them the savings earned. Rep. Meskers stated to Ms. Leino that he would like to have further conversations about the business model. Ms. Leino stated that we are absolutely a resource to anyone. We'd love as many organizations in this country and as many states to have these types of solutions.

Rep. Dennis Paul (TX) asked how do you set the price for the benefit amount? Ms. Leino stated that our rule of thumb is the benefit amount is always determined so that 50% of typical providers who provide that service are at or below the benefit amount. For the benefit amount number, we use commercial transparency data. We have data from a national actuarial firm, Centers for Medicare and Medicaid Services (CMS) benchmark data, our own claims data. And then we have an actuarial team that uses it, and it is specific to geography so we do have to get into things like if some counties are more rural, or if certain specialists can't be found in an area. Although we don't have a network, we hold ourselves to traditional network adequacy. Rep. Paul stated so somewhere in the middle of the range that you're looking at is what you'll be at? Ms. Leino stated yes, we aim to have 50% of providers at or below the benefits.

Rep. Paul stated that you said that the app shows you alternative choices, here's a list of these providers that provide that service. How do they get on that list? And if I as a consumer find somebody other than the provider on your list, can I still go to them? Ms. Leino stated you can absolutely see any licensed provider. We do attempt actually to have all providers. I'm a lawyer so I can't say we definitely have all providers, but we get data that includes information about providers throughout the country. There are some providers for which it's possible our data is wrong. In those cases, we do guarantee our members that the price they see in the app, we'll stand behind. So basically, they see the benefit amount, they see the provider, they can click and lock in a visit with that provider and they will earn or pay that amount regardless of if they end up going to the provider and they charge a slightly different amount. But if the provider's not there,

that's fine too. Rep. Paul asked if the consumer is able to negotiate with these providers themselves? Ms. Leino stated yes. Most providers are very comfortable telling you what a discounted cash price is, but we absolutely have savvy consumers who negotiate and get a lower price and then they get the benefit of that lower price.

CONTINUED DISCUSSION ON NCOIL MODEL ACT ENSURING ACCESS TO EYE CARE SERVICES AND MATERIALS THROUGH TRANSPARENT AND FAIR BUSINESS PRACTICES BY VISION PLANS

Rep. Pollack stated next on our agenda is our continued discussion on the NCOIL Vision Model. As a reminder, we discussed this model at our spring meeting and since that time, the sponsor, Rep. Deanna Gordon (KY), has been reviewing all the comments submitted by interested parties and determining next steps. There will not be a vote today but rather a continued discussion.

Rep. Gordon stated that by way of an update to the Committee since our last meeting, we've continued working with all interested stakeholders on this. Based on the discussions at our previous meeting in Louisville we did remove the private right of action section after hearing the concerns that were raised. I've also met with representatives from the Blue Cross Blue Shield Association (BCBSA) and we agreed to continue those conversations as they have suggested additional revisions for consideration. I've also met with the National Association of Vision Care Plans (NAVCP) to identify areas where we can work collaboratively. I'm optimistic we can continue making progress before the next meeting. We are also aware of a letter submitted regarding health savings accounts (HSAs). I appreciate the Committee's continued interest in this important issue. At its core, this legislation is about ensuring that patients and their providers have access to the tools and flexibility they need to deliver the highest quality care and to address concerns regarding vertical integration in health care as well as preserving the doctor-patient relationship. As these service integration models expand, it's essential that patients are given clear, transparent information about the programs they are being offered. True transparency helps ensure patients understand exactly what they are entitled to, and that their choices regarding care are fully respected and maintained. This model is patient driven and is meant to improve transparency, fairness, and competition for our constituents. I look forward to continuing these discussions and hopefully have something ready for voting at the November meeting.

Randi Chapman, Managing Director of State Affairs at BCBSA thanked the Committee and stated that my comments will be brief and will reiterate the written comments that we have submitted. First, I appreciate the opportunity to speak today and appreciate the opportunities that we've had to talk with Rep. Gordon about the model and I understand my colleagues have talked with her as well. So, I think we are on the way to helping make this model as strong as it can be. BCBSA supports the model's goals of transparency and fairness and believes that with some additional targeted clarifications on scope, payment integrity practices, and network participation and reimbursement flexibility, that the model can address some of the practices that it seeks to address without creating any unintended consequences for patients, providers or for regulators. We certainly appreciate the revisions that have been made in the draft, particularly with regard to the private right of action. We do think that there are additional areas where the language can be amended to make the model even stronger and keep vision benefits affordable and accessible for patients.

I'm going to focus my brief comments on three areas pertaining to scope, payment integrity, and business practices. First, with regard to scope, some of the definitions in the model are fairly expansive and make the model encompass the entire fully insured individual market and small group market, and could even capture self-funded employer plans. For example, because

pediatric vision is a mandatory essential health benefit under the ACA, it's embedded in every fully insured individual and small group medical policy. And the definition of "health benefit plan" and "insurer" in the model currently extends the model's requirements to all ACA medical products even in situations where an issuer does not offer standalone vision benefits. We would recommend a scaled-down version of the definitions to ensure that it's focused on standalone vision benefit administration that better targets the model's requirements. And that's language that we're happy to work with Rep. Gordon on. Secondly, in looking at standard payment integrity in claims adjudication practices, section four of the model effectively eliminates standard tools that plans commonly use to detect fraud, waste, and abuse and shifts those costs onto patients. Section four includes provisions that restrict coding edits, bundling logic, and modifier review and these are primary mechanisms that plans use to identify upcoding, duplicate billing and other improper claim practices. Section four also prohibits recovery of payments made based on invalid eligibility which removes a critical safeguard that plans often use against enrollment and identity fraud. These are not unfair practices that plans use to try and identify these fraudulent circumstances. These are essential to protecting the integrity of the vision benefit market and keeping costs affordable to patients. We would recommend that there's fraud exception language added to the model that could preserve the ability to recover payments made based on fraudulent misrepresentation of eligibility and we have included that language in our red lines that we submitted.

Finally, as we're looking at contractual issues and some of the interference with some existing contracts or disruption, there are provisions in the model that would automatically void contracts for notice and timing issues and we find that some of that language can be pretty destabilizing to the existing contractual relationships between plans and providers. For example, in section three, there's language there that would render amendments void and unenforceable solely due to the failure to meet a 90 day notice requirement regardless of materiality. But in practice and operation, many plans will update documents on a regular operational basis and that operational timing is embedded in contracts that have been agreed to and acknowledged by providers. So what we would recommend instead is a cure period and a materiality threshold that could protect providers without creating significant operational discussion.

Laura Minzer, President of the Illinois Life and Health Insurance Council thanked the Committee for the opportunity to speak and stated that we represent insurers in Illinois that provide major medical, dental, vision, life, and retirement products to millions of consumers, not just in Illinois, but across the U.S. I want to thank you for the opportunity to join you here today to share Illinois's very recent experience modernizing our vision care law. I hope it offers a useful perspective as you consider this model legislation. I did provide my testimony in written form so I'm going to provide the cliff notes version of that. I know is your time is limited, but I would like to touch upon three key points, and I expanded upon those in my written comments. Vision insurance should not be regulated like pharmacy benefits. The Illinois approach shows that provider protection and consumer affordability can coexist and balanced and collaborative policymaking is essential to producing good public policy. So, one of the central premises of the proposal before you is that vision care organizations should be regulated like pharmacy benefit managers (PBMs). Illinois reached a very different conclusion because vision insurance is fundamentally different. Unlike prescription drugs and as Ms. Chapman mentioned, pediatric vision, routine adult vision care is not an essential health benefit.

Consumers purchase vision coverage because they value it, not because they're required to do so by federal law. At a time when health care costs continue to rise, affordability also matters. Vision coverage remains one of the most affordable voluntary insurance benefits available today. And research consistently shows that people with vision insurance are more likely to receive

routine eye exams and obtain needed corrective eyewear. Illinois' experience also demonstrates that meaningful provider protections and affordable consumer coverage are not mutually exclusive. So, in 2023, insurers, optometrists, legislators, and other stakeholders came together to modernize our vision care law. But as implementation progressed, we identified areas that needed improvement rather than dismantle the framework we had negotiated. We did return to the table just this spring and worked collaboratively to address those concerns in Senate Bill, 3707, that is now awaiting the Governor's signature. It was also important as we proceeded in that exercise to keep the regulation of vision insurance products consistent with how we regulate other supplementary accident and health insurance products. I would be remiss if I did not give special acknowledgement to Sen. Cristina Castro (IL) and Rep. Jeff Keicher (IL) who set that collaborative table for us. And I'd also like to acknowledge Rep. Rita Mayfield (IL) and Sen. Willie Preston (IL) who are here today that also supported that compromise. So, thank you for that. So the result was bipartisan legislation that we found strengthened both provider protections and enhanced consumer transparency. It preserved broad access to an affordable vision insurance product that our employers, employees, unions, Medicaid, Medicare beneficiaries and families across Illinois rely on. And our experience reinforced an important lesson - good public policy recognizes that providers and insurers have legitimate interests, but neither succeeds unless consumers remain at the center of every discussion. As you consider this model legislation. I encourage you to preserve that balance and protect providers, strengthen transparency, but never lose sight of the importance of maintaining affordable access to the voluntary vision coverage that connects patients with the eye care that they need.

David Rose, Vice President of State Gov't Relations at MetLife thanked the committee for the opportunity to speak and stated that stated MetLife is a leader in providing vision benefits and strives to provide excellent vision benefits at affordable prices to its customers. In 2021 MetLife acquired Versant Health which has over 30 million people who have access to vision care through Versant's Superior Vision and Davis Vision contracted provider networks. MetLife and Versant are members of the National Association of Vision Care Plans (NAVCP). NAVCP did submit a letter to the Committee and to Rep. Gordon and we subscribe to those comments. So, I'm going to be very brief and sort of talk about what our experience has been before this committee on your favorite topic, which is dental, because we have both dental and vision. I've had the good fortune to work with many members of this Committee on a myriad of dental issues over the past few years, as MetLife is also a leader in providing dental benefits. My experience working on those past dental models included extensive collaboration between legislators, providers, and insurers, which led to significantly improved targeted workable models. Was everyone happy in the end? Of course not. But that typically is the result when parties engage in good faith negotiations. We have serious concerns that the proposed model's required reimbursement levels and limits on contracting flexibility will simply increase payments to providers without any benefit accruing to consumers.

Furthermore, new compliance disclosure and enforcement requirements could increase administrative costs, and there likely will be anticipated increases in state government expenditures. When payments are dictated by statute rather than the free market, plans have only a few levers left - higher premiums, higher co-pays and out-of-pocket costs, or reduced benefits. For many small and mid-sized employers, that will mean leaner vision benefits or no vision coverage at all. At MetLife and Versant, we strongly believe that vision health is critical to overall good health and we work to keep costs down to allow more people the ability to purchase affordable vision coverage in order to access vision care. For these reasons, MetLife and Versant have serious concerns with the proposed model because it would negatively affect consumers' ability to access important vision care and adds unnecessary confusion. This morning, Rep. Gordon arranged a meeting with NAVCP and the American Optometric Association (AOA) to have

the first face-to-face discussion over this model. This was a necessary first step, and we encourage legislators, providers, and insurers to engage in negotiations over the coming weeks and months to attempt to craft a targeted and workable model that benefits from the feedback of all stakeholders.

David Parker, O.D., for the Mississippi Optometric Association thanked the committee for the opportunity to speak and stated that I just want to share with you my perspective as I practice optometry in Mississippi. I've been there for 30 years as a practitioner. Now we are a collaborative group, but we are not part of any corporate arrangement. We are kind of like a partnership but we are not beholden to any corporate entities. I've held numerous positions within my profession and got so frustrated with some things that I decided to run for office several years ago. I was elected state senator in Mississippi, served for 13 years, retired in January, and there is an active campaign right now to have me come back but I'm not sure what I'll do.

But I do appreciate your time and effort here because I know you're already serving in the legislature so to come here and to look at issues like this is an additional amount of service that you're putting beyond that. I have seen this happen as I chaired accountability, efficiency, and transparency committee for most of my time in the Mississippi Senate and I've looked at issues like this as you are looking at in your state legislatures. My concern and the problem that we have with this is that the vision benefit paradigm as it exists, there is an increasing consolidation of power. As you all know, they are simultaneously the insurer, retailer, supplier, practice owner, and marketer and that level is creating more conflicts of interest. What I wanted to also share is that we're also seeing these plans evolve in ways that are putting more pressure on us as providers. The plans often begin with a certain set of provisions, they change those over time, and we never know how they're going to change. In our office, we've been fortunate enough for many years to make glasses for our patients, even ones on insurance plans, and what we're finding now is that plans that already are offering that as a benefit that we're participating in are removing that in additional ones and forcing us to go to plans that are outside of our area for fabrication. What that results in for my patient population is a longer wait time, a situation where we can't call and talk to someone about what's the status of something. And it leads to, in my opinion, patients who are more upset with their care. And I'll reference that there was a study that was done just recently by Vision Service Plan (VSP). VSP did their own research. They found that 81% of employees and 90% of HR leaders are not completely satisfied with their vision carrier, while 32% of employees are considering changing jobs for better vision benefits. Patients remain highly satisfied with their doctors of optometry but are dissatisfied with the vision benefit model and plan as it exists now.

The problem is not the quality of care being delivered by the doctors of optometry. The problem is the benefit design is increasingly placing corporate interest ahead of patients, employers, and the doctors who care for them. You know a lot about the model language, but I shared with you last time how I feel that there is some parallel here between this and our PBM issues that we dealt with in the state legislature, and you continue to deal with in your legislatures. As that corporate entity takes more control, it was interesting here when Ms. Leino was presenting and she listed the cost for a 90 day supply of prescription medicine. When I prescribe medicines such as Latanoprost and other glaucoma medicines, I have found the same thing. I've found that my local pharmacy has often got a lower price than what perhaps a CVS or Caremark has. And in our communities, if you leave the control more in the hands of the people within the community, I think you see happier constituents. You see happier patients. You see better care. And in the end, you see lower prices. At least that's what we've seen and I appreciate what Ms. Leino said on that because that was a perfect example of what I've noticed myself.

So I'm not going to tell you all of the things in the model, but as a father of a son who is now moving through the process to become a doctor of optometry himself, we were kidding earlier with the vision care benefit managers that we've lost a lot of hair. I've lost a lot of hair from being an optometrist, but I lost a lot of hair also from being in the legislative chairs that you're in and I would like our profession to not suffer the same types of things in the future that we've seen happen in the pharmacy arena. Because I do feel that if we don't remember the past, we indeed could repeat those mistakes. So, I thank you for your time and your interest. All I want to see is that we have transparency and balance in a system. I don't want to see any more money for me. I don't need any more money for me, but I do want the ability to continue to care for my patients and for my son to care for those patients. And if we have a corporate model that owns the entire system, I can guarantee you that it is going to be a much more difficult task for him to do it than it was for me.

Matt Jones, O.D., for the Arkansas Optometric Association, thanked the committee for the opportunity to speak and thanked the previous speakers as they have a lot of knowledge and they're doing a job on behalf of the big corporations and wanting to see this go smoothly. But for myself and Dr. Parker, our jobs revolve around our small communities. I practice in rural northeast Arkansas. I have four small clinics in four very small towns where we're pretty much the only eye care providers around and that happens in rural America every day where you only have one doctor, or one pharmacist, or one dentist, and access becomes an issue. And in Arkansas, we did pass a pretty substantial vision benefit manager (VBM) law in 2025 and we're still moving through the rules process with the insurance commissioner but we have seen some success from a few of the VBMs that transparently and proactively followed the law, while others haven't. And we're seeing success in that. There's been no increase in patient costs. There's been no increase in patient premiums, and the businesses that are offering those services are still offering it. I practice in America's largest steel producing county in Arkansas. In fact, we have three nuclear plants, and two U.S. steel plants, and they all offer vision benefits to their employees. It's not the greatest financial decision for our businesses to accept vision plans but we do so, I do so. I feel like I want to accept all and any that my community and my patients have.

And it's not their fault what vision plan they have but I can tell you when they walk in the door, they usually don't know what they have. They're very confused about the benefits that they have. Very rarely would they have an insurance card and that revolves on us and our staff to figure that out for them. Most importantly, to just piggyback on what Dr. Parker said, this is all about preserving the doctor and the patient relationship, being able to do what's best for our patients in our communities, being able to provide what frames or lenses or glasses or medicines that we feel that they need without being led or steered or tiered to other places. I know they don't like the PBM comparison, but doctors are tiered on these plans and ranked not based upon quality of care but strictly based on how much of a certain product they sell that the VBM owns. That's certainly not transparent in my mind. So there have been previous state laws that have passed most recently in Louisiana with zero dissenting votes that was much more broad than this. That actually included a reimbursement floor for services. Optometry is unique in that we have medical issues where we take care of people with diabetes or cataracts or glaucoma, and then we also spin the dials, "which is better one or two". And so we do have medical insurance and then there's vision insurance and again, that sometimes gets lost in translation for the patient in our chair. So, the majority of this is just about fairness and accountability and transparency. As we said, as small business owners that take care of our patients and our communities and our members of boards and chambers and hospital boards, we don't have the ability to negotiate with these multibillion dollar industries. Most of these are strictly contracts of adhesion, take it or leave it type of plans. And we just want to see that change and hopefully this model language can help do that.

Rep. Jim Dunnigan (UT), NCOIL Treasurer, stated that I have worked with optometrists for some years in my state. I just have some general questions about the bill. You can choose to answer them or not. On section three, it talks about disclosure transparency, and it provides a significant list of information that has to be provided, not only the on the vision plans website but all materials. I mean this this could potentially run some pages long depending on the history of the vision service plan. I'm just wondering what's the purpose of that? Even on enrollment materials, you're going to go out with an enrollment form, and you've got to provide this laundry list of materials. Dr. Parker stated that we talked about that this morning with NAVCP, and I believe he had a very similar question. It gets back to transparency. I think any and everyone who is choosing to negotiate or contract with anyone should have the right to know who you're dealing with. And for me, if I found a vision plan for example that owned the vision plan, owned the lab, was going to directly market to the patients and I shared this morning with NAVCP that I've had a patient in my chair who during the exam got marketing material from the vision plan asking them to go somewhere else after their exam and get their product.

Rep. Dunnigan stated that's not what I'm talking about, I'm talking about the legal address, any complaints against them, all agencies that have jurisdiction over them, and then it says all that information has to be provided on enrollment materials and sales materials. That's what I'm concerned about. Dr. Parker stated on that issue, we did have some conversations today that some of that might be a little bit laborious so there's room for some cleanup in that. What I found in my 13 years as a senator though is that you find one topic like that, and you make that be the reason to gut the bill. The reason I've traveled all the way here two times is to tell you the problem we have in our community and to tell you that this is model language that's been adopted in states like Illinois and other states. Rep. Dunnigan stated I want to stay on topic to my concern, and that is the significant amount of information that's required on all types of documents - employees don't want to see this. If you're giving an enrollment form to an employee, you've got to provide them a separate document with all this information. They don't want that. They don't care about that. That's just my input. I think maybe it provides a bunch to the doctor, so that you know what you're getting into, but certainly not to the employee and out on all the requests for proposals (RFPs) and things like that.

Rep. Dunnigan stated that also, in section 4(B), I just want to understand this, it says there should be no limitation on the ability of an individual eye care provider or a group of eye care providers under the same employer identification number (EIN) to negotiate and ultimately agree and so I agree that you should be able to negotiate. I'm just wondering what it means with "ultimately agreeing". What's the end game? What does that require? What if both sides don't come together? How do you ultimately agree? Dr. Parker stated I don't have the model in front of me but in any negotiation, I think there's always some give and take. We are in negotiations right now with one of our vision care plans about reimbursement rates and things like that and it has been a process of back and forth as we look towards getting to an ultimate agreement on that one issue. So, I think that's what it's intended but I do not have the language in front of me. Rep. Dunnigan stated I also have some concerns in section 5, but I'll stop there and let others ask questions.

Rep. Oliverson stated that full disclosure, I passed a bill along the same lines of this in Texas but there is some stuff in this model that we took out in Texas over some very specific concerns and I want to visit with you about it because interestingly enough, I find it back in this version. What is the purpose of including ophthalmologists in this model? Have you spoken to the American Ophthalmologic Society and asked for their opinion on this model? Dr. Jones stated we wrote the model for all eye care providers. We haven't spoken to them to my knowledge. Rep. Oliverson asked if you collaborated with the ophthalmologists on this model? Dr. Jones stated not the

American Academy of Ophthalmologists. In Arkansas, we did. One of our lead sponsors was an ophthalmologist, and I know in Texas, ophthalmology was asked to be taken out. In Arkansas, ophthalmology was asked to be put in and so I think that can be different state by state as optometrists do work for ophthalmologists.

Rep. Oliverson asked what is the purpose of section five and let me qualify my question. I don't know that there's a whole lot of practice overlap here between what you do and what ophthalmologists do, and certainly not in my state. And so this is part of the problem we run into. My concern is that you've taken an insurance bill, which I think has some merit to it. We passed part of this in my state, and we've now turned it into a scope of practice bill. So how necessary is section five to this model because I think it should be removed. Dr. Parker stated I would respectfully disagree. We did have that conversation this morning with NAVCP and they let us know that they do not see anything in here that deals with scope of practice. I will share that in my practice, we have an ambulatory surgical center. I have a total of four ophthalmologists who also come into my office and provide retinal oculoplastic and cataract surgery care. I work with them every single week. I'll bounce issues like this off of them, and to Dr. Jones' point, I believe there are some states that in model language would prefer ophthalmology to be included because the collaborations and the friendships are strong in states like mine, and as members of the legislature you know this issue, you may have states where that collaboration is strong, you may have states where they're not, but I believe that's the purpose of model.

Rep. Oliverson stated but my concern is that they're not here. You're speaking on their behalf. And so what I would like is when this comes back, if that section is still in this model, I would like to see a letter either from the American Medical Association (AMA) or the American Ophthalmological Society saying that they support Section Five of this model. Dr. Parker stated we will pass that along to the people who can make those connections.

Rep. Oliverson stated and I will say this, and nobody's talked about this, but the bill we passed in Texas which contains a lot of the similar language, about 85% of it's been struck down by the courts. Dr. Jones stated that was over the steering and tiering part which violates First Amendment rights. Rep. Oliverson stated one of my concerns is I don't want us to promulgate a model that has already been invalidated by the courts. Dr. Jones stated the steering and tiering provisions are still in the model but they have been adjusted to address concerns. Rep. Oliverson stated that's good to know. Dr. Jones stated we did work with people in Texas on that because they understood that dynamic.

Rep. Paul (TX) stated that I missed the last meeting in April on this so I apologize, but I don't even see what this model is supposed to do at all and it's got some very confusing things in it and it's very large and I agree with what Rep. Dunnigan. And it looks like you can't even negotiate a fee, or the benefit manager has to accept the fee that they provide. And section six, it's talking about you can't exclude any doctor. I mean if they have a problem with this person or not, there's no way they could get rid of a guy. What is the purpose? Could you tell me right now, if this is enacted, will my companies that buy this benefit plan pay less for insurance? And will the patients that go use eye service pay less for this? Is it going to save money for the companies or the consumer? But what does this do? Dr. Jones stated in in the states that have passed this, the fairness and transparency part provides the ability for the doctor to choose what labs to use to make glasses, which inherently lowers costs. Competition inherently lowers costs. There have not been any studies that show that costs have gone up or premiums have gone up on patients or employers in those states. Rep. Paul stated, so are you saying that what this bill does is allow you to use anybody to make glasses. Dr. Jones stated that's certainly one of the parts.

Rep. Paul stated what's this other part about money coming out and reimbursing people and I mean this looks more like a contract than a bill. Dr. Parker stated my intent in my remarks was to expound upon what we had discussed in Louisville. I had more detailed comments that I'll be glad to share with you afterwards on kind of the entire body of the bill, the merit of it and that kind of thing. I skipped over those as a courtesy. I don't mind doing that, but I do think that the fact that we do have a similar bill that is now in place in Texas that is continuing to be worked on would be a good reference for you to go to and I think there have been some discussions about other states that have put some of this in place and I think all of the parties involved, even from Blue Cross and others have recognized that the work by Rep. Gordon has been very well intended and has been very productive as we continue to seek a solution here that will be good for all parties, and for all specialties. And again my ophthalmology friends are dear friends. We don't have scope issues in my state because we have fixed that problem and I hope that in Texas that will become kind of the issue too. We are more concerned in my state about Medicare Advantage plans than we are scope of practice now so I would encourage you in all of your states to try to move past that if you can.

Rep. Paul stated I understand your comments today weren't intended to address specific provisions in the bill and that's what the Chair, Rep. Pollock intended, but maybe someone else can answer will this let my employers pay less money for eye care and will the patients pay less? Mr. Rose stated that we believe that they're going to pay more as a result of this due to the administrative costs. We think the reimbursement rates are going to go up as a result of this, and as a result, employers and employees will have to pay more. Let's say it's 30% on a $10 monthly premium for their vision care, 30% of that is quite a bit, and this is a benefit that people don't have to have. It's not not an essential health benefit, and I think the consumers are very price sensitive to this type of benefit. So, we think that it will go up.

Rep. Pollock stated to Rep. Paul that today's meeting was meant to bring us up to speed. What was very healthy in this conversation on this particular model was there was a discussion this morning amongst interested parties to go ahead and get these conversations moving forward. This meeting today was to hear what came out of that meeting this morning and what we're moving forward to do. I'm sure there's going to be a lot more conversations between now and Florida. There will be an interim meeting I'm sure of some sort to decide where we're at to make sure that it's clear enough whether to have a vote in Florida. So, in the meantime, that will bring everybody up to speed on where we're at that point with this particular model.

Rep. Gordon stated I just would like to close by saying I think that it's important that we talk about the original intent and purpose in filing this bill. And I've said it before, I'm an audiologist and this is happening in my field as well. So, although it's a little bit different, it's on the same theme of there does not need to be any layers of bureaucracy between a patient and their provider of care. And when terms are dictated as far as products that can be used, the way that it's delivered, it's very confusing for the patient. Just like was mentioned, they come in, I become the face of a product and they associate me with that product instead of me as their provider of care.

CONTINUED DISCUSSION AND CONSIDERATION OF NCOIL CHARITY CARE AND MEDICAL DEBT REFORM MODEL ACT

Rep. Pollock stated next on our agenda is continued discussion and consideration of the NCOIL Charity Medical Care and Medical Debt Reform Model Act. We've had great discussions on this at our previous three meetings, and it looks like we're at a point where this model is ready to be considered.

Rep. Oliverson stated I want to thank Sen. Paul Utke (MN), NCOIL President, and Rep. Brenda Carter (MI), NCOIL Secretary, for co-sponsoring this model and for working with me on this. And I also want to say a special thank you to Joe Burchfield from Ascension for being a tremendously good partner, and really I think understanding the spirit of the model and offering some truly good suggestions. I'm not going to rehash the whole model, but since our last meeting in April, we made a few changes. So, first in section 4(A) we've added a drafting note addressing the issue of whether or not you want in your particular state for this model to apply to only uninsured or self-pay patients. Also, Section 4(B)(1) has been revised to say that this would not apply in a circumstance where a hospital was being asked to provide coverage for cosmetic procedures.

Next, I've deleted language in section 4(G) to try to avoid encouraging bad attorney behavior while still maintaining a process by which a patient can be reimbursed. There was some concern that it may may create sort of a new type of lawsuit abuse and obviously that's the last thing we want to do. And finally, I've added a drafting note to the end of section 4 saying that states may wish to consider reporting requirements to add a little bit of transparency to this model. Some ideas and concepts on that have bene brought forward since the model's introduction but rather than add a whole new section and extend this process, we've simply added a drafting note just saying, "here are other things that are out there, you may want to consider this as well." I really appreciate everybody's work on this, and I'm happy to hear any comments or questions and hope that everybody supports this.

Joe Burchfield, National Director of State Policy at Ascension thanked the committee for the opportunity to speak and stated that I just want to echo what Rep. Oliverson said and thank him for the collaboration. Ascension is still in our first year of participation at NCOIL and this is the first bill we've worked on here, and I think it's appropriate that our commitment is to a patient focused, patient friendly charity care policy and financial assistance program. And the opportunity to work with Rep. Oliverson, NCOIL staff, and you as a committee, we just greatly appreciate the collaboration. We are here to find solutions and to work together on things that make life better for your constituents and I think we're doing that here. Thank you for that opportunity and I look forward to continuing the work on future issues.

Rep. Rita Mayfield (IL) asked if there was any input or opposition from the American Hospital Association (AHA) on this model? Rep. Oliverson stated that there was definitely input, and there was opposition. We did our best to incorporate some of their suggestions to the extent that we could without compromising essentially what the model was attempting to do. I can give you one example of where we just couldn't come to agreement and that is I felt very strongly that when there is a tax exempt hospital entity that continues to violate the model, then at some point it should be an option for the state to remove their tax exempt status and they were very opposed to that and we just couldn't come to agreement. I felt that obviously that shouldn't be the thing you immediately jump to, but ultimately, if you have a repeat offender, there's got to be a hammer to swing.

Rep. Pollock 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. Then, upon a motion made by Rep. Mayfield and seconded by Rep. Carter, the Committee voted without objection by way of a voice vote to adopt the model. Rep. Pollock thanked everyone and stated that the model will now be placed on the Executive Committee's agenda for final ratification.

DISCUSSION ON PROPOSED AMENDMENTS TO NCOIL TELEMEDICINE AUTHORIZATION AND REIMBURSEMENT MODEL ACT

Rep. Pollock stated that last on our agenda is a discussion on proposed amendments to the NCOIL telemedicine authorization and reimbursement model act. As a reminder, at our last meeting in April, this model was re-adopted temporarily until this meeting in order to have some discussions as to whether any changes should be made to the model. Since that time, the original sponsor of the model, NCOIL immediate past president Asw. Pam Hunter (NY) has introduced some proposed amendments to the model. We won't be voting on these amendments today as they are still under development.

Asw. Hunter stated as I mentioned at our meeting in April, as the original sponsor of this model, I thought it was worth having some discussions on how telemedicine has evolved so much in the past five years since the model's adoption to see if any changes were warranted. And since that time, I've put forward some proposed changes to consider. The amendments are fairly straightforward and really focus on modernizing the model by removing references to COVID-19, updating telemedicine licensure provisions, and updating reimbursement provisions. I look forward to the discussion today and hopefully by November, these amendments can be ready to be considered.

Robert Baratta, on behalf of the American Telemedicine Association (ATA) thanked the committee for the opportunity to speak and stated that the ATA is the largest standing national organization focused on telehealth and virtual care. We were founded in 1993 and we have a coalition of over 400 companies and organizations that are part of ATA, and they range from major health systems to academic medical centers, payers, health plans, clinicians, pharmaceutical companies, remote monitoring organizations and digital therapeutic companies. ATA Action is also part of ATA, and that's our advocacy arm and they're active in all 50 states and with the federal government. What I'm going to address very quickly for you is to take you on a quick trip down memory lane first so we can kind of figure out how we got to where we are now and give some focus over the last five years and then try to look over the horizon and give you some comments on the amendments to the model.

First, I'll just share with you that advancements in virtual care we believe based upon our experience over the past three decades is they depend on the synchronicity of five major factors. The first one is technology itself and those that are pushing for the innovations of technology and the capital that goes with it. The other is the consumer, their demands and their acceptance of the technology. The third is a licensed practitioner's acceptance and their kind integration of the technology into the standard of care and patient treatment along with the economic incentives that exist in order for them to accept those into their practices. Next is payer buy-in, and then part of the reason why we're here is because we live in a regulated community, the actual affirmation through statute and rule, and that's really part of what the model is about. So, unless all those things come together, virtual health doesn't move very far. Now as I mentioned, ATA was founded back in 1993, and 1993 was an auspicious year. That was the year the World Wide Web was released to the public. Very soon after, all of us started getting those American Online CDs in our mail to try to sign up for that 56 kilobyte per second dial-up. Apple shipped the first Newton that year, Intel rolled out the Pentium microprocessor and Mosaic released the first web browser.

And that really kickstarted telehealth, the technology that was starting to form in 1993. By 1997, 35% of all households had a computer. You would also note about that same time cellular technology was taking off. I remember turning in my pager for a Blackberry back then. And by 2000, broadband came about and that changed things forever, because now we can have video conferencing on at speeds that are efficacious. We had a little speed bump over the dot-com bubble, but by 2007 the iPhone came out and that changed everything. Now, we have a smart

device in the hands of consumers and they can have direct access to the internet and to all that technology. Kind of parallel with that, now we have the medical professions that are starting to look at telehealth and the development of telehealth and the Federation of State Medical Boards in 2014 issued its model policy on the appropriate use of technology in telemedicine and that really gave the different states the direction of how to address telehealth in the treatment of patients. But then, a few years later, the event happened that changed everything and that is COVID-19 and with COVID, we had a scramble among the states that those that were not progressive in their treatment of telehealth that the Governors had to issue executive orders and legislatures had to change statutes. And from 2019 to 2021, that's the environment that we all lived in. From 2021 to 2025 we started to see at the federal government and in the states, efforts to make these COVID exemptions permanent. Some of them are still lingering out there because the U.S. Food & Drug Administration (FDA) and the Drug Enforcement Administration (DEA) are still trying to deal with the opioid use disorder issues of the exemptions that they had sent forward and they keep kicking the can down the road. But most states now have made permanent those changes that happened during COVID-19 and that's what's before you today with the model. Now we also see an increase in the direct to consumer telehealth that you see on TV all the time. And a lot of that stuff you deal with in terms of GLP-1's or reproductive health and all that you see in the different states. That has accelerated in this post COVID environment, and also, the remote patient monitoring integration.

In 2026, we've seen an increase in the prescription digital therapeutics. There are about 20 different ones now before the FDA, and now artificial intelligence (AI). This past year was about 600 pieces of legislation across the country dealing with AI of one kind or another. Most of those dealing with health dealt with chatbots and on the behavioral health side. On the horizon, what do we see? We see having to deal with AI integration, both in administrative and clinical assistance. We see what is euphemistically called the internet of things, and I don't know if you've heard that term before, but that basically describes the integration of all the smart devices that are out there talking to each other, gathering data, analyzing the data, and then putting those all together and trying to basically manage chronic disease and disease prevention and control. And these devices are everywhere, and it's growing. And so between that and AI, we believe over the next two or three years, we're going to have to determine how we deal with those and whether or not they get reimbursed for that matter. With that, I'll just turn to the legislation before you, and I'll tell you that the ATA fully supports the amendments to the model. In particular, we're supportive of that amendment that says that if you are an exclusive telehealth company, that you should be able to negotiate for lower rates, which kind of makes sense if you've got two willing contractors on both sides of that, you have a payer that wants to pay less and a provider that wants to accept less, that should be able to be done.

Elizabeth Horton, Associate Vice President at American Specialty Health (ASH), thanked the committee for the opportunity to speak and stated that ASH is a national health care services organization specializing in physical medicine and musculoskeletal care. For nearly 40 years, ASH has partnered with health plans, employers, and providers to improve access, quality, and affordability of care. ASH supports more than 62 million eligible members through a nationwide network of over 127,000 clinical providers and delivers innovative in person, home based, mobile and telehealth care solutions across the country. ASH is here in support of NCOIL's re-adoption of the model. We see three areas to consider addressing during the re-adoption process. The first being removal of the COVID specific language, the second address emerging opportunities for telemedicine-only services amid the rapid growth and wide acceptance of telemedicine over the last six years, and lastly, updates to cross state licensure language to reflect the current environment better. You'll see section 2(D) makes several references to COVID, and by striking this language the model gains permanence. More specifically, it ensures that the act provides a

permanent framework for telemedicine access independent of emergency declarations or specific health crises.

The edits proposed to section 4(D) differentiate for telemedicine only services and prevent a mandate to utilize telemedicine only services. This strengthens telemedicine access while controlling costs. It ensures equal reimbursements for providers offering both in person and telemedicine services, protecting provider revenue and patient access. It creates cost saving flexibility by allowing telemedicine-only care to be negotiated to reflect costs appropriately. And lastly, it preserves patient choice by prohibiting insurers from forcing patients into telemedicine only care. In section 5, we address telemedicine licensure with two options for consideration to address the current environment. Option one would be a full strike of the language, remove the licensing provision entirely as existing interstate compacts adequately address cross-state licensure and reciprocity. Option two, which we think is the stronger approach, is to retain the provision but with an interstate compact exception. This future proofs the language acknowledging the growing network of interstate compacts while maintaining a default licensure standard where no compact exists. So, I'd just like to thank Asw. Hunter and other NCOIL leadership for allowing me the opportunity to speak on these amendments today.

Rep. Dunnigan stated I have a couple of comments and I appreciate the work on this. In Section 4(C), I think it's in artfully worded in a couple of places and it could be said better. For example, it says, you can't require a patient to have a previously established patient provider relationship. And then it goes on to say you can't use a telephonic conversation to establish a patient provider relationship. Why do we need that? Because you just said above that you don't have to have one anyway then it says that audio only doesn't count. I don't understand what that is getting at. In Section 4(D), it says that an insurer shall reimburse the treating provider on the same basis that the insurer is responsible for coverage for the provision of the same service through in-person consultation. This could, in my opinion, be worded better. And then below that you're talking about telemedicine can be done but they could accept a lower rate. I believe this could be drafted better.

Rep. Pollock stated hearing no other comments or questions, I'm going to entertain a motion to re-adopt the model temporarily until November while the amendments can be further developed. Upon a Motion made by Asw. Hunter and seconded by Sen. Lana Theis (MI), the Committee voted without objection by way of a voice vote to re-adopt the model until November.

ANY OTHER BUSINESS

Rep. Pollock stated that I'd like to raise one quick item. A couple of years ago in Kentucky, we passed a law that requires health insurance coverage for speech therapy for people with stuttering problems. And Sen. Willie Preston (IL) passed that in Illinois as well. This is really targeted toward younger folks who have stuttering problems, and it's really made a big impact in our community in Kentucky. I think it's really worth our consideration in discussing that here at NCOL. I just wanted to plant that seed, and we'll see if we can start that discussion in November.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Oliverson and seconded by Sen. Lang, the Committee adjourned at 5:00 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 October 21~~June 30~~~~March 18~~, 2026. To be ~~introduced and~~ discussed and potentially considered during the Health Insurance & Long Term Issues Committee on November 20~~July 17~~~~April 17~~, 2026.

Table of Contents

Section 1. Title
Section 2. Definitions
Section 3. Transparency and Disclosure Requirements for Insurers and Vision Benefit Organizations ~~Managers~~
Section 4. Covered and Non-Covered Services and Materials Provisions
Section 5. Prohibiting Coercive Tactics by Insurers and Vision Benefit Organizations ~~Managers~~; Providing Reimbursement Parity for Optometrists ~~and Ophthalmologists;~~ Requiring Affiliates to Comply with Statute
Section 6. Acceptance as Participating Optometrist ~~Eye Care Provider~~
Section 7. Permitting Participating Optometrists ~~Eye Care Providers~~ to Use any Lab or Supplier
~~Section 8. Private Right of Action for Eye Care Providers~~
Section 89. Relationship to Other Laws
Section 910. Enforcement
Section 1011. Severability
Section 1112. ~~Rules~~ Enactment Provisions

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. Nothing in this Act shall be construed to expand, restrict, or otherwise alter the scope of practice of any healthcare professional licensed under state law.

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~~ optometrist for which reimbursement from an insurer, vision benefit organization ~~manager~~, or subcontractor is provided to an eye optometrist ~~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 organization ~~manager~~, or subcontractor is provided to an optometrist ~~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~~ Optometrist" 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 optometrist ~~eye care provider~~" means an optometrist ~~eye care provider~~ that has entered into a contractual agreement or other business relationship with an insurer, vision benefit organization ~~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 organization ~~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 organization ~~manager~~ to an enrollee that solely provides for a discount for vision care services or materials.

J. "Vision Benefit Organization~~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 organization ~~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 organization ~~manager~~ to supply services or materials to another vision benefit organization ~~manager~~, optometrist~~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 organization~~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 organization ~~manager~~ and how much patients are charged by the insurer, vision benefit organization ~~manager~~, or optometrist ~~eye care provider~~.

Q. "Nominal" means, for the purposes of this Act, (any amount) less than what is published ~~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 Organizations~~Managers~~

A. An Insurer or Vision Benefit Organization ~~Manager~~ or participating optometrist 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 Organization ~~Manager~~ or participating optometrist 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 Organization's ~~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 Organization ~~Manager~~ shall provide notice to each participating optometrist ~~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~~ optometrist 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 organization ~~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 Organization ~~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 Organization ~~Manager~~ delivered to a participating optometrist ~~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 optometrist ~~eye care provider~~.

F. An Insurer or Vision Benefit Organization~~Manager~~ shall maintain:

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

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

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

G. An Insurer or Vision Benefit Organization ~~Manager~~ shall maintain a physical mailing address and an electronic mail address to company representatives to receive questions, disputes, and communications from participating optometrists ~~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~~ optometrists including on its website and in any provider agreements, provider handbooks, provider manuals, or related policy documents.

H. An Insurer or Vision Benefit Organization ~~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~~ three (3) business days in writing by use of a return electronic mail message.

I. An Insurer or Vision Benefit Organization ~~Manager~~ shall, at all times, make available to the participating optometrist ~~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 Organizations ~~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 Organizations ~~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 Organization ~~Manager~~ and

an optometrist ~~eye care provider~~ may seek to or require that an optometrist ~~eye care provider~~ provide services or materials at a fee limited or set by the Insurer or Vision Benefit Organization ~~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 Organization ~~Manager~~ and an optometrist ~~eye care provider~~ and all reimbursements paid by an Insurer or Vision Benefit Organization ~~Manager~~ to an optometrist ~~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 optometrist ~~eye care provider~~ or a group of optometrists ~~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 Organization ~~Manager~~ regarding reimbursement fee schedules, through the standard contract negotiation process, ~~and ultimately agreeing~~ to a different fee schedule than the fee schedule provided by the Insurer or Vision Benefit Organization ~~Manager~~ to other participating providers or groups.

C. A contract between an Insurer or Vision Benefit Organization ~~Manager~~ and an optometrist ~~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 optometrist ~~eye care provider~~, and any form of a cost-sharing amount paid by the enrollee to the optometrist ~~eye care provider~~.

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

E. A service or material provided by a participating optometrist ~~eye care provider~~ cannot be designated as a covered service or covered material by the Insurer or Vision Benefit Organization ~~Manager~~ in the design of a health benefit plan, vision benefit plan, or vision benefit discount plan if the reimbursement amount to the participating optometrist ~~eye care provider~~ is only comprised of an enrollee's payment to the participating optometrist ~~eye care provider~~. This subsection shall not be construed to prevent an enrollee from paying the total allowed amount or a cost-sharing portion of the allowed amount of covered service or covered material using a health savings account, health reimbursement account, or flexible spending account.

F. Insurers or Vision Benefit Organizations ~~Managers~~ shall not condition application to or network participation in a health benefit plan, vision benefit plan, or vision benefit discount plan by an optometrist ~~eye care provider~~ based on the optometrists ~~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 Organization ~~Manager~~ in violation

of the foregoing shall be void and unenforceable as a matter of law.

G. Insurers or Vision Benefit Organizations ~~Managers~~ shall not make conditional a fee schedule proposed or made to an optometrist ~~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 optometrist's ~~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 Organization ~~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 Organization ~~Manager~~ and an optometrist ~~eye care provider~~ shall not contain a provision, fee schedule, or reimbursement amount in which the optometrist ~~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 Organization ~~Manager~~ in violation of the foregoing shall be void and unenforceable as a matter of law.

I. An Insurer or Vision Benefit Organization ~~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 Organization ~~Manage~~r, or affiliate of the Insurer or Vision Benefit Organization ~~Manager~~.

J. Insurers or Vision Benefit Organizations ~~Managers~~ shall remit to the participating optometrist ~~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 optometrist ~~eye care provider~~ through customary verification methods of the Insurer or Vision Benefit Organization ~~Manager~~ to receive the covered service or covered material on the date of service.

K. Insurers or Vision Benefit Organizations ~~Managers~~ shall not retroactively reverse a reimbursement or withhold a future reimbursement to a participating optometrist ~~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 Organization ~~Manager~~, if the Vision Benefit Organization ~~Manager~~ later determines that the enrollee was ineligible to receive covered services or covered materials on the date of service.

L. Participating optometrists ~~eye care providers~~ are allowed, but not required, to offer an enrollee the opportunity to pay the participating optometrist ~~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 Organizations ~~Managers~~ shall not, in the course of adjudicating a claim for reimbursement by a participating optometrist ~~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 Organization ~~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 Organization ~~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 Organizations ~~Managers~~; Providing Reimbursement Parity for Optometrists ~~and Ophthalmologists~~; Requiring Affiliates to Comply with Statute

A. No agreement between an Insurer or Vision Benefit Organization ~~Manager~~ and an optometrist ~~eye care provider~~ shall coercively or through undue influence require that an optometrist ~~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 Organization ~~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 Organization ~~Manager~~ and an optometrist ~~eye care provider~~ shall require that an optometrist ~~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 Organization ~~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.~~

C. An Insurer or Vision Benefit Organization ~~Manager~~ shall not require an optometrist ~~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 Organization ~~Manager~~ in violation of the foregoing shall be void and unenforceable as a matter of law.

D. If an optometrist ~~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 shall be reimbursed ~~will seek reimbursement~~ from the plan or enrollee for the subcontracted services, the subcontract agreement must meet all requirements of this [chapter]or[act].

E. The provisions of this subsection shall also apply to any agreements an Insurer or Vision Benefit Organization ~~Manager~~r enters into with another entity to provide an enrollee in the vision plan with covered services or covered materials.

Section 6. Acceptance as Participating Eye Care Provider

A. An Insurer or Vision Benefit Organization ~~Manager~~ shall not exclude an optometrist ~~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 optometrists ~~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 optometrist ~~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 Participating Optometrists ~~Eye Care Providers~~ to Use any Lab or Supplier

A. No agreement between an Insurer or Vision Benefit Organization ~~Manager~~ and an optometrist ~~eye care provider~~ shall restrict or limit, either directly or indirectly, the optometrist's ~~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 optometrist ~~eye care provider~~ to an enrollee. Any such contractual language, policies or procedures set by the Insurer or Vision Benefit Organization ~~Manager~~ in violation of the foregoing shall be void and unenforceable as a matter of law.

B. An Insurer or Vision Benefit Organization ~~Manager~~ shall not directly or indirectly apply a chargeback to an enrollee or optometrist ~~eye care provider~~ if the chargeback is for a covered ~~product or~~ service or covered material for which the insurer or vision benefit organization ~~manager~~ does not incur the cost to produce, deliver, or provide to the enrollee or optometrist ~~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 8~~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 optometrists ~~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 9~~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;.

(iv) provide a mechanism for aggrieved individuals. whether actively or formerly enrolled with a pretesticular vision benefit organization. to submit complaints to the Insurance Commissioner for review. investigation. and as appropriate. discipline under applicable law;

(v) enforce this act using powers granted to the commissioner in the [State] Insurance Code [code citation];

(vi) ensure that Insurers and Vision Benefit Organizations comply with the requirement of this act: and

(vii) be entitled to seek an injunction against and Insurer or Vision Benefit Organization in a court of competent jurisdiction if the Insurer or Vision Benefit Organization:

a. 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:

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

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

~~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~~

B~~C~~. The Attorney General shall:

1.~~5~~. 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.~~6~~. Be entitled to seek an injunction against an Insurer or Vision Benefit Manager in a court of competent jurisdiction.

3. ~~7.~~ 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 10~~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 11~~12~~: Enactment Provisions~~Rules~~

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

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

2. An Insurer or Vision Benefit Organization ~~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 Organizations ~~Managers~~ upon the earlier of:

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

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

3. January 1, 202x.

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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 Executive Committee on April 19, 2026 and July 18, 2026 until the 2026 Annual Meeting while proposed amendments are developed.

Draft as of October 21~~June 16,~~ 2026. Proposed Amendments sponsored by Asw. Pam Hunter (NY). To be discussed and considered during the Health Insurance & Long Term Care Issues Committee on November 20, 2026.

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 and consistent with the plan's benefit design, 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~~ establish~~ed~~ a patient-provider relationship with a specific provider via an in-person interaction ~~in order~~ for the covered person to receive health care services provided through telemedicine services.~~;~~

(D) ~~however, t~~ The establishment of a patient-provider relationship may occur via telemedicine, but shall not occur via an audio-only telephonic conversation. Nothing in this subsection shall prevent an insurer, corporation, or health maintenance organization from applying clinically appropriate safeguards, including an in-person evaluation or periodic in-person follow-up, where warranted by the applicable standard of care or patient safety.

(E~~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.

(F~~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~~ counted toward the deductible, copayment, or coinsurance applicable to the same services provided through in-person diagnosis, consultation, or treatment.

(G~~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.

(HG) 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.

(IH) 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.

(JI) 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.

Drafting Note: States may wish to provide a definition of what constitutes "emergent" or "emergent telemedicine services" or refer to an existing definition of either term in the State's insurance code.

~~**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 56. 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 67. 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.

This language will be discussed alongside NH SB 408 during the Health Insurance & Long Term Care Issues Committee on Friday, November 20, 2026 and both will be used as the basis for development of Model Legislation sponsored by Rep. Brenda Carter (MI), NCOIL Secretary, and Sen. Bill Gannon (NH).

An Act to Improve Access to Prostheses and Orthoses for Adults and Children with Limb Loss, Limb Absence or Limb Impairment

BE IT ENACTED BY [STATE LEGISLATURE] THAT THE FOLLOWING SECTIONS BE ADDED TO [INSERT APPLICABLE STATE LAW]

SECTION 1. Required coverage. All individual and group health insurance policies providing coverage for hospital, medical or surgical expenses shall include coverage for prostheses and orthoses in all health plans subject to state regulation. Covered benefits must be provided for more than one prosthesis or orthosis when medically necessary and include coverage for each of the following:

A. A prosthesis or custom orthosis prescribed by the enrollee's physician (or other advanced practice provider) and deemed by the enrollee's prosthetic or orthotic care provider to be the most appropriate prosthesis or orthosis that adequately meets the medical needs of the enrollee to restore or maintain the individual's ability to perform activities of daily living or essential job-related functions and, at a minimum, equals the coverage [and payment] for prostheses and orthoses provided under federal laws and regulations for the aged and disabled pursuant to 42 United States Code, Sections 1395k, 1395l and 1395m and 42 Code of Federal Regulations, Sections 414.202, 414.210, 414.228 and 410.100, irrespective of cost sharing.

B. In addition to coverage of a prosthesis or orthosis required under paragraph A, a prosthesis or custom orthosis determined by the enrollee's prosthetic or orthotic care provider to be the most appropriate prosthesis or orthosis that meets the medical needs of the enrollee for purposes of performing physical activities, as applicable, such as running, biking, swimming, strength training, and to maximize enrollee's whole-body health and lower and/or upper limb function.

C. In addition to coverage of a prosthesis or orthosis required by paragraphs A and B, a prosthesis or custom orthosis determined by the enrollee's prosthetic or orthotic care provider to be the most appropriate prosthesis or orthosis that meets the medical needs of the enrollee for purposes of showering or bathing.

D. All materials and components necessary to use such prostheses and orthoses;

E. Instruction to the enrollee on using the device; and

F. With respect to the prostheses and custom orthoses covered under subsections A, B, and C above, the medically necessary repair or replacement of a prosthesis or orthosis.

SECTION 2. Medical Necessity and Nondiscrimination Standards for Coverage of Prostheses and Orthoses.

A. An individual health plan that is delivered, issued for delivery, or renewed in this state that covers prostheses and custom orthoses shall consider these benefits rehabilitative and habilitative services and devices for purposes of any state or federal requirement for coverage of essential health benefits.

B. With respect to a covered person receiving a prosthesis or orthosis under subsection A of Section 1 above, covered benefits under subsection B and C of Section 1 above shall require the treating physician (or other advanced practice provider) to determine that the additional prosthesis or custom orthosis is necessary to enable the person to engage in physical activities, as applicable, such as running, biking, swimming, strength training, showering, bathing, and to maximize enrollee's whole-body health and lower and/or upper limb function.

C. Determinations under this section are subject to applicable utilization review procedures, provided that such procedures are rendered in a nondiscriminatory manner. Utilization review procedures shall not deny coverage for rehabilitative and habilitative services and devices, including prostheses or custom orthoses, solely on the basis of an insured's disability.

D. An insurer shall not deny coverage of a prosthesis or custom orthosis for an individual with limb loss, limb absence, or limb impairment that would otherwise be covered for a non-disabled person seeking medical or surgical intervention to restore or maintain the ability to perform the same physical activity.

E. A health benefits plan that is delivered, issued for delivery, or renewed in this state that covers prostheses and custom orthoses shall include language describing an insured's rights pursuant to subsections C and

D of this Section in its evidence of coverage, and, with respect to claim denials based on medical necessity, such denials are in writing and include clear reasoning and descriptions of how and why the request or claim does not meet medical necessity standards.

F. Coverage of prostheses and orthoses shall not be subject to separate financial requirements that are applicable only with respect to that coverage. An individual health plan may impose cost sharing on prostheses or custom orthoses; provided that any cost-

sharing requirements shall not be more restrictive than the cost-sharing requirements applicable to the plan's coverage for inpatient, physician and surgical services.

G. A health plan that provides coverage for prostheses or custom orthoses shall ensure access to medically necessary clinical care and to prostheses and custom orthoses from not less than two distinct prosthetic and custom orthotic providers in the managed care plan's provider network located in the state. In the event that medically necessary covered orthoses and prostheses are not available from an in-network provider, the insurer shall provide processes to refer a member to an out-of-network provider and shall fully reimburse the out-of-network provider at a mutually agreed upon rate less member cost sharing determined on an in-network basis.

H. If coverage for prostheses or custom orthoses is provided, payment shall be made for the replacement of a prosthesis or custom orthosis or for the replacement of any part of such prosthesis or orthosis, without regard to continuous use or useful lifetime restrictions, if an advanced practice provider determines that the provision of a replacement prosthesis or orthosis, or a replacement part of such prosthesis or orthosis, is necessary because of any of the following:

1. A change in the physiological condition of the patient

2. An irreparable change in the condition of the prosthesis or orthosis or in a part of the prosthesis or orthosis; or

3. The condition of the prosthesis or orthosis, or the part of the prosthesis or orthosis requires repairs, and the cost of such repairs would be more than sixty percent of the cost of a replacement prosthesis or orthosis or of the part being replaced.

I. Confirmation from an advanced practice provider may be required if the prosthesis or custom orthosis or part being replaced is less than three years old.

SECTION 3. Reporting Requirement. No later than [INSERT DATE HERE], the [ENTER STATE NAME HERE] Department of Insurance shall publish a list of all insurance plans subject to the requirements outlined in this Section on its website and via a bulletin to insurance plans doing business in the state, unless otherwise required. Such information will be updated on an annual basis. No later than [INSERT DATE HERE], each health plan subject to this Section shall issue a notice to its members and update members' evidence of coverage that such law is in effect and applies to their plan. Each health plan subject to this section shall also report to the superintendent on its experience pursuant to this Section no later than [INSERT DATE HERE] for plan years [INSERT DATES HERE]. The report must be in a form prescribed by the superintendent and must include the number of claims and the total amount of claims paid in this State for the services required by this Section, unless otherwise required. The superintendent shall aggregate this data by plan

year in a report and submit the report to the joint standing committee of the Legislature having jurisdiction over health coverage and insurance matters no later than [INSERT DATE HERE].

SECTION 4. Application. The requirements of this Act apply to all policies, contracts, and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after [INSERT DATE HERE]. For the purposes of this Act, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date. All state laws in conflict with this legislation are hereby declared null and void.

CHAPTER 244

SB 408-FN - FINAL VERSION

2026 SESSION

SENATE BILL 408-FN

AN ACT relative to health insurance coverage for prosthetics.

SPONSORS: Sen. Gannon, Dist 23; Sen. Rosenwald, Dist 13; Sen. McGough, Dist 11; Sen. Fenton, Dist 10; Sen. Prentiss, Dist 5; Sen. Innis, Dist 7; Sen. Altschiller, Dist 24; Sen. Lang, Dist 2; Sen. McConkey, Dist 3; Sen. Abbas, Dist 22; Sen. Watters, Dist 4; Sen. Ward, Dist 8; Sen. Perkins Kwoka, Dist 21; Sen. Long, Dist 20; Sen. Rochefort, Dist 1; Sen. Reardon, Dist 15; Sen. Pearl, Dist 17; Rep. Litchfield, Rock. 32; Rep. Bernardy, Rock. 36; Rep. S. Minor, Belk. 5; Rep. L. Walsh, Rock. 15; Rep. Weyler, Rock. 14

COMMITTEE: Health and Human Services

ANALYSIS

This bill requires health insurance policies to provide coverage for adult prosthetics, including activity-specific prosthetic devices. The law currently requires such coverage for children's prosthetics.

- -

Explanation: Matter added to current law appears in ***bold italics***.

Matter removed from current law appears [~~in brackets and struckthrough.~~]

Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty-Six

AN ACT relative to health insurance coverage for prosthetics.

Be it Enacted by the Senate and House of Representatives in General Court convened:

244:1 Accident and Health Insurance; Coverage for Prosthetic Devices. Amend RSA 415:18-ff to read as follows:

415:18-ff Coverage for Prosthetic Devices [~~for Children~~].

I. Each insurer that issues or renews a policy of group [~~or blanket accident or~~] health insurance providing benefits for medical or hospital expenses shall provide coverage for prosthetic devices, including activity-specific prosthetic devices, for children under 19 years of age, who are residents of this state and covered by such insurance. The insurer may limit coverage for activity-specific prosthetic devices to one activity-specific prosthetic device per plan year. Medically necessary prosthetic devices shall not be subject to any annual limits. Coverage under this section shall be subject to such other terms and conditions of the policy that may apply.

II. Each insurer that issues or renews a policy of group health insurance providing benefits for medical or hospital expenses shall provide coverage for prosthetic devices, including activity-specific prosthetic devices, for individuals over 19 years of age who are residents of this state and covered by such insurance. The insurer may limit coverage for activity-specific prosthetic devices to one activity-specific prosthetic device every 5 years and may apply utilization management, including limiting or excluding coverage if the covered person has received an activity-specific device in the last 5 years. Medically necessary prosthetic devices shall not be subject to any annual limits. Coverage under this section shall be subject to such other terms and conditions of the policy that may apply, including any applicable cost sharing. This section shall also apply to the state of New Hampshire's employee health benefit plan under RSA 21-I.

[~~I.~~] **III**. Covered benefits shall include:

(a) All materials and components necessary to use the device;

(b) Instruction to the enrollee on using the device; and

(c) The repair or replacement of a prosthetic device that is determined medically necessary or is necessary for maximizing the enrollee's ability to engage in the specific activity.

[~~II.~~] ***IV***. In this section:

(a) "Prosthetic" means an artificial substitute for a body part for functional or therapeutic purposes.

(b) "Activity-specific prosthetic device" means a prosthetic device designed to allow an individual to participate in a specific activity that could damage the residual limb or everyday prosthesis, or when the everyday prosthesis would not function effectively to perform that specified activity.

[~~III~~.] **V**. This section shall not apply to plans available through the Small Business Health Options Program (SHOP).

244:2 Coverage for Certain Prosthetic Devices. Amend RSA 415:18-n, I to read as follows:

I. Each insurer that issues or renews any policy of group accident or health insurance providing benefits for medical or hospital expenses, except for supplemental policies covering a specified disease or other limited benefit, shall provide to each group, or to the portion of each group comprised of certificate holders of such insurance who are residents of this state and whose principal place of employment is in this state, coverage for benefits for prosthetic devices under the same terms and conditions that apply to other durable medical equipment covered under the policy, except as otherwise provided in this section ***and except as otherwise provided in RSA 415:18-ff***.

244:3 Effective Date. This act shall take effect January 1, 2028.

Approved: July 02, 2026

Effective Date: January 01, 2028

To be discussed alongside Illinois SB 2899 during the NCOIL Health Insurance & Long Term Care Issues Committee on November 20, 2026.

CHAPTER 69
(SB 111)

AN ACT relating to coverage for the treatment of stuttering.

Be it enacted by the General Assembly of the Commonwealth of Kentucky:

SECTION 1. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) As used in this section:

(a) "Habilitative services" means health care services that help a person keep, learn, or improve skills and functioning for daily living;

(b) "Habilitative speech therapy" means speech therapy that helps a person keep, learn, or improve skills and functioning for daily living;

(c) "Rehabilitative services" means health care services that help a person restore or improve skills and functioning for daily living that have been lost or impaired; and

(d) "Rehabilitative speech therapy" means speech therapy that helps a person restore or improve skills and functioning for daily living that have been lost or impaired.

(2) Except as provided in subsection (4) of this section, any health insurance policy, certificate, plan, or contract, including but not limited to a health benefit plan, that provides coverage for:

(a) Habilitative services, shall provide coverage for habilitative speech therapy as a treatment for stuttering, regardless of whether the stuttering is classified as developmental;

(b) Rehabilitative services, shall provide coverage for rehabilitative speech therapy as a treatment for stuttering; or

(c) Both habilitative services and rehabilitative services, shall provide the coverage required under paragraphs (a) and (b) of this subsection.

(3) The coverage required under subsection (2) of this section shall:

(a) Not be:

1. Subject to any maximum annual benefit limit, including any limits on the number of visits an insured may make to a speech-language pathologist;

2. Limited based on the type of disease, injury, disorder, or other medical condition that resulted in the stuttering; or

3. Subject to utilization review or utilization management requirements, including prior authorization or a determination that the speech therapy services are medically necessary; and

(b) 1. Include coverage for speech therapy provided in person and via telehealth.

2. The telehealth coverage required under this paragraph shall:

a. Not be less than the coverage required for health benefit plans under KRS 304.17A138; and

b. Include the use of any communication technology, application, or platform to deliver telehealth services, except coverage may be restricted to technology, applications, or platforms that are compliant with any applicable privacy provisions of the federal Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. sec. 1320d et seq., as amended.

(4) If the application of any requirement of this section to a qualified health plan as defined in 42 U.S.C. sec. 18021(a)(1), as amended, would result in a determination that the state must make payments to defray the cost of the requirement under 42 U.S.C. sec. 18031(d)(3) and 45 C.F.R. sec. 155.170, as amended, then the requirement shall not apply to the qualified health plan until the cost defrayal requirement is no longer applicable.

Illinois SB 2899

AN ACT concerning regulation.
Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 5. The Illinois Insurance Code is amended by changing Section 356z.15 as follows:

(215 ILCS 5/356z.15)

Sec. 356z.15. Habilitative services for children.

(a) As used in this Section, "habilitative services" means occupational therapy, physical therapy, speech therapy, and other services prescribed by the insured's treating physician pursuant to a treatment plan to enhance the ability of a child to function with a congenital, genetic, or early acquired disorder. A congenital or genetic disorder includes, but is not limited to, hereditary disorders. An early acquired disorder refers to a disorder resulting from illness, trauma, injury, or some other event or condition suffered by a child prior to that child developing functional life skills such as, but not limited to, walking, talking, or self-help skills. Congenital, genetic, and early acquired disorders may include, but are not limited to, autism or an autism spectrum disorder, cerebral palsy, and other disorders resulting from early childhood illness, trauma, or injury.

(b) A group or individual policy of accident and health insurance or managed care plan amended, delivered, issued, or renewed after the effective date of this amendatory Act of the 95th General Assembly must provide coverage for habilitative services for children under 19 years of age with a congenital, genetic, or early acquired disorder so long as all of the following conditions are met:

(1) A physician licensed to practice medicine in all its branches has diagnosed the child's congenital, genetic, or early acquired disorder.

(2) The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, licensed physician, licensed nurse, licensed optometrist, licensed nutritionist, licensed social worker, or licensed psychologist upon the referral of a physician licensed to practice medicine in all its branches.

(3) The initial or continued treatment must be medically necessary and therapeutic and not experimental or investigational.

(b-5) For any child under 19 years of age with an early acquired disorder that is diagnosed as a speech-language disorder, including stuttering, the coverage required under this Section shall include rehabilitative services in addition to habilitative services. As used in

this subsection, "rehabilitative services" means speech therapy that helps a child restore or improve skills and functions for daily living that have been lost or impaired.

(c) The coverage required by this Section shall be subject to other general exclusions and limitations of the policy, including coordination of benefits, participating provider requirements, restrictions on services provided by family or household members, utilization review of health care services, including review of medical necessity, case management, experimental, and investigational treatments, and other managed care provisions.

(d) Coverage under this Section does not apply to those services that are solely educational in nature or otherwise paid under State or federal law for purely educational services. Nothing in this subsection (d) relieves an insurer or similar third party from an otherwise valid obligation to provide or to pay for services provided to a child with a disability.

(e) Coverage under this Section for children under age 19 shall not apply to treatment of mental or emotional disorders or illnesses as covered under Section 370 of this Code as well as any other benefit based upon a specific diagnosis that may be otherwise required by law.

(f) The provisions of this Section do not apply to short-term travel, accident-only, limited, or specific disease policies.

(g) Any denial of care for habilitative services shall be subject to appeal and external independent review procedures as provided by Section 45 of the Managed Care Reform and Patient Rights Act.

(h) Upon request of the reimbursing insurer, the provider under whose supervision the habilitative services are being provided shall furnish medical records, clinical notes, or other necessary data to allow the insurer to substantiate that initial or continued medical treatment is medically necessary and that the patient's condition is clinically improving. When the treating provider anticipates that continued treatment is or will be required to permit the patient to achieve demonstrable progress, the insurer may request that the provider furnish a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

(i) Rulemaking authority to implement this amendatory Act of the 95th General Assembly, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(j) An insurer may not deny or refuse to provide otherwise covered services under a group or individual policy of accident and health insurance or a managed care plan solely because of the location wherein the clinically appropriate services are provided.
Section 15. The Illinois Public Aid Code is amended by adding Section 5-5j as follows: (305 ILCS 5/5-5j new)

Sec. 5-5j. Speech-language rehabilitative and habilitative services. Subject to federal approval, for services beginning on and after July 1, 2026, the medical assistance program shall provide coverage for medically necessary rehabilitative and habilitative services for individuals under the age of 21 with an early acquired disorder that is diagnosed as a speech-language disorder, including stuttering. As used in this Section, "rehabilitative services" means speech therapy that helps an individual restore or improve skills and functions for daily living that have been lost or impaired.

Section 99. Effective date. This Act takes effect July 1, 2026, except that Sections 5 and 10 take effect on January 1, 2028.

WORKERS' COMPENSATION INSURANCE COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
WORKERS' COMPENSATION INSURANCE COMMITTEE
2026 NCOIL SUMMER MEETING – BOSTON, MA
July 17, 2026
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Workers' Compensation Insurance Committee met at the Westin Copley Place Hotel in Boston, MA on Friday, July 17, 2026 at 9:00 a.m.

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

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Rep. Peggy Mayfield (IN)
Rep. Adrielle Camuel (KY)
Rep. Sarge Pollock (KY)
Rep. Brenda Carter (MI)
Sen. Lana Theis (MI)
Sen. Paul Utke (MN)
Sen. George Lang (OH)
Del. Walter Hall (WV)

Other legislators present were:

Rep. Zack Gramlich (AR)
Sen. Tim Grayson (CA)
Rep. Kerry Wood (CT)
Rep. Stephen Meskers (CT)
Sen. Adrian Dickey (IA)
Rep. Rita Mayfield (IL)
Rep. Dennis Bamburg (LA)
Rep. Mike Johnson (LA)
Sen. Franklin Foil (LA)
Sen. Jason Howell (KY)
Rep. Michelle Boyer (ME)
Rep. Rolf Olsen (ME)
Rep. Bob Foley (ME)
Sen. Mark Huizenga (MI)
Sen. Joseph Thomas (MS)
Sen. Bill Gannon (NH)
Sen. Mark Mann (OK)
Rep. Trey Wharton (TX)
Rep. Calvin Callahan (WI)
Rep. Pepper Ottman (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 Sen. Justin Boyd (AR) 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. Peggy Mayfield (IN) and seconded by Rep. Adrielle Camuel (KY), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's April 17, 2026 meeting.

“STATE OF THE LINE” PRESENTATION – AN UPDATE ON THE STATUS OF AND TRENDS IN THE WORKERS’ COMPENSATION INSURANCE MARKETPLACE

Jeff Eddinger, Senior Division Executive at the National Council on Compensation Insurance (NCCI), stated we’re going to take a quick look at workers’ compensation results. We’ll start off with looking at the calendar year combined ratios. Remember that the combined ratio for workers’ compensation is a ratio of the benefits paid out and the expenses related to those benefits, ratioed to premium. We’re looking at a 21 year history here of the combined ratio. And we just all remember that a combined ratio under 100 means that more premium was collected, then was paid out. So, in other words, a profitable year for workers’ compensation.
Calendar year 2025 is at 91%. It’s up 5 points from 86% the previous year. Prior to this year, we had seen 8 straight years of calendar year combined ratios under 90%. There has now been 12 straight years of underwriting profits. So, if we look at the components of the combined ratio, we see a 3.5% increase in the loss ratio. But even with that increase, that’s 9 straight years of a calendar year loss ratio under 50%. The other increase of a 1.5% is in the underwriting expense ratio, and that’s the highest it’s been in 20 years. And we’re looking at a 21 year history of the investment gain on insurance transactions. So, the estimate for the latest year is 9%, a bit lower than the long-term average of 11%. So, when you take that 9% investment gain and you combine it with a 9% underwriting profit gain, you’re looking at an 18% pre-tax operating gain for the last year. We had seen 8 straight years of gains over 20%, but still, this is 11 years in a row of operating gains of more than 15% percent. Now calendar year combined ratios are impacted by reserve changes, and for the latest year, we do see the second year of a drop in reserve adequacy. But loss reserves continue to be redundant, meaning higher than they need to be about $14 billion in the latest year. But again, it’s a very healthy reserve position for the workers compensation line.

So, now we’ll look at the premium. Here’s 21 years of net written premium with private carrier premium in blue and state fund premium in orange for those last two years that they’re colored. The total premium for the latest year is $45.6 billion, a 1.5% decrease from the year before, $46 billion. But you’ll notice that the premium level now is very similar to what it was 20 years ago and that’s due to the fact that workers’ compensation has payrolls as its exposure base, so the premium has stayed relatively stable. We’re going to go through the reasons why. One thing that affects total premium is the amount of premium in the residual market and the residual market premium has been dropping steadily since 2014. For the latest year, it’s about $640 million down from $660 million in 2024 and that corresponds to about 5% of the total premium share for 2025, just down slightly. But that tells us that the majority of risks are finding coverage in the voluntary market, and that’s an indicator of a healthy workers’ compensation system. If we take a closer look at the components of premium, payroll being a major component, payroll increased by 4.8% in the latest year. You can see the variation by job classification there with health care showing the largest growth in employment, and leisure and hospitality with the smallest wage growth. Also just notice that the payroll is made up of the growth in wages, and employment. The vast majority of the increase there is a 4.3% increase in wage growth and a very small increase in employment.

Now this shows the reason that premium has been remaining very stable. It’s caused by two offsetting changes: we’re seeing an increase in payrolls, but at the same time, we’re seeing a decrease in the loss costs. And so, for the latest round of rate filings for NCCI states, the loss cost decreased by about 5% compared to a decrease of about 6% for the previous year. You’ll notice in this 21 year history there was really only one year, 2012, that had an overall increase in loss costs. This slide just shows the range by state, ranging from a negative 22% in New York

to plus 22% in Nevada. And the highlighted states on this graph are actually non-NCCI states, what we call other bureau states. So, I guess you'll also notice that there's really no pattern necessarily with those non-NCCI states they also run the gamut.

So, the other side of this story are the loss drivers. There are many components to the loss drivers. We'll start out with what we call claim frequency and claim frequency did decrease 2% in the latest year compared to almost 6% the prior year. This is a smaller decrease than in previous years, but it is still a decrease and it is smaller than the long-term average. We have seen claim frequency dropping over time, an average of 3.8% every year. We call the average cost per claim severity. So, this is medical claim severity changes, and medical claim severity increased 4% for the latest year compared to 6% the previous year. So, there are many factors impacting the total cost of medical services. For example, for physician costs, if we look up there, we see that physician costs prices increased 3%, while utilization of services increased 4%. So again, when we look at the overall average cost per claim going up 6%, we can see overall across all of these categories it's an even split between price and utilization for medical.

Now, when we look over a long period, medical severity had been tracking very closely with what we call a medical workers' comp medical price index from 2014 to 2023. Those two things have been tracking fairly closely, but for the last two years we've seen medical severity outpace that medical price index a bit. Then we look at the indemnity portion, which is the wage replacement and indemnity claim severity increased 4% for the latest year compared to almost 5% the year before. Of course, driven primarily by wages. So, over the last 20 years, wage inflation has actually far outpaced changes in indemnity severity. It tracked with wages up till about 2013, but then it started growing faster than the wages through 2021. Then since 2021, these two things have been more in line, each up about 20%. But wages have increased 96% during this period compared to only 71% for the indemnity. So, when we put these two things together, total claim severities increased by 4% the latest year, compared to 5.6% the prior year. But as I mentioned, because workers' compensation exposure base is payroll, and is in fact affected by wages, it's meaningful to look at that adjusted for wages. So, when they're adjusted for wages, the latest two years are very flat. But you can see how the total severity over time has decreased steadily since 2009, when adjusted for wages on average, it's going down about 4.5% per year.

So, this is just showing that the overall loss ratio has dropped 3% in the latest year. So, we continue to be in an environment where payrolls are increasing, driven by wages and employment. But at the same time, claim frequency continues to decrease and in addition claim severity is relatively flat when adjusted for wages. So, this environment is still conducive to continued loss cost decreases. So, workers' comp has one of the lowest combined ratios in the P&C industry. Both the calendar and accident year results are under 100%. Claim frequency continues to improve, premiums are relatively stable, and reserves are strong.

Rep. Lampton thanked Mr. Eddinger and stated that we like to hear good reserves and low loss ratios. One of the things I had noticed on your frequency graph in 2021 there was a large increase. Was that a COVID related increase because of the frequency there? Mr. Eddinger stated yes, it's a good observation. I usually say that during this time period, there was really only one year 2010, where claim frequency went up. The 2020 and 2021 COVID time, you see a very large decrease in 2020, and then it bounced back in 2021. So yes, that that's a good observation. That was definitely affected by the COVID period.

Rep. Stephen Meskers (CT) said I am not as familiar with the product other than how it works in the payouts. Are the reserves managed as a portfolio? Is there any function in the return on

reserves versus the premiums that are charged every year and the adequacy of the funding? Or is it more like a cash management balance account in the reserves? Mr. Eddinger said I'm not an expert because I'm not from a carrier, but what I will say when we talk about the reserves, we're talking about insurance company estimates of what they expect to pay out over all of their claims and we have seen those estimates drop over time. So, it just means that the initial estimate or initial reserves that are put up are higher than they end up being when the claim is finally settled. Now, when I looked at the results and returns on investment, carriers are able to invest the reserves, so the premium they collect, they can invest in and the reserves that they put up that money can still be invested. But I can't speak to returns on those investments or how they're made.

Rep. Meskers stated I'm curious as to whether there's any correlation, because if you go through, '08, '09 in the financial crisis, I'm expecting unemployment goes up. There probably might be some incidence in workers compensation claims as well if their jobs are at risk. If their portfolios and the reserves go down, you could get a double incidence in the effect of the adequacy. I'm just trying to figure out reserve adequacy for these funds.

PRESENTATION ON AIR AMBULANCES IN WORKERS' COMPENSATION: USE AND COSTS ACROSS STATES

Rep. Lampton stated next on our agenda, we have a presentation from the Workers Compensation Research Institute (WCRI) on air ambulances in workers compensation, focusing on the use and costs across states. This discussion isn't geared toward development of a Model Law or resolution, rather just an interesting presentation, especially since air ambulances in general, have been an NCOIL agenda topic throughout the years in other lines of insurance.

Ramona Tanabe, President and CEO of the WCRI thanked the Committee for the invitation and opportunity to present WCRI's work. This is a much narrower question on air ambulance transport services. Last year, we did a study on hospital closures and the effect of those closures on access to care and claim outcomes. And the question we got repeatedly was, did you also look at air ambulances? So, we did and this is a report as a result of that. Today I want to share our findings with you and tell you a little bit about WCRI as well. Our first finding is that air ambulance transport services are used very infrequently, particularly in urban areas. When we look at rural areas, we saw that it was a little bit more than a percent of claims with more than seven days of lost time. What I'm using here is a compilation of 32 states combined together, and looking at only claims that had lost time payments made to them. So, it excludes medical only claims because those would be unlikely to be using services of air ambulances.

What do we mean by air ambulance transport services? We mean rotary wing transport services, not fixed wing. So, these are also from an injury site to a hospital or from a smaller hospital to a larger trauma center. So, it could include both. We also looked at rural areas to say, can we break rural areas down? And we used the rural urban and commute area codes developed by the Department of Agriculture and created micropolitan areas, small towns, and very rural areas. And you can see that there's some distinction between those in rural areas not having a hospital in a close proximity, perhaps to the injury. This is what you would expect how those services would be used. But it indicates the critical services that are provided by these air ambulances to those remote areas for potentially lifesaving situations.
We also looked at what types of injuries received these types of services. Not surprisingly, motor vehicle accidents and burns were the most common. This chart is showing the percentage of claims with those types of injuries that had air ambulance services. How has this changed over time? We also looked at how did that percentage of air ambulance services

change? And you can see that it didn't change all that much. It's relatively stable, somewhere a little bit over a percent, a little bit up and down. This chart divides it into all claims as well as claims with more than 7 days of loss time or rural claims, which is the top green line. I also wanted to look at this by jurisdiction to say, is it the same across all states? Here is the distribution across states, and you can see that for rural areas it's very different. This is looking at 2024 claims that occurred between 2022 and 2024. So, what you see is that in some states, it's less than 0.5%, up to 2%. Texas is standing out at about 3.5%. What that means is in a rural area one in 30 injured workers in those rural areas will receive air ambulance transport services.

Then we wondered about the cost. When we look at the cost by jurisdiction for that same time period from 2022 to 2024, you can see it varies greatly from $10,000 in Texas up to almost $60,000 in California. What might explain this variation in cost as well as the high cost? Some of it has to do with it's a highly specialized service that's being provided. There's a limited number of providers and there's not a lot of competition. The providers tend to not be in networks, so it's also an emergency. It's not a time to cost compare and there is uncertainty in the regulation. It differs across jurisdictions. The two states that we just looked at, Texas and California, at opposite ends. In Texas, their fee medical fee schedule, which regulates the reimbursement prices for medical services includes air ambulance transport services. In California, the fee schedule specifically excludes air ambulance transport services and says they will be governed under the Airline Deregulation Act (ADA).

So, how have the payments changed over time? And we can see that the average payment, which is the top line here, increased more than 60% over those 10 years. The median line, which is shown underneath that is increased at a lesser rate but still increased. That means that distribution across states, the differences, it's some states are much higher and increased at a more rapid pace. Let's look at it by jurisdiction then. The yellow bars here show 2013 to 2015, and then the blue bars show, 2022 to 2024. You can see in many states there was an increase. Texas was relatively stable at around $10,000. California almost doubled. Some states increased in the 80% range. But more than half of the states increased more than 50%. Notably, South Carolina decreased over that time period. In 2017, South Carolina put in place a regulation tying it to Centers for Medicare and Medicaid Services (CMS) reimbursement rates for air ambulance transport services.

This could also reflect fuel prices. One would expect the fuel prices to be part of the equation of the cost of these types of services. At the beginning of the time period, the fuel prices were at $3 a gallon. At the end of the time period, they were at $2.50 a gallon. Today they're at $3.50. I think it remains to be seen how that will affect services going forward as well. So, what we saw in this study was that while the use is infrequent these services can be expensive, with the payments varying depending on the jurisdiction. And that there has been an increase in those payments over time. A little bit about WCRI, we are a nonprofit, nonpartisan resource for public officials and all stakeholders in the workers' compensation system. We provide about 40-50 studies a year. And the studies are regularly used in public policy discussions. Our mission is to provide that information so that when there's a public policy discussion, it can be an informed discussion based on data. We don't make recommendations or take positions on the issues that we study.

Rep. Pepper Ottman (WY) stated this is all pretty new for me, but we have private companies that we as individuals get in Wyoming. I noticed Wyoming's not on here at all. And so, it looks like we don't use air ambulance, but we do a lot. And there's a company called MASA and it is extremely expensive to use the air ambulance in our area unless you have these companies. Do you have any comments on that? Ms. Tanabe said I should say that the study is based on

32 states. We excluded states where we did not have representative data in the state, and small cell sizes. So, for that reason Wyoming was not included in the study. That does not mean that there are not those services in those states however. It just means that the data that we had to support this study wouldn't support that study. I talked about fuel prices. Fuel prices for private companies as well tend to be about double what I quoted. So, there's a distinction between privately owned company fuel planes as well or rotary wing transport services. So that could affect some of the costs as well.

Rep. Lampton asked if you see an increase in air ambulance services. In other words, are there more helicopters flying around, or are is that relatively stable? Ms. Tanabe responded saying it's been relatively stable in the data.

DISCUSSION ON THE STATE OF WORK COMP COVERAGE FOR MENTAL INJURIES

Rep. Lampton stated next on our agenda is a discussion of the state of work comp coverage for mental injuries. This issue is growing in the marketplace and is something I know we've grappled with in Ohio. In fact, Ohio just passed some funding. So, in Ohio, you have to have a direct physical injury first in order for a post traumatic stress syndrome (PTSD) type injury to be covered under work comp. There's been a lot of discussion around that. We just passed a funding measure for those folks who would experience PTSD without the physical injury. So, that fund and all that is outside of a workers' comp claim, but we did provide funding for our first responders in that example. Several other states' have had bills come up and in some instances, laws have been enacted relating to this issue.

Mark Walls, Corporate Senior Vice President and Chief Marketing Officer at the Safety National stated I'd like to thank the Committee for allowing me to testify today on the state of workers' compensation coverage for mental injuries. Many of you may not be familiar with Safety National. We are an insurance carrier, we work with employers who use self-insurance and high-deductible policies, so we're kind of in the background. But collectively, we insure or reinsure about 1 out of 13 workers in the U.S. So, you may not have heard of us, but we're out there on a lot of different things. We are involved in many of the largest, most costly claims. We pay for a lot of air ambulance services. So those are the types of files that we get involved in. When workers' compensation started over a 100 years ago, the focus was on sudden and traumatic injuries. Workers' compensation has continued to evolve as the nature of work has evolved. Workers' compensation statutes have been amended to include other occupational risks, such as repetitive trauma claims or occupational diseases caused by workplace exposures. Mental health represents the next meaningful expansion of workers' compensation injuries.

For several years, most states have allowed what are called physical-mental claims. Those are claims like in Ohio, where there is a mental condition that arises from a physical injury. This is usually in the form of depression or anxiety as an added condition to the claim. While this tends to increase the costs of the claim and the duration of disability, the physical injury generally remains the primary driver of the costs. An interesting trend being seen post-pandemic is a higher prevalence of mental health as a complicating condition on claims. Several factors are contributing to this including an increased societal focus on the importance of mental health as a component of wellbeing. More people are receiving mental health treatment as part of their overall health care. It only stands to reason that this would mean you have more people with preexisting mental health diagnosis, who are suffering workers compensation injuries.

The trend in recent years is the expansion of mental claims in which the work-related mental health conditions were not caused by a physical injury. Much of this expansion started by allowing PTSD claims for first responders, and now many states have PTSD presumptions for first responders. Those presumptions actually change the burden of proof when establishing compensability for such claims. We are seeing more states allow mental claims for all employees, in part because of the inequity that resulted from only allowing such claims for first responders. Think about a workplace shooting. When the law limits mental claims to first responders, only they can receive workers' compensation benefits. However, the actual workers in the facility where the shooting occurred could not receive these same benefits. And it was that inequity that has led many states to make changes and allow mental claims to all employees.

While mental claims are relatively new in some states, they have been allowed in other states for many years, especially with first responders. From those states, we were able to gather data around the frequency and costs of such claims. Our experience shows that the per injury cost typically remained lower than most physical injury claims, but frequency can vary significantly. We've seen shooting claims with a couple of officers on the scene that resulted in over 100 PTSD claims being filed. In addition, that tied into that claim where the PTSD claims actually exceeded the costs of the physical injury claims from the people that were on the scene. As these claims expand, first responders continue to have the highest claims costs. However, the frequency of these claims is growing in several industries, in particular healthcare, schools, public transportation, even the retail settings. The debate over mental health and workers' compensation is often framed on whether or not these injuries are real. In my opinion, that's the wrong debate. Without question, mental injuries are real. The appropriate policy question is where workers' compensation should draw the line between compensable occupational trauma and the stresses that are part of everyday life and work. Sudden traumatic events that would cause a mental injury for a reasonable person should be covered under workers' compensation. We see statutes use language like unusual and extraordinary. Proximity of threat is an important addition to your statute.

However, workers' compensation is not designed to be a remedy for someone having a conflict with coworkers, feeling aggrieved by legitimate personnel process, or just the general stressors of the workplace. Workers' compensation is not a replacement for group health insurance or employee assistance programs. As mental health has expanded in workers' compensation, some states have established statutory standards for diagnosis while others rely on treatment guidelines adopted through regulation. In either case, clear diagnostic criteria and evidence based treatment protocols help ensure that the legislature's intent is consistently applied. One final note, the impact of mental health claims in workers' compensation is extremely difficult to fully quantify because of incomplete data. First, the coding for such claims is often inconsistent at the adjuster level. When we analyzed our own data, which comes from third-party administrators around the country, it showed that the leading cause of mental injury was "other." Not really good for your analysis, right?

In addition, there is not one single source of truth when it comes to workers' compensation data. When you hear somebody say, "Well, the data clearly shows," I would encourage a degree of skepticism. Workers' compensation data is by design fragmented. NCCI has about a third of it. The independent bureau states such as California and New York have about a third of the data, and about one-third of employees are covered under self-insurance, and their data is not reported typically to the bureaus. This covers most public sector employers, K through 12 schools, and a significant percentage of the workforce in higher education and health care. So, this incomplete picture of the data really makes fully understanding the impact of mental health

and workers' compensation challenging. Mental health will continue to be one of the most important issues facing workers' compensation for the next decade. As legislators your challenge is not determining whether these injuries are real. They are. Your challenge is defining where workers' compensation appropriately begins and ends.

Rep. Ottman stated this is an issue in the Wyoming Labor & Health meetings this last interim, we had a lot of testimony. Quite a few hours from dispatchers because we have the sheriffs, and we have the police, and we have the firemen. But the dispatchers that get on those calls and are there for the entirety of that. They gave amazing testimony about how they are not being recognized or served. I honestly never thought of workers' comp as that. I just looked at the mental health portion of it. So, this would be a good conversation, I think. Mr. Walls said I will tell you that's going to depend on how the statute is written because we've seen claims for dispatchers. The claim that I mentioned where we had over 100 PTSDs from an incident with only two people on site. That was dispatchers, that was coworkers on the force. It depends on how the statute is written, and if the statute requires a proximity to the threat, then such claims aren't eliminated. I also wanted to mention my wife's family lives in rural eastern Oregon, so they buy that insurance for the air ambulance, so they can have that coverage.

READOPTION OF MODEL LAWS

Rep. Lampton stated last on our agenda is the re-adoption of Model Laws. The two Models that are up for consideration of re-adoption are the Model Agreement Between Jurisdictions to Govern Coordination of Claims and Coverage, and the Trucking and Messenger Courier Industries Work Comp Model Act. The models are in your binders starting on page 58, also on the website and the app. We have not received any comments on these Models since they were distributed months ago.

Hearing no questions or comments, upon a motion made by Rep. Meskers and seconded by Rep. Michael Sarge Pollock (KY), the Committee voted without objection by way of a voice vote to re-adopt the Models.

ADJOURNMENT

Hearing no further business, upon a motion made by Del. Hall and seconded by Sen. Boyd, the Committee adjourned at 10:30 a.m.

LIFE INSURANCE & FINANCIAL PLANNING COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
LIFE INSURANCE & FINANCIAL PLANNING COMMITTEE
2026 NCOIL SUMMER MEETING – BOSTON, MASSACHUSETTS
JULY 16, 2026
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Life Insurance & Financial Planning Committee met at The Westin Copley Place Hotel in Boston, MA on Thursday, July 16, 2026 at 10:00 a.m.

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

Other members of the Committee present were:

Rep. Deanna Gordon (KY)
Rep. Edmond Jordan (LA)
Rep. Brenda Carter (MI)
Sen. Mark Huizenga (MI)
Sen. Lana Theis (MI)
Sen. Joseph Thomas (MS)
Asm. Jarrett Gandolfo (NY)
Asw. Pamela Hunter (NY)
Rep. Brian Lampton (OH)
Sen. George Lang (OH)
Rep. Carl Anderson (SC)
Rep. Matt Morgan (TX)
Rep. Tom Oliverson, MD (TX)
Del. Walter Hall (WV)

Other legislators present were:

Sen. Tim Grayson (CA)
Rep. Stephen Meskers (CT)
Rep. Elijah Pierrick (HI)
Rep. Ben Fuhrman (ID)
Rep. Rita Mayfield (IL)
Rep. Michael Meredith (KY)
Rep. Michael Sarge Pollack (KY)
Sen. Jason Howell (KY)
Rep. Adrielle Camuel (KY)
Rep. John Illg (LA)
Rep. Dennis Bamburg (LA)
Rep. Shaun Mena (LA)
Sen. Kirk Talbot (LA)
Rep. Poppy Arford (ME)
Rep. Michelle Boyer (ME)
Rep. Robert Foley (ME)
Sen. William Gannon (NH)
Sen. Tim McGough (NH)
Asm. David Weprin (NY)
Sen. Mark Mann (OK)
Rep. Kevin Norwood (OK)
Rep. William Slater (TN)
Rep. Calvin Callhan (WI)
Sen. Cale Case (WY)
Sen. Pepper Ottman (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. Justin Boyd (AR) and seconded by Del. Walter Hall (WV), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Sen. Lana Theis (MI) and seconded by 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 April 17, 2026 meeting.

PRESENTATION ON MORTALITY DRIVERS: PRACTICAL INSIGHTS FROM SOCIETY OF ACTUARIES RESEARCH

Kara Clark, Senior Research Actuary at the Society of Actuaries (SOA) Research Institute, thanked the Committee for the opportunity to speak and stated that understanding mortality and understanding future mortality requires recognizing both emerging headwinds and tailwinds and also separating population mortality from insured mortality. So, we're going to get into that throughout this presentation. Future mortality will be shaped by competing forces. So, if there are three things that I want you to take away from today, first, that behavioral risks remain significant. Medical innovation may improve outcomes, and then finally, population trends require thoughtful translation to insured experience. There are a number of research reports that are up on the screen now, and I'm going to be touching on each of these very briefly to provide an overview, along with another study that was conducted by Reinsurance Group of America (RGA). So, the first of our studies looks at an overview of the U.S. population mortality observations through 2022. It uses national death certificate data and applies coding from ICD 10, which is the diagnosis for cause of death. Everything is categorized into one of 14 categories, and it enables us to look at patterns across years and ages.

This particular slide is the percentage of deaths and this by age band and the different colors represent different causes of death so again, for each of these age groups, 100% of the deaths would be on this y-axis here, this vertical axis. And then the age bands go from the younger ages to the older ages here. Working ages are pretty much in the middle. And that's what we're going to be focusing on primarily in this presentation. And so, the point here is that working age deaths reflect a different cause of death mix than older ages. That probably isn't a huge surprise to you. If you look down here at some of the colors that stand out, we've got heart disease here at the bottom. This lighter purple is cancer. But for the younger ages, you can see that there are some different colors that become more prominent, and the light blue up here is suicide, and the teal is accidents, which includes drug overdose deaths. So, heart disease is important across the board, cancer is a leading cause of death. But when you get to the working ages, you can see that the distribution by cause of death is quite different than the older ages where you've got accidents representing a much larger portion as well as suicide. This is from 2020 to 2022. The red is COVID-related deaths.

So, we've done some additional research, really digging into drug overdose deaths and how those have been trending over time. So, this is another graph that looks by age band at drug overdose deaths and the percentage of deaths caused by drug overdoses at different age bands in two different time periods. We've got women here on the left and men on the right. And at certain age bands, 25 to 39, drug overdose deaths account for over up to and slightly over 30% of all deaths. These deaths occur at younger ages. The average age is approximately 45. The overdose epidemic evolved in some very distinct waves. And so, these are deaths over time by different types of drug overdoses. The total is here at the top, and then the different colors represent different drug types, including the early phases which were driven primarily by prescription opioids. Those were the early increases. Those of you who have been around for a while will remember a lot of prescription painkillers that were causing problems in some cases. The second wave became heroin, but things really started to take off due to fentanyl. That was a major shift in drug overdose deaths because you can see how much things increased once fentanyl came on the market. Fentanyl is very deadly. It is much easier to overdose and it has higher fatalities. So less than two milligrams can be fatal as compared to roughly 100 milligrams of heroin. In addition, fentanyl contaminates street drugs and it can be harder to reverse in those cases. Some substances mixed with fentanyl don't respond as well or require more naloxone to reverse. The recent data, the dotted line that shows some decreases in drug overdose deaths. In 2023 we saw the first decline in recent years and 2024 provisional data also saw a decline. So, the question is, is that going to continue? Is it stabilization or is it volatility? And that is a big question as we go forward. At the same time that we did this research The Society of Actuaries also commissioned a consumer sentiment survey and asked people what their perceptions were of drug overdose deaths and most of them did believe that drug overdose deaths would increase in the next five years rather than go down.

Some other important things to note, and you'll see this throughout the rest of our presentation, is that the risk of certain types of death is not evenly distributed. So, in this particular case, this looking at education levels. And those with lower levels of education showed higher mortality rates due to drug overdose deaths. That does not mean that lower education causes drug overdose deaths. It simply means that they are correlated. And this differential is widening over time. So, this is less than high school, high school, and then college educated is that yellow line on the bottom. There are other occupations again that correlate with overdose mortality risk. So certain occupations like construction, maintenance, service occupations have a higher rate of mortality than those in management jobs. Again, that does not mean that being in construction causes overdose mortality deaths. It may mean that there is different exposure either to injury or access to prescription drugs or a need for prescription pain drugs. But something to be aware of is that these risks do not impact groups of the population in even ways. One of the other interesting findings in this particular study is that alcohol-related deaths, alcohol-induced deaths, show a different pattern than drug overdose deaths in the working ages. So, here we're looking at alcohol-induced deaths, which is not just acute alcohol poisoning, but how alcohol contributes to other causes over the longer term. Alcohol deaths skew older. Less than 10% of alcohol-induced deaths are at ages younger than 40, whereas for drug overdose deaths, closer to 40% occur at ages younger than 40. The other interesting thing here is that for university-educated individuals, there is a higher risk of alcohol-induced death. In the most recent years, alcohol induced deaths were more than drug related deaths for the university educated population.

I am going to pivot now to another study that was conducted looking at mental health trends, again, something of importance in the working ages. So, here one of the things to point out is that suicides - this is for women over time here on the left, these are different age groups and for men here on the right - have been increasing. And it's another study that shows that socioeconomic context and geography contribute to different risk profiles. In this particular

study, we looked at data that came in part from the Mental Health Association and was information at the county level where there were self-reported surveys that included self-reported poor mental health days, suicidal ideation, severe depression. And we looked at how those particular components related to suicide and all cause mortality within those counties. So, the finding here is that mental health indicators, probably again not a surprise, do correlate with mortality risk. This is all cause mortality here on the left and suicide is on the right. Anything that is above the solid line means there is a positive correlation with all cause death or a positive correlation with suicide death. Meaning, the more severe depression from the survey, the more all-cause deaths we saw. And over on the right, the more severe depression results from these surveys, the more suicide deaths we saw.

So, the effects for all-cause mortality are strongest at the younger ages and for suicide and then it declines a little bit over time. And for suicide it's positive. These are positive correlations. And they persist really at all ages. I want to point out that these are correlations at the population level and studies at the county level, meaning it's not an individual person that is being studied and leading you to say this particular individual that has a high number of poor mental health days would necessarily result in a suicide death. One of the other components of this study is to show that suicide risk also clusters geographically, and these clusters persist over time. So, this particular graph, I would call it almost an actual to expected if we were looking at what we would expect the suicide rate to be in these different areas. Given everything that we know about the populations in those counties, the ones that are green and yellow are greater than expected suicide deaths. So, you can see that there is a persistent across years and across ages, where the western states show elevated suicide risk. We don't really know why that is. That is, there's something in the socioeconomic environment there that is a latent risk factor that we haven't modeled. And then finally, socioeconomic context also shapes suicide outcomes. So, we looked at again percentage at the county level of education levels and found that counties with higher levels of education were correlated with lower levels of suicide risk. Higher housing values correlated with lower suicide risk. Down at the very bottom, again, you can see most of that shaded area is above this solid line, meaning that high poor-related, poor mental health days as reported by the county residents correlated with higher suicide risk.

So, I've talked about mental health and I've talked about drug overdoses, those are some of the headwinds that are influencing mortality right now. What are some of the tailwinds and things that might have a positive impact on mortality? This is some modeling that was done by RGA looking at the potential impact of GLP-1's which may represent a positive influence on U.S. mortality. At the Society of Actuaries Research Institute we do have a couple of studies underway right now looking at the impact of GLP 1's that are not expected to be published until the fall or maybe early 2027. In their study, they estimated the impact of anti obesity medications, including GLP-1's on U.S. mortality looking at multiple adoption pathways over a 20-year horizon. And in particular they looked at assumptions related to clinical effectiveness, uptake in the market, persistence with treatment so adherence to the medications and how that reduced mortality risk. And what they modeled according to pessimistic, optimistic and kind of a central set of scenarios is that over time, GLP-1's could produce meaningful mortality improvements. So cumulatively, in their central set of scenarios, 3.5 cumulative mortality improvement over 20 years. The largest effects occurred at ages 45 to 59. What they would expect is that the insured population would have smaller absolute mortality gains and that is because the insured populations do not look the same as the general population. An insured population likely has a healthier baseline risk and lower obesity prevalence to begin with and so even though they may have greater access to these drugs, there might be a smaller base upon which they are applied.

And so that brings us to my final point here is that in all of these cases and I hope this has come through in the presentation, U.S. mortality is not one national trend. And I'm going to show you some additional information that brings home that point. In any of these studies, we cannot assume that the average applies to all individuals. And in addition, we need to be thinking about how population mortality needs to be thoughtfully translated into an insured population.
So, this is again one final study that I am going to mention here. We do this on an annual basis, and we look at mortality over time at different socioeconomic groups. So, each county in the U.S. is put into one of 10 deciles where the tenth decile is the, let's say most advantaged and the lowest decile is the least advantaged. And what goes into categorizing counties into these deciles are things like percent of the population that have higher levels of education, percent of the population that has less than an eighth grade education, average income in the county, average housing price in the county, some of the disparate housing prices and incomes within the county, etc. So, with that, there are some details here. You can see here are the results that we show where the red are life expectancy at birth. And the red is the least advantaged.

So, the green is the most advantaged set of counties, the red is the least advantaged set of counties. Men on the left, women on the right. And so, you can see that since 1982, which is the beginning of this chart there has always been a differential in the life expectancy of the most advantaged and least advantaged counties in the country. That differential has expanded over time. It has been widening over time. It's been persistent and it has been increasing. And so, when we hear about an average U.S. mortality rate, please understand that the average is not representative as there is a lot of dispersion and variation that goes into making up that average, and we have to be thinking about that as we translate to an insured population, which you can see again how much variation there is in the general population. An insured population is not going to look like the general population, and in many cases it may look more like the more advantaged counties that you see here at the top of the graph. And that mortality difference at the county decile level is largest in working age adults. So, again, there's significant overlap here with the core insured population, which means we again have to be thoughtful about how we're translating these trends to insured groups. So again, with key takeaways, behavioral causes are an important driver of working age mortality. Medical advances such as but not limited to GLP-1's may improve future mortality outcomes. There is a lot of differentiation in mortality results across socioeconomic groups, and there needs to be a thoughtful translation when we look at population experience as we consider how to apply it to any given insured population.

Rep. Stephen Meskers (CT) stated that on the second to last slide, could you go over your interpretation there because I had a question on the working age where you have the largest gap in mortality rates - does that reflect the incidence or occurrence of Medicare and insurance coverage at the age of 65 for the narrowing of the gap? And is it an insurance-related issue of treatment that's narrowing that gap? And is it all related to basically healthcare coverage, or is there an interpretation I should take from that? Ms. Clark stated that is not something that we have studied, so I don't think I can speak to it. Where I was coming from with this is, and I did go through this very quickly, but if you look here at the ages, this is the middle working ages here and if this is the average, that solid line, you can see how the gap difference from that solid central line is the widest between the most advantaged and least advantaged socioeconomic counties in this central section. So, that's why we're saying that those adult ages have the largest gap in mortality difference. I cannot say that the reason is because of insurance access one way or the other. That is not something that we have studied. It's an interesting question. Rep. Meskers stated that basically I'm thinking of at the state level, we manage insurance pools for all of our socioeconomic groups at some level, the Affordable Care Act, etc. And the only time the federal government steps in is at 65, with essentially a blanket coverage. The second

piece is I guess your GLP study is relatively incomplete in that it's only this year that GLPs are covered under Medicare, right? Ms. Clark stated that is correct and I'd have to go back and see what the assumption was in the RGA study with respect to seniors and GLP-1 access.

Rep. Tom Oliverson, M.D. (TX) stated that if I'm understanding your presentation correctly, it would seem to me that socioeconomic factors are valid measures of risk in terms of mortality. So a life insurance company that is trying to make actuarially valid decisions about pricing, if I'm understanding you correctly, this data would seem to indicate that the use of socioeconomic factors is an actuarially valid way to predict risk. Could you comment on that? Ms. Clark stated that I can't really speak to how any given organization would or should operate.

Rep. Oliverson stated that I'm not asking you to say whether it should be or it shouldn't be, or whether there should be disparities at all, or how we feel about that. I'm just saying it would appear to me that the math indicates that the higher your socioeconomic status, the lower your mortality and that's just mathematical. And so thus, if an insurer is attempting to quantify risk in order to price, that is a valid factor. Is it not? Ms. Clark stated that these are correlations and not causation. So, I need to be clear that we're not saying that any of these factors are causing lower mortality, but they are related. Rep. Oliverson stated that correlation is a valid factor, we talk about this all the time. You don't have to prove where something came from to consider that it is a valid association. Ms. Clark stated right, but I'm sorry I'm not sure how to answer the question. Rep. Oliverson stated that I think it's pretty straightforward and I'm not trying to make a value judgment or any kind of moral equivalency or statement about what the difference between what is and what should be, but I'm just trying to say from a mathematical standpoint, it would seem as though your data very conclusively shows that if you are at a higher socioeconomic status that your risk of mortality across all ages is not only lower, but seems to have gone down over time. And so that is just simple data and these are the facts. We cannot like them and we can seek to change them, but it is what it is. Ms. Clark stated that I think that at the individual level, that's where I hesitate because these are population based studies so individual underwriting when it comes to that needs to take into account individual level characteristics and I really can't speak to the range of those that might be based in practice.

DISCUSSION ON DEVELOPMENTS IN UNCLAIMED LIFE INSURANCE BENEFITS

Rep. LeBouef stated that next on our agenda is a discussion on developments in unclaimed life insurance benefits. The NCOIL model Unclaimed Life Insurance Benefits Act will be referenced, along with another NCOIL model, the Beneficiaries Bill of Rights. Copies of those models are on the app, website and in your binders starting on page 20. Today, we have two speakers who will update us on developments in these areas, including whether or not the death master file (DMF) remains an appropriate use of proving someone's death for life insurance purposes.

Brendan Bridgeland, Director of the Center for Insurance Research here in Massachusetts, thanked the Committee for the opportunity to speak and stated that the Center is a non-profit consumer advocacy organization. I've served as a consumer advisor to the National Association of Insurance Commissioners (NAIC) and the Interstate Insurance Product Regulation Commission (IIPRC), and in the past I've been on certain NCOIL panels as well, a couple of which I will address here today because I was involved in some of the drafting of the two models being discussed. I am here today to offer a few thoughts on developments and updates on NCOIL's excellent models that have protected tens of thousands of life insurance consumers and their families. The first is the Model Unclaimed Life Insurance Benefits Act originally adopted in 2011 and the second is the beneficiaries bill of rights that was originally adopted in 2010. The amount of unclaimed money held by abandoned property funds is massive, it totals

$70 billion, and overall states return about one third of this property to consumers and the other two thirds of it is going to stay with an abandoned property forever. But in some cases, that return rate has been less than 5% of unclaimed property, depending on the jurisdiction and the type of property. And in these difficult economic times, taking steps to help return unclaimed accounts to consumers could help millions more families around the country.

There's a number of slides here that will provide some background. I'm not going to cover them all today because that would take far too long. But feel free to look it over if you want to see some of the background. I started on this issue when I was working on a mutual to stock conversion, and I happened to look up some names in the unclaimed state property database, and I found the deceased father of one of my best childhood friends who died when we were both in grade school. And unknown to his widow, there had been a life insurance policy gifted to him as a newborn that he wasn't even aware of because he was one when it was taken out. When she ultimately contacted the state to claim the funds, she got both the death benefit and a demutualization payment. This was a tiny policy, originally only a couple hundred dollars, but due to the time and generation of interest and dividends and the demutualization, they ultimately received a payout of over $15,000. But this was money a family coping with the loss of a parent could have benefited from long ago and there was over two decades between his death and his family finally receiving this benefit. Now, under the law in most jurisdictions, a life insurance policy will not be transferred into the abandoned property fund until three years after the insured would have reached 100 years old. It's called the limiting age. So, if somebody passes away at 80, it's going to be another 23 years before it's going to show up in unclaimed property and at that point, the family is probably no longer looking, which is one of the reasons why these go unclaimed. But this has been addressed by the NCOIL Model Unclaimed Life Insurance Benefits Act that has protected tens of thousands of middle class families by requiring insurers to use the Social Security DMF.

For example, in 2010, one company took 1 million policies and used the DMF to identify 5,600 policyholder deaths that had not been reported and even when that was done, the leftover policies had a benefit around $1 million or about $3,600 per average death benefit. It shows this is an issue that particularly impacts families who purchase smaller policies to cover death and funeral expenses. The model act requires proper disclosure, transparency and accountability relating to the payment of life insurance death benefitsl; requires insurers to semiannually compare enforced policies against the DMF; and develop search protocols to adjust for things like name typos. And it requires a company to confirm or verify the status of an insured once a potential match is made. I've included some slides here from a colleague of mine, Richard Weber, who just made this presentation at the NAIC, and I wanted to give him due credit. So, I'm using some of his materials that we've worked on together for this. So, the next few slides will be from the recent NAIC presentation. Each year in the U.S., three million people die but not all are captured in the federal database that insurers rely on, and as a result, benefits are delayed or never received by beneficiaries. You can see here in the chart the change since the Model was first enacted. The DMF used to cover 95% of deaths that occur in the U.S., but due to changes that has dropped down in recent years, and now it only contains about 16% of all total deaths. And this is because in 2011, the Social Security Administraiton removed 4.2 million state death records from publicly available DMF files in response to privacy and identity theft concerns. And there was the bipartisan budget act of 2013 that restricted access to the full DMF so now insurers can only use what's called the limited access DMF, which is not as complete.

There are other potential tools that are available, but they have limits. There are 40,000 news outlets today providing 67% of the needed death data obituaries on top of the state and federal records. But obituary sources are unwieldy and inconsistent to be used for tracking, and it's

becoming less customary for families to post and pay for a published obituary. And this is some summary background, but I just want to note that the issue is important because of the amount and how it impacts American families. There's $14 trillion in individual life insurance for coverage enforce. There's $8.1 trillion in group life insurance and together, that's $22 trillion, and there's another $16 trillion in retirement plans, pensions and annuity contracts. And we're not talking about disputed claims or anything like that. These are benefits people have earned by paying into a lifetime life insurance policy, and they should get that benefit.

The other Model I was going to touch on is the NCOIL Beneficiaries Bill of Rights, which relates to retained asset accounts (RAAs) specifically. In 2010 press accounts emerged about the use of RAAs as a default settlement option for military families and the difficulties those families sometimes faced in accessing those funds. And RAA is one of the potential options for the settlement of a death benefit, an alternative to taking a lump sum cash payment. They operate like a checking account with insurers distributing their own checkbooks that can be used to draw upon the funds. However, unlike in a licensed banking institution, there's no Federal Deposit Insurance Corporation (FDIC) protection for RAA's, and there are some other differences. But in light of these problems in 2010, NCOIL began investigating and developing its beneficiaries bill of rights, which was adopted in 2010. I participated in that working group and it did an excellent job. Section five of that model act established important new consumer protections for RAAs, including disclosures about how they differed from a bank account, interest rates, fees, and any limitations on withdrawals.

Bill of Rights section six also required for the first time data collection and disclosure about the amount of funds held in RAAs by insurers each year and also the amount that is turned over to abandoned property. To date, transfers of RAAs to abandoned property funds appears to be the first and only source of data and disclosure requirement applied to unclaimed life insurance benefits and the transfers to unclaimed property funds. And while RAAs represent only a tiny portion of the life insurance benefits distributed each year, a review of that data, which I've done this year, shows the scope is potentially enormous. I was granted access to the recent RAA NAIC data on insurer annual statements from 2020 to 2025 and I was just going to share as I finish up a couple of key findings. During this timeframe, insurers turned over 8,233 individual and 4,995 group insurance RAA accounts to abandoned property funds. The total value of these accounts was $105 million, for an average per contract of approximately $8,000. The biggest individual insurer handed over 15.6% of all RAA's to abandoned property accounts during that period. They turned over accounts averaging $365,000, very big policies, very big accounts. And one problem that's arising from this may attract insurance fraudsters. A colleague of mine from the Coalition Against Insurance Fraud will be addressing that at the next NAIC meeting.

And closing, a couple of recommendations. The NCOIL model acts have already benefited tens of thousands of families, and hopefully will be maintained and updated as necessary. As alternatives to the DMF emerge and as that fades as the best source, NCOIL should consider adding alternative search options and there are some things being developed by private parties and private markets that may ultimately prove to be a better data source than the DMF which was fantastic but is becoming less so as time goes on. And also, I think more data collection and disclosure is necessary about insurance funds turned over to abandoned property. I'm working at the NAIC on the subject to help expand the reporting, and I welcome any support from NCOIL to help get more money back to families from their life insurance purchases.

Jill Rickard, Regional VP of State Relations at the American Council of Life Insurers (ACLI), thanked the committee for the opportunity to speak and stated that I'm just going to speak briefly because I think we share the same goal. And the key point of my presentation is that life

insurers make long-term promises to their customers, and they are committed to fulfilling those promises so we do share the same goal of putting money into the hands of the beneficiaries when a policy comes to its close. Our industry paid out $223 billion in benefits in 2023, which consisted of $89 billion in life insurance benefits and $104 billion in annuity benefits. The last year for which data is available, we paid out $199 billion in 2024 and Rep. LeBoeuf, in your state alone, we pay out $6.2 billion each year in benefits to Massachusetts families, which is $17.1 million each day. We are very supportive of the NCOIL Model Unclaimed Life Insurance Benefits Act and the Beneficiaries Bill of Rights which actually comes into play in the extremely small percentage of cases where benefits are not claimed through the traditional process, where more than 98% of policies are paid, meaning a beneficiary submits a claim, the insurer reviews it and then timely pays the claim. That's 98% of policies. So, in those 2%, which is real money, the NCOIL model comes into play and has been actually adopted in 36 jurisdictions, so we are supportive of the model, and have been since its inception and continue to support its adoption in the 15 or so jurisdictions that have not yet adopted it. I won't go over what the model does because Mr. Bridgeland did a great job there but in short, most major life insurance companies even in the states that have not adopted the model, do follow the model's recommendations and perform semi-annual searches of the DMF, which is the authoritative source at this point at least for death records. So, while we are open to hearing and learning about what additional sources may be available, right now the DMF is the authoritative source for death records in the US.

Another thing that I think is very helpful to beneficiaries that was recently launched in 2016 by the NAIC is the life insurance policy locator. Most insurance companies are participating in this, and it helps consumers determine if they're owed unclaimed life insurance benefits. The tool searches participating life insurers, it is voluntary, but as I said, I think most insurers are participating as well as annuity companies. As of April of this year, the Policy Locator has recovered $13 billion in life insurance benefits, which is a substantial amount and the tool is working very well. Submitting a request takes only minutes and it requires minimal documentation. Once the consumer submits the request, the NAIC then contacts the insurance companies on their behalf to determine whether policies exist and gets those claims paid out. Finally, escheat - after a certain number of years of dormancy on a policy, usually it's three, but it depends on the state, the insurers must turn over unclaimed life insurance benefits to the state in which the policy owner last lived, and then the state takes over and does additional enhanced searches with the state records. Consumers can also check their states unclaimed property office with usually a simple online search using just a last name. So, all of these are tools that are helping insurers accomplish their goals of getting these benefits paid out. I think the key overall point here is that we do share the goal of getting these benefits paid, and we support the NCOIL models.

UNDERSTANDING THE ELUSIVE LIFE INSURANCE CONSUMER

Rep. LeBouef stated that next on our agenda is the topic of understanding the elusive life insurance consumer. As many of you know, life insurance can serve as a very important safety net for people and families after a death as we just heard, but policy ownership in the U.S. is only around 50%. To explain the benefits of life insurance and how elusive the life insurance consumer is, today we have Steve Wood, Head of Market Research for LIMRA.

Mr. Wood thanked the committee for the opportunity to speak and stated that for those who don't know, LIMRA is a nonprofit trade association serving the insurance and financial industry. We do partner studies with our friends at the SOA quite often as well. I lead the consumer markets research team so everything that I have to present comes from the consumer side of things. If we believe that the customer is always right, their ideas of how life insurance should be

distributed, sold and underwritten is very different from what the industry thinks. But it also is important to get their viewpoint, especially from a marketing perspective. I usually do talk to life insurance marketers, distributors, and product developers so this is a little bit different tone here today. So, this first slide follows quite nicely with the previous speakers and this comes from a consumer survey and we just thought of the idea of what is life insurance? How would you term life insurance if it wasn't called life insurance? Life insurance as a term itself is acceptable to the majority of Americans, but as we see here, many do view it as death insurance or something surrounding death, which is fair, but what's interesting about that is when we talk about the elusive consumer, these are people we know through our research that tens of millions of people say they need life insurance, or they need more life insurance, but they never go about getting it. There are many reasons for that, but there are people who truly do want it, and we start asking them, what would an ideal policy be for you? Why are you not purchasing it?

And when I think about elusive, they're right there. I'll make a world cup analogy. Leo Messi, he's elusive but he's relatively small and it seems easy to take the ball off of him but it's not. So, these are people who are consuming media, they understand the need for life insurance, they're starting families, starting careers, but they're not taking that leap. So that's what I mean by elusive consumer. One other interesting thing about this, this word cloud here is the people who do understand life insurance a little bit more. They understand there are living benefits and as we'll see in my few slides today, living benefits is such a seller of life insurance. It's something that's very attractive to people, whether or not they can necessarily afford a policy with living benefits, or even understand what that means. The lack of awareness of different types of insurance that offer living benefits and other components of policies is astounding. It's the elusive consumer. It's very difficult to market life insurance for a multitude of reasons and we'll touch on a few of them today. I really like this quote – "Change has never been this fast. It will never be this slow again." When it was said, it was applying to artificial intelligence (AI) several years ago, without even understanding of where we'd be today. However, what's important I think for the life insurance industry is this is not just an AI thing. This is everything. AI is obviously affecting how we're underwriting policies much quicker to get into somebody's hands a policy which is a huge plus for the consumer. That's one of the top things that they didn't like years ago was how long it took to get fully underwritten. As those processes are changing, that's certainly going to help the consumer. But our distribution models are changing rapidly. Private equity is entering into the picture with our distributors, direct network marketing is a newish way of distributing life insurance, and that has shown massive success to certain socioeconomic demographics that are really attracted to that type of life insurance purchase and those smaller face amount policies. And everything is changing.

I have to touch on social media as well, how people are consuming information now. We started tracking social media consumption with regards to financial products, I think about 11 years ago. And it's astounding to me how many people, that is the only place they go to to learn about things like life insurance – 62% of people say that's where they go now, and you kind of say, wow, that's really high. But think about your own behaviors. If you're going to look for a restaurant tonight, you usually wind up looking at some form of Facebook, Yelp, Reddit, YouTube, what have you. It's not necessarily their actual website. That plays a role in life insurance as we'll touch on in a second. This is a slide showing life insurance policies and face amount. I think it goes back to 1960 or so. We see the money of life insurance policies are the bars that have grown significantly over the years, and the orange is policy ownership. And what's interesting about this is life insurance has had a great few years with large face amount policies. The tax advantages for a certain wealth class that can afford those types of policies has really put a lot of money into the life insurance industry. But meanwhile, the number of policies has remained pretty flat for a long time. So, that delta between the bar and the orange

line or red line, that's the elusive consumer. We know people are getting variable products, they're getting the tax advantages from it, they're putting a lot of money into that. And we also know that network marketing and lower face amount policies, final expense policies, low face amount term policies are doing quite well right now for a lot of people selling those products.

But that part in the middle is that elusive consumer, that upper middle class, middle class new family. They're the ones who say they need life insurance, and they're just not taking the step to get it. And a lot of our research tries to inform our life insurance company members of how best to attract that attention to get their eyes on marketing materials and to take that next step to actually purchase a policy. Importantly, with all the technology, with social media, with the way we communicate now, people who understand life insurance still want those in person conversations and in person. And when we include things like video calling, phone calling, video chatting, what have you, that number jumps over 50% and what's important about that is through all the technology there is always this sort of fear that we're kind of diminishing the role of the life insurance agent or the financial professional. When it comes to life insurance, as of mid-2026, have no fear, as people need to speak with people for any policy beyond a small term policy or end of life policy or final expense policy. And it's really important and we study this a lot at LIMRA. People are uncomfortable talking about death.

So, back to that first slide, the idea of naming it death insurance, there's some problems with that from a marketing perspective. I don't know how we would do that. I don't recommend that we call it death insurance. In fact, I have a second-to-die life insurance policy. The industry decided that didn't sound too good. So now they call them survivorship policies. I think that was a good move. But importantly, even younger generations still understand the need to have that in person conversation. And they're talking about life, death, their personal health, their personal finances. Those are very difficult conversations, and we are not at the point where people feel comfortable talking to an AI agent with those conversations. We're not necessarily at the point where people want to give their entire health records to an AI agent to underwrite them. I know that is a very interesting topic for some people in this room as far as how far AI would go with underwriting with prescriptions and personal health information and things like that. We ask consumers about that a lot. And it's interesting because they all say, down to 18 year olds, they are not comfortable with that. They want to protect their data. They want to protect their personal information. And I get very cynical in my job because I have a 15 year old and I have a 20 year old. They know what to say. They want to protect their information, but meanwhile, their lives are all out there. So, I don't think we're going to get to the point where we're fully AI underwriting policies but obviously it's already helping speeding along the underwriting process and that speed again is very important to consumers. They want to know what their policy is going to cost as quickly as possible. They don't want necessarily to give fluids anymore. They want some way to get fully underwritten as quickly as possible.

So, I mentioned social media and I mentioned my sort of hesitation of how we treat those questions on our surveys to the general population. For an example, a person I work with decided to add TikTok as an option for where people turn for financial information. And this was three years ago, and I said, are you kidding me? I don't even want to ask that because I already have a low opinion of the general population when it comes to these things. I am happy slash sad to report that the usage of TikTok for this information has grown significantly year over year as that platform's moved from dance trends to actually providing some content. The reason I have this slide here today is because it's a problem for the life insurance industry. It's a huge problem. I hear weekly from the folks in marketing at life insurance companies and elsewhere of how difficult it is to create content, whether it's TikTok, Instagram, Facebook, that provides relevant accurate information that attracts viewers. But most importantly, that does well against

so called influencers or as some are called now financial influencers. The problem with that is and what I hear from our people is that, obviously, our life insurance companies are held to brand standards, legal standards, regulations and what they can put out there on social media, and they're competing against influencers who do not have any of that. Most of them, if they ever held a license, they've given it up. They can say whatever they want to say. And we've collected examples of these so-called influencers who will just go out there. Some have two or three million followers, and they'll just say something like whole life insurance is a scam. Three million people see that and they trust that person, but meanwhile, an insurance company - how do you combat that? And we keep hearing that they wish they could create content quicker and not have to go through all the levels of regulation that their companies require. I don't know the answer to that. I know that's what their wish is. I think it's going to be a challenge regardless. We're way behind the social media landscape when it comes to life insurance companies. Let's be honest, it's not the coolest thing to follow on social media, but there have been successes. There's been some really successful campaigns on social media and there has to be. And it's not necessarily a social media account, it's just getting that person to take that time to understand that they're speaking to them and their life situation and then to click through and have those AI chatbots at the ready and to have the website at the ready, the life insurance calculators, and most importantly that button to talk to a human. That button to talk to a human is paramount for life insurance companies to get that person really in that purchase funnel. By the way, a lot of this stuff comes from the LIMRA and Life Happens Annual barometer study. For those in the room who do work at life insurance companies your company is almost assuredly a member of LIMRA and that study does publish on Monday three days from now. And the theme this year was asking consumers what they'd want from a life insurance policy. Interestingly, the top answers are things that exist, such as final expense coverages and retirement income. We purposely asked a bunch of choices that are impossible or ridiculous from an underwriting or actuarial perspective but we were just curious of what people would want from a life insurance policy. So self-directed policy changes and customization, we really dove into this year.

People were less interested in components of a policy that provided sort of life advice like planning and budgeting, estate planning services, drug and alcohol rehab, house down payment improvements, gym memberships, and things like that. But we wanted to look at the younger generations most, that's the elusive consumer. So younger millennials, older Gen Z who the majority of Gen Z now are legally adults. So, this was a question surrounding so-called embedded insurance you purchase something and life insurance comes with it, or you get a service and life insurance is offered with it. And we see here that there's general interest in it. It sounds fairly attractive to the younger generations when they purchase a gym membership. I thought it was interesting at the hospital or the pediatrician after the birth of a child. We know that starting a family is a top driver of purchasing life insurance. I would have thought that those percentages would have been higher, but there's a lot of components that go into this. A lot of people when they start a family, finances are even tighter than they are for the rest of us. So, the idea of purchasing life insurance is just another added expense, which is a whole other topic. The idea that people have of how expensive life insurance is is really eye-opening to people. We have slides, I don't have them here today, but generally healthy young males who are in their late 20s or early 30s, overestimate the cost of life insurance 10 times of what it would cost them. And again, going back to social media, being able to put pricing models out there, which does involve some regulatory changes, would be helpful to educate the younger consumer. I've seen it where you offer them a 20 year level term $200,000 policy. They'll divide 200,000 by 20 and they'll think that's how much it costs. So that fundamental misunderstanding of what life insurance is, is a hurdle to get over and it's not getting better for many reasons.

So, here we asked people what components of a life insurance policy would be attractive to you. The ones that are boxed are ones that are readily available to any and all of us. And they kind of slot right in there in the middle with the younger generations. Now, the same question for Gen X and boomers, those two in the box were far and away the most attractive. Part of that is because they know that they have that or it exists, so there's some bias towards knowing it's real and they can get it. And again, some of the other ones here, I know you can't read them in the back, but they don't exist. And a couple of them are ridiculous. But what we were trying to get at is the idea of customizing a life insurance policy. And by customizing, I don't really mean customizing, I mean giving the illusion of customization and control over life insurance. We tested a lot of ideas around that. And we're doing another study for the rest of this year that really gets into that and trying to understand a more realistic scenario, what is most effective on consumers. And I am confident in saying the data will show that the illusion of control of their policy will be greatly beneficial. And not just illusion, but some control in different ways to do conversion policies. I was just reading the other day in Canada, you can buy individual disability insurance that can later convert to critical illness or long-term care coverage. That is very attractive to people. Anything that converts and anything that you can take your money and put it into something else that's more relevant to you at that point in life is something that works with consumers. Obviously, we underwrite that at the time of purchase or we build those expectations in. The consumer does not know that. It gives them the idea that, hey, I've made it through this period in life. Now I can perhaps move some funds into an annuity, I can move it into long term care insurance. We know those riders exist. But one of the questions on here is the ability to toggle on and off a critical illness rider or a long term care rider.

We can't do that. You can't go to the doctor today, get diagnosed with something, go home and turn on your critical illness rider. But I think there are ways that we can look at the way we market and sell and build life insurance products that give these younger consumers the idea of control of their policies. And if you think about life now, they're controlling everything. Your streaming services you can turn on and off month to month week to week. The way that people shop for food now, you build meals, you get it delivered to your house. Lots of goods and services have moved to these sort of models where the people have this control over what they're doing month to month, year to year. And I think it would serve the life insurance industry very well to look at how we're building products, creating products, underwriting products, to provide consumers this idea of control. And lastly, this is just looking at other policy add-ons that are attractive to the younger consumers. This is a funny question because it was a multiple select question, and why wouldn't you want to add these things to your life insurance company? But people did think about it and some of these do exist through some products with wearables and sharing information with life insurers, it's very successful in other countries. It's sort of had a a slower go here in the U.S. I think there are some benefits to those products where we are sharing our daily health information with both health insurers life insurers, but to a younger consumer who's healthy and can get benefits from that and to learn from that. I think I still believe in those programs. I've been following them for many years and I'm really hoping they take off because I do think it's good for Americans, it's good for the general health of our country, which obviously helps life insurance and health insurers as well.

Rep. Peggy Mayfield (IN) stated that I am a mother of both a Gen Z and a millennial, and they seem to think they're going to live forever and I am paying for their health insurance. So, I just want to comment you're absolutely right. It is an elusive generation to capture because they just do not understand the value of life insurance. Obviously, as a Gen X, I understand the value of a of life insurance, which is why I have it for both of them but I think it would be better if we had more in person interactions. I know they have TikTok and all of that, but a lot of them don't see anything that is actually directed toward them marketing at an in person event. Like my daughter

just graduated college. There was nothing there leading into getting ready to find a job. They talk about moving forward in the workforce but nobody talks about moving forward and making sure that you have these things in line. They think that they're just going to get insurance from their job that's going to be sufficient and trying to explain to them that they need to have that separate policy is hard. So I think maybe at some of these job fairs would be a good place to have a table to start marketing it to them early and getting that information out there other than just having us parents do so. And also you had a good point there about where they could prepay for their services. I think that is a really good marketing strategy for them because they do like tangible things.

Mr. Wood stated that you made the point that they feel that they're going to be covered through their employer, which is largely true for a young single person. That's a perfectly valid response. But it's interesting as we've seen people have policies through their employers that they don't know that they have. That has become a massive issue for my organization in tracking life insurance ownership. We can't do it with consumer surveys anymore. We know that 52% of people say they have a life insurance policy. We know that number is north of 60% and that delta is almost entirely people who have life insurance through their employer and are completely unaware. That opens up the question as to why, which I will not take any more time, but there's many reasons why we don't have benefit fairs anymore. We don't have that time to speak to life insurance, and if you do have time, it's all trying to explain what a high deductible health plan is to somebody. So that's gone. You don't read emails anymore from HR with the form topics, so they're not learning about their life insurance through work and if they did that would engender the conversation of, I need more than my one time salary. I'm married now, I have a kid now, I'm going to make that secondary outreach.

UPDATE ON INTERSTATE INSURANCE PRODUCT REGULATION COMPACT (IIPRC) ACTIVITIES

Rep. LeBouef stated that last on our agenda is an update on IIPRC activities. It's important to remember that insurance products must meet the rules of each state in which they are sold, and with 56 U.S. jurisdictions, filing policy forms and rates was an enormous project. But with the Compact, there's been a streamlined and efficient product filing process, which has worked extremely well. Today we have the Executive Director of the compact, Karen Schutter, who will provide us an update on the latest compact activities. Before she begins, I would like to note that I do serve on the compact's legislative committee with several other NCOIL legislators and there was also a compact roundtable held yesterday in Boston and I know that many in the room attended that as well.

Ms. Schutter thanked the committee for the opportunity to speak and stated that I usually come before this committee every year just to tell you what we're doing. Hopefully, many of you in the room are familiar with what we are now calling the insurance compact. It's an interstate compact that has been enacted by your legislatures over the last 20 years. In fact, this is the compact's 20th anniversary of its inaugural meeting and implementation of operations. Many of your predecessors were there at our first meetings and have served on our legislative committee. We do have 46 states, D.C. and Puerto Rico in the compact. So, this is now a national compact, one of the first really effective compacts in the insurance space. And what it is, it's a state driven creature of every state. We are not associated or we're not part of the NAIC. They do give us services. I don't have staff for meetings, so they help us with that. But it is a group of about 20 people and what we do is we will approve insurance products for states under what we call uniform standards and these are product standards for individual and group life insurance, annuities, long term care insurance, and disability income insurance.

What's special about those products? Those products really are what we call mobile. You can actually buy a long term care product in my home state of Missouri and move to Massachusetts and claim on it. So, it really is unlike your P&C or even your health coverages. These are national products they're based on mortality and morbidity risks, and they compete with your securities and banking products now, especially over the last 25 years. So, it's important to have more of a central location uniformity across the products. Your regulation is built off a common set of model laws and framework. So that is what we do. One of the things important about the compact is it's a legislative and regulatory partnership. It can't happen without you all. You have to pass the legislation, and as I said, that has been an effort over the last 20 years. But what we do for you is we come together and develop uniform standards, and as I said your state insurance departments are fully engaged in that. And then once those standards are adopted, they go through a two-thirds majority requirement. And usually it's unanimous by the time we get to an adoption at our commission level. Every state, your chief insurance regulator is the member to the compact. Once it's adopted, what happens is an insurance company can make one product filing through the commission or an arm of your state. Your state actually sees the product, but our product team we have product form experts and we have credentialed actuaries that review that product for those uniform standards, which are incredibly detailed comprehensive, and very robust. Sometimes, they might have requirements that are even more stringent, more detailed than what would be in a particular state.

Once it's approved, then it can be issued on a uniform basis in all those states that are members of the compact. There is an important protection as states can opt out of a uniform standard if it does not work for them. We have seen that especially in the long-term care area. And again, that doesn't mean you have to leave the compact altogether. So, we have a very unique and flexible feature for states. One of the important things you'll like to know is that the compact is revenue neutral to all of the states. So, while companies will give us a fee for our services, we actually collect all the fees that otherwise would have been paid if that filing had been made to your state. So, in 2025, we collected and remitted to our states a combined $3.2 million. Also, as Rep. LeBoeuf alluded to, we have an important legislative committee. We don't call them an advisory committee because they are very much a part and integral to the work of the commission, even though that is regulatory driven. We have an eight person legislative committee. Four members are appointed by NCOIL, four members are appointed by the National Conference of State Legislatures (NCSL). And many times, you'll see both of them here at these meetings. So, we have Rep. LeBoeuf, Rep. Michael Sarge Pollock (KY), Rep. Ellyn Hefner (OK), Rep. Jim Dunnigan (UT), NCOIL Treasurer, and Rep. Matt Lehman (IN) who is chair of our legislative committee. And then we also have Del. Dean Jeffries (WV), Sen. Laura Fine (IL), and Rep. Brian Patrick Kennedy (RI). They are very important, and we're very responsive to the legislative concerns with regards to our activities.

So, 300 life insurance companies actively file within the compact. Life insurance companies is one of the smaller universes when you think of P&C and health companies. So, that is a really high majority of the companies that are filing through the compact. We've approved over 16,000 insurance products over the 20 years, which if you multiply that by 48 compacting states, that's exponential with what otherwise would have been required if companies had to file those products state by state. So, the compact has delivered speed to market, efficiency, and really confidence among our states that they know they're getting a very thorough prior review of the product, not only just the product but the actuarial information behind that. Does the non-forfeiture comply with the laws? What are the charges? Where are they embedded? We're looking at all those before it gets out into the marketplace.

As Rep. LeBoeuf mentioned, we've been twice a year having a compact roundtable. In fact, the first one was in New York City on the front end in 2022 of the NCOIL summer meeting. And we were very excited to have so many legislators there as well as NCOIL staff and it's a dialogue not only with commissioners and regulators, but with consumer representatives. Mr. Bridgeland attended and has been on our consumer advisory committee since 2006. So, he has a t-shirt to commemorate that. And we also have an industry advisory committee and we have companies and industry representatives coming to these roundtables. It's an interactive dialogue about product regulation, how can we make the product approval process more efficient and making sure it still preserves those consumer protections. Yesterday we talked about AI and what states are doing, what companies are doing. I think what we found is it's not as far developed as we all hear and think, but it's something we should all be thinking about. And we also talked about how to make products, especially the complex products, more understandable to the consumers and whether there's a role to play in a central clearinghouse with standards.

The other thing that our commission has greenlighted and we worked very closely with Rep. Lehman and the legislative committee in the 2024 timeline was a compact center of expertise. A product can only be filed with us if we have standards. That means the members have said, we're okay with the standards and we're going to let you approve these but there's a lot of other products out there and they're complex and can the compact with its expertise that we've built for our states, can we leverage that to help states when products that are outside of what are in those standards? So, we're trying to launch that as well. We have in person meetings at the NAIC meetings as well. Our next meeting is Thursday, August 13th at noon Eastern. Some of you may already be coming to Columbus, Ohio for it. This is the meeting where the NAIC works with commissioners to sponsor legislators to attend. And I would really encourage you if you are a member to come to our meeting and see it in action.

Rep. Carl Anderson (SC) thanked Ms. Schutter for your hard work and dedication and stated that there are efforts in South Carolina to come back on board with the compact. Ms. Schutter stated we stand ready to welcome you back with open arms as well as any of the other states that aren't members. We continue to work with them and answer questions. I will also mention we are working with the territories so American Samoa and Northern Mariana Islands and Guam are actively considering the compact.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Oliverson and seconded by Rep. Anderson, the Committee adjourned at 11:30 a.m.

BUDGET COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
BUDGET COMMITTEE
2026 NCOIL SUMMER MEETING – BOSTON, MA
JULY 15, 2026
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Budget Committee met at the Westin Copley Place Hotel in Boston, MA on Wednesday July 15, 2026 at 3:30 PM.

NCOIL Treasurer, Rep. Jim Dunnigan (UT), presided.

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Rep. Michael Meredith (KY)
Rep. Brenda Carter (MI)

Other legislators present were:

Rep. Edmond Jordan (LA)
Sen. Paul Utke (MN)

Also in attendance were:

Will Melofchik, NCOIL CEO
Pat Gilbert, NCOIL Director of Policy, Administration, & Member Services

MINUTES

Upon a Motion made by Sen. Justin Boyd (AR) 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 meeting in Atlanta, GA.

2027 BUDGET PLANNING DISCUSSION

Rep. Jim Dunnigan (UT), NCOIL Treasurer and Chair of the Committee, stated that the Committee is here today to discuss and plan for NCOIL's 2027 budget. Before going through the proposed budget, Rep. Dunnigan noted some procedural matters: today's meeting is only for the Committee to discuss the document distributed and determine if any changes should be made – no votes will be taken. The Committee will then meet at the NCOIL Annual Meeting in Sanibel, FL in November to formally adopt the 2027 budget and send it to the Executive Committee for final consideration at the conclusion of the Annual Meeting.

Rep. Dunnigan noted that in addition to a copy of the proposed budget, a document showing the organization's 2026 financials as of June 30, and a document showing the organization's year-end financials for 2025 and 2024 have been distributed. NCOIL is in the midst of having another strong year and the numbers in the proposed 2027 budget represent an expectation that things will remain positive for the organization. Rep. Dunnigan then turned things over to Will Melofchik, NCOIL CEO, to go through the proposed budget and entertain any questions.

Mr. Melofchik stated that starting with states dues - 32 states paid in 2025. Based on current commitments, we conservatively project 33 states to pay dues in 2027. As of today, 15 states have paid their 2026 dues, which generally tracks what we typically have at this time of the year. Most states operate on a July 1 fiscal year, so the majority of dues payments typically arrive after this meeting.

Rep. Edmond Jordan (LA), NCOIL Vice President, asked why we are forecasting a decrease in budgeted dues. Mr. Melofchik stated that the 2026 budgeted number was a bit ambitious. Even though we had a new state become a dues-paying NCOIL Contributing State last year, and another new state this year, we've learned through experience that the number of dues-paying states can really fluctuate year to year based on things like changes in state budgets, experienced NCOIL legislators leaving the legislature, and staff changes in the offices that process the state dues, so it is best to be conservative.

Sen. Paul Utke (MN), NCOIL President asked if the new state referenced for this year was Wyoming. Mr. Melofchik responded yes.

Mr. Melofchik then moved to Corporate & Institutional Partners (CIP) revenue: the proposed amount is $585,000. That is an increase in last year's budgeted amount which we think is justified given the reality of a thriving CIP program. Some of that money gets reallocated as conference revenue to realize that money where it occurred – registration discounts. Accordingly, that reclassification has happened for the Spring Meeting but will still happen for the Summer and Annual Meetings as well. As long as nothing changes in terms of the way the CIP program has been operating in terms of fairness and transparency, then I think we're in a great place to see the CIP program continue to grow as it really has become a great opportunity for interested parties to get engaged in the organization. Rep. Dunnigan stated that the CIP revenue increases and the program in general have been excellent.

Mr. Melofchik then moved to meeting support & revenue. The 2027 numbers are similar to those from 2026 but with some adjustments based on things such as the location of the meetings and anticipated meeting sponsorship levels.

Rep. Carter asked why the 2026 Spring Meeting in Louisville, KY had exceeded the budget. Mr. Melofchik responded that the attendance was very strong and the Kentucky-NCOIL delegation did a lot of great work in helping the Meeting be a huge success through sponsorships and encouraging local folks to attend.

Moving to interim calls, the number of $5,000 mirrors what we budgeted for last year and is almost exactly what we are tracking to receive for 2026. We will likely be having a couple of interim calls following the Summer Meeting which should get us to the $5,000 mark for this year.

Mr. Melofchik stated that overall, the total support & revenue number comes in at $1,965,000 which reflects consistency as well as continued growth.

Moving to the expense side – CIP expenses are expected to be similar to this year. As a reminder, we have seen an increase in CIP expenses over the past few years since we began holding the CIP Planning Meeting in locations outside the typical NCOIL conference cycle locations. We just held the Planning Meeting in Savannah, GA last month and are contracted to hold next year's at the Greenbrier in West Virginia and expect a similar cost.

Moving to the stipend program – as note 2 in the proposed budget states, the budgeted amount for the legislator stipend program assumes a complete consumption of $9,000 for all fully contributing states. The stipend program has been a huge success. If you look at the increase year over year it is a great sign that more legislators and staff are coming to Meetings and using stipends.

Moving to the retainer and incentive payment. For the retainer, as note 3 in your document shows, the number continues to reflect 100% of the retainer being paid from NCOIL, not the ILF. Additionally, it contains the annual contractual increase of 3%. For the incentive payment, that number is based on a contractual formula involving a change in NCOIL net assets over a contractual base amount. As the overall NCOIL performance results increase, so does the incentive payment to staff.

Moving to conference expenses, the numbers are similar to years past and generally correspond with which locations we expect to have more attendance which means more expenses.

Moving to future location deposits – that number is based on how future contracts read, and they all largely mirror past contracts.

Moving to travel, we retitled that line a couple of years ago to “Travel/Legislator Recruitment” to also account for expenses incurred during travel that are for the purpose of legislator recruitment such as our annual legislator recruitment dinner at the National Association of Insurance Commissioners (NAIC) Fall Meeting as well as trips taken to state legislatures and state departments of insurance.

Moving to Professional Fees. The amount of $35,000 reflects NCOIL bearing all of the audit expenses and the ILF none, and standard accounting fees.

Moving to Miscellaneous – that number remains the same. Lastly, the D&O insurance amount remains the same, with NCOIL Support Services, LLC paying half of the total.

Overall, the proposed budget plans for an excess of $127,740.52 which reflects consistency and continued growth.

Mr. Melofchik then asked if there were any questions before turning it back to the Chair.

Rep. Dunnigan then reminded the Committee that there would be no vote on this budget today as this meeting serves as an opportunity to discuss any changes that should be made prior to the Annual Meeting in November where the Committee will vote to adopt the final version of the budget.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Carter and seconded by Rep. Meredith, the Committee adjourned at 4:00 P.M.

FINANCIAL SERVICES & MULTI-LINES ISSUES COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
FINANCIAL SERVICES & MULTI-LINES ISSUES COMMITTEE
2026 NCOIL SUMMER MEETING – BOSTON, MASSACHUSETTS
JULY 16, 2026
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Financial Services & Multi-Lines Issues Committee met at The Westin Copley Place in Boston, Massachusetts on Thursday, July 16, 2026 at 3:45 p.m.

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

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Sen. Tim Grayson (CA)
Rep. Michael Meredith (KY)
Rep. Michael Sarge Pollock (KY)
Rep. Edmond Jordan (LA)
Rep. Shaun Mena (LA)
Rep. Brenda Carter (MI)
Sen. Lana Theis (MI)
Sen. Paul Utke (MN)
Asm. Erik Dilan (NY)
Asw. Pam Hunter (NY)
Asm. David Weprin (NY)
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)
Del. Walter Hall (WV)

Other legislators present were:

Rep. Stephen Meskers (CT)
Rep. Kerry Wood (CT)
Rep. Elijah Pierick (HI)
Rep. Rita Mayfield (IL)
Sen. Willie Preston (IL)
Rep. Peggy Mayfield (IN)
Rep. Dennis Bramburg (LA)
Rep. Aimee Freeman (LA)
Rep. John Illg (LA)
Sen. Kirk Talbot (LA)
Rep. Michelle Boyer (ME)
Rep. Robert Foley (ME)
Del. Pamela Guzzone (MD)
Rep. David LeBoeuf (MA)
Sen. Mark Huizenga (MI)
Sen. William Gannon (NH)
Sen. Tim McGough (NH)
Rep. Kevin Norwood (OK)
Rep. William Slater (TN)
Sen. Cale Case (WY)
Rep. Pepper Ottman (WY)

Rep. Rolf Olsen (ME)

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 Asm. Erik Dilan (NY) 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 Asw. Pam Hunter (NY), NCOIL Immediate Past President, 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 April 19, 2026 meeting.

PRESENTATION ON INSURANCE AND ARTIFICIAL INTELLIGENCE – LEVEL SETTING AND DISCUSSING THE ROAD AHEAD

Asm. Gandolfo stated that first up on our agenda today is a presentation on Insurance and Artificial Intelligence (AI) - level setting and discussing the road ahead. I think it's important to continue to have discussions about AI throughout the year as there's still so much to discuss and learn on the topic and today, we have a very interesting presentation on insurance and AI on our agenda. There are still so many unknowns surrounding AI and insurance, and as the technology continues to advance so quickly, it can clearly provide a wide array of benefits to both insurers and consumers but some are concerned around things like unlawful and unfair discrimination, underwriting declinations or claim denials without a human in the mix. Throughout the country, bills continue to be introduced in state legislatures at a rapid pace concerning insurance and AI. So, in light of all this activity, this is a great opportunity to level set some things surrounding insurers' use of AI so that we as policymakers better know and understand how the technology is being used.

Steve Armstrong, SVP and Chief Actuary at Allstate, thanked the Committee and stated that I truly appreciate this time to spend with you on a topic that is moving quickly, creating real opportunity and raising fair questions for policymakers, regulators, companies and consumers alike. I want to start by saying what this session is not going to be. First and foremost, there will be no actuarial formulas or equations. This is not going to be a technical lecture. Number two, this is not going to be a tour through every algorithm, every model or every new AI tool that's out there in the marketplace. And this lecture is not going to be a discussion about where we treat AI like one giant mysterious black box. Instead, I aim going to try to keep this conversation practical. Reason being because for consumers, AI is not an abstract technology debate. AI shows up in moments that matter every day in their lives. In insurance, AI may show up when someone is shopping for insurance. It may show up when they're trying to understand coverage. It may show up when they're trying to get a quote. It may also show up when a claim is routed or reviewed, and it can show up when a company might try to explain a price change, a coverage issue, or a claims decision. So, today my preference is to ground all of this discussion in one person. I want to call her "Maria". Maria is going to be the focal point of our conversation today. Maria has just moved. Maria is shopping for auto insurance and homeowners insurance.

She is busy like everybody is. Maria is trying to make a good decision, but she may not know all the insurance terms that exist out there. She wants a fair price. Maria wants coverage she understands, and if something does not make sense to her, she wants someone to explain it in plain language. And that's going to be our anchor today. As we go through the discussion, I'm going to ask you all to keep Maria in mind as a reminder that insurance decisions affect real people at real moments.

And I want to also ground us in three questions to hold on to. I'm going to repeat these questions throughout the presentation. The first question that I want everybody to keep in mind is, what is AI doing? Second, does it affect Maria? And third, can the company explain the AI and stand behind it? I truly believe if we can answer these three questions, we can have meaningful policy conversations. You all, contrary to what I like to do, do not need to become data scientists to ask strong oversight questions. Sometimes the strongest questions are often the plainest ones. For example, what is the tool doing? Does it affect the consumer? And who is responsible? And that's going to be our frame for today. We're going to start with the consumer and talk a little bit more about Maria. I'm going to attempt to demystify AI a little bit. We're going to talk about different levels of consumer impact. We're going to talk about both the benefits and the concerns of AI to a consumer. They're important because they're both real. Then we're going to talk about accountability as well as trust. And then we'll end with what I hope is a nice practical watch list that you can use in legislative, regulatory, and/or oversight conversations.

So, where should every conversation with AI begin? It should start with the consumer. Maria does not walk asking whether or not a tool is machine learning or generative AI or predictive analytics or agentic AI, she obviously does not care about the label. What Maria does care about is the outcome. She cares whether that coverage makes sense. She cares whether that price is fair. She cares whether the company has used information appropriately, and she cares whether someone can explain the answer if she has a question. So, that brings us back to that first question. I want everybody to think through what is the AI doing? Maybe AI is helping Maria compare coverage options. Maybe, it's translating that goofy insurance language that sometimes doesn't mean a lot into plain language that Maria can understand. Maybe it's also helping a company process her information more quickly. Maybe it's supporting underwriting or pricing analysis. Maybe the AI is helping route a claim. Or maybe it's helping support a decision that can materially affect Maria. The point here is all those maybes are very different things. So, what is AI doing is question number one.

Question number two, does it affect Maria? Does the AI touch her price? Does it touch her eligibility? Does it touch her coverage? Does it affect her underwriting? Does it affect a claim? Does it affect her renewal offer? If the answer is no to many or all of these questions, then the oversight question might actually be on the light side. However, if the answer is yes, then the accountability question becomes much more important. And, then that brings us to our third question. Can the company explain it and stand behind it? This isn't just about producing a big technical report but telling everybody what the AI is doing. It is about whether there is a clear explanation, a responsible owner, and a path for review and correction. Maria should not be trapped in a maze where every answer is the system said so. Because that is obviously not accountability. A good accountability framework should make sure that when AI affects a consumer's outcome, there is still a company and real people within that company responsible for the result.

So this slide is an attempt for some potential audience participation. I'd like to have us all put ourselves in Maria's shoes for a moment. Maria is in the process of shopping for insurance. She takes out her cell phone, goes to her favorite AI of choice, and she types in, "Hey, I just moved

and I need auto insurance and homeowners insurance. I do not know much about insurance. Can you help me understand what coverage I might need? What affects my premium? And what questions I should ask before I buy?" This is a very realistic future. Frankly, it's already becoming a realistic present. People are looking to shop for auto insurance with their phones more often. And so, consumers are obviously going and using AI before they ever go to a carrier website, before they ever talk to an agent, before they ever visit a comparison site and before they actually get a quote.

The poll up here is a question if you were Maria in this situation. Which of options A, B, C, D or E and it could be all, none or many. There's not one right answer, but what do you think is which AI supported use case would be most helpful to Maria as she's beginning shopping for insurance? So, A: AI explains the coverage in plain language. B: AI suggests questions to ask before buying. C: AI helps identify maybe a coverage gap that she didn't know about. D: AI explains what affects her premium? E: AI tells her what company and price she'll pay? So, arguably all of these sound helpful. I think all of these would help me if I was shopping for insurance, but arguably each one of these five do not carry the same consumer impact. So revisiting number A, if AI explains coverage options in plain language, that is useful because it helps Maria become a more informed shopper. Going to option B, if AI suggests questions to ask, that's also helpful because it will make Maria feel more prepared. Going to C, if AI helps identify coverage gaps, that can be very valuable for Maria, especially since she's someone who just moved and may not know the local risks or coverage differences in the state. Now for D, if AI helps explain her premium that can help kind of demystify insurance and have her trust it more. And with E, if it recommends a company and an estimated price, that might be where I'd ask you to pause and go, how helpful is that to Maria? In theory, it should be. But now AI has started to move away from education and a little bit more into recommendation. And that recommendation may sound really confident, even though it may not necessarily reflect an actual filed rate, current underwriting eligibility, company's coverage details, or the most current information. And therein lies the caution here. As AI moves from education to recommendation, the need for explanation, accuracy verification and accountability increases. A simple thing to remember is that AI can be a map, but it should not be necessarily the destination. If Maria uses the AI to understand that landscape it can certainly help her. But if AI starts telling her where to buy, what it will cost, and what she qualifies for, then the questions become a little bit more serious. Because what information is AI using in this case? Is that answer even accurate? Can Maria verify it? And who's accountable if the answer is wrong?

Moving on, let's talk a little bit more about Maria. She just started shopping for insurance and she asked AI for some help. Now Maria she can shop for insurance. Maria gets a quote, she chooses coverage, she receives a policy, she eventually makes a claim and throughout she might need explanations for questions that she otherwise has. The point of this is that these are all very different moments in an insurance journey and AI can and will show up very differently in each one of these. So, I'd like to overly simplify and put these into two different categories. On the left-hand side you have a category of AI that supports Maria directly as a consumer because it might help her get started. It might help her compare those coverage options. It may help her understand what uninsured motorist coverage is. It may help her get that quote. It may help reroute her request to the right place, and these uses can make the experience for Maria faster, clearer, and obviously less frustrating. On the right side though, the category is it supports company decisions. This might include helping the insurance company with quote and underwriting information, AI might support pricing and eligibility decisions. It might influence coverage recommendations. It might help triage a claim. It might help support claim handling or even provide a claim payment, and it could help obviously generate explanations.

This second category here on the right is the one that deserves special attention because it's closer to decisions that affect Maria's outcome. One of the mistakes sometimes I hear is that in AI and insurance is that it's just "AI insurance" as if that's all just one big thing. And I'm here to argue that I don't think it is one thing. AI is a set of tools used in different places for different purposes that require different levels, or that have rather different levels of consumer impact. So, the practical question to then ask again is, where is AI in the journey? Is it helping Maria understand? Is it helping the company do processes? Is it supporting a decision, and is it shaping an outcome? These are very important questions, which I'll come back to in a few more slides. Again, AI is not necessarily one label, but sometimes we see these three terms interchangeably used. So, I thought I'd maybe kind of talk about each and try to offer a policy lens in consideration for each.

Starting on the left, machine learning and predictive analytics are definitely the most established of all the AI on this page, because insurers and actuaries like myself have been using data, mathematical models and professional judgment for a very long time, decades actually. The tools have changed, but the underlying discipline of analyzing risk, testing assumptions, validating models, and applying judgment is nowhere new. Predictive tools rather may help identify patterns in data that can't be seen. And in insurance, we kind of boil that down to saying it's supporting risk assessment. So, the policy lens when looking at AI and the lens of machine learning and predictive analytics is really how well is the AI assessing that risk? And maybe even more importantly, how fair is that assessment? Moving more into the middle, generative AI or Gen AI as it's often called, is very different. Obviously, it can create or summarize text. It can explain things in plain language. It can turn complex information into something easy to understand. And here I would argue that the policy lens is how accurate is it, and what review process or review exists, because a generative AI answer can sound very polished, even when it can be completely wrong or incomplete. And then moving to the far right on this page, we have agentic AI and this is the one that's emerging and this is where tools may eventually take steps across systems, route work, trigger different workflows or act independently as well. The policy lens here is authority and responsibility review because if a tool can take action, we need to be clear about what authority it has and who is responsible ultimately for that decision. Bringing the discussion back again to ask, what job is the AI doing? It could be finding patterns. It could be summarizing. It could be explaining. It could be recommending. It could be routing. It can be supporting a decision or it can be taking an action. The label doesn't matter; the role and the impact of the AI are what's important.

And then bringing that back to our customer Maria one more time, what matters is not whether the tool is called something. What matters to her is that the tool affects her quote, her coverage, her claim and her ability to get a clear answer. I would argue that this slide and what's coming up are maybe, in my opinion, the two of the most more important slides. Simply said, slide seven says different impact, different accountability. There is a spectrum of impact. On the low on the left side, on what we're calling lower impact end-AI can be used potentially for internal productivity. Could be drafting a memo, sorting documents, helping with some coding, summarizing information for employees. These uses still do need appropriate controls, but they are generally further away from a direct consumer outcome. As we move over to the right, we have things kind of in the category of consumer guidance. AI might help explain coverage and summarize those options. This can be very helpful as we discussed, but accuracy does matter. If Maria gets an explanation that is unclear or wrong, that can make for a very bad decision. As we move further to the right, we have a category called decision support. AI might support pricing decisions, eligibility decisions, underwriting and claims review. Now, we start to see that the consumer impact grows and the potential for negative impact becomes much higher.

And finally, on the right, I have what I'm terming "consequential outcomes." These can be non-renewals, claim payments, material premium changes or other decisions that meaningly affect the consumer. And the rule of thumb here is very simple; scrutiny should rise as AI gets closer to material consumer outcomes. And that's the practical principle here every day, and it helps avoid treating every AI function like it carries the same risk. And it avoids pretending that high impact AI uses are just ordinary automation. The spectrum's important to determine where that scrutiny threshold plays out over time. And then bringing it back again to Maria, AI that explains a coverage term is different from AI that affects her when she might be looking for coverage, or what she pays in premium, or what happens when she files a claim. The more AI moves the outcome, the more the company needs to be able to explain it and stand behind it. That does not mean, though, that every step needs to be manually approved by a person. But it does mean that the controls, the testing, the documentation, the explanation and the escalation should match the level of impact on the consumer.

The next two slides address how AI can help consumers, and how AI can harm consumers. Two sides of the same coin. So how can AI help Maria? If used well, AI can make Maria's experience faster, clearer and more consistent. When Maria is shopping, she can compare options side by side. It can help explain coverage in plain language. It can speed intake and review, so she is not stuck repeating the same information across multiple channels. And once she has that coverage, arguably AI can help route a claim more efficiently. It can help explain what changed and why, and it can support smoother service because in insurance we all know clarity matters, speed matters, and consistency matters. We also know many consumers find insurance confusing. They may not understand what a deductible or a limit or endorsements or exclusions are, and AI can help translate that complexity into plain language, and that's no small benefit. If Maria as a consumer can better understand what she's buying and the advantage to her, she's more empowered. If she can get a faster answer, she's less frustrated. If a claim or service request gets routed more smoothly that can improve her experience at a very stressful moment. In short, Maria should benefit from better tools and technology. However, AI can go wrong. The same tools that can help her, can also disadvantage her if they're not governed well, and there are several ways that this can happen. The first one could be wrong data. If the information going in is wrong, the answer coming out is very likely to be wrong. That is true, whether we're talking about AI or any model. Quite practically, bad input usually leads to bad outcomes.

The next slide addresses unfair data patterns. A model might find a pattern in the data, but the company still has to ask whether or not that pattern is appropriate, fair and legally permissible. A pattern is not automatically a good reason just because a model found it. Third, poor explanations. An answer may be technically complex, but consumers still need plain language explanation of all the main reasons. If Maria cannot understand why something happened, then trust begins to break down. Fourth, no responsible review. If something goes wrong, Maria needs a path to a real answer, not a loop, not a dead end, not the system said so, a true path. And fifth, and maybe most important is overreliance on AI. This is a real risk. The tool may be treated like the final answer instead of support for human judgment, document and review and controlled decision making. The strip at the very bottom of the slide shows what things can go off track. Because data's going to feed a pattern, a pattern can support a decision, a decision's going to need an explanation, an explanation therefore may need a review and a review may need a correction. A weak link anywhere in that chain can definitely harm Maria. If the AI affects the data, the pattern, the decision, the explanation or the review process then accountability truly needs to follow.

I'm going to now talk about accountability. Accountability is the principle that people remain responsible. When AI begins to affect Maria, real people remain responsible for the decisions,

the explanations, the documentation and the review. That does not again mean a person must manually approve every AI supported action because that's not realistic, and it may not even be necessary for some of those lower impact cases. But it does mean that the company must be able to stand behind that process and that outcome. And so, again, looking at the slide here for the lower-impacted AI, monitoring and quality checks may be sufficient for accountability. But for medium-impact AI, as you may expect, which could include document review, exception handling and escalation, more controls need to be put in place for accountability. On the far right for high-impact AI, especially where AI affects price eligibility claim payments renewals or other meaningful consumer outcomes, way stronger human review and documentation are appropriate. So, the four things that I believe when you put together create an accountability package are a clear explanation, documentation, a responsible owner, and a path to review for correction. And if companies honestly want to keep using increasingly powerful tools in consequential areas then they need to build the accountability muscle that earns confidence. For Maria again, the question is very simple. If AI affects my price, my coverage, my claim, or my renewal, can that company tell me what happened, who owns it, and how I can get it reviewed if something goes wrong? That's not too much to ask. That's what she's owed.

Moving on, I want to talk a little bit about transparency. We talked earlier that accountability is about whether the company owns the outcome. Transparency on the other hand is about whether others can understand enough to hold that company accountable. And so, the important thing here is to not say a person reviewed it because that's not enough for transparency. It may be part of the answer, but definitely not the full answer. The company should be able to explain what happened, who owns that result and what review occurred and how can a consumer seek correction. This does not mean that every consumer needs a technical explanation of the model. Most consumers don't want that. What she needs is a clear answer to these questions: What role did AI play? Why did it matter for her? Who was accountable for the results, and how can questions or corrections be handled? These are the four prompts on the slide: what, why, who, and how. Again, it goes back to what did AI do? Why did it matter? Who owns the results and how can it be reviewed or corrected. That is transferable and usable transparency. And it's not transparency for show. It's transparency that helps a consumer, a regulator, or an oversight body understand the issue and act on it. And one more very important point is that transparency also has to respect privacy. The goal is not to expose any private data unnecessarily. The goal is to identify the type of information used, explain why it was relevant, and confirm that it was handled appropriately. So, transparency is not for just dumping information; it's giving a clear, useful answer to the consumer.

Moving on, building on the framework, it's important to know that there are existing frameworks because then we might not necessarily have to start from zero. There are already several accountability structures in play. First, one thing I hold dear and near to my heart is actuarial professionalism. Credentialled actuaries are required to work under professional standards. These standards address things like risk classification, modeling, validation assumptions and professional judgment. That matters because actuaries have long worked with data and models that affect insurance operations and outcomes. Second, maybe the most important thing on here: company governance. Companies need internal controls including documentation, record keeping, model testing, validation, risk assessments, privacy controls, cybersecurity controls, and ongoing monitoring. These are not optional extras when a tool or technology affects consumers, they are part of a responsible operation. And third, state insurance oversight, state insurance regulators already have important authority through rate and form review, market conduct exams, and consumer protection tools. So, the opportunity here is to potentially build on existing oversight where it fits while also asking whether AI creates new questions that need clearer answers.

Moving on, what builds trust in this world of AI? Trust is obviously not assumed; trust needs to be earned. And when AI supports an insurance decision, I think there are four practical signals of trust for us to consider. First is a plain language explanation. Not every technical detail, not a 1,000 page model document, but a clear explanation of the main reasons that matter to a consumer. Second, clear accountability by the insurer builds trust. The company cannot point to the tool as if the tool is the accountable party, the company is accountable. Third, testing and review by qualified professionals, including credentialed actuaries where any actuary or pricing work is involved. If a tool supports pricing, underwriting, risk class or other insurance decisions, that review needs to be done by people who are qualified who understand that work. And fourth, a path for review or correction. This may be the most human signal of them all, because consumers know that mistakes can happen. What they want to know is whether the company will listen, review and correct when appropriate. I might just want to add that none of these signals is enough by itself because an explanation without accountability is weak. Accountability without testing is incomplete. Testing without correction paths may not help a person like Maria, and a correction path without a clear explanation leaves people frustrated. But together they definitely build trust. So, for Maria again, trust does not come from the company saying do not worry we use AI responsibly. It comes from the company being able to answer here's what happened, here's why it mattered, here's who owns it, here's how it was tested, here's how you can ask for a review, and that's how I would argue trust is earned.

Moving on is what I am terming a practical legislator watch list. These are the questions that I hope can help in hearings, in oversight discussions, in bill drafting, and in conversations with regulators and companies. First again the role: What is AI doing? Do not stop at the label. Ask what the tool is performing. Number two, use: How is AI used? Is it internal? Is it consumer-facing? Is it advisory or is it part of a decision process? Third is impact. This is the hinge question. If the tool touches price, eligibility, coverage, claims, renewals or explanations, the stakes are arguably that much higher. Fourth again is accountability. Who is accountable and how can issues be corrected. If no one can answer that, that's a red flag. Fifth is an explanation. Can consumers get a clear explanation, not a technical dump. Sixth, testing - is testing and review matched to the impact. The higher the impact, the stronger the testing documentation review and monitoring should be. This watch list then supports a balanced policy focus across three different dimensions. Risk-based governance, consumer impact thresholds, and regulator access and documentation. This avoids treating every AI use as equally risky. It avoids ignoring high-impact uses, and most importantly, it keeps the consumer at the center. For Maria, this is simple: if it affects her, someone should be able to explain it; if it materially affects her, someone should own it. And if it's wrong, there should be a path to review or correction. This slide is something that you may want to be able to refer to later if helpful. In the actuarial profession, the American Academy of Actuaries, the Casualty Actuarial Society, and the Society of Actuaries are consistently publishing and researching AI and so that might be a nice resource as you're discussing this. Again, and in conclusion, the three questions I wanted to leave with you is the Maria test. If Maria's affected, can the company answer these three questions: What did AI do? How did it affect her outcome? And can the company explain it and stand behind it? That's the test because consumers deserve a clear answer and a responsible owner.

Asm. Gandolfo asked how has AI improved underwriting accuracy or claim outcomes? Are there any data points that you can provide or just a general thought on it?

Mr. Armstrong stated in terms of pricing or data accuracy, AI helps detect patterns nicely so it can detect data anomalies in ways that we might not be able to see today or humans might be missing. So it can help in terms of verifying that information's coming in and that it looks

appropriate or if it doesn't, it could flag something that might need extra review. So, I think it helps with data accuracy and some of the verification opportunities there. It's also helping us surface things like in that machine learning and predictive modeling world that I was explaining - AI is surfacing risk assessments that we may have never seen before that might be appropriate but need to be tested again obviously for bias and legal permissibility. So, it's opening the doors for better risk assessment, which arguably is better for the consumers because it allows us to price them more appropriately.

On the claim side, where I've seen AI most effective at this point in time is at that crucial moment when a consumer calls in and says, "I have a claim." In many cases today, you might call the insurance company and what will happen is that you might get a claim adjuster on the phone with you right away. That claim adjuster is supposed to treat everybody's claim through a certain protocol, the same way with the same dignity, respect, etc. But not all humans are the same. We want to have everybody have a very consistent start to their claims process. And so where I've seen it come in is helping everybody have a very consistent way of being able to say here's what happened, and here's how I reported my claim. The AI will ingest that, it'll transcribe it accurately, it'll confirm things appropriately and get everybody started on the same foot from a consistency standpoint. If a claim happens, it'll assign a claims adjuster at the same time and then what it can do is it can help you as a consumer who just had a claim stay very well informed throughout the path of the claim versus waiting for a claim adjuster to call every week and do a follow-up for you. So, it helps with consistent claims handling. That is claims intake at the very beginning and then keeps consumers more well informed throughout the claims process as well so that it can make sure that there's never a question that you have and you know everything that's going on every moment of time.

Rep. Ellyn Hefner (OK) stated you just described a process for claims. How do you disclose that to a customer or a client? Is that disclosed and what does your company do to disclose that? Mr. Armstrong stated, yes, at least at Allstate, our goal is to make sure that we know the consumer knows they're interacting with AI. So, the on front would be a disclosure like, "Hey I'm Steve. I'm your digital assistant here to help intake your claim." And so the consumer theoretically knows right away that I'm not talking to a human, but I'm talking to some AI and maybe the consumer likes it or doesn't. If they don't, they can opt out of it and reach a real person. But we try to inform them right up front that they're interacting with something artificial so that they can be aware and that may lead to different reactions and consequences.

Rep. Hefner asked Mr. Armstrong if he used AI for his presentation? Mr. Armstrong replied that he did. It helped me prep. I don't work with legislators on a day-to-day basis so the first thing I asked AI was what are the major concerns that legislators have concerning AI? And while AI can be wrong, it gave me a very good starting point to go off of.

Asm. Gandolfo stated as a broader industry trend, do you anticipate the use of AI eventually displacing some workers in the insurance industry? I know some of the items in the slide deck talked about document review and that kind of clerical work. Is there any thought on what it looks like five years from now as AI gets a little more ubiquitous in daily operations? Mr. Armstrong stated yes, but while we are cognizant that certain tasks are likely to be changed by AI in the future and that could be a part of someone's job or maybe someone's full time job, we want to think about upscaling them to do jobs in an AI world so that they don't have to lose their job. They just have to start learning new skills and do different things. And so, I think the answer will be yes, but if we do our jobs well, they will have different and equally meaningful jobs that they didn't have before. So, they might lose something but hopefully gain something in return.

Rep. David LeBoeuf (MA) stated I have a question regarding the experience with the AI agent. What guardrails do you have in place about making sure that the input into that or that interaction with the AI agent is accurately collected in the way that the consumer is actually putting it in, and the reason why I am raising this is I know there is a case in another state where a police department was using AI to enhance their police reporting, and it actually had ruined cases because of the way the AI did it. It didn't accurately capture what was said or what was visible because it polished it and it tanked a couple of cases. I know there's a couple of other states that have legislation around medical note dictating, making sure that the technology doesn't basically upcharge so that way the medical notes or something similar are coded in a way to bill the insurance companies more money. So, what guardrails are in place, whether it's your company or the industry, currently to make sure that the actual information is not polished in a particular way to present a different picture than the consumer is presenting?

Mr. Armstrong stated I hope I understood your question well enough that this answer works. If it doesn't, I'll be happy to talk more offline with you. But I think a lot of it goes into rigorous testing protocols, quite honestly. So, it's impossible to think of every element that could possibly be out there, but as you're trying to test an agent to be able to do and perform certain tasks and take inputs and then create outputs, you have to think through all the different ways that it can be input and test whether it's the accurate output. And so it's consistent testing to make sure that it's doing what it's supposed to be doing and not doing something like polishing or potentially hallucinating or anything to that extent. And it just requires a really robust testing protocol up front and then monitoring on the back end to make sure that if it does start to slip or does start to do something that it shouldn't, that it can be caught quickly and remediated back into compliance. So, I think the answer that comes to mind for me is just rigorous testing and monitoring thereafter after the fact. So that's maybe not exactly a guardrail, but it's a requirement I think operationally to make it work. But I'm looking at you and sensing that maybe I didn't understand your question completely.

Rep. LeBoeuf stated you did. When you have a call with a human, you can go back and listen to the call in case there was some error that was made. With AI, you can't necessarily always go back and trace it unless it's designed in a particular way that allows you to. Mr. Armstrong stated, yes, that's fair. I think there are steps with a lot of AI that you have to obviously ensure that it will document what it did and why it did what it did so you can have an audit trail going backwards. So if something is wrong, you can go back and go, "Oh, this is why it went wrong because this was unclear to the agent when we programmed it. We told it to do this and we thought it was doing this, but it just didn't do it." So now you can see that from the audit and kind of correct it. So, there are some of those audits, catching things as quickly as real time as possible so consumers aren't harmed which is obviously the most important part. But there should be ways that companies can go back and audit and not just say, "It made a decision. I don't know why it did that." If you ever hear that then that's not responsible use of AI.

PRIVATE CREDIT AND INSURANCE 101

Asm. Gandolfo stated next up on our agenda is a 101 presentation on private credit and insurance. And before we begin, I'd like to note that this next presentation is closed to the press. So, if there are any press in here, which I don't believe there are, please leave now. Now, private credit is a topic that has gained a lot of attention recently as there are some concerns about insurers who hold private credit having an illiquid investment and therefore, it's a hard to sell investment that might negatively impact paying claims. But similar to what we just heard about with AI and insurance, there are a lot of unknowns and misconceptions surrounding

private credit and insurance. So, this is a good opportunity today to provide some baseline understanding of some of these things.

Bridget Hagan, Managing Director & Global Head of Insurance Regulatory at Blackstone Credit & Insurance stated we really appreciate the opportunity to be here and we are going to try to keep the formal part of this presentation as brief as possible to allow as much time for questions as we can. Please don't hesitate to raise your hand as we're speaking. Blackstone is the world's largest alternative asset manager. I'll take a second just to talk about our presence in the insurance market and why it might be of interest to you all as state legislators that are focused on insurance policy. Of our $1.3 trillion in global assets under management, about $280 billion of that is investing assets for insurance companies. Blackstone does not own a majority stake in any insurance company on balance sheet. We have in our insurance asset management business and what we call an open architecture model because we would like to manage assets for as many insurance companies as would like to do business with us around the world.

Today, that's about 40 or so insurance companies that have independent contractual relationships with us to manage one or more categories of assets, many of which are private credit assets. So, I am very happy to answer more questions about our place in the market but just to sum all of that up, we are the largest arm's length, third party manager of private credit assets for insurance companies and particularly in the U.S. So, with that background, before I turn it over to my colleague and we can get into some of the specific assets and specific questions, we just wanted to spend a moment on the history of how did we get here and why is this happening in insurance investing.

As mentioned, this is in the news and I'm sure you're talking to folks about it in terms of other policymakers and insurance companies, and you're I'm sure very familiar with the low for long interest rate environment that did create some pressure on insurance company investing. That's very true and very much part of this picture but one of the phenomena that we think is a little bit under discussed in this conversation is that for much of the history of insurance company investing in the U.S, insurance companies had a high percentage of assets on their balance sheet that were relatively illiquid, specifically corporate bonds. Corporate bonds essentially didn't used to be nearly as liquid as they are today, and assets that are not liquid in general feature what we call an illiquidity premium, which is just a little bit of extra yield that you have to pay investors for the fact that they're not widely tradable on an open public market. That illiquidity premium is about 1.5 to 2 percentage points of yield relative to public assets. So, hearkening back to the corporate bond phenomenon, when corporate bonds became more liquid, among other reasons technology advanced and you had electronic trading platforms, the yields on corporate bonds decreased because you weren't getting that illiquidity premium anymore. And so insurance companies really needed to find another source of yield to capture that illiquidity premium and I know you all know this as legislators that deal with insurance every day, but relative to banks, for example, that have overnight deposits, insurance companies and life and annuity companies in particular are very good holders of illiquid assets. They're not great holders of credit risk, as you know, but their liabilities, the long duration liabilities, match up well with assets that feature that illiquidity premium. We just wanted to pause for one second and explain that this decrease in the yield on corporate bonds because they became more liquid is part of why private credit is growing as a percentage of insurance company balance sheets.

So, with that background, I will just briefly talk about how we at Blackstone define private credit and I think our definition is in line with a common definition in the financial markets. You all know obviously that there is no single agreed upon global definition of private credit so it's probably worth taking a second to talk about how we view what is private credit. The most important

component of private credit is that you are taking the borrower directly to the lender and matching them up directly. The distinguishing characteristic of that is that you're somewhat disintermediating the banks from that relationship. We partner with banks all the time. Banks are obviously hugely important to lending and to the overall financial markets, but there are some circumstances where it is appropriate to bring the borrower directly to the lender. What that does is cut out bank fees and so that 1.5 to 2 percentage point difference in the yield is largely attributable to the elimination of bank syndication and bank lending fees.

One last thing about what is private credit relative to other forms of credit, public credit, is that the credit rating, the credit opinion and assessment by credit rating agencies regarding that loan, regarding that security, is private. Meaning that it is available. The private credit rating itself is available to the contracting parties and to the National Association of Insurance Commissioners (NAIC) and the rating rationale report is available to the contracting parties and to the NAIC. But it's not public on the website of rating agencies often and maybe most commonly at the preference of the borrower. So you might have smaller companies that are not public companies that are issuing debt and they need that debt rated and insurance companies want to buy it, but it is not beneficial to that company to have that information out available to the public and might, for example, include trade secret information. However, as my colleague can speak to better than I, having worked at a rating agency, under federal law, the methodology and every other aspect other than the publication of that rating is identical to a public rating. Rating agencies must use the same methodology for public and private securities, and they must put those methodologies out for public comment when they're developed and upon any change. So, I'll wrap up on what is private credit by just saying there is a lot of conversation about ratings and private versus public ratings. They're identical in the development and the output. The only difference is whether it's publicly available on a website.

Rep. Stephen Meskers (CT) stated private credit lacks clarity and valuation. It's not very well defined on a maturity schedule sometimes because private credit many times is financing to a bridge to nowhere, assuming there's a refinancing opportunity. Our insurance industry is probably one of the last bastions of security. The agencies did a horrible job during the mortgage crisis in rating publicly traded securities. Now you're talking about insurance companies buying privately rated, non-disclosed ratings to acquire debt that doesn't have a secondary market valuation. I can't understand why I would want my insurance companies to own anything that doesn't have an ongoing market valuation on a bid and offer and an idea of the spread and the risk. Because you are ultimately taking me to a bridge to nowhere and I think they can do that in their equity portfolio. They can take the credit risk that they determine in publicly traded equities or even some privately traded equities, but when I go into the debt markets and I start putting people into securities that if there is a rush to the exit, there is no bid and there is only offers. I can't imagine why I would want my insurance companies locked up in that business unless it's for a speculative portfolio. I just don't understand.

Caitlin Colvin, Managing Director of Insurance Regulatory Solutions stated I think it's a completely fair question. Maybe we can bucket the two points. It sounds like one is valuation, and one is more what are we financing and where is the off ramp? Rep. Meskers stated and liquidity. Ms. Colvin stated I think we can speak to what Blackstone does and a lot of times what we're what we're talking about when we're talking about what Blackstone does is what we view as a best practice. So, let's start maybe with that sort of bridge to nowhere point and what we typically are financing at Blackstone on the private credit side of the world. I think what you are talking about is that sort of private direct lending bucket - that lending to middle market sponsor-backed companies. Blackstone has 20 plus year's experience investing in that type of product and I think when you hear our COO and President talk about this, you talk about the

underwriting and how important it is. We are not talking about credit ratings at all in this case. We are really talking about the underwrite and where are you on the loan to value? And this really gets to your valuation point. And Ms. Hagan and I sit on all of our investment committees and we think about is this an asset that makes sense for insurance companies to hold. And in many cases, those direct loans are not appropriate assets for insurance companies. You're absolutely right. They're typically rated non-investment grade in and of themselves. However, they're also typically very low value particularly when you look at a track record of a company in the higher and upper middle market range that really has a track record. I think there's also a distinction across companies of who you would lend to as well. So, when you're thinking about what we do, you're looking at senior secured loans at about a 30% loan to value and we can talk about that value and a lot of this has come up recently in the software space, for example. Those software companies were overvalued, and a lot of that led to a handful of news stories about some idiosyncratic issues. But that's just what we're seeing in that market, it's pretty idiosyncratic. And the minority of what we do is that kind of thing and where we are lending to any software company, the loan-to-value is very low, and we are a super senior lender.

Rep. Meskers asked if the origination is to sell out 100% or do you retain a portion for your own risk portfolio? Because I think that's very important too. Because if you're originating and selling out 100%, the only person holding the bag is the owner and there's always an argument that should you have skin in the game. Ms. Colvin stated when we're talking about the direct lending, they're just debt investments. If there is a Blackstone equity component alongside of it, it's likely small for the alignment of interest point. But when we think about what we do, we are an asset manager so we are originating that loan for our clients to hold and take that yield.

Ms. Hagan stated that we are a fiduciary for our insurance company clients by law and by contract. The distinction between what Blackstone does and what banks do is that banks will originate assets and move them off of their balance sheet for a lot of reasons. We originate an asset, and the same team manages and monitors that asset through the life of the asset in partnership with our insurance clients. And that is actually skin in the game and alignment of interest that we think is really important. We are on the hook. We are only in this business as long as we manage assets carefully for insurance clients. We're not originating assets and moving them off of our balance sheets. We're responsible for their performance.

Ms. Colvin stated that's absolutely right and I do want to go back to the insurance company holdings point because I think this was really your point in terms of are these really assets that make sense for insurance companies? This is not the majority of what we do for insurance companies in any way, shape or form and in many cases, our insurance clients are holding this type of credit exposure to middle market companies through a securitization form. So, there's diversification in that pool of assets that are in that transaction and the insurance companies are typically holding pieces of the debt that are very highly rated and are nowhere near the first loss. So you're sort of holding that call it triple A to single A rated and I know your point on the public ratings. I get it. Rep. Meskers stated I think we got those triple A ratings on the mortgage portfolios. Ms. Colvin stated you do but the NAIC now rates all of those and totally, you can't rely too much on the ratings, but you can rely on the underwriting. And that's really where we're telling our clients and how we're explaining this stuff to our clients. We're not saying "hey, here's your triple A rated thing, take it and go home." We're not doing that at all. But I will say most insurance companies are not holding these things individually directly on their balance sheet. They're holding them in a pooled form, in an entrenched form and not the first loss piece.

Ms. Hagan stated that stated one quick thing I wanted to add is this piece of the conversation I think sometimes gets lost - we talk to our clients all the time about asset liability management

and about the reason that these assets are important to reducing costs for consumers and increasing the availability and the affordability of insurance. It is very important to outcomes for consumers that insurance companies can invest in high-quality assets. On the illiquidity point, which gets back to the liability side of the balance sheet, we help our clients run cash flow testing. Every insurance company is doing that obviously; you need to do that. You can't be using your illiquid assets to pay liquid claims. That's why, for example, in the health insurance and property and casualty space, private credit will never be as large a part of their balance sheet and we are very mindful of that. But it is appropriate in our view for companies with long-duration liabilities to be holding long-duration assets. That's good governance as long as everyone understands that they have more than enough liquid assets to pay claims. Which is part of how we support them in that modeling.

Ms. Colvin stated I want to come back to your evaluation question in a second, But I think when you think we have a slide on this in the deck that talks about what we typically do for our insurance clients, and where are we spending most of our time. These days, we are spending most of our time on private transactions that are infrastructure or project finance related. You're financing hard assets so you're looking at something like power generation for a data center complex for Meta or Google or one of these hyperscalers that's currently investment grade rated. And in financing those assets, particularly for insurance companies, what we are most sensitive to is that debt amortizes or pays down in connection with a contract that is required to pay no matter what happens like a triple net hell or high water lease or contract. And that is really where we're focused these days and the majority of what we're originating for our insurance clients and we think these are really appropriate assets for insurance companies that are helping finance the real economy and they're long-dated and contracted.

Rep. Meskers stated in the banking crisis and going into the banking crisis, the bank originators no longer had that fiduciary responsibility in origination and sale. Are you telling me the asset managers do have a fiduciary responsibility in origination and sale? Ms. Hagan stated I can't speak to the legal framework around banks as I'm not a banking regulator. Rep. Meskers stated during the crisis it was fairly common that they didn't have that. It was more of a buyer beware. Ms. Hagan stated that I can speak to Blackstone's situation, which is we are a registered investment advisor subject to fiduciary responsibility rules and by contract, we accept fiduciary status and eagerly. It's not a reluctant thing we do at all with each of our insurance clients. We take that fiduciary responsibility very seriously.

Ms. Colvin stated so we talked about two big buckets of private transactions. We talked a little bit about the direct lending and that's not a huge part of what we're doing for insurance companies so it wasn't a major part of the slide presentation but really appreciate you asking because it's a really important point. So we talk about this bucket of infrastructure assets and financing the real economy. As you all know, and from your states you see it, there's a massive capital expenditure (capex) boom across all things relating to AI. We just had a really great AI presentation and that needs power, that needs data, and in order to do that, that requires a big build and a whole bunch of capex. So, those transactions that we're looking to help insurance companies invest in and be able to help finance that real economy at a little bit of a higher yield from public bonds, but at the same or better credit quality plus contracted cash flows and security over a real asset. We view this as a really attractive asset class for insurance companies and we're seeing a lot of these deals come in just given where everything lives today and what the world needs financed. Insurance companies are just a part of that. And then the other big bucket that I would say of assets that we look at on a private basis are private asset backed securities and we already talked a little bit about this, private middle market collateralized loan obligations (CLOs), which are those direct lending loans that are in a pool.

So, we have a little bit of information around what is the difference between a public and a private securitization or an asset backed security transaction. The answer is nothing other than the fact that the rating itself is more than likely private and not publicly available on Bloomberg or publicly available on the rating agency website. But both public and private securitizations have the exact same structures. They have the same type of collateral in them. Now, what collateral you focus on is very important when you're thinking about an insurance company. At Blackstone, when we're talking about securitizations, what we're typically talking about are high FICO secured consumer loans or residential mortgage loans or anything else financing hard assets or the real economy. We love doing that. So, any of those types of assets, typically in loan form, you can take those loans and pool them together and receive a diversification benefit. If one loan goes wrong, you still have all these other really great loans that are still paying and you have a capital structure in the debt that is protective and most of the time insurance companies sit at the top of that capital structure. And this is just an example just from creating the loan and originating the loan to putting them into a special purpose vehicle (SPV) to essentially issuing different tranches of debt, and those insurance companies stay at the top of that debt capital structure.

Ms. Hagan stated I want to add one point that isn't related to any of the specific asset classes that we discussed, which is with private credit it's important for everybody to understand this asset class why it's on insurance company balance sheet? Look under the hood. It's important for insurance companies to know what they're investing in and to be really comfortable in terms of underwriting, etc. I will just say that private credit is really not new and you've probably heard this, so forgive me, but a great example of it is that a lot of private real estate transactions in this country were insurance company lending to build things like the Empire State Building which was financed by MetLife. And one other last point I would make on a related note is that we are not obviously exclusively engaged in private credit lending with insurance companies. In addition to other asset classes, we have a lot of strong partnerships with sovereign wealth funds and public pensions specifically in the states, and that's something that's gone on for many years. Again, we do a lot of work with the states, including across asset classes but also including private credit. It's just those types of investors haven't been so much at the forefront of the conversation but I wanted you to be aware that they're very much part of the ecosystem.

Asm. Gandolfo stated this was a great presentation and this was 101 style and it does sound like there is interest in this and we might have to revisit this topic again in the future.

DISCUSSION ON FEDERAL EXECUTIVE ORDER "ENSURING A NATIONAL POLICY FRAMEWORK FOR ARTIFICIAL INTELLIGENCE"

Asm. Gandolfo stated now we will turn to our final presentation, which is a discussion on the federal Executive Order (EO) titled, Ensuring a National Policy Framework for AI. As a reminder, NCOIL did recently adopt a resolution affirming the U.S. state-based regulation of AI in insurance, which is consistent with the McCarran-Ferguson Act. Since the passage of the McCarran-Ferguson Act, states have consistently exercised primary authority over the business of insurance in a manner that protects policyholders and claimants, ensures insurer solvency and promotes fair, competitive, and stable insurance markets. Against that backdrop, NCOIL and nearly everyone interested in the state-based system of insurance was troubled by the issuance of this federal EO that essentially aims to preempt states' ability to legislate and regulate AI. Whether the EO can actually preempt states is an interesting question and we'll hear today information about that and about the EO and the practical implications for the states.

Oliver Engebretson-Schooley, Partner at Sullivan & Cromwell, thanked the committee for the opportunity to speak and stated that stated that I will preface that with I am not an AI expert, so if you have technical questions about AI, we're going to have to bring Mr. Arnstrong back in here but I can talk to you about what this EO means, and probably more importantly, what it doesn't mean. I won't bury the lead here. I'll get into this in more detail, but does this EO preempt state law? No, it does not. And that's true for any state law. Not just the state laws regulating insurance although as Asm. Gandolfo mentioned under McCarran-Ferguson, as many of you likely know, state insurance regulations are specially protected from federal preemption. So then, what does this EO do? It's really a roadmap. It lays out the administration's policy on the regulation of AI, and then it provides a roadmap of strategies for how the federal government might go about implementing that policy and making it a reality. And it's some of those strategies that I think are actually much more interesting, and that I'll talk a little bit about today. Some of them are already being implemented beyond the preemption question and we'll talk a little bit about what that means for state regulation of insurance. The EO was signed in December 11, 2025 and naturally spurred a lot of hand wringing from folks who from state legislators and regulators who are interested in regulating AI, it says it right there in the beginning the purpose of this EO right at the top is to create a national framework for the regulation of AI and limit states' ability to regulate the industry. Again, as I mentioned at the top, this EO does not preempt state law. It is purely precatory. It does not purport to preempt state law, and in fact it cannot, and I'll get into why in a moment. It doesn't actually impose any binding requirements at all on states, on developers, or on users.

Just taking a step back briefly, what is federal preemption? How does it work? So, this is a doctrine that's founded and grounded in the U.S. Constitution's Supremacy Clause which states that the laws of the U.S. shall be the supreme law of the land and courts have interpreted that to mean that Congress can enact laws that preempt state laws. So, Congress can do this in a couple of ways. It can be explicit about it. Like the federal Employee Retirement Income Security Act of 1974 (ERISA) explicitly preempting state laws that conflict with ERISA is a good example of that. It can also do it impliedly where courts interpreting statutes decide that Congress's intent, even though they didn't say it explicitly, was to preempt state law. And this can show up in what's called field preemption. So, that's when Congress passes legislation and then there's additional regulation so pervasive in a space that courts just say, look, Congress clearly here was intending to occupy this entire space, occupy the field, and states just can't go there. You have no authority to regulate in this space, regardless of whether there's any actual conflict between a state law and a federal law. States just can't go there. The other form is conflict preemption. This is much more common. That's when there is a conflict between a state law and a federal law. So, requiring someone to do one thing when the federal law requires another, or even when a state law is determined to prevent the objectives of the federal law, they can find preemption there as well.

But the key point to take away from all of this is that preemption requires Congressional action. But, to be clear, that does not mean that Federal regulations cannot preempt state law. Federal regulations are law, and agencies are creatures of statute. But they have to be acting within congressional authority that has been granted to them. They cannot just go out of their way and say, "I want to now regulate this space." And the Supreme Court has actually said that even sometimes EOs can preempt state law but in those narrow contexts, it's when Congress has said, "White House, you can regulate this particular space." And so, the White House has congressional authority to issue regulations that then preempt any state regulations in the same area. An EO cannot on its own without any sort of congressional authority, nor can an agency, just say we are now preempting this state law. So that's the general framework for preemption. As I mentioned, and again, as many of you are aware, state regulation of insurance is unique

because under McCarran-Ferguson, states are actually given the benefits of what is sometimes called reverse preemption or anti-preemption. So, when a state law is specifically enacted to regulate the business of insurance and the relevant federal law that has some sort of conflict is not specifically to regulate the business of insurance, the state law controls.

So, let's turn back to the EO and its key sections, which I've summarized up here on the slide. So, section two sets out the federal policy. As I mentioned, it's to sustain and enhance the U.S. global AI dominance through a minimally burdensome national policy framework that would displace what the federal administration has called a patchwork of state laws. Section three then directs the Attorney General to set up a litigation task force to challenge in court state AI laws that it views to be inconsistent with the policy laid out in this order. This one's particularly interesting, and we'll talk about it a little more in a moment. Section four and five, this directs Commerce to evaluate current state AI laws to identify ones they consider to be onerous and that conflict with the policy in the EO and then commerce can either refer those to the litigation task force or the EO also directs Commerce to come up with a framework for restricting certain grants and funding to states that have these laws in place. And then sections six and seven direct the Federal Communications Commission (FCC) and the Federal Trade Commission (FTC), two agencies that do have regulatory authority that has been found to preempt state regulations, and directs them to investigate "can you use these existing authorities to try to preempt state regulation of AI?" And then section eight says, "Let's come up with a legislative proposal that we can then present to Congress to actually put in place a federal uniform regulation of AI." So, then back to the key question that we started with what does this EO do? As I said, the key takeaway today should be that it does not and cannot preempt state law. It is just precatory and as I said, it does not purport to. It does set out executive policy on AI regulation and then provides this roadmap of strategies that I mentioned. At the moment, it does not seem that there is much appetite in Congress to create this national framework that was mentioned in the EO which would give agencies the authority to start issuing regulations that might preempt state law. And the White House can't do that on its own.

And again, even if there were congressional appetite at the moment to enact this type of broad legislation, under McCarran-Ferguson that still would not preempt states laws regulating the business of insurance unless that new statute specifically said this is to regulate the business of insurance. So there's that additional protection there even if Congress were to act here. And then I mentioned the FTC and the FCC. They do have authority to issue regulations that can preempt state law. They could, in theory, develop these regulations. So far, the FCC, I am not aware of them taking any particular action. A couple of weeks ago, the FTC did issue what it called a proposed policy statement where it was trying to lay out a framework for the FTC to try to preempt state laws regulating AI usage that would conflict with its section five authority to regulate unfair and deceptive practices. But again, these are just sort of patchwork attempts. And going back to McCarran-Ferguson, there's the additional protection from a preemption risk for insurance specific legislation.

But that does not mean that this EO should be ignored. There are a couple other strategies in here that are laid out that I think should be a particular interest to state legislators. The first is this evaluation of state laws and the directive to Commerce to come up with a list of laws that it views as contrary to the policy laid out in the EO. I am not aware of this list being public yet, that doesn't mean it doesn't exist in some form. What is clear is that federal funding is going to be a key tool of the administration to try to influence state policy. The BEAD (Broadband Equity, Access and Deployment) program was specifically mentioned in the EO but the Order also directs other agencies to examine discretionary grant programs to see if they can also be used as tools to try to influence state policy and regulation on AI. The far more interesting one, I think,

and the one that I will spend the rest of this presentation on is the new litigation task force. It is up and running and it may well prove to be one of the most active tools of the administration, at least in the short term, to try to carry out the policies that are laid out in the EO. There are three main litigation strategies that they seem to have developed. Two of them are mentioned specifically in the EO. One of them has been pursued in a particular case. These are strategies for the federal government to challenge in court state laws attempting to regulate AI development and use. So, these strategies are preemption, commerce clause challenges, and equal protection challenges. We already discussed preemption. There is very little risk, if any, of a preemption challenge to a state law or regulation in the area of insurance, and that's actually true as well for the second strategy or dormant commerce clause. Just a quick primer on that. So, the dormant commerce clause under that doctrine, a state law can be deemed unconstitutional if it unlawfully discriminates against other states, specifically if it doesn't have some sort of local purpose and if it imposes burdens on interstate commerce that are deemed excessive relative to the local purpose.

But again, under McCarran-Ferguson, because Congress has granted states the authority to regulate the business of insurance, Courts have said Congress has also granted states the authority to regulate the interstate flow of commerce. So not only is a preemption challenge off the table under McCarran-Ferguson for state regulations of insurance, but Commerce Clause challenges are as well. So, that leaves the Equal Protection Clause argument. Out of the three litigation strategies, if state insurance laws, at least at the moment, are to face litigation risks, from what we have seen, it's going to be from this one. So, the Equal Protection Doctrine stems from the Fourteenth Amendment, at least when it's applied to states, which prohibits states from passing laws that deny to any person within its jurisdiction, the equal protection of the laws. That means that state laws discriminating against certain classes of people are constitutionally suspect and as many of you are likely familiar, laws that discriminate based on what are called suspect classifications, like race, are going to be subject to strict scrutiny and will often be invalidated. As use of AI tools proliferate, many have been focused on ensuring that AI tools are not used to or do not perpetuate discrimination, one example of that is Colorado's since revised algorithmic discrimination law, which was designed to require developers to ensure that AI tools did not result in discriminatory impacts among a number of other things. These laws have become a target of the federal government and they face litigation risk, not just from the government, but also from private litigants, and I'll talk a little bit about a recent example of that. So, this actually involved the Colorado law that I just mentioned. This statute was passed, it sought to regulate AI use in what were deemed high-risk areas. High risk areas like employment, housing, credit, health care, and insurance. The law required AI developers and users to exercise reasonable care to prevent discrimination.

And specifically in the law, that included what it called disparate impact on protected groups. So, what does that mean in the discrimination context? Disparate impact is talking about even if the law or a policy or a tool does not intentionally or expressly discriminate against a particular group, controlling for other factors, the policy or tool ends up treating that group differently. It's not a subjective test. It's an objective one that looks at the outcomes and if there are disparate impacts, the Colorado law required developers and users to take certain actions to correct for that. xAI sued in federal court to block enforcement of this statute, and then shortly thereafter, the federal government intervened through this new litigation task force that was set up through the EO and it brought a Fourteenth Amendment claim saying that this law violates equal protection. The federal government argued that by requiring developers and users to prevent the risk of disparate outcomes based on demographics like race, it effectively required them to intentionally use those demographics when building and running the models. And that's a problem, the federal government said, because particularly in what are called zero-sum games,

so something like a scenario like hiring where only one person can get a role, if you are taking some action to try to improve outcomes for one group, you are necessarily discriminating against another. This was a concept that was discussed at length in the Supreme Court's affirmative action decision, the Harvard admissions case, that came out a few years ago. If you try to do something to favor one group, you are going to disadvantage another and that's unlawful discrimination. The Colorado case was dropped fairly shortly after the federal government intervened because Colorado rescinded the law. It has since passed a new one that does not include much of that same language that was being challenged in this case. So we don't know how this theory will fare in courts. I have not seen it come up since, but I have little doubt that we will see it soon as states continue to legislate in this space and as the federal government's litigation task force gets further up and running.

So to bring this back to state insurance regulation, what does this mean? For one, insurance regulations like the Colorado law that impose duties on developers and users to try to prevent discriminatory impact could face similar legal challenges from private litigants and from the federal government. Many states already have these types of regulations in place. Now, insurance is not hiring, it's not necessarily a zero sum game. And so there are some basis to argue that it should be treated distinct but in the affirmative action context, where this was being discussed in that case, there already was a recognized interest in universities to create a diverse student body. The Supreme Court has already said that just remedying societal discrimination generally is not a compelling interest and so it's likely that if states continue to try to issue regulations that require developers to make these types of changes that they will see additional challenges and courts could be receptive to them. As I said, though, the case law here is very much still developing. I suspect that we will see litigants, both private litigants and the federal government, pressing this broader theory that any state law that requires developers to favor a particular group, regardless of whether it's a zero sum context, is unconstitutional. But at a minimum, I think state legislators should continue to monitor the legal landscape here so that they know and understand the law as it currently stands and what the risks are as they continue to develop state regulations for AI and the use of insurance.

Asm. Gandolfo stated you mentioned before about a scenario where Congress does decide to step in and pass some kind of law to establish the federal government as the sole regulator of the use of AI and the development of AI. Now, with McCarran-Ferguson in place, would this hypothetical bill need to specifically reference the use of AI in insurance? Or would a broad encompassing attempt at preemption cover it? Mr. Engbretson-Schooley stated, no, my understanding based on McCarran-Ferguson is that if they were to enact a new statute establishing this uniform framework, if they wanted it to specifically preempt state laws regulating the business of insurance, even if in the AI context, they would have to specifically say that is what this law is doing. They could do that, but that's an additional step that they would have to take.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Lang and seconded by Rep. Lampton, the Committee adjourned at 5:30 p.m.

This bill will be discussed during the Financial Services & Multi-Lines Issues Committee on Saturday, November 21, 2026 and will be used as the basis for development of Model Legislation sponsored by Rep. Brian Lampton (OH).

An Act
ENROLLED SENATE
BILL NO. 1876

By: Reinhardt of the Senate and Tedford of the House

An Act relating to service of process; amending 36 O.S. 2021, Sections 621 and 622, which relate to service of process on foreign insurers; modifying persons that may be appointed as agent; modifying revocability of agent appointment; requiring certain agent information be submitted to the Insurance Commissioner; providing for alternate service of process in certain circumstances; modifying manner of service of process; updating statutory language; and providing an effective date.

SUBJECT: Service of process on foreign insurers

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. AMENDATORY 36 O.S. 2021, Section 621, is amended to read as follows:

Section 621. A. Each authorized foreign or alien insurer shall appoint the Insurance Commissioner, a resident of this state, or a person who is authorized to do business in this state as its agent to receive service of legal process, other than a subpoena, issued against it in this state upon any cause of action arising from its transaction of business in this state. ~~The appointment shall be irrevocable, shall bind any successor and shall remain in effect as long as there is in force in this state any contract made by the insurer or obligations arising therefrom.~~

B. Service of such process against a foreign or alien insurer shall be made only by service of process upon the ~~Insurance Commissioner~~ agent appointed pursuant to subsection A of this section. Service of process against a domestic insurer may be made upon the insurer in the manner provided by laws applying to business entities generally, or upon the insurer's attorney-in-fact if a reciprocal insurer or a ~~Lloyds~~ Lloyd's association.

C. Each such insurer at the time of application for a certificate of authority shall file with the Insurance Commissioner designation of the name and address of the person to whom process against it served upon the ~~Insurance Commissioner~~ agent appointed pursuant to subsection A of this section is to be forwarded. The insurer may change such designation by a new filing.

D. Any insurer appointing a registered agent other than the Insurance Commissioner shall electronically submit the name and address of the registered agent in the manner and form prescribed by the Commissioner along with any applicable fee. Registered agent names and addresses shall be made publicly available and kept current, and any changes to such information shall be submitted to the Commissioner within five (5) business days of such change.

E. If a person reasonably relies on the list of registered agents maintained by the Insurance Commissioner pursuant to this section and serves otherwise valid process on an insurance company's designated registered agent, and it is later determined that the registered agent listed by the Commissioner is incorrect, the person may serve process upon the Commissioner. Such process shall be served upon the Commissioner and a copy forwarded by the Commissioner to the insurer in accordance with Section 622 of this title. If the person uses due diligence to serve the Commissioner, the applicable statute of limitations shall be tolled for the period of time beginning when the incorrect registered agent received process and ending when the Commissioner receives process.

SECTION 2. AMENDATORY 36 O.S. 2021, Section 622, is amended to read as follows:

Section 622. A. Triplicate copies of legal process against an insurer for whom the Insurance Commissioner is agent shall be served upon the Commissioner at the principal offices of the Insurance Department. When legal process against an insurer for whom the ~~Insurance~~ Commissioner is agent is issued, it shall be served in triplicate by any manner now provided by law or in lieu thereof by mailing triplicate copies of such legal process in the United States mails with postage prepaid to the ~~Insurance~~ Commissioner with return receipt requested, in which event service shall be sufficient upon showing of proof of mailing to the Commissioner with the return receipt attached. At the time of service, the plaintiff shall pay to the ~~Insurance~~ Commissioner Twenty Dollars ($20.00), taxable as costs in the action. Upon receiving service, the Insurance Commissioner shall promptly forward a copy ~~thereof~~ by mail with return receipt requested to the person last so designated by the insurer to receive the same.

B. ~~Process served upon the Insurance Commissioner and copy thereof forwarded~~ Copies of the petition and summons forwarded by the Commissioner to the insurer's designated registered agent as provided in this section shall constitute service upon the insurer.

SECTION 3. This act shall become effective November 1, 2026.

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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)

Insurer Division Model Act

Sponsored by Sen. Matt Lesser (CT) and Asm. Ken Cooley (CA)
Adopted by the Financial Services & Multi-Lines Issues Committee on April 17, 2021, and the Executive Committee on April 18, 2021.

To be discussed and considered for re-adoption during the Financial Services & Multi-Lines Issues Committee on November 21, 2026.

Table of Contents

Section 1. Title
Section 2. Definitions
Section 3. Plan of division - general requirements
Section 4. Plan of division - dividing insurer to survive division
Section 5. Plan of division - dividing insurer to not survive division
Section 6. Amending plan of division
Section 7. Abandoning plan of division
Section 8. Approval of plan of division - articles of incorporation and bylaws
Section 9. Commissioner approval of plan of division
Section 10. Confidentiality – records
Section 11. Certificate of division
Section 12. After division is effective
Section 13. Resulting insurers' liability for allocated assets and debts
Section 14. Shareholder appraisal rights
Section 15. Rules
Section 16. Enforcement by commissioner
Section 17. Merger or consolidation effective with division
Section 18. Effective Date

Section 1. Title

This Act shall be known and may be cited as the "[State] Insurer Division Act."

Section 2. Definitions.

As used in this Act, the following words and phrases have the meanings given to them in this Section unless the context clearly indicates otherwise:

(A) “Asset” means property, whether real, personal, mixed, tangible, or intangible, and any right or interest in the property, including all rights under a contract or other agreement.
(B) “Capital” means the capital stock component of a statutory surplus, as defined in the National Association of Insurance Commissioners’ Accounting Practices and Procedures Manual, version effective January 1, 2001, as revised.

(C) “Commissioner” means the State Insurance Commissioner

(D) (1) “Contract holder” means the owner of an annuity contract.

(2) “Contract holder” does not mean a certificate holder of a group annuity contract or any other covered person under a group annuity contract.

(E) “Divide” or “Division” means the act by operation of law by which a domestic stock insurer splits into two or more resulting domestic stock insurers in accordance with a plan of division and this Act.

(F) “Dividing insurer” means a domestic stock insurer that approves a plan of division.

(G) “Domestic stock insurer” means an insurance company that has capital stock and is incorporated under the laws of this state.

(H) “Liability” means any liability or obligation arising in any manner.

(I) “Plan of division” means a plan of division that is approved by a dividing insurer pursuant to section 8.

(J) (1) “Policyholder” means the owner of an insurance policy.

(2) “Policyholder” does not mean a certificate holder of a group insurance policy or any other covered person under a group insurance policy.

(K) “Resulting insurer” means a dividing domestic stock insurer that survives a division or a new domestic stock insurer that is created by a division.

(L) “Shareholder” means a person in whose name shares are registered in the records of a corporation or the beneficial owner or shares to the extent of the rights granted by a nominee certificate on file with a corporation.

(M) “Surplus” means the total statutory surplus minus capital, calculated in accordance with the National Association of Insurance Commissioners’ Accounting Practices and Procedures Manual, version effective January 1, 2001, as revised.

(N) “Transfer” means an assignment; assumption; conveyance; sale; lease; encumbrance, including a mortgage or security interest; gift; or transfer by operation of law.

Section 3. Plan of division - general requirements.
(A) A domestic stock insurer may, in accordance with this Act, divide into two or more resulting insurers pursuant to a plan of division. A domestic stock insurer's plan of division must include:

(1) The name of the domestic stock insurer seeking to divide;

(2) The name of each resulting insurer created by the proposed division and, for each resulting insurer, a copy of the resulting insurer's:

(a) Proposed articles of incorporation; and

(b) Proposed bylaws;

(3) The manner of allocating assets and liabilities including policy liabilities, between or among al resulting insurers;

(4) The manner of distributing shares in the resulting insurers to the dividing insurer or the dividing insurer's shareholders;

(5) A reasonable description of all liabilities and all assets that the dividing insurer proposes to allocate to each resulting insurer, including the manner by which the dividing insurer proposes to allocate all reinsurance contracts;

(6) All terms and conditions required by the laws of this state and the articles of incorporation and bylaws of the dividing insurer; and

(7) All other terms and conditions required by the division.

Section 4. Plan of division - dividing insurer to survive division.

(A) If a dividing insurer will survive a division, the plan of division must include, in addition to the requirements described in section 3:

(1) All proposed amendments to the dividing insurer's articles of incorporation and bylaws;

(2) If the dividing insurer intends to cancel some but not all shares in the dividing insurer, the manner in which the dividing insurer intends to cancel the shares; and

(3) If the dividing insurer intends to convert some but not all shares in the dividing insurer into shares, securities, obligations, rights to acquire shares or securities, cash, property, or an combination thereof, a statement disclosing the manner in which the dividing insurer intends to convert the shares.

Section 5. Plan of division - dividing insurer to not survive division.

If a dividing insurer will not survive a division, the plan of division must include, in addition to the requirements described in section 3, the manner in which the dividing insurer will cancel or convert shares in the dividing insurer into shares, securities, obligations, rights to acquire shares or securities, cash, property, or any combination thereof.

Section 6. Amending plan of division.

(A) A dividing insurer may amend the dividing insurer's plan of division in accordance with any procedures set forth in the plan of division, or, if no such procedures are set forth in the plan of division, in a manner determined by the board of directors of the dividing insurer. A shareholder that is entitled to vote on or consent to approval of the plan of division is entitled to vote on or consent to an amendment of the plan of division that will affect:

(1) The amount or kind of shares, securities, obligations, rights to acquire shares or securities, cash, property, or any combination thereof to be received by any of the shareholders of the dividing insurer under the plan of division;

(2) The articles of incorporation or bylaws of any resulting insurer that become effective when the division becomes effective except for changes that do not require approval of the shareholders of the resulting insurer under its articles of incorporation or bylaws; or

(3) Any other terms or conditions of the plan of division that effect a change that may adversely affect the shareholders in any material respect.

Section 7. Abandoning plan of division.

(A) A dividing insurer may abandon its plan of division only as follows:

(1) After the dividing insurer has approved the plan of division without any action by the shareholders and in accordance with any procedures set forth in the plan of division, or if no such procedures are set forth in the plan of division, the dividing insurer may abandon its plan of division in a manner determined by the board of directors of the dividing insurer; or

(2) After the dividing insurer has filed a certificate of division with the secretary of state pursuant to section 11, the dividing insurer may file a signed certificate of abandonment with the secretary of state and file a copy with the commissioner. The certificate of abandonment is effective on the date it is filed with the secretary of state.

(B) A dividing insurer shall not abandon its plan of division after the plan of division becomes effective.

(C) If a dividing insurer elects to abandon its plan of division after the plan has been filed with the commissioner but before it becomes effective, the dividing insurer shall notify the commissioner.

Section 8. Approval of plan of division - articles of incorporation and bylaws.

(A) A dividing insurer shall not file a plan of division with the commissioner until the plan of division has been approved in accordance with all provisions of the dividing insurer's articles of incorporation and bylaws. If the dividing insurer's articles of incorporation and bylaws do not provide for approval of a plan of division, the dividing insurer shall not file the plan of division with the commissioner unless the plan of division has been approved in accordance with all provisions of the dividing insurer's articles of incorporation and bylaws that provide for approval of a merger.

(B) If a provision of a dividing insurer's articles of incorporation or bylaws adopted before the effective date of this Act requires that a specific number of or percentage of the board of directors or shareholders propose or adopt a plan of merger or impose other procedures for the proposal or adoption of a plan of merger, the dividing insurer shall adhere to the provision in proposing or adopting a plan of division. If any such provision of the articles of incorporation or bylaws is amended on or after the effective date of this Act, the provision applies to a division thereafter only in accordance with its express terms.

Section 9. Commissioner approval of plan of division.

(A) After a dividing insurer approves a plan of division pursuant to section 8, the dividing insurer shall file the plan of division with the commissioner. Within ten business days after filing the plan of division with the commissioner, the dividing insurer shall provide notice of the filing to each reinsurer that is a party to a reinsurance contract allocated in the plan of division.

(B) (1) A division does not become effective until it is approved by the commissioner in accordance with this section.

(2) Before approving a plan of division, the commissioner shall:

(a) In large or complex divisions, hold a public hearing on the terms and conditions of the proposed division;

***Drafting Note**: Although this Model Act requires the commissioner to hold a public hearing in especially large or complex divisions, some state insurer division statutes provide the commissioner discretion to hold such a hearing regardless of the size or complexity of the division. When considering whether or not to require a public hearing, legislatures should take note that state insurance departments are situated and staffed differently with varying degrees of expertise across the country, and, as such, the size, public interests affected and level of complexity of a division necessary to warrant public hearings may vary from state to state.*

(b) Provide notice of the public hearing required pursuant to subsection (B)(2)(a) of this section to state insurance regulators and appropriate state guaranty

associations in state in which the dividing insurer is authorized to do business; and

(c) Be satisfied that the dividing insurer has made reasonable efforts to provide all policyholders, contract holders, reinsurers, and other persons with an interest in the proposed plan of division at least thirty days prior notice of the public hearing if the commissioner determines that it would be unreasonable or unfair to not provide such notice to such other persons. For the purposes of this subsection (B)(2)(c), a notice must:

(i) Provide information regarding the proposed division under consideration and the location, date, and time of the public hearing; and

(ii) If the dividing insurer has the last-known address or last-known e-mail address of the policyholder, contract holder, reinsurer, or other person on file, either be mailed to the last-known address of such person or sent via electronic means to the last-known e-mail address of such person.

(3) The commissioner shall:

(a) Consider any simultaneous merger or acquisition of a resulting insurer as part of the plan of division;

(b) In the case of a simultaneous merger, apply to the resulting insurer involved in the simultaneous merger the requirements of this Act that are applicable to the resulting insurer as merged into the surviving entity in the merger and not to the resulting insurer prior to the merger;

(c) Consider, among other things, all assets, liabilities, and cash flows, the nature and composition of the assets proposed to be transferred in support of the plan of division, and all proposed assets of the resulting insurer, which consideration must include an assessment of the risks and quality, including the liquidity and marketability, of the proposed portfolio of the resulting insurer; consideration of asset and liability matching; and the treatment of the material element of the portfolio based on statutory accounting practices.

(4) After making the considerations described in subsection (B)(3) of this section, the commissioner shall approve a plan of division if the commissioner finds that the following requirements are met:

(a) The financial condition of a dividing insurer, a resulting insurer, or an acquiring party of a resulting insurer, if any, will not jeopardize the financial stability of the dividing insurer or prejudice the interests of its policyholders, contract holders, or reinsurers, in each case, in a manner that is unfair to its policyholders, contract holders, or reinsurers;

(b) The terms of the plan of division are fair and reasonable to the dividing insurer's and any resulting insurer's policyholders, contract holders, or reinsurers;

(c) Neither a dividing insurer, a resulting insurer, not an acquiring party of a resulting insurer, if any, has plans or proposals to liquidate the dividing insurer or any resulting insurer, sell assets of the dividing insurer or of any resulting insurer, consolidate or merge the dividing insurer or any resulting insurer with a person, or make any other material change in the dividing insurer's or any resulting insurer's business or corporation structure or management that is unfair or unreasonable to the dividing insurer's or resulting insurers' policyholders, contract holders, or reinsurers and not in the public interest;

(d) The competence, experience, and integrity of the persons who would control the operation of a dividing insurer if it survives the division, and any resulting insurer are such that it would be consistent with the interest of the dividing insurer's and any resulting insurers' policyholders, contract holders or reinsurers and the general public to permit the division;

(e) The division is not likely to be hazardous or prejudicial to the insurance buying public;

(f) The interest of the policyholders of the dividing insurer that may become policyholders of a resulting insurer will be adequately protected by the resulting insurer or acquiring party of a resulting insurer, if any;

(g) The dividing insurer, if it survives the division, and the resulting insurer will be solvent upon the consummation of the division;

(h) The assets allocated to the dividing insurer, if it survives the division, and to resulting insurers will not, upon the consummation of the division, be unreasonably small in relation to the business and transactions in which the insurers were engaged or are about to engage;

(i) The proposed division is not being made for the purpose of hindering, delaying, or defrauding any policyholders, contract holders, or reinsurers;

(j) Each resulting insurer that will be allocated life insurance policies, annuity contracts or [accident and sickness or health insurance policies as defined in appropriate state licensing statutes] will be licensed in each line of business in each state where the dividing insurer was licensed or had ever been licensed with respect to such insurance policies or annuity contracts issued by the dividing insurer that are allocated to that resulting insurer as part of the plan of division; except that, the resulting insurer need not be licensed with respect to any line of business in any state where, at the time of division:

(i) The dividing insurer is not licensed and had never been licensed with respect to the line of business; or

(ii) The state does not provide guaranty association coverage or similar coverage with respect to the allocated policies or contracts;

(k) For each resulting insurer that will be allocated property or casualty insurance policies, the dividing insurer has demonstrated that the laws of each state where any such policies issued by the dividing insurer are allocated to any resulting insurer extend eligibility for guaranty fund coverage to persons who hold such policies and/or claims allocated to the resulting insurer to the extent and only to the extent such policies were eligible to be covered by the guaranty fund in the state prior to the division; and

(l) If the plan of division allocates policies of long-term care insurance, as defined in [insert citation to state insurance code definition of long-term care insurance], the liabilities associated with the allocated policies do not constitute more than a de minimus amount of the insurance liabilities allocated to the dividing insurer, if it survives the division, or to any resulting insurer.

(5) A dividing insurer that files a plan of division shall pay all expenses incurred by the commissioner in connection with proceedings under this section, including expenses for attorneys, actuaries, accountants, and other experts not otherwise a part of the commissioner's staff as may be reasonably necessary to assist the commissioner in reviewing the proposed plan of division. A dividing insurer may allocate the expenses in the plan of division in the same manner as any other liability.

(6) In large or complex divisions, the commissioner shall select and retain an independent expert who shall review the plan of division and issue a report to the commissioner, which report addresses the following:

Drafting Note*: Although this Model Act requires the commissioner to select and retain an independent expert in especially large or complex divisions, some state insurer division statutes provide the commissioner discretion to retain an independent expert regardless of the size or complexity of the transaction. When considering whether or not to require the retention of an independent expert, legislatures should take note that state insurance departments are situated and staffed differently with varying degrees of expertise across the country, and, as such, the size, public interests affected and level of complexity of a division necessary to warrant independent experts may vary from state to state.*

(a) The business purposes of the proposed division;

(b) Capital adequacy and risk-based capital, including consideration of the effects of asset quality, non-admitted assets, and actuarial stresses to reserve assumptions;

(c) Cash flow and reserve adequacy testing, including consideration of the effects of diversification on policy liabilities;

(d) Business plans;

(e) The impact, if any, of concentration of lines of business following the proposed division; and

(f) Management's competence, experience, and integrity.

(7) If the commissioner approves a plan of division, the commissioner shall issue:

(a) An order that is accompanied by findings of fact and conclusions of law; and

(b) A certificate of authority authorizing the resulting insurers to transact the business of insurance in this state; except that the commissioner may waive this requirement if a resulting insurer will not survive a merger simultaneous with the division in accordance with the plan of division.

(8) The conditions in this section for freeing one or more of the resulting insurers from the liabilities of the dividing insurer and for allocating some or all of the liabilities of the dividing insurer are deemed to have been satisfied if the commissioner approves the plan of division in a final order.

Section 10. Confidentiality - records.

(A) All information, documents, materials, and copies of documents and materials submitted to, obtained by, or disclosed to the commissioner in connection with a plan of division or in contemplation of a plan of division, including any information documents, materials, or copies provided by or on behalf of a domestic stock insurer in advance of its adoption or submission of a plan of division, are confidential and subject to the same protection and treatment described in [insert citation to state insurance holding company systems law] for information and documents disclosed to or obtained by the commissioner in the course of an examination or investigation made under [insert citation to state insurance holding company systems law], until the time, if any, that a notice of the hearing contemplated by section 9 is issued.

(B) After the issuance of a notice of the hearing contemplated by section 9, all business, financial, actuarial, and other proprietary information for which the domestic stock insurer requests confidential treatment, other than the plan of division and any materials incorporated by reference into or otherwise made a part of the plan of division that must not be eligible for confidential treatment after the issuance of a notice of the hearing, continues to be confidential, is not available for public inspection, and is subject to the same protection and treatment as described in [insert citation to state insurance holding company systems law] for information and documents disclosed to or obtained by the commissioner in the course of an examination or investigation made under [insert citation to state insurance holding company systems law]. However, if the commissioner determines that the public's interest in making the information

available for public inspection outweighs the interest of the dividing insurer in keeping the information confidential, the commissioner may, after notice and an opportunity to be heard, make the information available to public inspection in accordance with [insert citation to state public/open records law].

Section 11. Certificate of division.

(A) If the commissioner approves a dividing insurer's plan of division pursuant to section 9, an officer or duly authorized representative of the dividing insurer shall sign a certificate of division that sets forth all of the following:

(1) The name of the dividing insurer;

(2) A statement disclosing whether the dividing insurer survived the division. If the dividing insurer survived the division, the certificate of division must include any amendments to the dividing insurer's articles of incorporation or bylaws as approved as part of the pan of division.

(3) The name of each resulting insurer that is created by the division;

(4) The date on which the division is effective;

(5) A statement that the division was approved by the commissioner pursuant to section 9;

(6) A statement that the dividing insurer provided reasonable notice to each reinsurer that is a party to a reinsurance contract allocated in the plan of division;

(7) Articles of incorporation and bylaws for each resulting insurer created by the division. The articles of incorporation and bylaws of each resulting insurer must comply with the applicable requirements of the laws of this state. The articles of incorporation and bylaws may state the name or address of an incorporator, may be signed, and may include any provision that is not required in a restatement of the articles of incorporation or bylaws.

(8) A reasonable description of the capital, surplus, or other assets and liabilities, including policy liabilities, of the dividing insurer that are to be allocated to each resulting insurer.

(B) A dividing insurer's certificate of division is effective on the date the dividing insurer files the certificate with the secretary of state and provides a concurrent copy to the commissioner, or on another date as specified in the plan of division, whichever is later. However, the certificate of division becomes effective not later than ninety calendar days after it is filed with the secretary of state. A division is effective when the relevant certificate of division is effective.

Section 12. After division is effective.

(A) (1) On the effective date of a division pursuant to section 11, if the dividing insurer survives, all of the following apply:

(a) The dividing insurer continues to exist;

(b) The dividing insurer must amend its articles of incorporation if the amendments are provided for in the plan of division; and

(c) The dividing insurer must amend its bylaws if the amendments are provided for in the plan of division.

(2) On the effective date of a division pursuant to section 11, if the dividing insurer does not survive, the dividing insurer ceases to exist and any resulting insurer created by the plan of division comes into existence.

(3) Each resulting insurer holds any capital, surplus, and other assets allocated to the resulting insurer by the plan of division as a successor to the dividing insurer by operation of law, and not by transfer, whether directly or indirectly. The articles of incorporation and bylaws, if any, of each resulting insurer are effective when the resulting insurer comes into existence.

(4) All capital, surplus, and other assets of the dividing insurer:

(a)That are allocated by the plan of division vest in the applicable resulting insurer as provided in the plan of division or remain vested in the dividing insurer as provided in the plan of division;

(b) That are not allocated by the plan of division remain vested in the dividing insurer if the dividing insurer survives the division and are allocated to, and vest pro rata in, the resulting insurer individually if the dividing insurer does not survive the division; and

(c) Otherwise vest as provided in this section without transfer, reversion, or impairment.

(5) A resulting insurer to which a cause of action is allocated may be substituted or added in any pending action or proceeding to which the dividing insurer is a party when the division becomes effective.

(6) All liabilities, including policy liabilities, of a dividing insurer are allocated between or among any resulting insurers as provided in section 11, and each resulting insurer to which liabilities are allocated is liable only for those liabilities, including policy liabilities, allocated as a successor to the dividing insurer by operation of law, and not by transfer or assumption, whether directly or indirectly.

(7) Any shares in the dividing insurer that are to be converted or canceled in the division are converted or canceled, and the shareholders of those shares are entitled only to the rights provided to the shareholders under the plan of division and any appraisal rights that the shareholders may have pursuant to section 14.

(B) Except as provided in the dividing insurer's articles of incorporation or bylaws, a division does not give rise to any rights that a shareholder, director of a domestic stock insurer, or third party would have upon a dissolution, liquidation, or winding up on the dividing insurer.

(C) The allocation to a resulting insurer of capital, surplus, or other asset that is collateral covered by an effective financing statement is not effective until a new effective financing statement naming the resulting insurer as a debtor is effective under the "Uniform Commercial Code", title 4.

(D) Unless otherwise provided in the plan of division, the shares in, and any securities of, each resulting insurer are distributed to the dividing insurer, if it survives the division, or are distributed pro rata to the shareholders of the dividing insurer that do not asset any appraisal rights pursuant to section 14.

(E) A division that becomes effective pursuant to this Act is not an assignment of any insurance policy, annuity, reinsurance agreement, or other type of contract.

Section 13. Resulting insurers' liability for allocated assets and debts.

(A) Except as expressly provided in this section, when a division becomes effective, by operation of law all of the following apply:

(1) A resulting insurer is individually liable for the liabilities, including policy liabilities:

(a) That the resulting insurer issues, undertakes, or incurs in its own name after the division; and

(b) Of the dividing insurer that are allocated to or remain the liability of the resulting insurer to the extent specified in the plan of division;

(2) The dividing insurer remains responsible for the liabilities, including policy liabilities, of the dividing insurer that are not allocated by the plan of division if the dividing insurer survives the division; and

(3) A resulting insurer is liable pro rata individually for the liabilities, including policy liabilities, of the dividing insurer that are not allocated by the plan of division if the dividing insurer does not survive the division.

(B) Except as otherwise expressly provided in this section, when a division becomes effective, a resulting insurer is not responsible for an does not have liability for:

(1) Any liabilities, including policy liabilities, that another resulting insurer issues, undertakes, or incurs in the resulting insurer's own name after the division; or

(2) Any liabilities, including policy liabilities, of the dividing insurer that are allocated to or remain the liability of another resulting insurer under the plan of division.

(C) If a provision of indebtedness, whether secured or unsecured, or a provision of any contract other than an insurance policy, annuity, or reinsurance agreement that was issued, incurred, or executed by the dividing insurer before the effective date of this Act, requires the consent of the obligee to a merger of the dividing insurer, or treats such a merger as a default, the provision applies to a division of the dividing insurer as if the division were a merger.

(D) If a division breaches a contractual obligation of the dividing insurer, all resulting insurers are jointly and severally liable for the breach. The validity and effectiveness of the division is not affected by the breach.

(E) A direct or indirect allocation of capital, surplus, assets, or liabilities, including policy liabilities, occurs automatically, by operation of law, and may not be treated as a distribution or transfer for any purpose with respect to either the dividing insurer or any resulting insurer.

(F) Liens, security interests, and other charges on the capital, surplus, or other assets of the dividing insurer are not impaired by the division, notwithstanding any otherwise enforceable allocation of liabilities, including policy liabilities, of the dividing insurer.

(G) If the dividing insurer is bound by a security agreement governed by Articles 5 or 9 of the Uniform Commercial Code, or by the substantial equivalent as enacted in any other jurisdiction, and the security agreement provides that the security interest attaches to after acquired collateral, a resulting insurer is bound by the security agreement.

(H) Unless otherwise provided in the plan of division and specifically approved by the commissioner, an allocation of a policy or other liability may not:

(1) Affect the rights that a policyholder or creditor has under any other law with respect to the policy or other liability; except that the rights are available only against a resulting insurer responsible for the policy or liability under this section; or

(2) Release or reduce the obligation of a reinsurer, surety, or guarantor of the policy or liability.

(I) A resulting insurer is liable only for the liabilities allocated to the resulting insurer in accordance with the plan of division and this section and is not liable for any other liabilities under the common law doctrine of successor liability or any other theory of liability applicable to transferees or assignees of assets.

Section 14. Shareholder appraisal rights.

If a dividing insurer does not survive a division, a shareholder of the dividing insurer is entitled to appraisal rights and to obtain payment of the fair value of the shareholder's shares in the same manner and to the extent provided for a corporation as a party to a merger pursuant to [insert citation to state shareholder right of dissent law].

Section 15. Rules.

The commissioner may adopt rules to administer this Act.

Section 16. Enforcement by commissioner.

The commissioner may take any action within the commissioner's authority to enforce compliance with this Act.

Section 17. Merger or consolidation effective with division.

(A) To facilitate the merger or consolidation of any resulting insurer with and into another company simultaneously with the effectiveness of a division authorized by this Act, a dividing insurer, including its officers, directors, and shareholders, may:

(1) Adopt and execute a plan of merger or consolidation on behalf of a resulting insurer;

(2) Execute and deliver documents, plans, certificates, and resolutions; and

(3) Make any filings, in each case, on behalf of the resulting insurer.

(B) If so provided in a plan of merger or consolidation described in this section, the merger or consolidation is effective simultaneously with the effectiveness of a division authorized by this Act.

(C) On request of the dividing insurer, the commissioner may waive the other requirements of this section with respect to any merger or consolidation involving only domestic stock insurers and may issue the commissioner's final approval of the merger or consolidation as part of the commissioner's approval of a plan of division under this Act.

Section 18. Effective Date

This Act shall take effect _____.

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Asw. Pamela Hunter, NY

National Council of Insurance Legislators (NCOIL)

Uniform Captive Insurer Model Act

***Sponsored by Sen. Jason Rapert (AR)**
***Adopted by the NCOIL Financial Services & Multi-Lines Issues Committee meeting on November 18, 2021 and the NCOIL Executive Committee on November 20, 2021.**

***To be discussed and considered for re-adoption during the Financial Services & Multi-Lines Issues Committee on November 21, 2026.**

Table of Contents

Section 1. Title
Section 2. Purpose
Section 3. Definitions
Section 4. Name
Section 5. Requirements and Limitations of Captive Insurance Companies
Section 6. Capital and Surplus Requirements
Section 7. Formation {state specific}
Section 8. Organizational Documents
Section 9. License Suspension/Revocation
Section 10. Investments
Section 11. Reinsurance
Section 12. Taxes
Section 13. Rules for Controlled Unaffiliated Business
Section 14. Rules and Regulations
Section 15. Recognition in Other States
Section 16. Examinations and Investigations
Section 17. Dividends
Section 18. Laws Applicable
Section 19. Delinquency
Section 20. Reports and Statements
Section 21. Exemption from Compulsory Associations, Rating Organizations; Memberships
Section 22. Severability

Section 1. Title

This Act shall be known and may be cited as "The Uniform Captive Insurer Act."

Section 2. Purpose

The purpose of this Act is to provide uniform requirements for licensing of captive insurance companies within each of the fifty states in the United States of America.

Section 3. Definitions

As used in this Act, unless the context requires otherwise:

(1) "Affiliated company" means any company in the same corporate system as a parent, an industrial insured, or a member organization by virtue of common ownership, control, operation, or management.

(2) "Association" means any legal association of individuals, corporations, limited liability companies, partnerships, associations, or other entities, the member organizations of which or which does itself, whether or not in conjunction with some or all of the member organizations:

> (A) own, control, or hold with power to vote all of the outstanding voting securities of an association captive insurance company incorporated as a stock insurer; or
>
> (B) have complete voting control over an association captive insurance company incorporated as a mutual insurer; or
>
> (C) constitute all of the subscribers of an association captive insurance company formed as a reciprocal insurer; or
>
> (D) have complete voting control over an association captive insurance company formed as a limited liability company.

(3) "Association captive insurance company" means any company that insures risks of the member organizations of the association and that also may insure the risks of affiliated companies of the member organizations and the risks of the association itself.

(4) "Captive insurance company" means any pure captive insurance company, association captive insurance company, or industrial insured captive insurance company, formed or licensed under the provisions of this Act.

(5) "Commissioner" means the Commissioner of Insurance {state specific chief insurance regulator}.

(6) "Controlled unaffiliated business" means any person:

> (A) that is not in the corporate system of a parent and its affiliated companies in the case of a pure captive insurance company, or that is not in the corporate system of an industrial insured and its affiliated companies in the case of an industrial insured captive insurance company;

(B) that has an existing contractual relationship with a parent or one of its affiliated companies in the case of a pure captive insurance company, or with an industrial insured or one of its affiliated companies in the case of an industrial insured captive insurance company; and

(C) whose risks are managed by a pure captive insurance company or an industrial insured captive insurance company, as applicable, in accordance with rules established by the Commissioner.

(7) "Excess workers' compensation insurance" means, in the case of an employer that has insured or self-insured its workers' compensation risks in accordance with applicable State or federal law, insurance in excess of a specified per-incident or aggregate limit established by the Commissioner.

(8) "Industrial insured" means an insured:

(A) who procures the insurance of any risk or risks by use of the services of a full-time employee acting as an insurance manager or buyer;

(B) whose aggregate annual premiums for insurance on all risks total at least $25,000.00; and

(C) who has at least 25 full-time employees.{or per State’s Industrial Insured exemption requirements}

(9) "Industrial insured captive insurance company" means any company that insures risks of the industrial insureds that comprise the industrial insured group, and that may insure the risks of the affiliated companies of the industrial insureds and the risks of the controlled unaffiliated business of an industrial insured or its affiliated companies.

(10) "Industrial insured group" means any group of industrial insureds that collectively:

(A) own, control, or hold with power to vote all of the outstanding voting securities of an industrial insured captive insurance company incorporated as a stock insurer;

(B) have complete voting control over an industrial insured captive insurance company incorporated as a mutual insurer; or

(C) constitute all of the subscribers of an industrial insured captive insurance company formed as a reciprocal insurer; or

(D) have complete voting control over an industrial insured captive insurance company formed as a limited liability company.

(11) "Member organization" means any individual, corporation, limited liability company, partnership, association, or other entity that belongs to an association.
(12) "Mutual corporation" means a corporation organized without stockholders and includes a nonprofit corporation with members.

(13) "Parent" means a corporation, limited liability company, partnership, other entity, or individual, that directly or indirectly owns, controls, or holds with power to vote more than 50 percent of the outstanding voting:

(A) securities of a pure captive insurance company organized as a stock corporation; or

(B) membership interests of a pure captive insurance company organized as a nonprofit corporation; or

(C) membership interests of a pure captive insurance company organized as a limited liability company.

(14) "Pure captive insurance company" means any company that insures risks of its parent and affiliated companies or controlled unaffiliated business.

Section 4. Name

No captive insurance company shall adopt a name that is the same, deceptively similar, or likely to be confused with or mistaken for any other existing business name registered in the State of {STATE} nor any name likely to mislead the public.

Section 5. Requirements and Limitations of Captive Insurance Companies

(a) Any captive insurance company, when permitted by its articles of association, charter, or other organizational document, may apply to the Commissioner for a license to do any and all insurance comprised in subdivisions {state definitions of insurance, except worker's compensation, which must be fronted} of this title and may grant annuity contracts as defined in {state specific} of this title; provided, however, that:

(1) No pure captive insurance company may insure any risks other than those of its parent and affiliated companies or controlled unaffiliated business.

(2) No association captive insurance company may insure any risks other than those of its association, those of the member organizations of its association, and those of a member organization's affiliated companies.

(3) No industrial insured captive insurance company may insure any risks other than those of the industrial insureds that comprise the industrial insured group, those of their affiliated companies, and those of the controlled unaffiliated business of an industrial insured or its affiliated companies.

(4) No captive insurance company may provide personal motor vehicle or homeowner's insurance coverage or any component thereof.
(5) No captive insurance company may accept or cede reinsurance except as provided in {state specific} of this title.

(6) Any captive insurance company may provide excess workers' compensation insurance to its parent and affiliated companies, unless prohibited by the federal law or laws of the state having jurisdiction over the transaction. Any captive insurance company, unless prohibited by federal law, may reinsure workers' compensation of a qualified self-insured plan of its parent and affiliated companies.

(7) Any captive insurance company that insures risks described in subdivisions {state specific health care laws/regulations} of this title shall comply with all applicable State and federal laws.

(b) No captive insurance company shall do any insurance business in this State unless:

(1) it first obtains from the Commissioner a license authorizing it to do insurance business in this State;

(2) its board of directors or committee of managers or, in the case of a reciprocal insurer, its subscribers' advisory committee holds at least one meeting each year in this State;

(3) it maintains its principal place of business in this State; and

(4) it appoints a registered agent to accept service of process and to otherwise act on its behalf in this State; provided that whenever such registered agent cannot with reasonable diligence be found at the registered office of the captive insurance company, the Commissioner shall be an agent of such captive insurance company upon whom any process, notice, or demand may be served.

(c) (1) Before receiving a license, a captive insurance company shall:

(A) File with the Commissioner a certified copy of its organizational documents, a statement under oath of its president and secretary showing its financial condition, and any other statements or documents required by the Commissioner.

(B) Submit to the Commissioner for approval a description of the coverages, deductibles, coverage limits, and rates, together with such additional information as the Commissioner may reasonably require. In the event of any subsequent material change in any item in such description, the captive insurance company shall submit to the Commissioner for approval an appropriate revision and shall not offer any additional kinds of insurance until a revision of such description is approved by the Commissioner. The captive insurance company shall inform the Commissioner of any material change in rates within 30 days of the adoption of such change.

(2) Each applicant captive insurance company shall also file with the Commissioner evidence of the following:

(A) the amount and liquidity of its assets relative to the risks to be assumed;

(B) the adequacy of the expertise, experience, and character of the person or persons who will manage it;

(C) the overall soundness of its plan of operation;

(D) the adequacy of the loss prevention programs of its insureds; and

(E) such other factors deemed relevant by the Commissioner in ascertaining whether the proposed captive insurance company will be able to meet its policy obligations.

(3) Information submitted pursuant to this subsection shall be and remain confidential, and may not be made public by the Commissioner or an employee or agent of the Commissioner without the written consent of the company, except that:

(A) such information may be discoverable by a party in a civil action or contested case to which the captive insurance company that submitted such information is a party, upon a showing by the party seeking to discover such information that:

(i) the information sought is relevant to and necessary for the furtherance of such action or case;

(ii) the information sought is unavailable from other nonconfidential sources; and

(iii) a subpoena issued by a judicial or administrative officer of competent jurisdiction has been submitted to the Commissioner; and

(B) the Commissioner may, in the Commissioner's discretion, disclose such information to a public officer having jurisdiction over the regulation of insurance in another state, provided that:

(i) such public official shall agree in writing to maintain the confidentiality of such information; and

(ii) the laws of the state in which such public official serves require such information to be and to remain confidential.

(d) Each captive insurance company shall pay to the Commissioner a nonrefundable fee of ${state specific} for examining, investigating, and processing its application for license, and for

issuing same, and the Commissioner is authorized to retain legal, financial, and examination services from outside the Department, the reasonable cost of which may be charged against the applicant. The provisions of {state specific examination laws/NAIC model examinations} of this title shall apply to examinations, investigations, and processing conducted under the authority of this section. In addition, each captive insurance company shall pay a license renewal fee for each year thereafter of ${state specific}.

(e) If the Commissioner is satisfied that the documents and statements that such captive insurance company has filed comply with the provisions of this Act, the Commissioner may grant a license authorizing it to do insurance business in this State until {state specific date} thereafter, which license may be renewed.

Section 6. Capital and Surplus Requirements

(a) No captive insurance company shall be issued a license unless it shall possess and thereafter maintain unimpaired paid-in capital and surplus of:

(1) in the case of a pure captive insurance company, not less than $250,000.00 {state specific};

(2) in the case of an association captive insurance company, not less than $500,000.00{state specific};

(3) in the case of an industrial insured captive insurance company, not less than $500,000.00{state specific};

(b) The Commissioner may prescribe additional capital and surplus based upon the type, volume, and nature of insurance business transacted.

(c) Capital and surplus may be in the form of cash, cash equivalents, or an irrevocable letter of credit issued by a bank approved by the Commissioner and in a form approved by the Commissioner. The Commissioner may reduce or waive the capital and surplus amounts required by this section pursuant to a plan of dissolution for the company approved by the Commissioner.

Section 7. Formation

(a) Subject to the approval of the Commissioner, a captive insurance company may be formed as any type of entity permissible under {STATE} law.

(b) A captive insurance company incorporated or organized in this State shall have one or more incorporators or one or more organizers, at least one of which shall be a resident of this State.

(c) Before any required formation documents are transmitted to the Secretary of State, the incorporators or organizers shall petition the Commissioner to issue a certificate setting forth the Commissioner's finding that the establishment and maintenance of the proposed entity will

promote the general good of the State. In arriving at such a finding, the Commissioner shall consider:

(1) the character, reputation, financial standing, and purposes of the incorporators or organizers;

(2) the character, reputation, financial responsibility, insurance experience, and business qualifications of the officers and directors or members of the governing board; and

(3) such other aspects the Commissioner deems advisable.

(d) The capital stock of a captive insurance company incorporated as a stock insurer may be authorized with no par value.

(e) In the case of a captive insurance company:

(1) formed as a corporation, at least one of the members of the board of directors shall be a resident of this State;

(2) formed as a reciprocal insurer, at least one of the members of the subscribers' advisory committee shall be a resident of this State;

(3) formed as a limited liability company, at least one of the managers shall be a resident of this State.

Section 8. Organizational Documents

The application documents shall include the National Association of Insurance Commissioners Uniform Certificate of Authority Application forms 1P, 2P, 8, 11, and 13.

Section 9. License Suspension/Revocation

(a) The license of a captive insurance company may be suspended or revoked by the Commissioner for any of the following reasons:

(1) insolvency or impairment of capital or surplus;

(2) Failure to meet the requirements of section 6 of this Act;

(3) refusal or failure to submit an annual report, as required by this Act, or any other report or statement required by law or by lawful order of the Commissioner;

(4) failure to comply with the provisions of its own charter, bylaws, or other organizational document;

(5) failure to submit to or pay the cost of examination or any legal obligation relative thereto, as required by this Act;

(6) use of methods that, although not otherwise specifically prohibited by law, nevertheless render its operation detrimental or its condition unsound with respect to the public or to its policyholders; or

(7) failure otherwise to comply with the laws of this State.

(b) If the Commissioner finds, upon examination, hearing, or other evidence, that any captive insurance company has violated any provision of subsection (a) of this section, the Commissioner may suspend or revoke such company's license if the Commissioner deems it in the best interest of the public and the policyholders of such captive insurance company, notwithstanding any other provision of this title.

Section 10. Investments

(a) No captive insurance company as defined in the Act shall be subject to any restrictions on allowable investm3nts; provided that the Commissioner may prohibit or limit any investment that threatens the solvency or liquidity of any company. Each company shall file with the Commissioner a statement of investment policy approved by its governing body that describes the types of investment that the company may elect to undertake, and may not make investments that materially deviate from the statement of investment policy that is on file with the Commissioner.

(b) The Commissioner may require any company subject to this subsection to limit or withdraw from certain investments or discontinue certain investment practices if the Commissioner determines that such investments or practices of the company might be hazardous to the policyholders or the general public.

(c) No captive insurance company may make a loan to or an investment in its parent company or affiliates without prior written approval of the Commissioner, and any such loan or investment must be evidenced by documentation approved by the Commissioner. Loans of minimum capital and surplus funds required by section 6 of this title are prohibited.

Section 11. Reinsurance

(a) Any captive insurance company may provide reinsurance on risks ceded by any other insurer, and may provide reinsurance of annuity contracts that are granted by any other insurer.

(b) Any captive insurance company may take credit for the reinsurance of risks or portions of risks ceded to reinsurers complying with the provisions of {insert appropriate citation to state credit for reinsurance law} of this title. Prior approval of the Commissioner shall be required for ceding or taking credit for the reinsurance of risks or portions of risks ceded to reinsurers not complying with {insert appropriate citation to state credit for reinsurance law} of this title, except for business written by an alien captive insurance company outside the United States.

(c) In addition to reinsurers authorized under the provisions of section {insert appropriate citation to state credit for reinsurance law} of this title, a captive insurance company may take credit for the reinsurance of risks or portions of risks ceded to a pool, exchange, or association acting as a reinsurer which has been authorized by the Commissioner. The Commissioner may require any other documents, financial information, or other evidence that such a pool, exchange, or association will be able to provide adequate security for its financial obligations. The Commissioner may deny authorization or impose any limitations on the activities of a reinsurance pool, exchange, or association that, in the Commissioner's judgment, are necessary and proper to provide adequate security for the ceding captive insurance company and for the protection and consequent benefit of the public at large.

(d) For all purposes of this Act, insurance by a captive insurance company of any workers' compensation qualified self-insured plan of its parent and affiliates shall be deemed to be reinsurance.

Section 12. Taxes (To Be State Specific)

The tax provided for in this section shall constitute all taxes collectible under the laws of this State from any captive insurance company, and no other occupation tax or other taxes shall be levied or collected from any captive insurance company by the State or any county, city, or municipality within this State, except meals and rooms taxes, sales and use taxes, and ad valorem taxes on real and personal property used in the production of income.

Annually, X percent of the premium tax revenues collected pursuant to this section shall be transferred to the Department of Insurance for the regulation of captive insurance companies under this Act.

Section 13. Rules for Controlled Unaffiliated Business

The Commissioner may adopt rules establishing standards to ensure that a parent or its affiliated company, or an industrial insured or its affiliated company, is able to exercise control of the risk management function of any controlled unaffiliated business to be insured by a pure captive insurance company or an industrial insured captive insurance company, respectively; provided, however, that, until such time as rules under this section are adopted, the Commissioner may approve the coverage of such risks by a pure captive insurance company or an industrial insured captive insurance company.

Section 14. Rules and Regulations

The Commissioner is authorized to promulgate rules and regulations necessary to effectuate the purposes of this Act. All such rules and regulations shall be promulgated in accordance with the {State} Administrative Procedures Act.

Section 15. Recognition in Other States

Notwithstanding anything in this Act to the contrary, a captive insurance company duly licensed in this State shall be recognized by the several States of the United States as a single-state insurer subject to regulation by the state of domicile.

Section 16. Examinations and Investigations

(a) Whenever the Commissioner determines it to be prudent, but not less frequently than once every five years, the Commissioner shall personally, or by some competent person appointed by the Commissioner, inspect and examine each captive insurance company to ascertain its financial condition, its ability to fulfill its obligations, and whether it has complied with the provisions of this Act. The expenses and charges of the examination shall be paid to the State by the company or companies examined.

(b) All examination reports, preliminary examination reports or results, working papers, recorded information, documents and copies thereof produced by, obtained by, or disclosed to the Commissioner or any other person in the course of an examination made under this section are confidential and are not subject to subpoena and may not be made public by the Commissioner or an employee or agent of the Commissioner without the written consent of the company, except to the extent provided in this subsection. Nothing in this subsection shall prevent the Commissioner from using such information in furtherance of the Commissioner's regulatory authority under this title. The Commissioner may, in the Commissioner's discretion, grant access to such information to public officers having jurisdiction over the regulation of insurance in any other state or country, or to law enforcement officers of this State or any other state or agency of the federal government at any time, so long as such officers receiving the information agree in writing to hold it in a manner consistent with this section.

Section 17. Dividends

No captive insurance company may pay a dividend out of, or other distribution with respect to, capital or surplus without the prior approval of the Commissioner. Approval of an ongoing plan for the payment of dividends or other distributions shall be conditioned upon the retention, at the time of each payment, of capital or surplus in excess of amounts specified by, or determined in accordance with formulas approved by, the Commissioner. Notwithstanding the provisions of {state specific laws regarding dividends made by a not for profit corporation} may make such distributions as are in conformity with its purposes and approved by the Commissioner.

Section 18. Laws Applicable

No provisions of {state insurance laws}, other than those contained in this Act or contained in specific references contained in this Act, shall apply to captive insurance companies.

Section 19. Insolvency

Except as otherwise provided in this Act, the terms and conditions set forth in {state specific bankruptcy laws} shall apply in full to captive insurance companies formed or licensed under this Act.

Section 20. Reports and Statements

(a) Captive insurance companies shall not be required to make any annual report except as provided in this Act.

(b) Prior to March 15 of each year, each captive insurance company shall submit to the Commissioner a report of its financial condition, verified by oath of two of its executive officers. Each captive insurance company shall report using generally accepted accounting principles, statutory accounting principles, or international financial reporting standards as approved by the Commissioner, in each case with any appropriate or necessary modifications or adaptations thereof required or approved or accepted by the Commissioner for the type of insurance and kinds of insurers to be reported upon, and as supplemented by additional information required by the Commissioner. As used in this section, statutory accounting principles shall mean the accounting principles codified in the NAIC Accounting Practices and Procedures Manual.

(c) Any captive insurance company may make written application for filing the required report on a fiscal year-end. If an alternative reporting date is granted, the annual report is due 75 days after the fiscal year-end.

Section 21. Exemption from Compulsory associations, Rating Organizations; Memberships

(a) No captive insurance company shall be permitted to join or contribute financially to any plan, pool, association, or guaranty or insolvency fund in this State, nor shall any such captive insurance company, or any insured or affiliate thereof, receive any benefit from any such plan, pool, association, or guaranty or insolvency fund for claims arising out of the operations of such captive insurance company.

(b) No captive insurance company shall be required to join a rating organization.

Section 22. Severability

If any clause, sentence, paragraph, section or part of this act or the application thereof to any person or circumstances, shall, for any reason, be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair or invalidate the remainder of this act, and the application thereof to other persons or circumstance, but shall be confined in its operation to the clause, sentence, paragraph, section or part thereof directly involved in the controversy in which such judgment shall have been rendered and to the person or circumstances involved.

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

IMMEDIATE PAST PRESIDENT:
Asw. Pamela Hunter, NY

National Council of Insurance Legislators (NCOIL)

Identity Theft Protection Model Act

Adopted by the NCOIL Executive Committee on November 21, 2003. Readopted by the NCOIL Executive Committee on November 11, 2006, November 20, 2011, November 20, 2016, November 20, 2021.

To be discussed and considered for re-adoption during the Financial Services & Multi-Lines Issues Committee on November 21, 2026.

Section 1. Short Title

The Act shall be known and may be cited as the Identity Theft Protection Act.

Section 2. Purpose

The purpose of this Act is to protect consumers from the misuse of their personal financial information by those with the intent to defraud another person or with intent to commit any violation of federal, State or local law and to make such offenses a felony.

Section 3. Definitions

For the purposes of this Act, these defined words have the following meaning:

(A) "Document-making implement" means any implement, impression, electronic device, or computer hardware or software, that is specifically configured or primarily used for making an identification document, a false identification document, or another document making implement;

(B) "Identification document" means a document made or card issued by or under the authority of the United States Government, a state, political subdivision of a state, a foreign government, political subdivision of a foreign government, an international governmental or an international quasi-governmental organization which, when completed with information concerning a particular individual, is of a type intended or commonly accepted for the purpose of identification of individuals;

(C) "Means of identification" means any name or number that may be used, alone or in conjunction with any other information, to identify a specific individual, including any:

(1) Name, social security number, date of birth, official state or government issued driver's license or identification number, alien registration number, government passport number, employer or taxpayer identification number;
(2) Unique biometric data, such as fingerprint, voice print, retina or iris image, or other unique physical representation;

(3) Unique electronic identification number, address, or routing code; or

(4) Telecommunication identifying information or access device as defined in 18 U.S.C. section 1029(e).

(D) "Produce" means to manufacture, alter, authenticate, or assemble an identification document; and

(E) "State" includes any state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, and any other commonwealth, possession, or territory of the United States; and

(F) “Financial Information” means any of the following information identifiable to an individual that concerns the amount and/or condition of an individual’s assets, liabilities or credit:

(1) Account numbers and balances;

(2) Transactional information concerning any account; or

(3) Codes, passwords, social security numbers, tax identification numbers, driver’s license numbers or any other information held for the purpose of account access or transaction initiation.

Section 4. Identity Fraud

(A) Any person who shall:

(1) knowingly and without lawful authority produce an identification document or a false identification document;

(2) knowingly transfer an identification document or a false identification document knowing that the document was stolen or produced without lawful authority;

(3) knowingly possess with intent to use unlawfully or transfer unlawfully five (5) or more identification documents (other than those issued lawfully for the use of the possessor) or false identification documents;

(4) knowingly possess an identification document (other than one issued lawfully for the use of the possessor) or a false identification document, or financial information with the intent that the document or financial information be used to defraud the United States, this State, any political subdivision of it or any public or private entity;

(5) knowingly transfer or possess a document-making implement with the intent that the document-making implement will be used in the production of a false identification document or another document-making implement which will be so used;

(6) knowingly possess a false identification document that is or appears to be a genuine identification document of the United States, this State or any political subdivision of it or any public or private entity which is stolen or produced without lawful authority knowing that the document was stolen or produced without such authority; or

(7) knowingly transfer or use with intent to defraud, without lawful authority, a means of identification or financial information of another person living or dead, with the intent to commit, or to aid or abet, any unlawful activity that constitutes a violation of federal, state or local law; shall be guilty of a felony and shall be subject to the penalties set forth in section (insert appropriate statutory reference).

(B) The provisions of this section shall not apply to any person who has not reached his or her twenty-first (21st) birthday who misrepresents or misstates his or her age through the presentation of any document in order to enter any premises licensed for the retail sale of alcoholic beverages for the purpose of purchasing or having served or delivered to him or her alcoholic beverages or attempting to purchase or have another person purchase for him or her any alcoholic beverage pursuant to section (insert appropriate statutory reference).

Section 5. Penalties

(A) Every person who violates the provisions of this Act shall be imprisoned for not more than three (3) years and may be fined not more than five thousand dollars ($5,000) for a first conviction.

(B) Every person who violates the provisions of this Act shall be imprisoned for not less than three (3) years nor more than five (5) years and shall be fined not more than ten thousand dollars ($10,000) for a second conviction.

(C) Every person who violates the provisions of this Act shall be imprisoned for not less than five (5) years nor more than ten (10) years and shall be fined not less than fifteen thousand dollars ($15,000) for a third or subsequent conviction.

Section 6. Effective Date

This act shall take effect upon passage and shall apply to those offenses which occur after the date of passage.

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National Council of Insurance Legislators (NCOIL)

Remote Notarization Model Act

Adopted by the Financial Services & Multi-Lines Issues Committee on November 19, 2021 and the NCOIL Executive Committee on November 20, 2021.

Sponsored by Rep. Edmond Jordan (LA)

To be discussed and considered for re-adoption during the Financial Services & Multi-Lines Issues Committee on November 21, 2026.

AN ACT concerning remote notarial acts, and other acts for executing and verifying certain documents, by notaries public and certain other authorized officials using communication technology.

(A) As used in this section:

"Communication technology" means an electronic device or process that:

(1) allows a notary public or an officer authorized to take oaths, affirmations, and affidavits, or to take acknowledgements, and a remotely located individual to communicate with each other simultaneously by sight and sound; and

(2) when necessary and consistent with other applicable law, facilitates communication with a remotely located individual who has a vision, hearing, or speech impairment.

"Foreign state" means a jurisdiction other than the United States, a state, or a federally recognized Indian tribe.

"Identity proofing" means a process or service by which a third person provides a notary public or an officer authorized to take oaths, affirmations, and affidavits, or to take acknowledgements with a means to verify the identity of a remotely located individual by a review of personal information from public or private data sources.

"Notarial act" means any official act performed by a notary public appointed pursuant to the provisions of the [State notary law], or otherwise qualified and commissioned as a notary public in this State, or performed by an officer authorized to take oaths, affirmations and affidavits

under […] or to take acknowledgments under […]. "Notarial act" shall include the following: taking acknowledgments; administering oaths and affirmations; executing jurats or other verification; taking proofs of deed; and executing protests for non-payment.

"Outside the United States" means a location outside the geographic boundaries of the United States, Puerto Rico, the United States Virgin Islands, and any territory, insular possession, or other location subject to the jurisdiction of the United States.

"Remotely located individual" means an individual who is not in the physical presence of a notary public, or an officer authorized to take oaths, affirmations, and affidavits, or to take acknowledgements, performing a notarial act under subsection c. of this section.

"Satisfactory evidence" means a passport, driver's license, or government issued nondriver identification card, which is current or expired not more than three years before performance of the notarial act; another form of government identification issued to an individual, which is current or expired not more than three years before performance of the notarial act, contains the signature or a photograph of the individual, and is satisfactory to the notary public or officer authorized to take oaths, affirmations, and affidavits, or authorized to take acknowledgements; or a verification on oath or affirmation of a credible witness personally appearing before the notary public or officer and known to the notary public or officer or whom the notary public or officer can identify on the basis of a passport, driver's license, or government issued nondriver identification card, which is current or expired not more than three years before performance of the notarial act.

(B) Notwithstanding the provisions of any law or regulation to the contrary, a notary public appointed pursuant to the provisions of the [State notary law], or otherwise qualified and commissioned as a notary public in this State or an officer authorized to take oaths, affirmations and affidavits under […] or to take acknowledgements under […] may perform notarial acts using communication technology for a remotely located individual if:

(1) the notary public or officer:

(a) has personal knowledge of the identity of the individual appearing before the notary public or officer, which is based upon dealings with the individual sufficient to provide reasonable certainty that the individual has the identity claimed;

(b) has satisfactory evidence of the identity of the remotely located individual by oath or affirmation from a credible witness appearing before the notary public or officer; or

(c) has obtained satisfactory evidence of the identity of the remotely located individual by using at least two different types of identity proofing;

(2) the notary public or officer is reasonably able to confirm that a record before the notary public or officer is the same record in which the remotely located individual made a statement or on which the remotely located individual executed a signature;

(3) the notary public or officer or a person acting on their behalf creates an audio-visual recording of the performance of the notarial act; and

(4) for a remotely located individual who is located outside the United States:

(a) the record:

(i) is to be filed with or relates to a matter before a public official or court, governmental entity, or other entity subject to the jurisdiction of the United States; or

(ii) involves property located in the territorial jurisdiction of the United States or involves a transaction substantially connected with the United States; and

(b) the act of making the statement or signing the record is not prohibited by the foreign state in which the remotely located individual is located.

(C) If a notarial act is performed under this section, any required certificate shall indicate that the notarial act was performed using communication technology.

(D) A notary public appointed pursuant to the provisions of the [State notary law], or otherwise qualified and commissioned as a notary public in this State, or an officer authorized to take oaths, affirmations and affidavits under […] or to take acknowledgments under […], a guardian, conservator, or agent of such person or, if such person is deceased, a personal representative of the deceased person, shall retain the audio-visual recording created under paragraph (3) of subsection B. of this section or cause the recording to be retained by a repository designated by or on behalf of the person required to retain the recording. Unless a different period is required by rule adopted pursuant to subsection G. of this section, the recording must be retained for a period of at least seven years after the recording is made.

(E) (1) Notwithstanding the provisions of the [State administrative procedures act], to the contrary, the State Treasurer may, in her discretion, adopt rules or append provisions to the manual distributed pursuant to section [State notary law] as necessary to implement the provisions of this section, which rules or appended provisions may include the means of performing a notarial act involving a remotely located individual using communication technology; standards for communication technology and identity proofing; and standards for the retention of an audio-visual recording created under paragraph (3) of subsection B. of this section.

(2) Before adopting, amending, or repealing any such rule or appended provision pursuant to this subsection, the State Treasurer shall consider the most recent standards

regarding the performance of a notarial act with respect to a remotely located individual promulgated by national standard-setting organizations such as the Mortgage Industry Standards Maintenance Organization and the recommendations of the National Association of Secretaries of State.

(F) This act shall take effect immediately.

NCOIL – NAIC DIALOGUE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
NCOIL-NAIC DIALOGUE COMMITTEE
2026 NCOIL SUMMER MEETING – BOSTON, MASSACHUSETTS
JULY 17, 2026
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) NCOIL – NAIC Dialogue Committee met at The Westin Copley Place Boston Hotel in Boston, MA on Friday, July 17, 2026 at 10:45 a.m.

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

Other members of the Committee present were:

Sen. Justing Boyd, AR
Rep. Stephen Meskers, CT
Rep. Peggy Mayfield, IN
Sen. Jason Howell, KY
Rep. Michael Sarge Pollock, KY
Sen. Kirk Talbot, LA
Rep. David LeBoeuf, MA
Rep. Brenda Carter, MI
Sen. Lana Theis, MI
Sen. Paul Utke, MN
Rep. Ellyn Hefner, OK
Sen. Mark Mann, OK
Rep. Tom Oliverson, MD, TX
Rep. Jim Dunnigan, UT
Del. Walter Hall, WV

Other legislators present were:

Rep. Zack Gramlich, AR
Sen. Tim Grayson, CA
Rep. Steven Meskers, CT
Rep. Kerry Wood, CT
Rep. Ben Fuhriman, ID
Sen. Willie Preston, IL
Rep. Mike Meredith, KY
Rep. Shaun Mena, LA
Rep. John Illg, LA
Rep. Dennis Bamburg, LA
Rep. Aimee Freeman, LA
Rep. Michael Bayham, LA
Rep. Poppy Arford, ME
Rep. Michelle Boyer, ME
Rep. Rolf Olsen, ME
Rep. Robert Foley, ME
Rep. Pamela Guzzone, MD
Sen. Mark Huizenga, MI
Rep. Joseph C. Thomas, MS
Sen. William Gannon, NH
Sen. Tim McGough, NH
Rep. Julie Miles, NH
Asw. Pamela Hunter, NY
Sen. George Lang, OH
Rep. Kevin Norwood, OK
Rep. Matt Morgan, TX
Sen. Cale Case, WY
Rep. Pepper Ottman, 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. Steven Meskers (CT) 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. Justin Boyd (AR) and seconded by Sen. Utke, the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's April 17, 2026 meeting.

INTRODUCTORY REMARKS

Rep. Jordan stated before we dive into today's agenda I just want to thank everyone for their participation and I want to acknowledge the great turnout of commissioners we have at this meeting. On behalf of NCOIL, it is truly a pleasure to work with you as we continue to strengthen our partnership. Your engagement and collaboration here is a big part of the progress that we've all made together over the years. Throughout this year, we've had several positive discussions and interactions with many of you and the NAIC in general and we certainly look forward to today's discussion. Rep. Jordan asked everyone to introduce themselves: North Carolina Commissioner Mike Causey, Oklahoma Commissioner Glen Mulready (OK), Montana Commissioner James Brown, Rhode Island Director and NAIC President-Elect Elizabeth Dwyer, Washington Commissioner Patty Kuderer, Texas Commissioner Amanda Crawford, Idaho Director Dean Cameron, New Mexico Superintendent Alice Kane, and Florida Commissioner Mike Yaworsky.

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

Rep. Edmond Jordan stated first, we're going to hear an update on the U.S. Treasury meetings with insurance regulators on private credit markets. As you know, when we met last in April, the U.S. Treasury announced that it would be meeting with insurance regulators regarding the growth of private credit in the insurance marketplace. We understand since that time, those meetings have taken place, and we're hoping you can brief us on how those meetings went and what was discussed and also what Treasury's support was like for the state-based system of insurance. To us at NCOIL, it seemed a bit odd and concerning that in Treasury's announcement of the meetings, it was seeking to be somewhat of an authority as it relates to insurance, despite having no direct regulatory authority over insurance.

Dir. Dwyer stated our meeting with Treasury was quite good and actually very supportive of state regulation. We had some of the same concerns as you, but they were extremely supportive. We went in May and there were over 25 commissioners there to discuss the growing role of private credit in the insurance sector and how state regulators oversee these

investments. Treasury is looking at private credit in many contexts, and their consultation with us was specific to the insurance industry but as you're aware, private credit is a rapidly growing market for loans made outside of traditional banks. That includes direct lending, private placement, and other forms of non-bank financing. It is certainly not limited to insurers, but some insurers, particularly life insurers, have increasingly invested in these assets because they can offer attractive long-term returns and we as insurance regulators have been very closely watching this development, and we were happy to share our experiences and what state-based regulation is doing in these areas with Treasury.

The discussions focused on offshore reinsurance, risk-based capital, investment oversight, and relationships between insurers and affiliated asset managers. It was primarily information sharing. It gave us an opportunity to explain how state solvency regulation works in practice and how regulators are responding to the changes in investment strategies. Following the meeting, Treasury released a public statement saying the administration is a strong supporter of the state-based system, and that they appreciate the work that we all do in our states to protect consumers and look forward to continued engagement. We found it to be a very positive meeting. We have ongoing discussions with them. I am actually the NAIC representative to the Financial Stability Oversight Council (FSOC), which met earlier this week. And so we continue to have an ongoing dialogue on these issues. We did not receive any criticism of how legislators and regulators are approaching these issues so we're going to continue on course.

Rep. Stephen Meskers (CT) stated yesterday we had a presentation by an asset management firm about private credit markets, suggesting all is good and you can't find a better product basically. Now one of the assertions was, and I guess the asset management industry has supposedly a fiduciary responsibility, and the investment banks only have a suitability assessment in the sale of the product, but I'm not sure that distinction had any value during the mortgage meltdown. And given those concerns and valuation, are you looking at both third-party guarantees limits on the amount of exposure to private credit? How are you going to hedge valuation risks for the insurance industry when they buy things that you can basically check into, but can't check out of?

Dir. Dwyer stated we have a domestic deference form of financial solvency regulation. In other words, I focus on my domestic companies as does every other commissioner here. And if you've seen one investment, you've seen one investment. So, we are focused on what our companies are doing specifically. We're looking at what our individual companies are investing in and how does that affect the financial solvency of that company. We are not accepting any platitudes of this good or this bad. We are looking at individual investments, and the NAIC actually helps all of us through the Securities Valuation Office (SVO), which is located in New York, and they look at individual investments. So, it's not a one-size-fits-all. If it was, we'd be entering into problems. Each individual regulator is looking at the overall investments of their domestic companies, the concentration risk, the type of investments and we are continuing as the market moves to adjust our regulatory involvement.

Rep. Jordan asked if the companies are being properly stress tested? Dir. Dwyer stated I'm not going to take anything on the private equity company itself, but the investment of insurers in private equity, I believe that we are addressing those investments appropriately on an individual insurance company basis.

DISCUSSION ON NAIC'S NATURAL CATASTROPHE AND RESILLIENCE TASK FORCE (EX) AND NAIC DEVELOPMENT OF MODEL LAW ON MITIGATION GRANT PROGRAMS

Rep. Jordan stated next up for discussion is the NAIC's natural catastrophe risk and resilience task force and the NAIC's development of a model law on mitigation grant programs. Natural catastrophe risk and resilience is an important topic and coming from Louisiana, I can certainly attest to that. We've done a lot of work as you are aware dealing with fortified roofs. We're hoping that you can provide us with an update on what the task force is working on in this area, and specifically, we'd like to hear about the NAIC's development of a model law on mitigation grant programs.

Cmsr. Mulready stated we too in Oklahoma have a program. There are eight states with programs. Let me start first with the NAIC task force, the NAIC Catastrophe Risk and Resilience Task Force is front and center. The new focus is on mitigation. We have two working groups that have been working on that, the pre-disaster mitigation working group, and the risk modeling working group, for which I am the Vice Chair. We are focused on improving how regulators assess and communicate catastrophe risk while promoting and talking about mitigation and resilience efforts to help consumers as well. The current work includes evaluating catastrophe models which are estimating potential losses for natural disasters, developing tools and some best practices. One project is pre-disaster planning for wind events where there is a mapping feature showing data where we could hover a certain area where we could see where that is most likely to impact. And then on the post-disaster we get exact real-time data to know exactly how many homes are impacted, what companies they're with, etc. For mitigation, NCOIL passed the model act that Oklahoma had enacted which was based on Alabama's law which had a very successful program. I think now at this stage, nationwide, 70,000 homes have been fortified.

Oklahoma is a little bit behind that, but we've got a group working on a model act at NAIC and really the idea is to enhance or update the model act that was passed here. And so we are looking forward to collaborating and really hoping to bring those in sync. I think the main efforts within that model act are to make some of those things more agnostic. So, whether that peril is wind or whether that's hail or whether that's fire or even flood or something else that might come along, it would be sort of peril agnostic. Also, within that model act, it's very specific to Insurance Business and Home Safety (IBHS) standards that most programs in those eight states are utilizing so we want to make that a little more agnostic too that as other programs develop or in some of the certain areas where that may not work, to try to give more freedom and flexibility. And then as well on the funding side, different states have used different models of how to fund like through an appropriation or I know when we did ours, it was more of a when I went to the legislature, the first question they would ask me was, "how much money do you need?" And my response was always, "I don't need money; I just need permission." We were utilizing leftover funds to fund mitigation. Oklahoma has a fund of about $10 million that we're utilizing. But bottom line, we're just hoping to give some more flexibility in how those are funded, whether that's through grants or as I mentioned this morning in the breakfast meeting, talking about the Federal Emergency Management Agency (FEMA) Building Resilient Infrastructure and Communities (BRIC) program, which are federal funds which we understand are going away, but trying to just make sure that folks have all the options in front of them with a little more flexibility, but that will be exposed at our August meeting in Columbus for public comment. And then the idea is to get all comments and piece that together and hopefully and ideally with some of you folks to figure out how we could kind of sync those up and then bring that before our executive committee at our fall meeting at the end of November.

Rep. Jordan stated I appreciate that and I think it gives us some comfort to know that we're working together and collaborating and trying to sync those and trying to make one rather than having two separate model laws that might differ in some ways. So, we certainly appreciate that.

DISCUSSION ON NAIC'S SECURITY INCIDENT

Rep. Jordan stated that next on our agenda is a discussion on the NAIC's recent security incident. We understand that last month, the NAIC experienced a security incident where unauthorized access was obtained to data that the NAIC was holding. First, we certainly hope that things have calmed down a bit for you, and we had a conversation on this topic this morning. Going through something like that must be stressful, but can you provide us with some details on the incident, starting with when exactly it happened, what data was accessed, and what the timeline was like for rectifying everything?

Dir. Dwyer stated, unfortunately, it's not if but it's when you are breached, and the NAIC experienced a cybersecurity event. It was not a targeted attack to the NAIC. It was actually a vulnerability in Oracle's Peoplesoft, which the NAIC was using for internal financial information. The first vulnerability was noticed, and the unauthorized access was noticed on June 11th, but it did not reach a National Institute of Standards and Technology (NIST) security event at that time. Companies get a lot of these potential unauthorized access events but there are certain criteria that once it rises to those criteria, that's when there is the trigger is to notify people. That is also true of the insurers that we regulate. When it reaches the NIST level for notification, we give insurers I believe 72 hours after that to notify. That trigger was determined on June 13th, and within 48 hours we notified the public.

We immediately started looking at what data was involved and how broad was the unauthorized access. Unfortunately, the bad actor put out information that the access was much broader than it actually was. The access we have found was limited to financial data, which is actually already public, and some rating organization data that goes to our SVO. We have been working with all of the companies who's data was implicated and the rating organizations, and just about everything is back up at this point. What was not involved was any personally identifiable information of anyone, whether it be NAIC employees or anyone that is licensed by the states and by their state insurance departments. Also, no confidential data of insurers was implicated. Our Systems for Electronic Rates & Forms Filing (SERFF) system was not implicated. Neither were the National Insurance Producer Registry (NIPR) and State Based Systems (SBS), which both contain producer information. So, in addition to the fact that the NAIC has a pretty robust state-of-the-art technology which is SOC compliant, we are lucky enough to have Cmsr. Crawford with us, who was most recently a Chief Information Officer. So, in addition to the experts we have on the NAIC staff, we also have her to consult with us, which I really appreciate because she knows all of the terminology.

Cmsr. Crawford stated just to add a little color on my prior role, for the previous seven years, as I've only been in this role five months, I ran Texas's Department of Information Resources, Texas's technology agency, having operational responsibility over technology and cybersecurity matters for the state. So unfortunately, I am familiar with incidents like this and their impact on entities. And so understandably, as you all can imagine, when I heard news of this, I paid a lot of attention to it and was very interested in the response of NAIC. To add more color around what this is, this particular threat actor is well known. It's a criminal organization. They are full-time engaged to seek out and exploit vulnerabilities. This particular one I think was mentioned is what's called zero day exploit. So essentially, that means it's new, not known, and not tested before. And so, this bad actor takes advantage of those when they're discovered, and then they do something that would essentially be equated to a "spray and pray" where they're just trying to hit targets of opportunity. And we know that there were others that were impacted. And so, as was mentioned earlier, unfortunately, because of the world we live in, it's not a matter of if, but

it's when, and it's how you're able to respond to that. So, the tools that the NAIC had in place to be able to provide adequate security protection because cybersecurity not only is it a team sport, but it is a sport that requires multiple levels of defense and one of the defensive tools that the NAIC employs is something that probably your organizations do as well, and if they don't, you should. It's an EDR or endpoint detection response technology that goes out to detect the kind of behaviors that you would see when there is an intrusion and it immediately detects it and shuts it down to be able to isolate and prevent spread.

So, the tools worked, which is a good thing. The other thing I think just to put into context here is that this is a criminal act. It's a criminal activity that happened by a bad actor and this is what they do all day long is try to exploit these vulnerabilities to get data, to make money and profit off of it. And when those criminal acts happen, as the victim of a criminal act, you unfortunately, in a cybersecurity incident, not only are you the victim, but you are also the first responder. So, you're trying to isolate, you're trying to control it. You're trying to determine what was impacted. You're trying to preserve evidence because there might be a chance that you could actually catch the bad guys. And so, it is complex in responding to those and I do give my hats off to the NAIC team in the way that they did respond, because based on my prior experience and the incident response playbook, they did what they were supposed to do. Of course, there's always lessons learned, and I know this. Unfortunately, sometimes they're hard lessons to learn. In my previous job you move on, and you learn from the lessons. You hope you don't have to apply them again. And there's always communication challenges on all of these events. In any event, I am hopeful that some of the color from my prior role might help provide a little context here.

Sen. Lana Theis (MI) stated thank you for your transparency. The NAIC has a requirement for insurers when they have a data breach to report to the regulators and to the consumers. What is your requirement and what is the authority that you are relying on that demands that? Dir. Dwyer stated that it's 72 hours when the security incident is at the NIST level that reporting is required. That level was reached on June 13th. We have 72 hours for insurers to report to us. The NAIC reported within 48 hours, so it was timely. Sen. Theis asked reported to whom? Dir. Dwyer stated that the NAIC reported to the commissioners. The NAIC also reported to the insurers who file data with the NAIC who also put out a public statement. Kay Noonan, NAIC Chief Legal Officer, is here today and she's actually on the incident response team and she can provide more details in terms of reporting.

Ms. Noonan stated I should preface these remarks by saying I am not a technology person. I do that for two reasons: one, it's accurate; and two, it will become readily apparent if we get too far into this. So, it was actually June 15th that we declared a cybersecurity event. We then informed our internal operating board, our Executive Committee, our members, and law enforcement the next day and then the next day we made an announcement to the public, which we did on our website. We used a couple different methods to communicate with insurers. We used different insurer mailing lists that we have available. We used what's called their annual statement content contacts because that's the bucket of information that we understood had been accessed. And then we also notified the credit rating providers because that was the other bucket of information that we at least had reason to believe at that point had been accessed. As Dir. Dwyer indicated, the threat actor put out some information that they had a whole bunch of information from other NAIC systems. At that time, we had no reason to believe those had been impacted, but unfortunately, we were not in the situation where we felt like our investigation was far enough along that we could say here is what it wasn't. I want to say that was later that week that we gave a subsequent notice on what was or wasn't accessed. And that was when we finished our first initial forensic investigation which was done through a combination of our

internal resources, and we also use a third party as I expect many of your states or organizations do as well.

Sen. Theis stated it sounds like you did what you should have done. What are the requirements that you impose on yourselves and where does that authority reside? So, you've got the NAIC model that instructs insurers, but what about the NAIC? What authority is there requiring that you do this should you decide to change your mind? Dir. Dwyer stated from an individual state perspective, we all have requirements within our states if it's any of our information. In this particular case it didn't happen to be, although we do send information to the NAIC. The NAIC itself I don't believe it is subject to any statutory authority. It's just best practices and it's in accordance with our SOC 1 and SOC 2 practices.

Ms. Noonan stated I think we certainly would have the same obligations as any organization would if there would have been impact of, for example, personal identifiable information (PII), confidential or proprietary information or information that we had courtesy of a license or a contract. We would have obligations there. In terms of our obligations we felt our primary obligations were first to our members, to make sure that they understood what had happened. And in particular, if there was any impact on either information that we collect either directly from the state or on behalf of the state. And then also because our systems are all interconnected, we wanted to make sure that the states had been informed to the extent that their systems might have been impacted. And then our second level of obligation, I think, was to the insurance companies and potentially producers on whose behalf we hold information for the states. We actually have very little PII from those institutions, we don't hold policyholder information. There may be some on the producer side, so our second stage was identifying what it was, and then we decided to give a very broad notification and then narrowed it down from there. So, I would say we followed our incident response plan, which is based on the NIST framework, and corporate best practices on what to do when you're the subject of one of these things.

Rep. Michael Sarge Pollock (KY) stated thank you for the transparency through this whole process that you went through. Obviously it's early in what you experienced but do you anticipate any change in your cybersecurity protocols? Hopefully, it doesn't happen again but obviously the threat is there. Dir. Dwyer stated we are constantly updating our cybersecurity protocols. So, the best practice is that you are always looking for it. I know that we're going to be doing a retrospective look and we will see whether there were any vulnerabilities in this particular one and making changes.

Ms. Noonan stated that after we went through the identification and eradication stages, we moved immediately to remediation. We had some immediate short-term steps that we took both based on what we identified happened and also based on recommendations from our cybersecurity consultant. So, we've got kind of a short, medium, and long term remediation plan that's ongoing. I would be out of bounds if I started talking about the specifics of it. I know some of the words but I just don't know the details. But if you've got questions about any specific efforts that we've taken, I am certain that we can follow up with either you directly or through others at NCOIL. But we took recommendations from Mandiant, our cyber consultant, and we have finished what they identified as sort of the immediate risk factors because that's what allowed us to issue the statement that we had verification that they were out of the system, and there was not an ongoing risk. And now we're taking some of those short-term remediations and applying them to the parts of the system that weren't impacted to the extent that they're helpful there as well. So, I would say that is ongoing. And then as Dir. Dwyer indicated, kind of the final stage in our incident response plan is an after action plan and we've already started to have meetings about that. Interestingly, we had scheduled internally kind of a tabletop exercise where

we were going to simulate a cyber breach and test our response. We no longer need to simulate it. We are going to use what actually happened and test our procedures there and take a look at our incident response plan, update that if we need to, and continue with the remediation efforts.

Asw. Pam Hunter (NY), NCOIL Immediate Past President, stated that it was mentioned that the states were informed of the breach. Did the carriers have to notify their policyholders about the NAIC's breach? And also, since this has happened, has there been any internal conversations with you all about the insurer data holding practices, and should you be holding all that data? Dir. Dwyer stated that there was no PII implicated in this breach. Under the NAIC cyber model, which I would say more than half the states have adopted, the insurers only have to notify policyholders if PII is implicated so the insurers I do not believe had an obligation to notify their customers in this case. Again, we being the state send data to the NAIC and that was not implicated so this was a very narrow group of information that was implicated, most of which was already public. So, insurer financial statements are public documents, and that was the majority of what was accessed here. There was also the second category of the rating organizations. Nothing to do with insurers. This is rating organizations that file information that have to do with investments. So the facts surrounding this limited the amount of notification that had to be sent to individuals, and that's why we did public notification. Regarding the data holding practices, we're always looking at that. It is inefficient, honestly, for 56 jurisdictions to request data separately from insurers. So, we do utilize the NAIC as a forum for that but as a result, the NAIC has very high-level cybersecurity protocols to make sure that we are doing everything that we can to protect that data. We look at it constantly. In this case none of that data was accessed but we'll certainly be looking at it, and we look at it on a go forward basis constantly anyway.

UPDARE ON WORK OF NAICE WORKING GROUPS

Rep. Jordan stated that we'll move on to a discussion on the activity of NAIC working groups. Let's first start with the market conduct regulation modernization working group. Can you provide us with an update as to what the working group is working on and also about the market conduct modernization efforts in general and specifically what problems were identified by the NAIC causing it to form this effort?

Dir. Cameron stated that as a former chair of the NAIC Market Conduct Committee, during my time as chair, we were able to see some inefficiencies in areas that could be improved upon. So, this year under the direction of Illinois Director Ann Gillespie, who chairs the Market Conduct Modernization Working Group, we have led a comprehensive and ambitious review of the market conduct framework which ensures regulators have the appropriate data and tools and supervisory approaches needed to oversee today's evolving marketplace. Since its creation in the spring, the working group has been meeting every other week holding listening sessions. We've heard from all kinds of insurers, consumer representatives, regulators, and other stakeholders and really had open opportunities for folks to express to us areas of concern or areas of improvement to modernize our market oversight while maintaining strong consumer protections. Current work includes evaluating our market data collection, examination practices, interstate collaboration, third party oversight, consumer complaint process and the use of regulatory technology to improve efficiency and consistency across states. The working group has also examined ways to make the market conduct examination more risk focused and improve coordination amongst the states and reduce unnecessary regulatory burden, on both sides of that aisle, and enhance oversight of insurer and third party data vendors and data driven systems. The working group is expected to provide initial recommendations here later

this year. I would anticipate this is going to be a long-term process. This is not going to turn on a dime, and we will certainly value NCOIL's input as we start making recommendations.

Rep. Jordan stated that I heard you mention listening sessions and I know several of them were public but I know a lot of them were closed door and only with regulators. Do you anticipate any more closed door meetings? Dir. Cameron stated that all the listening sessions were open meetings and I anticipate many of the discussions regarding modernization to be open. There are times where there is the need for regulator to regulator conversations as we are carrying out the work and discussing carriers' potential inappropriate activity. We obviously don't want to talk publicly about any one carrier that hasn't been properly investigated. So there is work of the market conduct committee that is regulator to regulator to preserve confidentiality and privacy of particular carriers. But the modernization work, I don't believe much of it will be, if anything, regulator to regulator.

Seeing no question, Rep. Jordan thanked Dir. Cameron and stated let's now discuss the healthcare affordability and mitigation working group. As you know, healthcare affordability unfortunately remains a top issue in this country. I think it's great that you have formed a working group to address this issue. Can you provide us with an update on what the working group has done so far and what are the goals in terms of developing any work product like white papers or model laws?

Cmsr. Mulready stated that I was speaking with my family recently and mentioned that we don't have a health care crisis in the U.S., we have a healthcare financing crisis. We have good healthcare, how do we finance that? So, the working group is working on developing some solutions on how do we improve healthcare affordability and access? I had the privilege last year of chairing the NAIC's health committee and I still serve on that committee and we did produce a prior authorization white paper last year. The working group is also focused on state-based solutions. What are the underlying drivers of health care? Rather than simply talking about affordability, what is driving that? Practical solutions for state policy options that might be available for regulators and lawmakers and important. And then producing that series of concise issue briefs to highlight those state approaches and best practices is a goal. Initial topics that they're reviewing and talking about are utilization review, market consolidation, reference-based pricing, price transparency, and impact of direct-to-consumer drug platforms on insurance affordability. All words and topics that we are all used to hearing about. The working group's plan is to continue working on that and then to kind of finalize those by year end.

Rep. Mike Meredith (KY) asked if vertical integration is something you all have looked at in the working group? Cmsr. Mulready stated that they will. The focuses are the ones that I mentioned but vertical integration certainly has a big impact. It's being addressed more so in that pharmacy benefit manager (PBM) space in many states right now.

Rep. Michelle Boyer (ME) asked if it could be clarified as to whether the working group would have any model laws developed by the end of the year. Cmsr. Mulready stated there won't be model laws but rather issue briefs.

Seeing no further questions, Rep. Jordan stated that we'll move on to the childcare insurance working group. We discussed this briefly at our last meeting in Louisville, and I know this is an issue that the NAIC is very interested in. Can somebody please provide us with an update on what that working group intends to do?

Cmsr. Kuderer stated that the NAIC's property & casualty committee recently established the Child Care Insurance Working Group to examine growing challenges related to the availability and affordability of insurance for childcare providers, child placing agencies, and foster care organizations. The working group is studying liability market conditions, including increased litigation, evolving liability exposures, increased coverage limit requirements, reduced insurer participation, and changes in underwriting practices that have made coverage more difficult and expensive to obtain. And I can tell you from speaking with my legislators and organizations that work in this space in the state of Washington, this has reached a crisis level. And in speaking with commissioners at our conferences, I know that this is a national issue as well, which is why we're focused on it. The working group is monitoring state legislative and regulatory developments including liability reforms, risk pooling approaches and other policy options that may improve insurance availability and affordability for child care providers. Regulators are working with insurers, childcare providers, and advocacy groups, legislators, consumer representatives, and other stakeholders to better understand these challenges and develop practical recommendations that states can consider to improve insurance availability while maintaining appropriate consumer protections.

Early findings suggest the insurance challenges vary by provider type, with child placing agencies and group foster homes facing the most significant liability insurance availability concerns. And the working group is evaluating targeted policy solutions that reflect those differences. And we view NCOIL as a partner in this work, because this is going to take system - wide changes. This is not singularly a regulatory issue or a legislative issue. There are other things that are at play here that we have found in our working group. To underscore the sense of urgency that we're feeling, we are meeting twice a month on this. We are giving an interim update to the insurance commissioners at our next meeting in Columbus and we will have recommendations for states to act on at our December meeting. That is our plan. And like I said in speaking with all stakeholders, we know that there is a real sense of urgency around this, and we know what's at stake but we want to hear from all sides so that we make as reasonably informed recommendations as possible to the NAIC and also to all the stakeholders.

Rep. Kerry Wood (CT) stated that this past session we just passed a feasibility study. We put $200,000 out to bid, and a report will be generated by February 1, 2027, which is right at the start of our legislative session, to look at liability risk pooling, forming a captive, other risk management options, provide actuary and financial analysis. And I would be happy to share the report with this group because we are also in crisis mode where Connecticut just invested $300 million in basically universal pre-K and we are struggling to find providers that can get insurance to provide those services. So we understand how important this is, and we would be glad to share our recommendations with the team as well. Cmsr. Kuderer stated we would welcome that. We in Washington did a study as well on whether we could use joint underwriting associations and that study is also part of the foundational information that we're using when we're taking a look at the recommendations for the group. So, any states that have studies on this issue, we more than welcome to have them sent to me.

Rep. Pepper Ottman (WY) asked if the recommendations are going to include things about who is causing the litigation and what kind of things they are litigating about? Cmsr. Kuderer stated that it's an interesting questions and I can say that one of the issues that's come up in our working group is the role of private equity and direct solicitation by attorneys and private equity groups of potential victims. And that is something that we are definitely looking at what are the best recommendations for how to deal with that.

Rep. Peggy Mayfield (IN) stated that when we think about childcare, we typically think about daycares, but you also said that this category includes child placement agencies. Would that be for the high acuity sex offenders of children - residential treatment centers? And how are different places covered under insurance compared to state agencies? Cmsr. Kuderer stated that we're looking at it very broadly in terms of the organizations that are impacted, the nonprofits. In terms of the state agencies, they are insured separately but there are things that state agencies are doing that are impacting this issue. For example, in our state, the state agency , Department of Children, Youth & Families (DCYF) has an indemnification clause in all of their contracts with these child placement agencies and group foster homes. And that has been pointed out by the agents, the non-profits, as a real problem for them to be able to obtain insurance. And so, irrespective of the fault of the state, all of the judgment then is passed on to the nonprofit. And we think that we need to be looking at things like should there be joint and several liability in these instances? Should that go away? And other reforms like that. Again, the direct solicitation is a real problem. I think we should be looking at that. Third party funding of these cases we need to be looking at that. So, there's a lot at play here and when I say that system wide changes need to be made, it's because it is so complex and it's interrelated, and we have to be thinking holistically or we're not going to really solve the problem. And I think that's the motivation behind the working group given what we've been hearing from the nonprofits in our state.

Rep. Mayfield asked if the report is available. Cmsr. Kuderer stated we haven't issued it yet. We're going to be making a report of recommendations at our December meeting, and it will be made available then.

ADJORNMENT

Hearing no further business, upon a motion made by Asw. Hunter and seconded by Sen. Theis, the Committee adjourned at 12:00 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 SUMMER MEETING – BOSTON, MA
July 16, 2026
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Joint State-Federal Relations & International Insurance Issues Committee met at the Westin Copley Place Hotel in Boston, Massachusetts on Thursday, July 16, 2026 at 11:30 a.m.

New York Assemblyman Erik Dilan, Chair of the Committee, presided.

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Rep. Rita Mayfield (IL)
Rep. Deanna Gordon (KY)
Rep. Michael Meredith (KY)
Sen. Kirk Talbot (LA)
Rep. Brenda Carter (MI)
Sen. Lana Theis (MI)
Sen. Paul Utke (MN)
Sen. Tim McGough (NH)
Rep. Brian Lampton (OH)
Rep. Dennis Paul (TX)
Rep. Tom Oliverson, M.D. (TX)

Other legislators present were:

Rep. Zack Gramlich (AR)
Rep. Stephen Meskers (CT)
Rep. Elijah Pierck (HI)
Sen. Adrian Dickey (IA)
Rep. Ben Fuhriman (ID)
Rep. Adrielle Camuel (KY)
Rep. Dennis Bamburg (LA)
Rep. Aimee Freeman (LA)
Rep. John Ilg (LA)
Rep. Edmond Jordan (LA)
Rep. Shaun Mena (LA)
Del. Pam Guzzone (MD)
Rep. Poppy Arford (ME)
Rep. Michelle Boyer (ME)
Rep. Bob Foley (ME)
Rep. Rolf Olsen (ME)
Sen. Bill Gannon (NH)
Asm. Jarett Gandolfo (NY)
Asm. David Weprin (NY)
Sen. Mark Mann (OK)
Rep. Kevin Norwood (OK)
Rep. Carl Anderson (SC)
Rep. Matt Morgan (TX)
Rep. Calvin Callahan (WI)
Del. Walter Hall (WV)
Sen. Cale Case (WY)
Rep. Pepper Ottman (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 Sen. Tim McGough (NH) and seconded by Rep. Michael Meredith (KY), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Brenda Carter (MI) and seconded by Rep. Brian Lampton (OH), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's April 18, 2026 meeting.

INTRODUCTION AND DISCUSSION OF THE NCOIL STRENGTHENING TRANSPARENCY IN THE 340B DRUG PRICING PROGRAM MODEL ACT

Asm. Erik Dilan (NY), Chair of the Committee, stated we'll start today with the introduction and discussion of the NCOIL Strengthening Transparency in the 340B Drug Pricing Program Model Act. There was a great first discussion on this topic at our Spring Meeting in Louisville, KY and I know this is an issue that many of us have dealt with in our respective states across the country. And with that, I'd like to recognize Rep. Tom Oliverson, M.D. (TX), who is sponsoring this Model, for some brief remarks.

Rep. Oliverson stated it's a pleasure to sponsor this Model. You can find a copy of the Model starting on page 33 in your binders. I would point out that this Model is already state law in Indiana and other states. We all recognize the fact that the 340B Program is critically important, especially to the grantees, the Federally Qualified Health Centers (FQHCs), the Ryan White clinics, the Black Lung clinics, and those for which it was originally intended to be beneficial. However, it has grown massively. I think even the most ardent supporters of the 340B Program would agree that it's kind of gone beyond what it was originally designed to do, maybe for better, maybe for worse. So, all we're proposing to do with this Model is allow state lawmakers the opportunity to have some transparency and to be able to see how the Program is being utilized in their states with the various 340B pharmacies, participants, hospitals, facilities, medical practices, etc. That's essentially all it does. I do want to be clear that my intent here is not to do away with the 340B Program. Similarly, this is a federal program so any Model or any ideas around structurally changing the conditions of participation or the way the Program works would need to be done at the federal level. However, sunlight is a good disinfectant for everybody, and I think transparency is really important. I do want to say a special thank you to NCOIL President, Sen. Paul Utke (MN), for being a co-sponsor on this model.

Sayeh Nikpay, PhD, Associate Professor, Division of Health Policy & Management at the University of Minnesota stated thank you very much for inviting me here to be with you today. I'm so pleased to see that this Committee is thinking about 340B transparency. The 340B Program is a program that is starting to touch so many different lives and in ways that I believe were really unanticipated by the people that created it. I'm an economist and I've been doing research on this Program for over a decade, and the more you pull the threads, the more the garment sort of falls apart and you learn. I'm pleased that you're considering transparency here. I should say that I want to give a brief disclaimer. My views don't represent the University of Minnesota, which does have a 340B hospital included in it. My views also don't represent the views of the Minnesota Prescription Drug Affordability Board (PDAB), of which I am Vice Chair.

Getting started here, these figures are very fresh. Just a few days ago, the Health Resources and Services Administration (HRSA), the agency that regulates the 340B Program, came out with new numbers on the size of the Program and the discounted value of drug purchases under 340B reached $100 billion last year. Now that has grown significantly as you can see over time. To put that number in context, 340B is now a bigger program than the Medicaid drug rebate program by about 70%. It's also on its way to potentially reaching up to the Medicare Part B program net of premiums, which is about $140 billion a year. This is an important

program. Maybe one of the most important statistics here is that its penetration is great. Part of that is because about half of U.S. hospitals, or if you think about it just in terms of nonprofit hospitals, it's reaching up to about two-thirds of hospitals that are participating in this Program. Now before I talk about 340B and really any topic related to 340B, I like to talk about its history. The Program's primary beneficiaries today are nonprofit hospitals. When the Program was created in 1992, it was designed to solve a very specific problem for a narrow set of providers with a very specific solution. So, this is from some findings of a study that I just concluded this Spring. It's an open access paper, so feel free to find it. We did interviews with 20 different people who were around in 1990 to 1992 when the policy was actually being created, talked to bipartisan staff, members of the Bush Administration, advocates, lobbyists, the whole host, and we reviewed about 200 internal memos. What we learned is that when 340B was created, it was really focused on Public Health Service Act clinics. That's things like your community health centers, Ryan White programs, and then about 200 public hospitals that were members of the National Association of Public Hospitals.

And what we have seen over time is that because of some compromises that were made and some sort of loopholes, hospitals have begun to participate in it and that participation is surging. So, there are some important words when you hear about 340B. You'll hear the words like stretch scarce resources as far as possible. The stretching here was really designed for that original group of participants, those Public Health Service Act clinics and the public hospitals that had the same problem when Medicaid drug rebate got introduced. It made prices soar as manufacturers rushed to cancel their discounts with these clinics that were some of their best prices in the market. And these providers that had fixed budgets that relied heavily on federal grants or state and local funds. In the case of public hospitals, all of a sudden you go from a $100 budget when you were spending $10 on drugs and now it's blown up. Now you're spending $40 on drugs, which means you have $30 less to do other things. And so, those words were about stretching the resources for these particular types of safety net providers. So, because of issues with the way this federal policy was created, we have this program that went from this targeted population to now exploding and growing in both size and scope. As policymakers have tried to do things in their individual states, they come to me and I hear from them about this. They increasingly bump up against 340B. Minnesota enacted a 340B transparency program because lawmakers were trying to work on a policy that they thought they had no idea it interacted with 340B and the constituency that stood up in opposition to a policy was 340B hospitals and legislators were very confused. And in an effort to gain an understanding of why 340B was interacting with this other policy, they created the 340B transparency report.

I am going to show you some findings from Minnesota's transparency report and what is possible when you do transparency reporting. I've looked at your draft Model, I think it's a really great start and looks very close to what Minnesota does. I know Indiana's law is really great too. So, this is sort of the top line result from Minnesota. You can see the economics of the 340B Program pretty clear here. Largely, hospitals and clinics that participate in this Program accepted $3 billion from insurers and patients for outpatient drugs that were purchased for a cost of $1.5 billion. After you net out the, call it $160 million in fees to third parties, you get what's left on the table, which is $1.34 billion. And that money is important to providers. I am not going to say that this is not money that health care providers depend on. What I'm going to say though is that it's a lot of money. And whether you like the 340B Program or don't, understanding how the money flows and who benefits and who is potentially struggling is very important. One of the features of the Minnesota covered entity report that I think is really powerful is that they collect information on contract pharmacy fees and Third-Party Administrator (TPA) fees. What we learned from the report is that $1 in every $10 of that, you

can call it savings, you can call it 340B net revenue like they do in Minnesota, $1 in every $10 of that spread is eaten up by an outside party. That's not the hospital or the clinic. When you look here across the different types of providers that can participate in the 340B Program, some of them are giving up a lot of fees. If you're talking about big hospitals, the top 10% end up giving away 25% of what they generate from 340B. For critical access hospitals, it's getting close to half gets given up in fees. And then when you're talking about FQHCs, there are at least 10% of them that are underwater on 340B meaning 340B lowers their cost, but they're not generating any revenue from the Program.

Also in Minnesota, we were able to look at the concentration of net 340B revenue across the different types of providers that are participating, and what comes out of it is that we see that 95% of that $1.34 billion number is coming from hospitals. And when we talk about which type of hospitals, we're really talking about the large urban medical centers. So, I believe 80% of net revenue is generated by those hospitals and because Minnesota has an appendix where the top 90% of revenue generators are actually published, we can see that it's about a handful, 4 or 5 of these hospitals that account for almost half of that $1.34 billion. So, it's highly concentrated. Minnesota's covered entity report also collects data by payer, which I see the draft Model does as well. I think that's fantastic. You learn some important facts from looking at things by payer, the chief being that the largest single source of funding for net 340B revenue is commercial patients and a lot of them are going to be employer sponsored employees who are depending on an employer sponsored plan. What's the issue with this? First, I would say that we know that people who are on employer-sponsored plans, commercial plans, face a lot of cost sharing even when they're under their deductible. Typical cost sharing for drugs might be somewhere between 20-30%. That means a big chunk of this spread of this net revenue is also generated from patients who may or may not have been able to easily pay that bill even with insurance. On top of that, we know that employers spend a lot of time and a lot of money asking Pharmacy Benefit Managers (PBMs) to negotiate rebates on their behalf to lower their total expenditure at the end of the year, which helps them lower premiums and helps them grant higher wages to employees. When 340B discounts, which are given out before the transaction, stack on top of rebates that are negotiated by the PBMs, those rebates get canceled, which means that employers end up paying more for drugs at the end of the day, because a big chunk of what they were expecting in cost reductions has just gone poof. The other thing that I think is important for anyone who's regulating insurance within a state is the interactions with Medicaid. What the Minnesota Covered Entity Report also showed is that about 1 in 5 of those net revenue dollars comes from paying providers significantly more than their actual acquisition cost when they bill through Medicaid managed care. The total in Minnesota was about $260 million of extra spending relative to if they paid based on actual acquisition costs.

There are some limitations here. I'm going to skip over these because I fear that I've been talking too much. I'm glad to hear that the NCOIL Model was based on Indiana's legislation. I think Indiana's law is very good. We also have some states that have done sort of a partway version of this by doing a one-time report, and we have federal legislation and policy that's moving forward. However, I would say that it's not clear to me that these policies will pass and even if they do pass, state policymakers need some flexibility in the data in order to answer state-specific questions. And so, I would argue that passing this type of legislation at the state level can be really powerful for states to understand where the dollars are flowing. And finally, I'll just say it one more time, my research has sort of led me to believe that there's no bad guys in this world. We have among the organizations that are participating, FQHCs who my research shows, when a dollar comes in, a dollar goes back out in care. There are public hospitals. We have one public hospital in Minneapolis where I'm from whose 340B margin is essentially the same as the uncompensated care they provided in that same year. I'm not saying this is a bad

program, and you shouldn't do it. I really do think it's very important. So, I appreciate your remarks, Rep. Oliverson, that it is critically important. But I do think that policymakers need to understand where the dollars are going and how they spend the next dollar.

Molly Smith, Group VP, Public Policy at the American Hospital Association (AHA) thanked the Committee for having her today. I'm definitely not going to belabor this. I think Dr. Nikpay did a great job going through at least the origins of this Program. But I think what's really important to underscore here is that truly, this started because of concerns around the high and rising price of drugs. Those concerns persist today, and they have over the last 30 plus years of the Program. Which is actually why, after Congress initially established the Program in the early 1990s, it actually revisited the program several times just to make technical corrections, but two times to make substantive changes to the Program. And in both instances, it was either to expand the Program or to protect the participants in the Program due to kind of unforeseen situations, specifically COVID. And I just want to really underscore two points. When we talk about how many hospitals are participating in the Program, the vast majority of those are small rural hospitals, and that's who was included in one of the primary types of hospitals that was included in the expansion. So, I don't think that should be a surprise because Congress very intentionally wanted to add them to the Program. The other thing is about the high and rising price of drugs. You saw the latest figures out of HRSA that the Program has grown to $100 billion. One of the things that HRSA said, is that about 62% of that actually is flowing through really high priced drugs. So let me just give you some specific examples.

The numbers that were on the slide were from 2017 to 2025. In that time period let's think about a couple of things that have happened in the outpatient drug space. We've had CAR-T, which originally started as an inpatient therapy, now safely being able to be delivered in an outpatient setting. So, this is a six-figure cost drug. We have Keytruda, a very important cancer drug delivered in the outpatient setting, also introduced during that time, up to millions of dollars. We also have had GLP-1s come on the scene. So, we've had a lot of changes in the pharmaceutical space that have actually driven growth in the Program that have nothing to do with the behavior on the part of the covered entities. It's just that there are new drugs and there are very expensive drugs. The more the drug costs, the higher the discount. So, a lot of that growth in the Program is actually solely a reflection of drug manufacturer decisions around pricing and their introduction of new drugs. Also to underscore what the 340B Program does, this is not about changing what anyone pays in terms of a service, what an employer pays, what a public program pays, or what an individual pays. The difference here is in expenses. As Dr. Nikpay mentioned, the concern was really about more of certain providers budgets were getting eaten up by drug costs. So, this is really just trying to give them more of a cushion back into their budgets by lowering their expenses.

I appreciate that this Model Act is not touching the underlying program, but if that's what we were talking about, to be clear, making changes or scaling back of the 340B discounts would not accrue any benefit to those people who are paying for the service because it hasn't actually changed what they're paying to begin with. If you as a payer or as an employer, for example, have negotiated $100, you're paying that whether or not something's 340B and if their discount goes down, you're still paying $100. I want to be really clear that this is an expense side issue and not a payment side issue. I think there are some consistent misperceptions and I'm not suggesting you have those misperceptions, but we hear them a lot. So, I thought I would go ahead and emphasize a couple of key points. One is the one that I just made that it does not change how a covered entity is reimbursed by payers and therefore does not increase costs for payers. But the Program also very clearly does not dictate a specific use for the savings. So again, the idea here was that concern around more of providers budgets getting eaten up by

drug costs wanting to free up more of those dollars so that they could expand access to care. I think that if you look at the various providers in your communities and across your state, I think it's fair to say that communities can vary quite a bit one from the other and what their needs are. Congress gave covered entities the flexibility in order to meet those needs in the way that they thought was most appropriate for their community. So, whether it's expanding access to certain preventive services and screenings, or for example, dealing with a particular gap in behavioral health services, or something else. I just want to be clear that there's no specific use dictated by the statute.

I very much appreciate that this Model is really around reporting, but I do want to be clear that there's also already a fair amount of reporting that we believe policymakers could be looking to. So, in the 340B space, all 340B covered entities report a fair amount of information to the federal government through the registration and annual recertification process. The federal government also audits providers who participate in the Program, and substantially more covered entities get audited each year than drug manufacturers. And then also there is voluntary compliance with something called the 340B Good Stewardship Principles. This is something that we facilitated several years ago within the hospital community, and we have more than 1,400 340B hospitals who are members of the AHA who have signed on to this and publicly make available their savings of the program, how they use the savings, and then, of course, just attest that they are in compliance with all program rules. But throughout this discussion what I think we've also heard is that policymakers at the state level really feel like they need a better handle on just the overall financial picture of the hospitals in your communities, particularly if you're hearing about financial stress and sort of wondering how much of this is true or where exactly that stress is coming from. Looking just at the 340B Program is not going to get you very far. It's just one piece of a very complex financing picture. So, we really do encourage policymakers to look at audited financial statements, which of course all 340B hospitals would provide federally and then of course many of you at the state level have those requirements as well. While also incomplete, but still far more robust than any reporting on 340B would offer, are the Medicare cost reports, which of course are fully publicly available.

In terms of how covered entities are using the savings, there's a lot of reporting from hospitals around the benefits that they provide to their community through the IRS 990's. The Medicare cost reports also include information, for example, on charity care through the S-10 worksheet. And then all nonprofit hospitals also do their community health needs assessments and have to publish their execution plans. And in some states, the licensure process for providers actually requires some of that same reporting, particularly around community needs. I do want to acknowledge that we should be concerned about reporting if it doesn't have a clear purpose and if it is duplicative. Right now, in the U.S. healthcare system, we spend upwards of a quarter of all healthcare spending on administrative tasks. That is more than $1 trillion. I think we're up to about $1.4 trillion this year that we will spend on things like adjudicating claims and checking insurance. Aside from managing the coverage aspects of care, the other biggest cost in terms of administrative costs in the system is reporting, whether it's quality reporting or financial reporting.

So, when we're talking about reporting, we need to understand that there is a real consequence to the healthcare system and it goes beyond financial. It also impacts staff. So, both the National Academies of Medicine and the U.S. Surgeon General several years ago found that administrative burdens on clinicians was one of the primary drivers of workforce burnout and that we all needed to do more to try to alleviate some of those burdens. When it comes to the 340B Program, certainly there are administrative staff who help support some of this reporting.

But it also does involve pharmacists and pharmacy techs and people with real expertise in the drugs and how the program works. So, this is both administrative and clinical staff who need to be pulled to comply with all of this reporting. And as much as we wish that our IT systems were in some amazing state, the reality in healthcare is that a lot of this data will have to be pulled manually, compiled manually and submitted manually. So, I just want to at least underscore that we need to be conscientious of the reporting costs. With that, I will just say that our recommendations really are to look to existing reporting, particularly hospitals audited financial statements and try to avoid duplicative reporting where we can. And then frankly, if you're concerned about what benefit your 340B covered entities, including hospitals, are delivering to their communities, we strongly encourage convening them and talking with them because again unfortunately while you can definitely pull the information on that, like I said from the 990's, etc., the reality is it's just very different. And sometimes you just need to actually get in there and figure out what's going on in their community that they feel like they are needing to address. So, we of course are always happy to facilitate that although I encourage you to work closely with your state hospital associations, which are obviously even closer to the ground in your state about what might be going on.

Sen. Mark Mann (OK) asked Rep. Oliverson if he could identify a single required data element in this Model that directly measures whether more low income individuals receive care because of the 340B Program? Rep. Oliverson stated I'll have to get back to you. That's obviously a very pointed question, and I will get you an answer.

Rep. Ellyn Hefner (OK) stated similar to Sen. Mann's question, I support meaningful transparency. Because there's so many requirements with this and all the reporting, my concern has always been what happens when we pass this legislation and what that's going to be used for, especially when this seems like more financial instead of that direct care. I serve in a city that has a big hospital that supports a lot of rural hospitals. I'm happy of how the expansion of 340B has changed because of our growth and population, and especially since our rural area has changed so much from thriving to not thriving right now. My concern is supporting the health care outcomes of Oklahomans and when we start getting this information out there it could be misunderstood. So, my question is, because you've done this research, what is the outcome that you see with this information coming out?

Dr. Nikpay responded I think there are several different outcomes. I'll give you an example from my own, and I'm speaking more as a taxpayer right now than as a researcher, although my research does inform these questions a little bit. I think that reporting of this nature gives policymakers a sense of the potential tradeoffs. So, there's an example from my market. We have a public hospital that is on the verge of failing, and we have other hospitals that are located in that same market that are benefiting a lot from 340B but have a much lower uncompensated care and community benefit, even though they are many times larger. Policymakers in Minnesota entertained the idea of a sales tax in my county, which would have landed especially on the people who use that public hospital, and then have been contemplating a statewide tax. I would as a consumer and as a taxpayer like to see policymakers grapple with the idea of, well, is it reasonable to raise taxes on me and other Minnesotans? Or should we be thinking about adjusting the way that this Program is distributed across hospitals? Is there a way to get other hospitals to participate and potentially help support that public hospital that we all benefit from and is using the Program in in a really good way? I would also say that it informs decisions about how you structure your Medicaid program. We've had several attempts in Minnesota to contemplate whether we should follow other states in paying hospitals their acquisition cost for drugs in Medicaid, potentially using that $260 million and reallocating it to some other need within the state. So, I understand that there are consequences for making this

data available, but I would argue that citizens like to see that policymakers are using data in this way, and I think that it can really help understand what the Program is doing and where it's heading.

Ms. Smith stated I want to reiterate one point that Rep. Oliverson made which is that you can collect the data at the state level. Some of the changes that you just indicated would not have the authority to do at the state level. They would require federal changes to the Program. But I think that if you are concerned about understanding how the Program works and how it's impacting your state, and it might implicate policies as big as Medicaid, I would encourage you to think about ensuring that you are actually collecting all of the data that you need on the Program because right now, there's a huge gap in that there is no additional reporting for the drug manufacturers. And in fact, these are companies many of which are earning double digit margins. I think the average margin for drug manufacturers was hovering near 40% recently. Medicare and Medicaid spend a lot on prescription drugs and that is flowing to those organizations. So, I think that if you are interested in understanding the totality of the Program for making state policy, you might want to expand it to actually ensure that you're getting that data. And I will say that a lot of the reporting that I mentioned that happens at 340B hospitals already do. That reporting does not exist in the pharmaceutical space. So, there is no current source to go for a lot of that data where it already does exist in the hospital space.

Rep. Hefner stated I think that's my apprehension for moving forward with this, because your situation in your state is so different than the one in mine and I don't think people fully understand it. If you want to change parts of the 340B Program, that is something that Congress would do, and I think there's a discussion there. But I don't think that the parts about transparency work if one side is not willing to bring them in too. Because as legislators, we need to see the full amount of what we're making decisions on, not based on where I've seen some lobbyists come into my state and given misinformation. And a lot of people are really lost. I know a ton about Medicaid having gone through the system and filling out an application, has anyone done that? So, I do know that we throw stuff around out there that people don't fully understand. And then we get a vote on it. So, my concern moving forward is if we want greater transparency, and we say that word all the time, and we're asking one side to do it, I don't think that what we have a full picture to take a vote.

Rep. Rita Mayfield (IL) stated I just want to mention that we in Illinois currently passed similar transparency legislation. It passed almost unanimously through both Houses. I believe we had 8 dissenters, but other than that it had bipartisan support on both sides. We actually had our hospital association, which is a very strong advocate against most things 340B that we try to do, and they were actually neutral on the bill. So, asking for transparency is not a bad thing, particularly when you are looking at the amount that the states are paying in 340B Medicaid costs and everything else. That is one of the reasons that we wanted to have the transparency. Yes, there are a lot of things that are available on the federal level as far as reporting but I don't know if you've ever read through those thousand page documents that were written by professors. They are not very easy to understand. They're very confusing. So, to have a simplified report actually is beneficial. Illinois HB 4327 is currently on the Governor's desk waiting to be signed. And again, it did pass with overwhelmingly bipartisan support. So don't shy away from looking at something that will provide transparency. I think this is a good thing. The goal was not to change what the hospitals are currently doing. We're not looking to reduce their benefits or anything else and yes, to your point, we do need some legislation for the pharmacy side as well. Both sides need to be looked at and have more transparency. But it was just more to give legislators a better idea. In Illinois, we actually had several bills that came through that wanted to take away 340B because people didn't understand what it does. This will at least help

to solidify or validate why 340B is needed. So, don't push away from transparency because it actually stops bad legislation that may negatively impact that Program.

Rep. Stephen Meskers (CT) said there are two drivers to the 340B Program right now, which is, how are we providing subsidized health care and who's bearing the cost for that subsidized health care? But it goes back to pharmaceuticals. In the U.S. we've decided on a business model that the pharmaceutical industry can charge 3 to 4 times what it charges in the Organisation for Economic Co-operation and Development (OECD) countries for drugs. On a policy basis, I think we want to see the drugs developed in the U.S., manufactured, and sold in the U.S. And, the real question is, should they get a 20-30% premium over a profit rate on that? And should they lay off the costs on the rest of the developed world instead of us subsidizing the entire industry? So that's kind of more a statement than a question. When we go through this process, it gets very confusing to me about whether we're calling it an expense or benefit. Because ultimately, I think the important issue is we're not reducing the cost of drugs from the pharmaceutical purchase point. What we're doing is cost shifting for a benefit. I think if we're looking on a policy basis for more transparency, we do have to ask who are the beneficiaries of the policy and are we getting to the targeted audiences that we're trying to help through this policy. And it's very complicated. It's either very simple or very complicated, depending on how you look at it. Who's bearing the cost? How do we want to drive it forward? I'm not sure that the transparency, without a full conversation, that we're going to understand the impact of the policies. It might be the best thing to start with what are the criteria for awarding the 340B benefits and are we serving the most vulnerable populations? Are we getting the benefits to reduce costs or to hospitals who are serving the most uncompensated care? And I think that really needs to be the question because I think it does become a pool of revenue and it's fungible. So, I think the question is, how do we make sure that they're doing "God's work" with the benefits?

Ms. Smith stated the first thing I would note is that uncompensated care is obviously a really important part of community benefit and how hospitals care for their communities and help some of the most vulnerable finance their care. I do want to caution that it is not the only benefit and there are others, and I'll give you some examples. For example, some of the most financially stressed hospitals are not going to be able to invest in a new behavioral health clinic or in inpatient capacity. That is something where I would say we hear the most from our members about how they use some of these savings is to bolster that gap to build behavioral health workforce and access points. So, when we think about the benefits that the community is accruing, I think we need to be very conscientious that there are things beyond charity care or financial assistance policies and it goes beyond that. Rep. Meskers stated the only thing I would say to that is everything we talk about in the legislatures that I hear suggests that it's social media that's causing our mental health crisis, and now you're suggesting that 340B should be a subsidy to take care of those mental health care issues? I'm not advocating against taking care of those issues but now we're moving from are we serving our most vulnerable population, and are we using it for other issues?

Dr. Nikpay stated my north star on this issue is always patients and one of the things I was struck by several times during this process of interviewing people who were there in the 1990s, is that several people said to us, "We never in a million years could have imagined that the 340B Program would be a source of revenue. It was never supposed to be a source of revenue." These providers I talked about, a narrow set of providers for whom this was for, those providers have requirements, and you can see those requirements today. If you go to your local FQHC's website, you will be able to find a page that gives you the sliding fee scale price menu for drugs where you can say, okay, if my income is in this range, I'm going to pay the actual

acquisition cost, that 340B cost plus some amount. It's very transparent. It's really clear for patients. They're not going to leave with a bill that they don't understand. They can see upfront that they're going to get some support and same thing with our public hospitals, which also does presumptive eligibility for patients below 300% of the federal poverty level. So, they're really using the 340B Program in the way I believe Congress intended, which is access for patients. A little bit of revenue gets generated on privately insured patients, but it goes right back out the door in the form of more charity care. What I have seen myself, this is not for the state of Minnesota, but Minnesota does have this appendix where you see at a hospital level how much of 340B savings or net revenue or however you want to describe it is being generated. And when you stack that up against uncompensated care or community benefit, the line showing the relationship is basically flat. And so I think this question of are patients benefiting is a really important one. Unfortunately, the way that Congress set up this Program, even though they intended it to benefit patients, it is not set up in this way. And so, transparency is a way for you to understand how this policy is affecting your taxpayers, your constituents, and get a more nuanced picture of where the benefits are accruing.

Sen. Justin Boyd (AR) said between 2016 and 2026 in Arkansas, the total number of retail pharmacies has dropped from 802 to 735, while at the same time nonprofit, so entities not really being taxed, 340B entity owned pharmacies have increased from about 6 to over 50. My question is, at some point, while 340B has some good, it also brings the question of how's it being administered? Why can the nonprofit entities seem to make it where the ones who are out there paying taxes are struggling to survive? Ultimately what's this going to do for patient choice and innovation?

Ms. Smith stated that I think there are a number of providers in our healthcare system where we are at a real crisis point. So, primary care is another example, behavioral health care is another example. And one of the things that I think that we have heard over the last couple of years is a lot of concern about integration between, for example, hospital systems and these other providers. But when you ask a lot of these providers, why did those pharmacies have to shut their doors? Why did the primary care practice merge with a hospital or health system? Consistently, you're hearing that the business model just no longer worked for them, and that is either because their expenses, their input costs, have risen beyond what they're able to bill for and part of that is also the administrative overhead. So, thinking about reporting requirements, cybersecurity requirements, a whole bunch of stuff that they have to deal with when they're trying to give drugs to patients or deliver care. So, in many instances they don't want to have to go into a relationship with a hospital or a health system or any other entity, because as I think many people know today, the largest employer of physicians is actually UnitedHealth Group, but they are sort of forced to. I think when we think about these policies, we need to think about them holistically like, what are we doing that is frankly, just not supporting independent pharmacies, not supporting independent physician practices so that they end up in these situations. I just want to be clear that I think we're very sympathetic to this desire and I think we want as many providers who want to remain independent as possible can do so, but it's just the business model is not working.

Dr. Nikpay stated I think that's exactly the rationale for why you need transparency because fees that go to pharmacies are accruing and that has an impact on the covered entity. But the other thing that I have learned from my own research is that, in the contract pharmacy space, about two-thirds, maybe a little bit north of that, of contract pharmacy relationships are between covered entities and some of the biggest pharmacy giants you could imagine. Your CVSs, your Walgreens, that are in kind of a vertical chain where they are part of a PBM. As an economist, we don't really like vertical integration because there's a lot of shenanigans that can happen

across that vertically. And collecting data on what is actually happening, what these fees are, is very important. And I think some of the states that I've been talking to who are contemplating this are starting to talk now about actually asking for the contracts. They want to see what the fee structure looks like, which also can tell them something about what's happening to independent pharmacies potentially and how they are or are not benefiting from 340B.

Rep. Oliverson stated just a couple things I want to point out. One is that NCOIL already has a comprehensive Model on pharmaceutical price transparency and so you might recommend some improvements to that in the future when it comes up for re-adoption. We can obviously look at that, but I don't want to get into a game of pass the buck here, especially on a situation where we already have a pharmaceutical transparency Model. As the sponsor of that particular Model, I will say the same thing that I said when we passed that Model several years ago, which is that there really is nothing to fear. We're not talking about changing the Program structurally or disenfranchising people or really doing anything other than just wanting to understand where the money goes. The only people that have to fear from transparency for a program like this are people that are misappropriating those funds. I would say to Rep. Meskers that there is some language on page 35 (Section 4(a) and (b)) that I think gets at some of what you were talking about. But I am very happy to work with you if you have some more specific pieces of information that you would like to see included in the report that would help establish what portion of this $1 billion and climbing profit margin is actually going to help people who cannot afford care and hospitals and FQHCs and other clinics who are desperately trying to provide that care at a loss and truly depend upon this program for survival and not as a revenue source. That is where we're at. At the end of the day, we could sit here and probably talk for several hours about who's doing what or whether this is good or bad but the reality is that we don't really know and that's what this is about. This is about gaining knowledge. I will tell you how I would use this information. As a lawmaker in Texas, I sit on the Appropriations Committee and I sit on the Article Two Subcommittee, which is health and human services. So, one of the things that I want to know is to what extent my public hospitals that provide the vast infinite majority of indigent health care in my very urban county of Harris County, to what percentage are they benefiting from, being disadvantaged by, or struggling to keep up with the indigent care that they are providing in lieu of the fact that they are surrounded by tax-exempt 340B entities that may or may not be diverting that benefit away from them? So, that would be helpful to me. As somebody who sits on Appropriations, who makes decisions about where state funds go, to make sure that those entities that are out there are truly doing charity are able to keep up. And that's what this program was designed to do. It's morphed into a whole lot of other things, and that's the conversation we've had. The last thing I'm going to say about this is that NCOIL has a history because insurance has typically been the business of states. NCOIL has done great work with transparency legislation in terms of shining a light and encouraging the federal government to take action. And so, if we're not going to take leadership by providing data and providing an impetus for action to be taken on a program that is exclusively under federal control, then what are we doing?

Asm. Dilan thanked Rep. Oliverson and everyone for their comments. If anyone has any further follow-up questions or comments they can reach out to me, Rep. Oliverson or NCOIL staff.

PRESENTATION ON DEVELOPMENTS IN THE FLOOD INSURANCE MARKETPLACE

Asm. Dilan stated that we just heard about one federal program that is experiencing issues. Well, another such program is the National Flood Insurance Program (NFIP), which similar to the 340B program, serves a great purpose but has experienced difficulties. With further reforms to the NFIP being contemplated and also with the continued growth of the private flood

insurance market, it's a great opportunity to have a dialogue about flood insurance in general and the road ahead.

Jake Clark, Managing Director, U.S. Public Sector at Guy Carpenter thanked the committee for the opportunity to speak and stated we are the reinsurance arm of Marsh. Together with the broader Marsh, we bring some unique insights to the flood insurance landscape here in the U.S. Torrent, a subsidiary of Marsh, acts as a TPA for a number of write your own (WYO) companies that support the NFIP. In addition to that they've recently stood up Managing General Agent (MGA) that's looking to offer low limit flood solutions to homeowners in a handful of states with the concept that over time, that would be expanded. Marsh, meanwhile, services both residential and their commercial clients by sourcing flood solutions across a number of insurance carriers in the U.S., and we at Guy Carpenter support clients and entities that are holding portfolios of flood business through both reinsurance, which includes capital market solutions. Our work also includes engagements on behalf of the NFIP. We've been supporting the Federal Emergency Management Agency FEMA since it began exploring private market support in 2013. All of the work around flood typically entails supporting analytics and advisory services. We do this utilizing commercial modeling vendors, but around that we have also built flood models and brought on actuarial support to supplement the manner in which these tools evaluate the peril. So, over the course of the next 20 minutes or so, I'll provide some colors to the trends and challenges our firm is seeing, and some of the opportunities that we see in this space.

First, the natural inclination people have when the topic of flood insurance comes up is to focus on FEMA, but it's important to recognize a few aspects around this peril. Currently only about 4% of U.S. homeowners purchase flood insurance, an frequently cited statistic and one that has held steady for quite a number of years. At the same time, 99% of counties across the U.S. have experienced significant flooding events in recent times. While we see positive signs of change and enhanced capabilities that enable the insurance sector to play a larger role addressing the financial impacts of flooding, the challenges associated with the protection gap that exists around this peril are challenging. We point to some high level observations regarding flood exposure in the U.S. We often think of flood risk in terms of FEMA's maps and the special flood hazard areas. The Specialized Flood Hazard Areas (SFHA) is FEMA's designation for the 1 in 100 year floodplain. These maps, however, are often either outdated or do not fully represent the flood risk from all sources of flooding.

Private companies have recently been stepping in to create more comprehensive flood risk maps. While studies have shown that approximately 25 million people live in these SFHAs, that number significantly underestimates those that are exposed to 1 in 100-year flooding. When capturing all sources of flooding, including fluvial or riverine flooding, pluvial which is precipitation and rainfall, or coastal so think of storm risk, that figure is closer to 40. On the right side of the slide, we compare the SFHA figures to this more granular cut of data. And we show some figures at the bottom right that showcase some of the larger NFIP states.
The other point to draw out on this slide is the fact that 30% of losses emanating from flooding often happen and come from outside the SFHA, and those are statistics often cited by FEMA data. The peril of flood is not abating, and we believe strongly that to truly address the protection gap that is associated with flooding, the private public sectors need to be working more in concert to affect that.

On this next slide, overall flood insurance policy counts have remained relatively stable from our perspective since 2021. The NFIP, their in-force counts have been trending lower each year over the past decade, while private flood has been growing. Currently, we see over 60 entities

offering private flood insurance in the U.S., although we believe it's sort of the top 10 that are really dominating. Since 2021, in force residential policies with private carriers have increased by over 100%. But as you can see on this slide, they still only represent about 10% of the market at large. The private market remains slightly more skewed also toward commercial risk. Commercial risk, and we respect this is in part driven both by sort of their business distribution of the carriers involved, but also in part by strategies, these carriers are using to manage their portfolios against broader natural catastrophe exposures and concerns as well as distribution channels that they utilize to manage their business.

This next slide further drills down in color regarding the market and the distribution of flood policies and related premiums. The states in yellow represent the 10 largest NFIP states, California being the only one that doesn't present a significant hurricane exposure. In addition to residential, we illustrate commercial in force policies and premiums on the right. Of 5.2 million policies in place in total, over 35% are located in Florida, and then the next largest state Texas comes in at about 12.5%. From our perspective, we see muted private market interest in Louisiana and Texas. A handful of states bring other challenges that extend beyond the perils of flood but likely are influencing broader flood take up. Additional color around Louisiana, the largest MGA focusing on flood that's actually made some pretty impressive inroads in this area is avoiding the state given both the frequency and potential severity of the peril that exists there. And so, for reasons like that, but others as well, it suggests to us that FEMA and the NFIP are not going anywhere soon. But more robust action could be taken to help bring greater private market solutions online faster. On this slide, in respect to product offering, we've seen an evolution over the past decade of product offerings that are varied and illustrate that there is market appetite across the insurance sector to take on this peril. There are currently 48 markets working with the NFIP through the WYO platform. Not that long ago, there were well over 70. We're aware of a few carriers that have left the WYO space in recent years, and we think this is both due to their perceptions of potential reputational risk of being involved, as well as the expense versus the offered compensation for handling the business. Certainly, the challenges associated with federal shutdowns, lack of long-term reauthorization of the NFIP, and some bureaucracy that's associated with a federal program have not helped. On the private side of the equation, we're seeing a variety of approaches develop. We're seeing lower limit and lower risk offerings. Typically, these are insurance offerings providing $5,000 to 50,000 of limit being offered both via endorsement or standalone offerings. We've seen admitted and excess and surplus line solutions, managing general agencies and underwriters facilitating placements in this space as well as white label offerings, and the use of parametric solutions. Typically, all flood offerings made by primary carriers are relying on reinsurance support behind them and we've also noted that some states recently have enabled markets to utilize surplus lines offerings a little easier, trying to entice and facilitate a growing market.

We can't leave the topic without some comments regarding FEMA and the Review Council. For a long time, and we believe beyond politics, if you will, many have pointed to the unsustainable state of affairs surrounding not just the framework of the NFIP, but the broader framework of disaster risk management across the country. And from our perspective, what we see is an overreliance on debt financing at both the state and the federal level to address recovery efforts after events have happened. Specifically, the Council suggested 10 guiding principles, of which one focused on the NFIP, generally calling for greater private sector involvement. We agree, and what we're seeing suggests the primary carriers are developing offers and want to see this happen. Frankly, we don't believe the issue is a supply issue on the part of the insurance sector. The challenge is trying to figure out ways to grow demand and cover the number of people that should have insurance, but don't. As already mentioned, we believe there will always be a role for the NFIP. Issues like severe, repetitive loss properties in states like Louisiana that see both

frequency and severity of flooding events, and the current rate structure of some of the federal offerings are issues that are going to be with us for some time. The progress that has been made since 2017 when FEMA started engaging with reinsurers, we believe needs to continue. And we'd like to see certainly some actions expanded and see some of these processes move faster.

As a summary slide, I'll just finish with a few observations. FEMA's engagement with reinsurance we would argue has sparked some of the transformation we have seen over the past decade in this area. The analytic tools available in the market would not have evolved as quickly or to the extent that they have without it. While some of the analytics involved can be complicated given the nature of the peril, our industry is in a good position, we think, to understand and manage the risk in their portfolios. More importantly than that, they've got a greater ability to communicate risk to residents and businesses. And those skills have improved markedly. FEMA's engagement also primed the market by bringing reinsurers and capital markets to the table. The primary market has the ability to write and better manage their catastrophe exposures by spreading risk across the financial system and insurance linked securities (ILS) help facilitate greater consistency with both product offering and pricing to the original customer. Finally, across Marsh, we're trying to find solutions to move and help close this protection gap. We believe greater and enhanced private-public partnerships can help facilitate this. We are currently working with a number of stakeholders to promote the Community Resilience Act, which is designed to help pair risk transfer solutions with mitigation efforts that are rolling out. And we believe these can be effective tools to help support low to moderate income elements of our communities, as well as small business components of communities that often lack flood insurance, but yet play a vital role in the economic vitality that our communities are trying to build.

Rep. Meskers stated it seems to me that at some level, the prime focus you have is on demand for flood insurance policies and the ability to place flood insurance policies, is that the right assessment? Mr. Clark responded maybe in part. I think the amount of residential flood insurance that exists in the market, I think you can make a pretty solid argument it's been pretty stable for a long period of time despite some of the developments we're seeing. So, where NFIP policies are going down a little bit, maybe some of those policies predominantly are moving to the insurance community. But there's not enough going on to protect the many people that get impacted by this peril that have no insurance at all. Rep. Meskers stated, as legislators, our biggest issue, we hear it from every point in the political spectrum is affordability. And yet we have an uncovered liability, which is flood insurance, in the proper way. The underwriting of all of our mortgages is Sallie Mae, Fannie Mac, etc. It sounds to me like we don't have a way of, or we haven't used our tools at the federal government, to further require the right levels of flood insurance in those policies. And the problem at the local and at the national level is that's going to raise a premium cost in your mortgage rates. So, part of it may be that as a solution. I know the federal government is running around in circles deciding whether or not to privatize the entities they had to intervene in the last financial crisis. Perhaps the sale of those entities and the revenue generated should go to subsidize premiums to create a sustainable flood insurance market. But what I'm just wondering is how you create the demand. And it sounds like if it becomes part of the mortgage process, it's almost one of the simplest solutions.

Mr. Clark stated I would agree that that could be part of it. I think another step that we think could be made right, ever since the mandatory purchase provisions came in, everybody's been focusing in on that 1 in 100-year threshold, and you're either on one side of the line or the other. FEMA already in their rate making approaches is trying to mute that distinction a little bit so that more people become aware. So we see things whether it's make offer provisions mandatory or

maybe looking beyond the 1 in a 100. So, we're forcing that dialogue with more people. That could help. We've seen a few other efforts out there with private carriers, putting out a quote on every offer that they put out. And again, some of these efforts that we've seen are only currently happening in a few states right now, but they seem to be having success in in growing flood sales.

Rep. Bob Foley (ME) stated just two points I'd like to make. Has there ever been any discussion with the private insurance companies to require them to cover flood insurance as a normal coverage on all property & casualty policies? Spreading the risk has always been what insurance has been about and it seems that we're trying to cover a large risk with a small pool of people. And if we spread that risk over all property & casualty, we could certainly make sure the coverage is there and that the pricing becomes a lot more affordable. My other point would be, after September 11th, we created the terrorism risk insurance act (TRIA), which was a mandatory coverage that had to go on all commercial policies. And it created an enormous amount of revenue that sits there waiting for the next terrorism event to happen. Has there been any discussion about perhaps looking at that sort of a model? A concern that I have, and I write a lot of flood insurance back in Maine, is you have a duplicate system going. You've got the federal government and their expense, and you got the private sector and their expense. And now you have two companies that are taking expense out of the system rather than paying it towards benefits and costs. So just curious if those have been discussions.

Mr. Clark stated I believe at certain times those have been discussions and they seem to always get constantly hung up with how can you force people to buy the product. At the same token, I think there needs to be more of a debate in terms of how much basically taxpayer funded debt is going to pick up the problems after they happen. So, I do think there's a place for that debate. My own personal feeling is there's a solid portion of the NFIP portfolio that certainly could move to the private sector. There's a component of that portfolio, if you think about severe repetitive loss properties or some of the grandfathered policies that exist within that portfolio, that are completely underfunded where some sort of public role still needs to happen, but we do think there could be other solutions to cover some of the adverse exposure that flows from that through private, public partnerships.

DISCUSSION ON RECENT FEDERAL EXECUTIVE ORDERS ON "ACCELERATED MEDICAL TREATMENTS FOR SERIOUS MENTAL ILLNESS" AND "INCREASING MEDICAL MARIJUANA AND CANNABIDIOL RESEARCH"

Asm. Dilan stated the next item on our agenda is a discussion of the recent federal Executive Orders (EO) on "Accelerated Medical Treatments for Serious Mental Illness" and "Increasing Medical Marijuana and Cannabidiol Research." You can review both of these Executive Orders starting on page 37 in your binders and on the website and the NCOIL app. These orders will certainly have significant policy implications for states and the marketplaces they touch so it's important that legislators know how these developments will affect our constituents.

Daniela Sharfstein, Regional Director of State Government Affairs for Jazz Pharmaceuticals stated Jazz is a global biopharmaceutical company dedicated to developing life-changing medicines for people with rare diseases. We are also the company with the only Food & Drug Administration (FDA) approved cannabis derived drug in the U.S. Jazz has over 25 years of cannabinoid research and we've invested over $1 billion in this and our drug Epidiolex was approved by the FDA in 2018 to treat rare forms of epilepsy. And like other prescription drugs, like statins or antibiotics, we are available nationwide, we're prescribed by doctors and dispensed at pharmacies. So, I always like to set that standing. What I am supposed to talk

about is some of the changing landscapes in cannabis and hemp, which is evolving quickly. At the outset, what I want to focus on is that we are not dealing with a single market. We are dealing with three distinct categories. First is FDA approved medicines. Second are state authorized medical and recreational cannabis, and then third are hemp derived products. And the thing that I want to really emphasize is the need to keep these three categories different. All of these categories operate under different laws, different safety standards, and different implications for insurance and of course patient safety.

So first, the FDA lane. In the U.S., the FDA determines what is safe and effective medicine. FDA medicines undergo rigorous clinical trials, FDA reviews, strict manufacturing standards. State cannabis and hemp products do not meet these standards, and this creates real risk for patients. So, what does the EO do? It essentially creates two categories and for the purposes of the Controlled Substance Act (CSA), it recognizes accepted medical use for FDA approved products and then it reduces the federal state conflict for state medical programs. And then third, it expands research opportunities. So, what it does not do is also important, and it does not make state run medical cannabis an FDA approved drug, nor does it legalize marijuana federally. And it does not apply to recreational cannabis. So those are the things that it does and what it doesn't do, and we want to keep the lanes separate there. In a similar manner and equally important is the hemp policy space, which is legally distinct from marijuana. And Congress is cracking down on intoxicating hemp products by revising the federal hemp framework, and these new rules and regulations go into place November 2026 which is effectively the federal government asking states to reconcile their intoxicating hemp and marijuana policies. We're seeing a lot of activity at the state level in this area. There were 45 bills across 30 states and we're seeing four Models emerging for this area. Of course, the first is aligning with new hemp federal definitions. The second is putting hemp into existing cannabis regulatory systems. The third is banning intoxicating hemp products completely. And the fourth is creating new adult use hemp frameworks.

So, to sort of sum up the purpose of my area, it's as you're evaluating these options and you're reconciling with what your state is going to do for both marijuana and hemp, I want to emphasize that there are meaningful differences between these three categories in testing, labeling, clinical evidence and that the lanes are not interchangeable. Blurring the lines between FDA approved medicines, state cannabis, and hemp creates risks for everyone. Policy changes in one lane can have unintended consequences in another lane. And we saw this directly at the federal level when they were revising the hemp definition, Epidiolex was pulled into that definition, and that would have limited access to our patients and their use of Epidiolex. And so just making sure that those lanes are separate is really important. And getting these distinctions right is important for innovation and for patient safety.

Gretchen Shaub, Senior Director of Government Affairs at Definium Therapeutics stated we are a pre-commercial biopharmaceutical company focused on brain health and psychiatry innovations, primarily at this point, using schedule one psychedelic compounds going through the FDA approval pathway. I think to level set on kind of where the industry is right now, there are several companies that are in late stage clinical trials with different types of psychedelic drugs that are currently in development but standing in schedule one under the CSA. And so, really needing to work in these very large four areas to understand potential patient access should any receive approval by the FDA in the near future.

So, we are focused not only at Definium, but as an industry, on the interagency coordination between Department of Justice, particularly the Drug Enforcement Administration (DEA) on the rescheduling of these products, and FDA approval and that really gets into infrastructure and

systems readiness, adoption by insurance, upscaling and updating the state controlled substances acts is another bucket that we are trying to work in parallel to really prepare for potential approval of these products. And then the fourth is ensuring providers have clarity on prescribing, and patients have timely access. And all of that really gets to the timing and the need for a sense of urgency in updating existing statutes and policy frameworks for controlled substances. So, this is kind of the four levels within this pathway. Most of the work is in the top category, so we are seeing a number of clinical trials moving further along. Several companies have been designated breakthrough therapy designation by the FDA for their psychedelic compound, given the mental health indications that we are also looking at, including generalized anxiety disorder, severe depression, Post Traumatic Stress Disorder (PTSD), among others. Once these applications are put in front of the FDA, which feels fairly imminent for at least a couple companies, the FDA will review and move through the approval process. Once something is approved the DEA at the federal level then it has 90 days to determine where on the controlled substances list that product will be placed and then all 50 states have their own process for moving through aligning with the DEA to ensure rescheduling updates are made for those approved products. Recently in April, the Administration released an EO on Accelerating Medical Treatments for Serious Mental Illness. Part of that EO comes from years of work that has been conducted in the clinical trial space. We're also seeing a lot of accelerated enthusiasm both across administrations and Congress to really start to think about the next steps for operationalizing these treatment options should they gain FDA approval and become available. Excitingly, just this past week, as in a direct result of both the EO and a lot of work that has been happening on the industry side and both academic research as well, the FDA issued finalized clinical trial guidelines. There were draft guidelines that were put out in 2023. Now, we were at a place where there are over 25 companies that are all in late stage clinical trials, and so to have finalized guidance for how those trials should be conducted is very promising and shows how in lockstep the agency has been with research and taking this seriously and seeing the promise across the entire category.

The FDA also put notice for a public hearing on September 14th that will be focused on provider training and credentialing, patient safety, and overall best practices for data collection for these new innovations. And it's important to note that and HRSA also issued an RFI with similar themes, really seeking broad feedback and helping to further prepare the landscape to operationalize these things and making sure that at the federal level, there is a floor or a foundation being set for these new innovations that states can look to as individually we proceed in hopefully being able to have access to these treatments for patients. And then, in tandem on the congressional level, Congressman Morgan Luttrell from Texas introduced a bill early this week to codify the EO, and I think one of the bigger things to note within that EO is that it really doesn't change the work that has already been underway in terms of the clinical trials and development and following the existing regulatory pathway for approval of a medication. It's really asking that the FDA and the DEA and other federal agencies of jurisdiction are working together sooner rather than later to make sure that there is a cohesive and coordinated strategy for working within the myriad issue areas that are captured with these new treatment options. And there is also the Path Caucus, which is the Psychedelics Advancing Therapies Caucus which holds quarterly briefings and really shifting the narrative now thanks to the EO around systems readiness rather than clinical research and design.

A lot of this work was happening prior to the EO but tying a line and taking an opportunity based on a lot of the work that was done for Epidiolex over a decade ago to modernize patient access and a part of that at the state level is updating the CSA for FDA approved medications that are subsequently DEA rescheduled. It matters greatly because most of these statutes were written and adopted in the early 1970s with a focus really on illicit drug use and drug diversion and they

largely remain unchanged today. We are seeing great advancements in science and technology that have really been accelerated with the use of controlled substances so there's an opportunity to have a larger conversation about creating efficiencies there. Timely action at the state level, particularly for rescheduling, is critical for supply chain and ultimately treatment administration. We can't have conversations about getting on formulary or prescribing if we're not able to manufacture and distribute the product once it's approved legally across the states. And to that end, any delays in rescheduling at the individual state level due to regulatory alignments really do create unintentional access barriers for both physicians, health systems, and ultimately patients. Definium successfully ran legislation in Arizona, Colorado, Georgia, Illinois, Tennessee, and Utah this past session. Very technical bills and at the top here, there's some language that we have been using as model legislation to improve the timing and clarity around rescheduling of FDA approved products that are DEA rescheduled. So just all that to say, the EO does not impact the work that's already being done by companies that are seeking FDA approval and now with the announcements that have come out early this week at the federal level they are all intended to help with these key considerations for patient access across all of the different innovations within psychedelic medications for mental disorders.

ANY OTHER BUSINESS

Asm. Dilan stated you can take a look at the NCOIL website and app for an update on the state of catastrophe savings accounts legislation from the American Bankers Association (ABA). If you are interested, please reach out to Kevin McKechnie of the ABA with any questions. And we'd like to thank Mr. McKechnie and the ABA for working with NCOIL on this.

ADJOURNMENT

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

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
JOINT STATE-FEDERAL RELATIONS & INTERNATIONAL INSURANCE ISSUES COMMITTEE
INTERIM COMMITTEE MEETING – SEPTEMBER 25, 2026
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Joint State-Federal Relations & International Insurance Issues Committee met via Zoom on Friday, September 25, 2026 at 12:00 p.m. ET.

New York Assemblyman Erik Dilan, Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Matt Lehman (IN)
Rep. Michael Meredith (KY)
Rep. Brenda Carter (MI)
Sen. Lana Theis (MI)
Asm. Jarett Gandolfo (NY)
Rep. Meredith Craig (OH)
Rep. Brian Lampton (OH)
Rep. Tom Oliverson, M.D. (TX)
Sen. Cale Case (WY)

Other legislators present were:

Rep. Carolyn Hall (AK)
Rep. Zack Gramlich (AR)
Sen. Mike Webber (MI)
Sen. Jeff Barta (ND)
Rep. Carl Anderson (SC)

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 Sen. Lana Theis (MI) and seconded by Rep. Michael Meredith (KY) the Committee voted without objection by way of a voice vote to waive the quorum requirement.

INTRODUCTORY REMARKS
Asm. Erik Dilan (NY) stated the purpose of today's meeting is to conduct some business before our November meeting in Florida. Today we will continue discussion on the NCOIL Strengthening Transparency in the 340B Drug Pricing Model Program Act and take any comments on the model laws scheduled for re-adoption in November. This will help ensure that we move through the agenda in a timely manner in Florida.

CONTINUED DISCUSSION ON THE NCOIL STRENGTHENING TRANSPARENCY IN THE 340B DRUG PRICING PROGRAM MODEL ACT

Asm. Dilan stated this topic first came on the Committee's radar at last year's Annual Meeting in Atlanta. As we all know, this is something that's been frequently discussed both at the state and

federal levels over the past several years. I know many of us here today have dealt with this program extensively in our respective states, and significant effort has gone into shaping this Model so far. The goal of today's meeting is to take final comments on the Model so that the committee can continue preparation for a potential vote on this matter at the Annual Meeting in November. We've held discussions on this topic at two meetings, and now both I and the sponsor believe that it could be ready for potential vote in Florida this November and that is consistent with NCOIL's typical model law development timeline.

Of course, if things change and it's determined that we need more time, we can adjust but as of right now, I feel like we're in a good place heading into November. That said, I know there is a lot of interest in this Model, so this meeting will provide an opportunity to gather more thoughts and use them to guide our discussion in advance of the November Meeting. I want to note that all meeting materials that we will discuss today including the draft Model have been posted on the NCOIL website for this meeting, and with that, I'd like to turn things over to the sponsor of the Model, Texas Representative and Past NCOIL President Tom Oliverson.

Rep. Oliverson thanked everyone who has reached out and provided thoughts and comments on the Model. Before I begin my comments, I specifically want to take a moment to thank and recognize Michigan Representative and NCOIL Secretary Brenda Carter, as well as NCOIL President and Minnesota Senator Paul Utke, for serving as co-sponsors on this important piece of model legislation. Being strongly bipartisan is sending a great message which is consistent with our mission at NCOIL to be focused on good and timely policy.

As the Chairman stated, the goal here is to take final comments and then release an updated version of the Model in the 30-day materials for consideration in November. I think the Model is in a good place. I have received some good feedback from various stakeholder groups, much of which we've been able to incorporate, some of which we are probably not going to, and I'm going to go into that just to kind of give you a bit of a heads up here in a second. But I do want to, before I get into the nuts and bolts, just make a couple of quick points. As I said at the Summer Meeting, the intent of the Model is not to do away with the 340B Program. I think, and hopefully everybody on this call recognizes, that eliminating the 340B Program would not be a good public policy decision. It is a critically important program for expanding access to care, especially for our most vulnerable citizens.

And so eliminating it is neither the goal of this particular Model, nor would it even be possible to do as it's a federal program so obviously structural changes would need to be done at the federal level. With that being said, I think we can all recognize that the current Program, as it is today in 2026, has certainly grown in some strange directions or far away from where the Program began and the population and types of covered entities that it was designed to protect and assist. As state policymakers, what we can do is require transparency in terms of how these dollars are flowing into the state and how these dollars are being spent and what the costs are. I would point out that since we first took up this conversation, we initially were looking at a law out of Indiana. Since that time, other states have added their own take on 340B transparency and some of the very good comments that we've received, which are going to be incorporated into a subsequent draft of this Model, concern some positive changes that were made in Illinois as they attempted to look at the same issue. And so, more states are looking at this: red states, blue states, big states, small states.

Accordingly, it is very timely for us to act and serve as a unifying voice and put our best foot forward as far as what is the best policy. I think meaningful transparency certainly is something that needs to be balanced with not creating an unworkable administrative burden. I've heard that over and over again from various stakeholders. For example, one comment that was

submitted, which I believe is pretty reasonable, is having hospitals submit 990H forms instead of filling out a brand new form, and it would essentially capture similar sought after information without creating a duplicate reporting requirement that would be cumbersome. We send a strong message that I think states have a right to have information, they have a right to know. But that doesn't mean that we have to be the most difficult as far as how we obtain that information. If similar information is being obtained in another document, then incorporating that document seems a reasonable alternative.

There has been conversation that's come up repeatedly about including drug manufacturers in this Model. I'm just going to say that's probably not going to make it into the final version of this Model. This Model is tailored towards covered entities. NCOIL has a separate model act looking at pharmaceutical price transparency which specifically deals with the manufacturers and their costs and their prices. Many states have already adopted that or some version of that, and I would point out that the covered entities in this model are not part of that particular model. So the idea that just because it touches a certain space that we have to loop everybody into it is not consistent with how NCOIL has operated in the past.

That's where I think we're going to draw the line on this. I am certainly open to the idea that we could incorporate a drafting note to just say something to the effect of manufacturers have a role in the 340B Program, and if your state already doesn't have a transparency piece looking at the pharmaceutical manufacturer side of things, you may want to consider incorporating some transparency language. But I don't want to go as far as to put that in the Model because, as I said, we already have a model on that, and multiple states have already adopted it and it is working.

I think those are some of the main things I want to say. I'm appreciative of the comments that I've received, specifically from the American Hospital Association (AHA) and we're trying to find some common ground there. But I think we are moving forward with the Model with the consent of the Committee. I also want to say that I appreciate the hard work and willingness to work offered by the Ascension Hospital System, which has been very good about providing constructive feedback and sort of how we can get to a workable middle ground on transparency that's not overly burdensome. I really appreciate the good faith effort there, and look forward to continuing the conversation.

Joe Burchfield, National Director of State Policy at Ascension stated first, I want to thank the committee for the opportunity to speak today and express my appreciation to Rep. Oliverson and NCOIL staff for their time over the last few weeks to collaborate and work on this Model. As a multi-state Catholic health system, we're focused on care of the poor and vulnerable, and as a result of that, the 340B Program plays a central role in helping us fulfill that mission. We operate 39 qualified covered entities across 9 states, so we have good experience in this area and good perspective. Our commitment to program integrity and transparency is foundational to how we operate as an organization. We have 3 guiding principles we use for the 340B Program that our work benefits: that benefits from the Program are used to provide services to the poor and vulnerable; that our participation can serve as a model for others to follow; and that our program is implemented with integrity and is aligned with our mission, vision, and values. We have built and maintained a comprehensive, compliant 340B program that's guided through four other internal pillars: compliance through internal system and regional governance that ensure program integrity; advocacy partnerships like we're having today with policymakers that demonstrate accountability and our commitment to transparency; stewardship to implement programs that bring access and affordability for poor and vulnerable patients; and optimization to evaluate opportunities to grow services that support indigent populations.

We publish information on this work on our website. That includes details about our approach and commitment, as well as the ways the program supports our mission in our communities across our 9 states. Across our footprint, discounts for manufacturers through the 340B program support free or reduced cost medication and community and patient tailored services and programs. These discounts help fund programs that address a wide variety of conditions among our most vulnerable populations, including diabetes, cancer, and behavioral health. Discounts also help support programs that meet unique community needs, like transportation, primary care, and other health and well-being initiatives. We support transparency. We support streamlined policy approaches that identify the acquisition cost and reimbursement for 340B drugs, and how those lower acquisition costs help safety net providers like Ascension fund critical community care programs.

Our experience with enacted transparency laws across multiple states provides insight into the challenges created by expansive reporting requirements that don't always meet the goals that have been shared for this Model. As Rep. Oliverson noted, the draft Model follows similar stipulations in Indiana's law, where we completed our first reporting cycle just earlier this year in April and while it's inclusive of the key points, we think there is an opportunity to streamline and better align with the stated goal of the Model Act. As Rep. Oliverson has alluded, one such way that we think we can do that is through modeling off of the Illinois law that passed earlier this year, which notably did pass with support of the state's hospital association. I think it represents a meaningful approach to this work with all sides coming together. This streamlined dataset still identifies elements that are essential to the stated goals of the Model but keeps that administrative burden in check by leveraging existing reportable data. Again, as Rep. Oliverson noted, I will spare you the list of specific requirements there, but it does cover the three primary goals as well as including descriptions of any adverse program audits a covered entity receives in the previous 12 months and descriptions of how savings are used, especially to increase access to care for patients. We also understand, as Rep. Oliverson noted, the intent here to focus on hospital and covered entity reporting, but we do see that value in more holistic reporting, and we are appreciative of any consideration to a drafting note. I'm happy to answer any questions you may have about this but really, I just want to express our continued appreciation for the partnership we have here at NCOIL and look forward to continuing to work together.

Rep. Matt Lehman (IN) stated I'm from Indiana and when this law went into effect, I think there was some concern on how that's all going to look and I think we've had a good first year. I think we're getting the data that we wanted to see. If I look at the Model, it pretty much is what Indiana has done. Now I've not seen the Illinois changes, but I support building on this and I agree with you, Rep. Oliverson, that there's a movement of some folks to just eliminate the program and I think that would be disastrous. It just has to have some parameters put around it, and that's reporting. I'm fully supportive of where Rep. Oliverson wants to go on this but I just want to let you know, being from Indiana and helping shepherd this through, it has worked out very well.

Hearing no other comments or questions, Rep. Oliverson stated I really appreciate everyone's time today. I want to again express my appreciation to our friends from Indiana, especially Rep. Lehman. I think they gave us a great sort of direction to follow. And thanks specifically to Mr. Burchfield because he really has actually brought some very constructive ideas. I do believe at the end of the day, Mr. Chairman, that we're going to end up with a really good Model that essentially all 50 states can confidently adopt for transparency purposes. With that, I appreciate your time today, and I look forward to seeing everybody in November.

Asm. Dilan thanked everyone and stated that and I guess being that there's not much opposition, I'm confident that we'll be in a good place to vote on this in November. We still have a month or so to work on any minor changes, which it sounds like Rep. Oliverson has already been working on. Please reach out to myself, Rep. Oliverson, or NCOIL staff with any questions on this between now and November.

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

Asm. Dilan stated the next item on our agenda is an opportunity for comment and discussion on the model laws scheduled for re-adoption by the committee at the upcoming Annual Meeting. The Committee has two model laws that are scheduled for consideration for re-adoption. As a reminder, per NCOIL bylaws, all NCOIL model acts are scheduled to be considered for re-adoption every five years. If a model is not re-adopted, it sunsets. The models taken up for re-adoption by this committee in Florida are the Resilient Revolving Loan Fund Model Act and the Company Licensing Modernization Act. I note that these models will not be voted on for re-adoption here today. Rather, this is an opportunity for any initial comments and discussions in advance of the next meeting where the actual vote will take place.

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

ADJOURNMENT

Hearing no further business, upon a Motion made by Rep. Lehman and seconded by Rep. Meredith, the Committee adjourned at 1:00 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 and Rep. Brenda Carter (MI) – NCOIL Secretary

Draft as of ~~June 16 October 21~~November 9, 2026. To be discussed and considered during the meeting of the Joint State-Federal Relations & International Insurance Issues Committee on November 21~~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 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 specified in 42 U.S.C. 256b(a)(4)

(2) A copy of the 340B covered entity’s most recently filed Internal Revenue Service Schedule H Form 990 detailing the entity’s community benefit and community building activities, bad debt and collections practices, and related policies.

(~~2~~ 3)The aggregate acquisition cost for all prescription drugs obtained under the 340B program and dispensed or administered to patients.

(~~3~~ 4)The aggregate payment amount received for all drugs obtained under the 340B program and dispensed or administered to patients.

(~~4~~ 5) The aggregate payment made to pharmacies under contract to dispense drugs obtained under the 340B program.

(~~5~~ 6) The number of claims for prescription drugs described in subdivision (~~3~~ 4).

(7) A description of any adverse 340B program audits within the preceding 12 months.

(~~7~~ 8) 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.~~ how the covered entity utilizes savings to directly lower patient out of pocket costs ~~increase access to care~~.

~~(8) 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.~~

(9) The aggregate payments made for any ~~other administering~~ administrative expense for the 340B program~~.~~, including 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.

(10) The aggregate number of prescription drugs dispensed or administered to patients for which a payment was reported under subdivision (~~3~~ 4).

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

~~(12) 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.~~

(~~13~~12) The 340B covered entity's total operating costs.

~~(14) The 340B covered entity's total costs for charity care.~~

~~(15) 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~~ 4) through (a)(~~5~~ 6) 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.

Drafting Note: This Model is intended to strengthen transparency requirements for covered entities authorized to participate in the 340B Drug Pricing Program. Some States have also set forth transparency requirements on pharmaceutical manufactures that participate in the Program; however, this Model is intentionally limited in scope to apply only to covered entities, the entities for which the Program was created. Also, NCOIL has an existing Healthcare Cost Transparency Model Law which sets forth reporting requirements for pharmaceutical manufactures. States that have not yet adopted that Model are encouraged to do so.

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.

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National Council of Insurance Legislators (NCOIL)

Company Licensing Modernization Model Act

Adopted by the NCOIL Executive Committees on July 12, 2002. Readopted by the NCOIL Executive Committee on November 19, 2004, November 11, 2006, November 20, 2011, November 20, 2016, November 20, 2021.

To be discussed and considered for re-adoption during the Joint State-Federal Relations & International Insurance Issues Committee on November 21, 2026.

Purpose – The purpose of this act is to promote consistency among the 50 states in licensing insurance companies by use of common licensing requirements, forms, and procedures.

Section 1 – The Commissioner of Insurance shall apply only the requirements set forth in form and detail in the Uniform Certificate of Authority Application (UCAA), and any supplemental forms promulgated pursuant to the UCAA published by the National Association of Insurance Commissioners (NAIC), as of the effective date of this act, in order to license insurers to do business in this state.

Section 2 – Revisions to the Uniform Certificate of Authority Application (UCAA) and supplemental forms promulgated pursuant to the UCAA, published by the NAIC, are incorporated by reference into this law, and are applicable to insurers, upon notice from the commissioner, as to all applications made after the effective date of the revisions. Provided, however, the commissioner may reject new requirements and forms, if after notice and hearing, the commissioner finds that they are not in the best interests of the public and that they unduly burden insurers applying for a license in this state. The Commissioner's determination shall be subject to legislative review.

Section 3 – This Act repeals all company licensing requirements and all licensing forms not contained in or required by the Uniform Certificate of Authority Application and any supplemental forms published by the NAIC in connection with it, including, but not limited to: (cite specific state law provisions to be repealed).

Section 4 – This law is effective upon enactment and applies to license applications submitted to this state after the effective date.

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National Council of Insurance Legislators (NCOIL)

Resilient Revolving Loan Fund Model Act

***Sponsored by Sen. Katie Fry Hester (MD)**
***Adopted by the NCOIL Joint State-Federal Relations & International Insurance Issues Committee and NCOIL Executive Committee on November 20, 2021.**

***To be discussed and considered for re-adoption during the Joint State-Federal Relations & International Insurance Issues Committee on November 21, 2026.**

Since 1980, the United States has experienced 265 weather and climate related events that have each cost $1 billion dollars or more in damages. Further, recent data shows that natural disasters are increasing in both frequency and strength. This puts increased burden on insurance markets, can make certain risks increasingly difficult to insure, and can increase the cost of insurance for consumers. According to the Natural Institute of Building Sciences, every dollar spent on natural disaster mitigation saves $6. It is therefore in the best interest of states to support resilience and mitigation projects to reduce this burden, reduce the cost of natural disasters, and to save lives and property. Recent federal law, the "Safeguarding Tomorrow through Ongoing Risk Management Act" or the "STORM Act" authorizes the Federal Emergency Management Agency (FEMA) to enter into agreements with certain state agencies to provide capitalization grants for hazard mitigation revolving loan funds to provide low interest loans to fund local mitigation projects, including mitigation projects on buildings that reduce damage risk, reduce insurance rates and bring buildings into FEMA minimum National Flood Insurance Program (NFIP) requirements. This model legislation aims to provide states with a framework to be able to access this funding and fund local disaster mitigation projects.

Table of Contents

Section 1. Title
Section 2. Purpose
Section 3. Definitions
Section 4. Revolving Loan Fund
Section 5. Effective Date

Section 1. Title

This Act shall be known and cited as the "Resilient Revolving Loan Fund Act."

Section 2. Definitions

For the purpose of this Act:

(a) “Fund” refers to the Resilient Revolving Loan Fund.

(b) “Emergency Management Department” refers to the state agency responsible for emergency management of the state passing the “Resilient Revolving Loan Fund Act.”

(c) “Finance Authority” refers to a government authorized finance authority with lending experience for private property.

(d) “STORM Act” refers to the “Safeguarding Tomorrow through Ongoing Risk Management Act” (Public Law 116-284).

Section 3. Purpose

For the purpose of establishing a special, non-lapsing loan fund, the Resilient [State] Revolving Loan Fund, to provide loans for local resilience projects that address mitigation of all natural hazards, including natural disasters and additional projects related to man-made threats and hazards. Currently, Federal mitigation grant programs are set up in a way to allow for co-benefit related to man-made threats and hazards, but the primary focus of the project must be to reduce or eliminate risks from natural hazards.

Section 4. Intent

(a) It is the intent of the legislature that the Emergency Management Department or other appointed administrative or financing agency apply to the Federal Emergency Management Agency under the provisions of the STORM Act, when funding is available, to enter into an agreement to capitalize the revolving loan fund established under this Act with money appropriated to the Fund.

(b) The Emergency Management Department or other appointed administrative or financing agency may grant loans under this Act to local jurisdictions, at least in part, to meet federal matching requirements for federal resilience grants, including BRIC, Flood Mitigation Assistance (FMA), Hazard Mitigation Grant Program (HMGP), Housing and Urban Development (HUD) Community Development Block Grant Disaster Relief/Mitigation (CDBG-DR/MIT) and U.S. Army Corps of Engineer flood risk reduction projects such as levees, closures, pump stations and non-structural projects like elevation and wet/dry flood proofing.

(c) Loans can be granted to property owners to provide the financing for natural hazard mitigation projects such as wind retro fits, flood mitigation elevation and wet or dry flood proofing projects, fire mitigation retro fit projects and earthquake retrofit mitigation projects.

Section 4. Revolving Loan Fund

(a) This Act establishes the Resilient Revolving Loan Fund.

1. The Fund is a special, non-lapsing fund that shall be available in perpetuity for the purpose of providing loans in accordance with the provisions of this section.

2. The Fund is not subject to [any article of state code which dictates that at the end of a fiscal year, the unspent balance of an appropriation to special funds or accounts reverts to the general fund of the state].

3. The State Treasurer shall hold the Fund separately, and the Comptroller [or state equivalent] shall account for the Fund.

4. The Fund consists of:

i. Money appropriated in the state budget to the Fund;

ii. Investment and interest earnings of the Fund;

iii. Repayments of principal and interest loans made from the Fund;

iv. Any other money from any other source accepted for the benefit of the Fund; and

v. The loan program shall have a restricted fund that will hold private capital that is allocated for the hazard mitigation of buildings only and not available for other uses.

5. The Fund is administered by the Emergency Management Department or financing authority.

6. The Fund may be used only to provide low – or no – interest loans to financing authorities and non-profit organizations for hazard mitigation and resilience projects. These loan funds can be made to private property owners for the use in hazard mitigation projects for the building.

7. The loans provided under the Fund shall be for a fixed loan period and can be attached to the property taxes, allowing the property to be sold as long as the new owner agrees to assume the debt obligation.

8. Any interest earnings of the Fund shall be credited to the Fund.

9. Money expended from the Fund is supplemental to and is not intended to take the place of funding that otherwise would be appropriated to local governments for resilience projects.

10. Loans from the Fund may be used to satisfy the nonfederal match for federal mitigation grants.

(b) The Emergency Management Department shall, taking into consideration requirements from the STORM Act, establish application procedures and eligibility criteria for loans from the Fund.

The eligibility criteria shall require that a local government or non-profit organization demonstrate:

1. Need for a loan to address hazard mitigation; and

2. The ability to repay the loan, if required, at a later date.

Section 5. Effective Date

And be it further enacted that this Act shall take effect _____.

PROPERTY & CASUALTY INSURANCE COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
PROPERTY & CASUALTY INSURANCE COMMITTEE
2026 NCOIL SUMMER MEETING – BOSTON, MASSACHUSETTS
JULY 18, 2026
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Property & Casualty Insurance Committee met at The Westin Copley Place in Boston, MA on Saturday, July 18, 2026, at 10:45 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. Kerry Wood (CT)
Rep. Peggy Mayfield (IN)
Rep. Michael Lee Meredith (KY)
Rep. Michael Sarge Pollock (KY)
Rep. David LeBoeuf (MA)
Rep. Robert Foley (ME)
Rep. Edmond Jordan (LA)
Sen. Paul Utke (MN)
Asw. Pam Hunter (NY)
Sen. George Lang (OH)
Rep. Brian Lampton (OH)
Rep. Tom Oliverson, MD (TX)
Rep. Matt Morgan (TX)
Del. Walter Hall (WV)
Rep. Calvin Callahan (WI)

Other legislators present were:

Rep. John Illg (LA)
Rep. Dennis Bamberg (LA)
Rep. Michael Bayham (LA)
Rep. Rolf Olsen (ME)
Sen. William Gannon (NH)
Rep. Ellyn Heffner (OK)
Sen. Cale Case (WY)
Rep. Pepper Ottman (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. George Lang (OH) and seconded by Asw. Pam Hunter (NY), NCOIL Immediate Past President, the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Asw. Hunter and seconded by Rep. Brian Lampton (OH) ,the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's April 18, 2026 and June 8, 2026 meetings.

CONTINUED DISCUSSION OF PROPOSED AMENDMENTS TO NCOIL TRANSPORTATION NETWORK COMPANY (TNC) MODEL ACT.

Sen. Theis stated that we're first going to continue our discussion on proposed amendments to the NCOIL TNC Model Act. Sen. Theis then asked Rep. Edmond Jordan (LA), NCOIL Vice President, to provide an update on the status of the amendments which are sponsored by Sen. Walter Michel (MS) who couldn't be with us here today.

Rep. Jordan stated that I have been working with all the stakeholders on trying to get this model in a posture that we could have a vote today but we're not quite there yet. All parties have been working in good faith so there's no issue of parties not being able to work together or trying to reach a resolution. But there's recently been a court decision out of Florida that's kind of on point with the model and that has kind of thrown a little bit of a monkey wrench in what we're trying to do. So I have spoken about this with Sen. Michel and I am proposing that we defer everything until November to figure some things out as that case is also so we can try to resolve some of the issues and the court may as well. And it also gives us a little bit of an opportunity to digest what the court has said and get the model in a posture that would comply with the court's decision.

Upon a motion made by Rep. Lampton and seconded by Rep. Tom Oliverson, M.D. (TX), the committee voted without objection by way of a voice vote to re-adopt the model as-is until the November meeting.

Sen. Theis stated that it is my intention to have an interim meeting of this committee where we'll discuss this further, and we can go into more detail at that point in time with

the amendments that are currently on the table and the changes that are being proposed from that.

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

Sen. Theis stated that next, we're going to continue our discussion on the NCOIL Model Act regarding insurers' use of aerial images. We're not going to be voting on this today. It is my intent to vote on this in November. I will now recognize one of the sponsors of the model, Rep Brian Lampton (OH).

Rep. Lampton stated that I want to thank my colleague and other sponsor of the model, Rep. Matt Lehman (IN), for his work on this. I'd also like to thank Rep. Matt Morgan (TX) for co-sponsoring, and also Rep. David LeBoeuf (MA) who carried this issue last year. As mentioned during our interim meeting last month, the model is essentially based on the bill that Rep. Lehman sponsored in Indiana, which has been signed into law. It's pretty straightforward and represents a prior version of the NCOIL model, together with some changes necessary to reach consensus. Rep. Lehman and I are in agreement that we're coming at this from the same place in that we need to start putting some parameters around insurers' use of this specific technology. We're definitely are not looking to prohibit it, just put some reasonable parameters around it. I know some carriers are concerned that we could prohibit them from using a tool in underwriting, but this model will not do that. Underwriting tools are good things and result in lower prices for consumers. I think this just provides some reasonable guardrails. Some states have already enacted laws on this and several bills have been introduced and that's why we think it's a good opportunity for NCOIL to provide some guidance. Now, guidance doesn't mean that you cut and paste this into statute; obviously, your individual state would need to adjust it to what best fits your state's needs.

If states want to make changes like to the age of the photos for example, or the time periods for curing defects and providing notice, of course they can do that. Many states have enacted bulletins on this issue, but we know as leadership in insurance departments can change quickly so can bulletins. So, that's why we feel like legislation is more stable and a better way to address this. Some folks have issues with the model talking about the aerial images being the sole reason for non-renewal. But states need to start somewhere, and this model can do that. Again, you can choose to change that if you wish in your state. For example, Georgia recently passed a law on this issue that goes a lot further in some areas of this model. So again, each state's going to be able to custom fit it for their purposes. This issue is not going away. We believe this model is a good starting point. I want to leave you with a couple of things here. It's pretty narrow. This model deals with only non-renewals, so it's limited in scope that way. Secondly, when we first began discussing the issue last year, the market was much harder. It's softening now, and we believe that aerial images and non-renewals were at a fever pitch then and it's probably lightening up but in this business, it's not the last hard market we'll face. Markets will turn hard again, and we'll just have to deal with it. Also, I would like to hear from all interested parties today as to their thoughts on the sole language. I was kind of curious what objections there might be for that.

Amy Bach, Executive Director of United Policyholders, thanked the committee for the opportunity to speak and stated just a bit of a background for those who may not be familiar with our organization. This is our 35th year of service as a 501c3 focused on educating consumers and assisting consumers with regard to property insurance matters. We do a lot of disaster preparedness and recovery work and we very much appreciate all the effort that has gone into developing a model here. We worked closely with the sponsors of the previous version because we like many of you, especially those of you who are agents, have been hearing a lot from consumers who are upset, angry, confused as to why if they've been insured with a company for many years and to their knowledge, nothing has really changed and suddenly they're getting dropped and they don't really know why. So, there's a lot of good in this model, in the sense that it's straightforward. I just want to give a quick history of the concessions that were already made to the previous model, and that are in this one, just to show I think, how flexible those of us who are trying to have this come out helpful to consumers have been. Originally, we thought, why should it only be a mandate on admitted insurers? We were really getting more concerned as a consumer group about the ways in which admitted insurers are being disadvantaged now that excess surplus and non-admitted companies are coming into the residential market, we felt like it should be applied to both. But that concession was already made.

As far as the duty to provide, it's now no longer an obligation on the insurer to provide the information to the consumer. The consumer now has to ask. The consumer has to know that they have the right to ask, and they have to ask. We talked a lot about the value of this concept to give a homeowner knowledge and information about conditions that are problematic and give them an opportunity to cure those conditions, particularly because most people do not go up on their roofs on a regular basis, and if it's not leaking, they would not have any reason to know. So, this is a good thing to give the consumer that information. So as far as the concessions, now it's admitted only and it's got the 24 months. We are actually okay with the America Property Casualty Insurance Association's (APCIA's) suggestion that it just talk about that there not be a number in the model - just say "reasonably recent." I think that would be okay if there's not an agreement about 24. A lot of the states that have already issued bulletins have gone with either a year or even six months just to make sure that the images are reasonably current and accurate. And then finally, adding the word sole kind of really does defeat the purpose of the whole thing and if you're going to keep that in there I'm not sure it's really worth pursuing it. I do think it's an important initiative, but if an insurer says it wasn't the sole reason, then there's no protection and you really haven't accomplished anything.

Wes Bissett, Senior Counsel for the Independent Insurance Agents and Brokers of America (IIABA). We represent the agent broker community nationally and in each of all your states. We appreciate this committee continuing to take up this issue. We think having a model would be incredibly helpful for the reasons that Rep. Lampton indicated. To put it mildly, the use of aerial images by carriers has been bumpy at best. It's garnered the attention of insurance departments and the media. There have been 14 states that have issued regulatory bulletins. States have begun to act legislatively.

Georgia, under the leadership of NCOIL member and Sen. Larry Walker, just adopted a fantastic law that should be a model for all of you. And this proposal is very similar to what Georgia has done. I won't go into all the reasons and the details, I think we've kind of covered that ground in the past. I do though want to echo Ms. Bach's point about the revisions that have been made to this model along the way, often at the behest of my insurance carrier friends. The proposal initially by Rep. LeBoeuf didn't just apply to existing policyholders, it applied to applicants for insurance. That's been changed. It used to apply to surplus lines carriers; that has been changed.

So there have been a number of changes and revisions, reasonable ones I think, that have been made along the way. But when this committee took up this issue in the fall, the biggest outstanding issue was the question of whether when you're non renewed, because an image has been used, whether that image should be shared with you by a carrier proactively, or whether you have to as a consumer request the image. The upon request approach has now been built in to the model, which we have no objection to. But that is a major change and concession that's been made. That was the big issue that the carrier community was voicing back in the fall. That has now been incorporated into this and we think that's appropriate. We're open to any other reasonable revisions that might be made as well but we are extremely troubled by and opposed to the sole reason limitation that's been incorporated into this bill. So, if the review of an aerial image was a big reason why you're non-renewed or the significant reason why you're non-renewed or the primary factor why you're non-renewed, none of these protections would apply. So, we think unfortunately having that kind of approach makes this largely meaningless. Carriers in a practical sense are always weighing a variety of factors when they make any decision, they don't look at one thing in isolation.

So, we fear, unfortunately, that in practical terms, you will not accomplish anything if you adopt a model along these lines. And as someone who's been coming to NCOIL for more than 25 years and as someone who represents an organization that strongly believes in state regulation of insurance, we think this would be something of almost a black eye for the organization, an organization we care a lot about. We'd also urge you to look at the states that have acted in this area. So, the 14 states that have adopted regulatory bulletins, none of them have this sole reason limitation. The Georgia law that I mentioned, that should be a model for everybody, doesn't have this. And I think the only state that has anything along these lines is the Indiana law that was just adopted. I'm not even sure what the reason would be to limit it in cases where it would only be the sole reason. What we think NCOIL should do is say is if the non-renewal was based in part or in whole on a review of an aerial image, then the requirements and protections ought to apply. Or sort of stated a different way, if the non-renewal would not have occurred, but for the review of an aerial image, then the requirements of the model ought to apply. So, we appreciate all the work and focus on this issue, but if you're going to limit this to only instances where it's the sole reason for an action, frankly we'd urge you not to even adopt the model at all. It takes any meaning or impact out of it altogether. It's largely a poison pill.

Paul Martin, VP of State & Policy Affairs at the National Association of Mutual Insurance Companies (NAMIC), thanked the committee for the opportunity to speak and stated that

I am pleased to announce that NAMIC is neutral on this model in large part out of acknowledgement and respect for the work that this body has done in addressing a lot of the concerns that we raised last year. We think we've gotten this to a point where when I visited with NAMIC members, we think we can be neutral here.

Rep. Kerry Wood (CT) asked if the inclusion of the 24 months requirement was a concession. Sen. Theis stated that's actually my push. We have the Upper Peninsula in Michigan. You don't have planes randomly flying there and taking pictures very often. Rather than increase their premiums because insurance companies have to hire somebody go get those images, I prefer to leave that photo age requirement at 24 months and not go shorter. I don't like the loose language that it has to be a reasonable time frame, because then that leaves it up to the regulator to determine what reasonable looks like, and that can vary dramatically. So I prefer the 24 months and I have pushed hard for it. Obviously other states can choose to go shorter if they'd like to.

Asw. Pam Hunter (NY), NCOIL Immediate Past President, stated that I'm really shocked actually to see this model here in this form because when we had a conversation about this at the interim meeting last year and we had a vote on an amendment that passed and then we had a vote on the model that failed, the basis of the concern was the carriers not wanting to be mandated to provide the information upfront due to cost, although it was never communicated when asked what the cost would be. So, I am looking at this model now which essentially is entirely gutted from the model that we had originally. And in my opinion, this model does nothing and I would say that if somebody brought it back to their state, they would probably need to add way more comprehensive information here. And I was the primary supporter of brining this model back after it was voted down but this version is not like last year's and I don't know if it's just like the bare bones template and you can bring it back to your state and add on the things that you need. In New York I introduced the original model with the amendments.

Rep. Jordan stated that the big issue that I have is that the committee chair last year and I had talked about the cost associated with storage and sending the photos to the insurer and we were told that there was a great expense in dealing with that. And so we gave the stakeholders time to come back and tell us exactly what those expenses would be and the response we got was, well, we don't have an actual number, but it would be expensive. And I think that's kind of why we went back again to say, okay, let's give you another opportunity to come and deal with this issue and, in part, I think why Asw. Hunter had asked for it to be brought back. But again, this is a totally different version and I guess we don't have to account for cost because it doesn't even address the requirement to provide the pictures initially. So, I share my disappointment with how the model has come back but understand we're not voting today. So, hopefully we'll have some time to revisit this once again.

Sen. Theis stated that it will give the industry an opportunity to interact prior to the interim meeting that we have coming up and to defend that position.

Rep. Matt Morgan (TX) thanked everyone for their work on this and stated he is glad to see NAMIC neutral and also he understands the frustration on sole reason provision

because insurance companies use so many different metrics to measure things. I want to share a story and then ask for some feedback from our panel. So, since our last discussion on this, my chief of staff actually got a non-renewal notice from his insurance company. He lives in Austin and the city will not let you cut down a tree. They will fine you if you do cut one down. The image that was taken over his home was during the winter. He got his non-renewal notice in the spring. They said, "You have to cut down the dead tree" and they sent him the picture of the tree so there are carriers already doing this. So he went outside, took a picture of the tree, sent it to his agent and said it's not a dead tree, it's a live tree because you just took the picture at the wrong time. So I think there are instances like that which make the model important to ensure that good data is used. No one wants to stop carriers from being able to price the market right. I want you to use all data points that are available to you in order to price all of us so that we are priced as best we can and we can each get the best rate we possibly can. But I would like some feedback from the panel on what my chief of staff went through and then just some concerns about we're not trying to regulate what you guys can use for rating us, but we want to make sure that there's transparency in how it's used in case there's mistakes that occur like I explained.

Ms. Bach stated that the first conversation I had on this issue with a regulator or a lawmaker was with the Kentucky Insurance Commissioner and she said she had a constituent write to her saying they got non-renewed and they didn't know why. And I helped them communicate with their insurer about what it was and the insurer said it was because we saw roof damage but it was not specific. And at the time, the technology hadn't really gotten to where it is now in terms of very granular pictures and those kind of disputes were originally what I think spurred a lot of the drive to have a model and to have restrictions. And I think your example is a perfect illustration of why you want the homeowner to have access to the images so that they can correct something that a computer missed like interpreting a tree at a certain time of year to be dead. So again, I think that just really underscores the goal here is to give the homeowner information so that they can make improvements that will make their home less likely to get damaged, and that will qualify them to keep their insurance. So, I think we're on the same page with that goal. We just haven't quite gotten to the right way of getting the information. I always felt like it's a digital image so where's the expense at of forwarding the digital image as a PDF? I don't get it.

Mr. Bissett stated that I think the scenario you outlined is exactly what this model was intended to address. So, setting the sole reason issue to the side for a moment, what the model would provide is an opportunity. So, let's say it's the wrong house, the wrong address, that insured would be able to go back to insurance and say, you got the wrong property, or in the case of a tree, if it was a shadow and not a real issue, you'd be able to have an opportunity under this model to go back and make your case. Or if the tree really was a problem, to actually address that tree issue within a reasonable period of time and make sure that you're meeting the conditions and guidelines of that insurer. So if we could get over this sole reason issue, I think we'd be creating a framework that would be exactly what the insurer that you mentioned did in that particular case.

Mr. Martin stated that first, I would encourage your chief of staff to look at the Austin Wildland-Urban Interface (WUI) code because if the tree is, in fact, dead, he probably does, in fact, have the right to remove it, and that's something we've advocated for. So that's just a helpful tip in case he wants to push that with the city. Rep. Morgan stated to Mr. Martin, just to make sure you have the facts right, the picture was taken in the winter and they said it's a dead tree and they sent him an image but he then walked outside in the spring and showed all the leaves on the tree showing it was not dead which is why he can't cut it down. Mr. Martin stated that I live in Austin so I understand it's confusing but there's a lot of property owners in Austin who have more ability to remove trees than they did just a few years ago. I'm just sharing that as an FYI. But this makes the case for solely because if we had this law on the books in Texas, based on the fact pattern as I understand it, there would be a process by which the policyholder could ask for the images and make the corrections. The reason we wanted solely in there is because if you use that example, and let's say an adjuster or underwriter went to the house and did an examination and they looked at a number of things and went around the property and looked at the claim history - at that point, how much weight do you place on the image and how much weight do you place on the other factors? That was the concern with the last version of the bill and that is if you use imaging even in part, even if it's only 5% of the analysis, you now have this whole framework of requirements that the insurance company must go through. So, the feedback we got for some time was if whatever flies over your house takes a picture and you get non renewed based on the picture, that's not fair. This current version of the model addresses that concern. If you send someone out to the house to look at the property, or if you look at other factors, maybe those other factors should trump whatever is in the image. I think we would probably all agree on that and if that is the case, then we shouldn't have to worry about what's in the image and that's why we think this version of the bill is better.

Rep. LeBoeuf stated that to provide some more background on this, the amendments that passed during last year's interim meeting were a concession that the trades had asked us to make. And then during that discussion there was confusion raised around the language of "in whole or in part" that was never brought to our attention previously which has led the version now to using "sole." And also, we never got those numbers on the cost of providing the images. How I even got aware of this issue when I brought it up previously was because I had a constituent who was a senior citizen that had a tree fall on her garage. Her policy was non-renewed. She had repaired that on her own. The company had also given her the photo without her asking, and she said, "well, I corrected it" and the insurer said "oh, well, sorry, we're still going to non-renew you." And that was the impetus of why this happened. And the key thing to keep in mind with these images is no one wants to ban this technology. This technology is helpful. Using this technology will reduce your rates. It's also really good in natural disaster responses. But when using any new technology, similar to the discussion we had with artificial intelligence (AI), there needs to be guardrails and there needs to be protections for the consumer. And I know we're not voting today, but think about this when we look at future revisions and future models. Because these images, when the insurers are using them, there's not someone in the office that's analyzing each individual image. They're going through some type of computer program or software program, whether it's an algorithm or AI or something. And maybe you should think about what did the use of this

technology and its analysis do? Did it affect their outcome and can the company explain and stand behind it? I think we can do more work on this model to put in practices to make sure that this model matches those questions.

Rep. Stephen Meskers (CT) stated that there's no question that this technology is going to be very helpful but if the technology is used as one of a number of factors in not renewing, and you don't enhance the rights of the consumer, that's difficult. The insurance industry suffers losses. If they decide to withdraw from a market or they decide to reduce their exposure to the market, and they use the aerial images as part of the factors in non-renewal and those aerial photos create errors and omissions, people are going to get factored out of the market without any coverage, just on the back of the fact that it wasn't the sole reason. So, more information is valuable in underwriting risks. There's no question. Hopefully we'll reduce the risks, ultimately maybe reduce the premiums, but I'm concerned that the use, in the way it's designed here, it can just be used to, if you will reduce the pool from what they perceive as risky underwritings without an error and so they're kicking people out of the pool. And insurance is a pooled instrument for risk mitigation. So, I'm concerned that we make sure that we give people those rights. The way I look at this is and way I see it is unless underwriters tell me differently, I'm thinking that the aerials are replacing a lot of physical inspection and reducing costs. So, I'm hesitant to think that the aerial photos is a supplement to a physical review. My guess is there is there is no need for aerial if you've done the physical and I just want to make sure that the consumer is well protected. So, I think we might need to look at that going forward.

Sen. George Lang (OH) stated I can support this bill as-is. I'm sensitive to Rep. Jordan's and Asw. Hunter's concerns. I would much prefer that be addressed in a drafting note, rather than a change of the bill. I would rather see the bill have less teeth with the option of states to add teeth since it will be a model bill. And if we added teeth, I would most likely become a no vote. But I would be okay with the drafting note. I just wanted to put that on the record.

REPLACEMENT COST VALUE AND ACTUAL CASH VALUE COVERAGES – DISCUSSION ON THE FEDERAL AGENCY'S (FHFA) HOMEOWNERS' INSURANCE RULE

Sen. Theis stated that next on our agenda is a discussion on replacement cost value (RCV) and actual cash value (ACV) coverages and the federal housing finance agency's (FHFA) homeowner's insurance rule. Our speakers will address this in more detail, but this rule would have required properties with Fannie Mae and Freddie Mac mortgages to have full replacement cost coverage for roof damage repair rather than actual cash value. This is a good opportunity to hear different perspectives on that as well as provide some education on replacement cost coverage versus actual cash value coverage.

Ms. Bach thanked the committee and stated that I appreciate the opportunity to support this committee's work and focus. And this issue has been on my organization's radar for many years. We had conversations with Fannie Mae and Freddie Mac executives and even the FHFA before they implemented the recent rule change, and they were very

worried about it. Many people are worried about it. And so my presentation will sort of recap why we're worried and what we would suggest you all be considering as lawmakers. We do characterize this phenomenon as short term gain, long term pain. I've been an insurance consumer advocate for my entire career, 40 years, and I did cut my teeth in the New York State Legislature starting as an intern and moving on to be a lead staff director. So, I very much appreciate how complicated these issues are and how many differing considerations you have to make when you're looking at a federal initiative like what just happened.

So, shrinking coverage for roofs. Basically, if you didn't know what this issue was about, there is a longstanding congressional rule that if a home has a mortgage in place through a federally backed loan, that the coverage that's in place on that mortgaged collateral should be adequate to restore it. So, it should be replacement value coverage. But for a lot of reasons, and while we recognize that marketplace forces have been driving this move, insurers have been pushing to be able to weaken that rule so that they can sell depreciated actual cash value coverage in place of replacement value coverage. And obviously you don't need me to explain why industry wants to be reducing their exposure and in this era, you all are familiar with that. But the reality is that a roof is key to both the structural integrity and the real estate value of a home, and ACV-only coverage causes significant protection gaps and leads to devalued mortgage collateral which I think should concern you as lawmakers because if you were around in 2008, you know that there is a very close relationship between mortgages, home values, and our entire financial health system. So just briefly, RCV pays what it actually costs to repair or replace damaged property. ACV only pays a depreciated amount reflecting the age and condition. If you have ACV-only on your home, it means you have to come up with the cash, take on debt, or you leave your home unrepaired, which means we've got impaired mortgaged collateral, which is not healthy. So, it makes a huge difference.

My organization has been in disaster areas now for 35 years and the difference where a homeowner has RCV versus ACV in terms of their ability to repair, restore their damaged or destroyed assets is huge. Properly maintaining and insuring roofs matter for a number of reasons such as structural integrity. The roof's water resistance is critical to the overall structure's strength. The real estate value is important as is the mortgage collateral. And then this is not to be undervalued, consumer confidence in the value of insurance is important. I would say at this stage, it's at an all-time low and some of that is being driven by images you see in the media of blue tarps in areas that have been hit by hurricanes and tornadoes, and people are mad at their insurer. And those are all drivers of decreasing confidence that the public has that if they pay for home insurance, it's going to be there for them. And they're not going to have paid all these premiums and find themselves without insurance benefits. So, the ACV-only coverage experiment has been underway in Florida now for a couple years. They had a law in that state that if a roof was damaged more than 25%, it needed to be replaced, and that was based on engineering and construction best practices. That got changed at insurers' behest. And now the legislature also authorized separate roof deductibles. And insurers now can insure homes for ACV- only there. That law change is part of what drove the FHFA to move because they said, well if the market is going this way, we're out of step. I guess we better adjust. And I think my point to you is that's maybe not a good enough reason

to take these risks because the result is that households with older roofs either have to pay out of pocket or they just don't repair or restore the collateral. And when you see the stats now of the number of hurricane claims that got closed without payment in Florida after the last hurricane, it's shocking. We're talking well over half and obviously high deductibles are a reason for that, but also ACV-only coverage is a big reason.

And so this is a kind of an example from the consumer perspective on how the coverage in a home policy keeps on shrinking. This is called shrinkflation. We had every year starting in 1992 with Hurricane Andrew, we're seeing less coverage in a home policy and that phenomenon is leading to this phenomenon of homeowners going bare, which has been documented by Lisa Miller, which I'm sure she's presented to you over the years. She's an expert on the Florida insurance market. So, we have this growing gap and consumers need help. They need your help. Both prioritizing the most important coverages to buy, choosing the right deductible, and making risk reduction home improvements. So, a lot of the good work that's been happening here and at the National Association of Insurance Commissioners (NAIC) around state programs that help people fortify their roofs, that's a really great place to put your energy. But letting this trend of moving towards ACV-only coverage on homes, I just want you all to have your eyes and ears open to what the downside risk is long-term of allowing coverage to be shrunk in that way. So, thank you for your attention. I know this is a tricky subject. You're state lawmakers, not federal, but this is going to trickle down on you in your states and so I think it's good to be talking about it here. And frankly, my answer to FHFA was, could you just leave the rule intact because it's really important but look the other way? And I think what they did was sort of their attempt to kind of split the baby. And here we are.

Mr. Martin stated the year was 2024 and in February of that year, the Biden administration's FHFA which has oversight of both Fannie and Freddie published new requirements for insurance policies that insure the collateral for the mortgages. And rather than doing simply a notice and comment period, they simply issued what they thought was a clarification, requiring RCV coverage on all policies. Now, Fannie and Freddie collectively have about 50% of the mortgage market so that was not an insignificant amount of mortgages that would be touched by this. In May of 2024, just three months later, given the feedback from stakeholders including NAMIC and others, FHFA decided to pause implementation of this clarification. Later on that year in October, eight Democrats on the House Financial Services Committee sent a letter to FHFA, citing an increased likelihood of reduced consumer choice, increased premiums and a reduction in the availability of insurance. Over the next 15 months, 64 House Republicans and 19 Senate Republicans sent similar letters to FHFA. Fast forward to March of this year, after all this feedback and after a number of conversations, and to be clear, FHFA was a good partner and was very candid and very willing to hear the concerns of various people from various organizations, they decided to rescind for the most part the requirement for RCV coverage.

So, why is mandating RCV a problem? When an insurance company agrees to insure something at RCV, they necessarily take more premium for that because they are taking on more risk. And so, the RCV implication is that insurance consumers will have to pay more than they would if they had an ACV policy. So, the rebuilding cost for roofs even

exceeds the garden variety inflation cost, coupled with increased frequency and severity of storms, it is becoming more costly to repair and replace roofs. So, a lot of people decide they will agree to take on that risk of needing a new roof and they will purchase an ACV policy to help manage their finances. Under the requirement from the FHFA, your contents would also have to be insured at replacement cost coverage and the concern there is that you've got things in your house, televisions, appliances, things like that, that also depreciate over time. And if you are replacing that at replacement cost value, that's a problem. Fixer uppers, sometimes people purchase a home for far less than it would be the replacement cost and so if you bought a fixer upper and then got a replacement cost coverage policy, that would be a problem because it'd be very expensive. Manufactured homes, a lot of people might purchase a used manufactured home. That home may have depreciated depending on the condition of the home, and an ACV policy might make more sense for them. Investment properties, a lot of folks invest in properties and insure them at ACV. They're willing to take on that risk themselves, and that allows them to offer rents to their renters at a lower price than they would had they purchased an RCV policy. And we have a lot of member companies who write farm properties and a lot of exterior buildings and things like that and a lot of those buildings have aged and requiring them to insure those at replacement cost coverage could be really expensive, given the value of the structure.

Irrespective of how you feel about ACV policies, there's a fundamental issue here that I think needs to be expressed to NCOIL, and that is this is incursion by the federal government into insurance regulation by mandating this. That isn't their sandbox. This is your sandbox, along with your state regulator. So, irrespective of how you feel about ACV policies, I do think you need to be concerned about a federal government agency or Congress intervening and requiring something in an insurance policy because we are with you on the state-based regulated system. So, you need to be concerned about that irrespective of what the mandate is. ACV policies provide budget-conscious folks with an insurance option. It allows them to decide what they want to pay. We talk about the need for consumers to have choice, ACV is one of those critical choices. Bear in mind, these products are regulated by your state regulator. Your state regulator has the ability to review the forms and review the rates and all the things that go along with ACV policies. This is not unregulated. There are ACV policies for roofs that if the home is destroyed by wind or hail, the entire property is replaced at replacement cost coverage. Even the roof, even if you just have ACV on your roof. So again, that's another choice that consumers can make to decide what is best for them. So, to wrap up, FHFA decided at a challenging time to make both home ownership and home insurance more expensive. Thanks to a bipartisan effort by Members of Congress and various stakeholders, including NAMIC, FHFA paused and decided not to implement this. We would remind you that ACV policies are regulated by your departments of insurance, just like any other policy. And as a reminder, as I mentioned before, this an incursion by the federal government into a space that under McCarran-Ferguson is limited to you. And you need to be aware that this not going to be the first time or the last time that this happens so we need to be cognizant and diligent about that.

Sen. Lang stated that I'm not very familiar with the home portion of the P&C world. My assumption is, and I'm just asking if this is a valid assumption, that the majority, if not all,

insurers do what you have suggested and offer a homeowner the option of purchasing one or the other. Is that a fair assumption? Mr. Martin stated many companies do. We do have members companies who only write ACV policies. Those companies tend to write in rural areas. A lot of those parts of the country are not wealthy by any stretch of the imagination. The market there really demands ACV policies, and that's why those companies provide those. Sen. Lang stated my question was do most offer? Is that a fair assumption or is that an unfair? Mr. Martin stated I would say the vast majority of the market offers people some sort of RCV coverage. So, even if you're in a rural part of the state, you can always get an RCV policy. Maybe not with the insurance company you choose, but there's someone out there who will offer it to you.

Sen. Lang stated that we saw the slide of homeowners going without coverage which is very alarming. My concern is if we put more handcuffs on the insurers, we run the risk of what you were suggesting regarding federal takeover. Would that result in something similar to insurers going bare? Mr. Martin stated there are already efforts in Congress now for the federal government to get more involved in homeowners insurance, either through reinsurance backstops or things like that. And that is a conversation for another day. The more options we give insurance companies, more latitude we give them to offer products, then consumers can pick a product. At the end of the day, it becomes more of a philosophical question than anything else. Is an ACV policy better than no policy? We would submit that it is because it provides some coverage, maybe not as much as an RCV policy, but the consumer gets to choose and set the parameters of their own coverage.

Rep. Jordan stated that I'm from Louisiana and share some of the same issues that Florida has. In the New Orleans area and certainly on the coast, we do have people who are going bare. And it disturbs me because it's mostly an elderly population that's already had their homes paid for so they don't have a mortgage. They're just out there and if something drastic happens, then they have no coverage at all. So, on one hand I would tell you ACV would be better than nothing. But the real question is if ACV doesn't fully replace your home, then are you in a better condition at all? And so, part of the question is for Mr. Martin, but then part of the question is for Ms. Bach because I'm trying to figure out why in Florida, half of those claims will close with no payment and so please give me some context and color to that, because that certainly affects us in Louisiana.

Ms. Bach stated that Florida Insurance Cmsr. Mike Yaworsky has pegged a lot of the claims closed without payment to the high deductibles. I'm a consumer advocate and I worry and that's part of my job is to worry. I want people to have access to insurance they can afford. I agree ACV is better than nothing. However, if it is illusory in the sense that it actually doesn't restore the asset, what I was trying to get at with my slides was, let's be helping consumers make better choices than reducing the coverage on the structure. So, by the way, the FHFA rule has been in place for a long time so this not some sudden incursion. This is a reduction in strength of the rule, but it's been on the books for a long time. And so what I've been struggling with is since many states are having affordability and availability crises with property insurance, what are the things people can cut without it really hurting them? Contents is number one. By the way, this rule does not apply to contents. The FHFA rule only applies to the coverage on the

structure. So, we are telling people cut your contents coverage, cut your other structures if you can, but whatever you do try to keep replacement coverage on your home so that if nothing else, you'll be able to put it back if Humpty Dumpty falls off the wall. And unfortunately, we seem to be going in the opposite direction. So, it's just a challenge for all of us who are trying to strike a balance where insurers are now saying between inflated construction costs and increasingly frequent severe weather events, we've got to cut corners somewhere. But my goal was to just sound this alarm that this is short-term gain, a cheaper policy that has the potential to create long-term pain in terms of unrepaired mortgaged assets.

Rep. Jordan stated that I would separate the high deductible from the ACV. At least with a high deductible, you know what you're looking at. You have a definitive number. At time of a disaster, you know exactly what you're facing. I think with ACV, I'm hesitant that we're giving people who are either on fixed incomes or with limited means, a false sense of security that you have something that you really don't have because when disaster strikes you are not going to be able to afford it. And I think that's a concern for all my colleagues in Louisiana. We really have spirited debates about this and I think we're all concerned about our constituents and how they deal with that. And we've had several hearings on that. We can talk offline about it but I do think we need to figure out a way that if you have an ACV policy, that the constituent has an idea of what they're going to be facing as far as cost in the event that disaster strikes down the road based on consumer price index or based on inflation so they would be more in line with somebody that has a high deductible policy.

CONSIDERATION AND RE-ADOPTION OF MODEL LAWS

Sen. Theis stated that next, we have consideration of model laws. The first up is the Post Assessment Property and Liability Insurance Guaranty Association Model Act. The importance of cyber events has led Rep. Lehman to sponsor proposed amendments to the model, and as a reminder, these amendments were distributed during our interim meeting last month. No comments were received during that meeting or since. As Rep. Lehman cannot be with us today, I'll present the proposed amendments on his behalf. These amendments serve an important purpose. The state guaranty associations exist to safeguard policyholders when their licensed insurance company fails or becomes insolvent. These amendments are fairly straightforward in that they essentially recognize cybersecurity insurance as being within the scope of guaranty association coverage. And this makes sense since cyber insurance functions as property and casualty coverage but most of the guaranty association statutes across the country were developed well before cyber insurance was a thing and offered in the marketplace. There have been over a dozen states that have adopted these types of amendments, so it's important that the NCOIL model be amended as well. These targeted amendments provide needed statutory clarity, ensure consistent coverage determinations, and promote uniform insolvency administration.

Hearing no questions or comments, upon a motion made by Rep. Lampton and seconded by Rep. Jordan, the committee voted without objection by way of a voice to adopt the amendments. Then, upon a motion made by Rep. Jordan and seconded by

Asw. Hunter, the committee voted without objection by way of a voice to re-adopt the model, as amended.

Sen. Theis stated that next up is the NCOIL Coronavirus Limited Immunity Model Act. The original sponsor of the model is no longer in the legislature, but Rep. Lehman was a co-sponsor and asked me to provide some remarks on his behalf. As this model was enacted to specifically address the issues pertaining to business liability and COVID-19, it is outdated and no longer relevant. Therefore, he doesn't believe we should re-adopt it and the committee should allow it instead to sunset. I agree with Rep. Lehman. This model was good at the time but is no longer necessary and I agree that it should sunset. If there is, God forbid, another similar scenario in the future, we can always bring it back up and adopt a model at that point in time. Hearing no questions or comments, the model sunset.

Sen. Theis stated that next up is the NCOIL Peer-to-Peer Car Sharing Program Model Act. During the interim meeting last month, there were some comments made about how there have been some changes in the peer to peer car sharing marketplace, and some interested parties would like to see some changes to the model. I'm interested in having those discussions so I think we should re-adopt the model until the November meeting in order for people to put pen to paper with suggested changes to the model, rather than re-adopting the model for the full five years. Hearing no questions or comments, upon a motion made by Del. Walter Hall (WV) and seconded by Sen. Justin Boyd (AR), the committee voted without objection by way of a voice vote to re-adopt the model until the November meeting.

Sen. Theis stated next up are the NCOIL Distracted Driving Model Act, the Property Casualty Insurance Modernization Act and the Property Casualty Flex Rating Regulatory Improvement Act. Sen. Theis noted that no comments were received on these models throughout the past several months.

Rep. Lampton stated that I'd like to just note that I introduced the distracted driving model in Ohio and I thought it was going to be easy to enact it as I had just began my time in the legislature but it took nearly two years to get it passed. I am pleased to say that we did pass the law and it is based on the NCOIL model and as a result we've experienced a 7% reduction in fatal crashes in Ohio. If your state has not done this I strongly recommend you do it. It does save lives.

Hearing no further comments or questions, upon a Motion made by Asw. Hunter and seconded by Rep. Wood, the committee voted without objection by way of a voice vote to readopt the remaining models.

ADJOURNMENT

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

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PRESIDENT: Sen. Paul Utke, MN
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TREASURER: Rep. Jim Dunnigan, UT
SECRETARY: Rep. Brenda Carter, MI

IMMEDIATE PAST PRESIDENT:
Asw. Pamela Hunter, NY

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 and Executive Committee on July 18, 2026 until the 2026 Annual Meeting.**

***To be considered for re-adoption by the Property & Casualty Insurance Committee on November 22, 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 <u>for-</u>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. <u>A digital network is not a product under the laws of this State.</u>

3. “Transportation Network Company <u>(TNC)</u>" 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 November 9~~September May 18~~, 2026. To be discussed and considered during the meeting of the Property & Casualty Insurance Committee on November 22~~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

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

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

(c) “Renewal” means:

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

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

Section 5. Insurers’ Use of Aerial Images

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

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

(b) Establish a point of contact and a process for the named 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 but only for a reason unrelated to the defects or conditions identified under subsection (a).

Drafting Note: The provisions in Section 5 relating to communicating standards that repairs must adhere to, providing documentation of work, providing time to cure, and offering a renewal policy are not intended to apply to non-renewal decisions that are not curable by the named insured.

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)

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.

Re-adopted by the Property & Casualty Insurance Committee and Executive Committee on July 18, 2026 until the 2026 November Annual Meeting while potential amendments are developed. To be considered for re-adoption during the Property & Casualty Insurance Committee meeting on November 22, 2026.

Proposed amendments sponsored by Rep. Meredith Craig (OH).

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. Specifically, definitions and any statutory references chosen for definitions should not affect obligations related to taxation or airport regulation.

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

<u>Liability</u> 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.~~

(b~~e~~) 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.

Physical Damage Insurance During Car Sharing Period

Sec. 8. (a) A peer-to-peer car sharing program shall own and maintain as the named insured a policy of insurance written by an insurer admitted or authorized in this state covering physical damage for collision and comprehensive losses to the shared vehicle during the car sharing period.

(b) The policy of insurance required by this section shall apply when the policy of insurance maintained by the shared vehicle owner excludes or otherwise does not provide coverage for physical damage for collision and comprehensive losses to the shared vehicle during the car sharing period.

(c) The policy of insurance required by this section may include a deductible in an amount no greater than one thousand dollars per occurrence.

(d) The policy of insurance required by this section may include subrogation rights against a tortfeasor.

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.

(c) A shared vehicle owner or a representative of a peer-to-peer car sharing program must perform an inspection of the driver's license of any individual prior to turning over possession of the shared vehicle to that individual to ensure that the individual possesses a facially valid license and is the same individual who entered into the car sharing program agreement.

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.

Utah SB 292 will be discussed during the Property & Casualty Insurance Committee on November 22, 2026 in an effort to gather feedback on potential development of autonomous vehicle model legislation in 2027. Proposed language submitted by Waymo also appears following Utah SB 292.

Enrolled Copy S.B. 292
Autonomous Systems Amendments
2026 GENERAL SESSION
STATE OF UTAH

Chief Sponsor: Kirk A. Cullimore
House Sponsor: Jordan D. Teuscher

LONG TITLE

General Description: This bill amends and enacts provisions related to product liability for automated driving systems.

Highlighted Provisions:

This bill:
▸ amends and enacts definitions related to automated driving systems and product liability;

▸ imposes a statutory limit on awards of noneconomic loss in product liability cases related to automated driving systems;

▸ amends provisions related to product defects and liability related to automated driving systems and reasonably alternative technologies available at the time of manufacture;

▸ creates an affirmative defense against product liability if certain state-of-the-art technology standards are met;

▸ limits liability of certain automated driving system manufacturers and developers to certain types of claims;

▸ requires a sunset review of provisions related to liability of automated driving systems and vehicles; and

▸ makes technical and conforming changes.

Money Appropriated in this Bill: None

Other Special Clauses: None

Utah Code Sections Affected: AMENDS:
41-26-102.1, as last amended by Laws of Utah 2022, Chapter 134
41-26-104, as enacted by Laws of Utah 2019, Chapter 459
63I-1-278, as last amended by Laws of Utah 2025, Chapter 26
78B-6-702, as enacted by Laws of Utah 2008, Chapter 3
78B-6-703, as renumbered and amended by Laws of Utah 2008, Chapter 3

ENACTS:
78B-4-901, Utah Code Annotated 1953
78B-4-902, Utah Code Annotated 1953
78B-4-903, Utah Code Annotated 1953
78B-4-904, Utah Code Annotated 1953
78B-6-708, Utah Code Annotated 1953

Be it enacted by the Legislature of the state of Utah:

Section 1. Section 41-26-102.1 is amended to read:

41-26-102.1 . Definitions.

As used in this chapter:

(1) "ADS-dedicated vehicle" means a vehicle:

(a) designed to be operated exclusively by a level four ADS or level five ADS for all trips within the given operational design domain limitations of the ADS, if any[~~.~~] ; and

(b) that conforms to all applicable U.S. federal motor vehicle safety, bumper, and theft prevention standards in effect on the date of the vehicle's manufacture, unless an exemption has been granted under applicable federal law.

(2) "ADS-equipped vehicle" means a vehicle with a level three, level four, or level five ADS that is designed for:

(a) complete trips in driverless operation under routine or normal operating conditions within the vehicle's operational design domain; or

(b) operation by an in-vehicle driver.

~~[(2)]~~ (3)(a) "Automated driving system" or "ADS" means the hardware and software that are:

(i) collectively capable of performing the entire dynamic driving task on a sustained basis, regardless of whether the ADS is limited to a specific operational design domain, if any[~~.~~] ; and
(ii) conforming to all applicable U.S. federal motor vehicle safety, bumper, and theft prevention standards in effect on the date of the vehicle's manufacture.

(b) "Automated driving system" or "ADS" is used specifically to describe a level three, four, or five driving automation system.

~~[(3)]~~ (4) "Commission" means the State Tax Commission as defined in Section 59-1-101.

~~[(4)]~~ (5) "Conventional driver" means a human driver who is onboard the motor vehicle and manually performs some or all of the following actions in order to operate a vehicle:

(a) braking;

(b) accelerating;

(c) steering; and

(d) transmission gear selection input devices.

~~[(5)]~~ (6)(a) "Dispatch" means to place an ADS-equipped vehicle into service in driverless operation by engaging the ADS.

(b) "Dispatch" includes software-enabled dispatch of multiple ADS-equipped motor vehicles in driverless operation that may complete multiple trips involving pick-up and drop-off of passengers or goods throughout a day or other pre-defined periods of service, and which may involve multiple agents performing various tasks related to the dispatch function.

~~[(6)]~~ (7) "Division" means the Motor Vehicle Division of the commission, created in Section 41-1a-106.

~~[(7)]~~ (8) "Driverless operation" means the operation of an ADS-equipped vehicle in which:

(a) no on-board user is present; or

(b) no on-board user is a human driver with a valid driver license or fallback-ready user.

~~[(8)]~~ (9) "Driverless operation dispatcher" means a user who dispatches an ADS equipped vehicle in driverless operation.

~~[(9)]~~ (10) "Driving automation system" means the hardware and software collectively capable of performing part or all of the dynamic driving task on a sustained basis.
~~[(10)]~~ (11) "Driving automation system feature" means a specific function of a driving automation system.

~~[(11)]~~ (12)(a) "Dynamic driving task" means all of the real-time operational and tactical functions required to operate a motor vehicle in on-road traffic, including:

(i) lateral vehicle motion control through steering;

(ii) longitudinal motion control through acceleration and deceleration;

(iii) monitoring the driving environment through object and event detection, recognition, classification, and response preparation;

(iv) object and event response execution;

(v) maneuver planning; and

(vi) enhancing conspicuity with lighting, signaling, and gesturing.

(b) "Dynamic driving task" does not include strategic functions such as trip scheduling and selection of destinations and waypoints.

~~[(12)]~~ (13) "Engage" as it pertains to the operation of a vehicle by a driving automation system means to cause a driving automation system feature to perform part or all of the dynamic driving task on a sustained basis.

~~[(13)]~~ (14) "External event" is a situation in the driving environment that necessitates a response by a human driver with a valid driver license or driving automation system.

~~[(14)]~~ (15) "Fallback-ready user" means the user of a vehicle equipped with an engaged level three ADS who is:

(a) a human driver with a valid driver license; and

(b) ready to operate the vehicle if:

(i) a system failure occurs; or

(ii) the ADS issues a request to intervene.

~~[(15)]~~ (16)(a) "Human driver" means a natural person who performs in real-time all or part of the dynamic driving task.

(b) "Human driver" includes a:

(i) conventional driver; and

(ii) remote driver.

~~[(16) "Level five automated driving system" or "level five ADS" means an ADS feature that has the capability to perform on a sustained basis the entire dynamic driving task under all conditions that can reasonably be managed by a human driver, as well as any maneuvers necessary to respond to a system failure, without any expectation that a human user will respond to a request to intervene.]~~

~~[(17) "Level four automated driving system" or "level four ADS" means an ADS feature that, without any expectation that a human user will respond to a request to intervene, has:]~~

~~[(a) the capability to perform on a sustained basis the entire dynamic driving task within its operational design domain; and]~~

~~[(b) the capability to perform any maneuvers necessary to achieve a minimal risk condition in response to:]~~

~~[(i) an exit from the operational design domain of the ADS; or]~~

~~[(ii) a system failure.]~~

~~[(18) "Level three automated driving system" or "level three ADS" means an ADS feature that:]~~

~~[(a) has the capability to perform on a sustained basis the entire dynamic driving task within its operational design domain; and]~~

~~[(b) requires a fallback-ready user to operate the vehicle after receiving a request to intervene or in response to a system failure.]~~

(17) "Level five ADS" means a level five automated driving system as defined in SAE

International Standard J3016_202104, "Taxonomy and Definitions for Terms Related to Driving Automation Systems for On-Road Motor Vehicles," April 2021 edition, as adopted by the National Highway Traffic Safety Administration.

(18) "Level four ADS" means a level four automated driving system as defined in SAE International Standard J3016_202104, "Taxonomy and Definitions for Terms Related to Driving Automation Systems for On-Road Motor Vehicles," April 2021 edition, as adopted by the National Highway Traffic Safety Administration.

(19) "Level three ADS" means a level three automated driving system as defined in SAE International Standard J3016_202104, "Taxonomy and Definitions for Terms Related to Driving Automation Systems for On-Road Motor Vehicles," April 2021 edition, as adopted by the National Highway Traffic Safety Administration.

(20) "Level two DAS" means a level two driving automation system as defined in SAE International Standard J3016_202104, "Taxonomy and Definitions for Terms Related to Driving Automation Systems for On-Road Motor Vehicles," April 2021 edition, as adopted by the National Highway Traffic Safety Administration.

~~[(19)]~~ (21) "Minimal risk condition" means a condition to which a user or an ADS may bring a motor vehicle in order to reduce the risk of a crash when a given trip cannot or should not be completed.

~~[(20)]~~ (22) "Object and event detection and response" means the subtasks of the dynamic driving task that include:

(a) monitoring the driving environment; and

(b) executing an appropriate response in order to perform the dynamic driving task.

~~[(21)]~~ (23) "On-demand autonomous vehicle network" means a transportation service network that uses a software application or other digital means to dispatch or otherwise enable the prearrangement of transportation with motor vehicles that have a level four or five ADS in driverless operation for purposes of transporting persons, including for-hire transportation and transportation for compensation.

~~[(22)]~~ (24) "Operate" means the same as that term is defined in Section 41-1a-102.

~~[(23)]~~ (25) "Operational design domain" means the operating conditions under which a given ADS or feature thereof is specifically designed to function, including:

(a) speed range, environmental, geographical, and time-of-day restrictions; or

(b) the requisite presence or absence of certain traffic or roadway characteristics.

~~[(24)]~~ (26) "Operator" means the same as that term is defined in Section 41-6a-102.

~~[(25)]~~ (27) "Passenger" means a user on board a vehicle who has no role in the operation of that vehicle.
~~[(26)]~~ (28) "Person" means the same as that term is defined in Section 41-6a-102.

~~[(27)]~~ (29) "Remote driver" means a human driver with a valid driver license who is not located in a position to manually exercise in-vehicle braking, accelerating, steering, or transmission gear selection input devices, but operates the vehicle.

~~[(28)]~~ (30) "Request to intervene" means the notification by an ADS to a fallback-ready user indicating that the fallback-ready user should promptly begin or resume operation of the vehicle.

~~[(29)]~~ (31) "Sustained operation of a motor vehicle" means the performance of part or all of the dynamic driving task both between and across external events, including response to external events and continued performance of part or all of the dynamic driving task in the absence of external events.

~~[(30)]~~ (32) "System failure" means a malfunction in a driving automation system or other vehicle system that prevents the ADS from reliably performing the portion of the dynamic driving task on a sustained basis, including the complete dynamic driving task[, that the ADS would otherwise perform].

~~[(31)]~~ (33) "User" means a:

(a) human driver;

(b) passenger;

(c) fallback-ready user; or

(d) driverless operation dispatcher.

Section 2. Section 41-26-104 is amended to read:

41-26-104 . Licensing -- Responsibility for compliant operation of ADS-equipped vehicles.

For the purpose of assessing compliance with applicable traffic or motor vehicle laws:

(1)(a) When an ADS is operating a motor vehicle, the ADS is the operator, and shall satisfy electronically all physical acts required by a conventional driver in operation of the vehicle.

(b) The ADS is responsible for the compliant operation of the vehicle and is not required to be licensed to operate the vehicle.
(2)(a) If a vehicle with an engaged level three ADS issues a request to intervene, the ADS is responsible for the compliant operation of the vehicle until disengagement of the ADS.

(b) If a vehicle with an engaged level four or five ADS issues a request to intervene, the ADS is responsible for the compliant operation of the vehicle until or unless a human user begins to operate the vehicle.

(3) The ADS is responsible for compliant operation of an [~~ADS-dedicated vehicle~~] ADS-equipped vehicle when the ADS is engaged.

Section 3. Section 63I-1-278 is amended to read:

63I-1-278 . Repeal dates: Title 78A and Title 78B.

(1) Subsection 78A-7-106(7), regarding the transfer of a criminal action involving a domestic violence offense from the justice court to the district court, is repealed July 1, 2029.

(2) Section 78B-3-421, Arbitration agreements, is repealed July 1, 2029.

(3) Section 78B-4-518, Limitation on liability of employer for an employee convicted of an offense, is repealed July 1, 2029.

(4) Title 78B, Chapter 4, Part 9, Limitations on Liability for Automated Driving System-Equipped Vehicles, is repealed on July 1, 2030.

[~~(4)~~] (5) Title 78B, Chapter 6, Part 2, Alternative Dispute Resolution Act, is repealed July 1, 2026.

(6) In Section 78B-6-702, the following definitions are repealed on July 1, 2030:

(a) "ADS-equipped vehicle";

(b) "Automated driving system"; and

(c) "State of the art knowledge".

(7) Subsections 78B-6-703(3) and (4), related to product defects for automated driving systems, are repealed on July 1, 2030.

(8) Section 78B-6-708, related to state of the art affirmative defense against product liability for an automated driving system, is repealed on July 1, 2030.

~~[(5)]~~ (9) Section 78B-22-805, Interdisciplinary Parental Representation Pilot Program, is repealed December 31, 2026.

Section 4. Section 78B-4-901 is enacted to read:

Part 9. Limitations on Liability for Automated Driving System-Equipped Vehicles.

78B-4-901 . Definitions.

As used in this part:

(1) "ADS-dedicated vehicle" means the same as that term is defined in Section 41-26-102.1.

(2) "ADS-equipped vehicle" means the same as that term is defined in Section 41-26-102.1.

(3) "Automated driving system" means the same as that term is defined in Section 41-26-102.1.

(4) "Developer" means a person that designs, creates, or produces the software or algorithms that constitute an automated driving system.

(5) "Driverless operation" means the operation of a motor vehicle exclusively by a level four or level five automated driving system.

(6) "Dynamic driving task" means the same as that term is defined in Section 41-26 102.1.

(7) "Level five ADS" means the same as that term is defined in Section 41-26-102.1.

(8) "Level four ADS" means the same as that term is defined in Section 41-26-102.1.

(9) "Manufacturer" means a person that manufactures, assembles, or produces an ADS-equipped vehicle or the hardware components of an automated driving system.

(10) "Noneconomic loss" means nonpecuniary harm that results from an injury or loss to a person or property, including:

(a) pain and suffering;

(b) loss of society, consortium, companionship, care, assistance, attention, protection, advice, guidance, counsel, instruction, training, or education;
(c) disfigurement;

(d) mental anguish; or

(e) other intangible loss.

(11) "Operational design domain" means the same as that term is defined in Section 256 41-26-102.1.

Section 5. Section 78B-4-902 is enacted to read:

78B-4-902 . Limitation of award of noneconomic losses related to an automated driving system.

(1) Subject to Subsections (2), (3), and (4), in an action relating to an ADS-equipped vehicle or an ADS-dedicated vehicle, the amount of the award for noneconomic losses, if any, may not exceed $1,000,000.

(2) The limit described in Subsection (1) does not apply to a claim for wrongful death.

(3) In an action relating to a level four ADS or level five ADS under this chapter, punitive damages may not be awarded.

(4) For a claim brought under Section 78B-4-903, the recoverable amount may not exceed the amount described in Subsection 78B-4-903(1)(c).

Section 6. Section 78B-4-903 is enacted to read:

78B-4-903 . Driverless operation liability.

(1)(a) This section applies only to an incident that occurred related to an ADS-dedicated vehicle or an ADS-equipped vehicle that is equipped with a level four ADS or level five ADS while the automated driving system is engaged and performing the entire dynamic driving task.

(b) This section does not apply to an incident that involves any driving assistance or task not performed by the automated driving system.

(c) Notwithstanding Section 78B-4-902 and any other provision of law, the total amount recoverable by a plaintiff under this section, including all damages, costs, and fees, may not exceed $100,000.

(d) A prevailing plaintiff may recover compensatory damages available under this section, subject to the limitation described in Subsection (1)(c).

(e) If a plaintiff recovers damages under this section, that recovery is the exclusive civil remedy for injury or property damage arising out of the operation of a level four ADS or level five ADS.

(2)(a) A person who suffers injury or property damage directly caused by an ADS-dedicated vehicle or an ADS-equipped vehicle that is equipped with a level four ADS or level five ADS while the automated driving system is engaged and performing the entire dynamic driving task has a right of action under this section.

(b) A person who suffers injury or property damage directly caused by an ADS-dedicated vehicle or an ADS-equipped vehicle that is equipped with a level four ADS or level five ADS while the automated driving system is engaged and performing the entire dynamic driving task may bring an action against:

(i) the registered owner of the ADS-equipped vehicle; or

(ii) a person that dispatched the ADS-equipped vehicle into driverless operation, including a driverless operation dispatcher or an on-demand autonomous vehicle network.

(3) A plaintiff establishes liability under this section by proving, by a preponderance of the evidence, that:

(a) the automated driving system was engaged at the time of the incident; and

(b) the automated driving system was a proximate cause of the injury or property damage.

(4) Any liability established under this section may be mitigated in proportion to the degree that the claimant's or a third party's negligence, recklessness, or breach of duty of care contributed to the occurrence of the incident or the resulting harm.

(5) A plaintiff bringing an action under this section is not required to prove negligence, breach of duty, or product defect.

Section 7. Section 78B-4-904 is enacted to read:

78B-4-904 . Limitation of causes of action against manufacturers and developers of automated driving systems.

(1) A manufacturer or developer of a level four ADS or level five ADS is not subject to liability under a theory of negligence for personal injury, death, or property damage arising from the operation of an ADS-dedicated vehicle or an ADS-equipped vehicle equipped with level four ADS or level five ADS while the automated driving system is engaged.

(2) A manufacturer or developer of a level four ADS or level five ADS may be held liable for personal injury, death, or property damage arising from the operation of an automated driving system of an ADS-dedicated vehicle or an ADS-equipped vehicle only under:

(a) Section 78B-4-903; or

(b) Chapter 6, Part 7, Utah Product Liability Act, if the plaintiff establishes the elements required under that part.

(3) Nothing in this section affects:

(a) the liability of any person or entity other than a manufacturer or developer of a level four ADS or level five ADS; or

(b) the application of comparative fault under Section 78B-5-818 to reduce a plaintiff's recovery based on the plaintiff's own conduct.

(4) For purposes of this section, a claim alleging that a manufacturer or developer of a level four ADS or level five ADS was negligent in the design, development, testing, manufacture, or deployment of the automated driving system is a product liability claim subject to Chapter 6, Part 7, Utah Product Liability Act, and not a claim for ordinary negligence.

Section 8. Section 78B-6-702 is amended to read:

78B-6-702 . Definitions.

~~[As used in this part, "unreasonably dangerous" means that the product was dangerous to an extent beyond which would be contemplated by the ordinary and prudent buyer, consumer, or user of that product in that community considering the product's characteristics, propensities, risks, dangers, and uses together with any actual knowledge, training, or experience possessed by that particular buyer, user, or consumer.]~~

As used in this part:

(1) "ADS-equipped vehicle" means the same as that term is defined in Section 41-26-102.1.

(2) "Automated driving system" means the same as that term is defined in Section 41-26-102.1.

(3) "State of the art knowledge" means the technical, mechanical, and scientific knowledge of manufacturing, designing, testing, or labeling the same or similar products that was in existence and reasonably feasible for use at the time of manufacture.

(4) "Unreasonably dangerous" means that the product was dangerous to an extent beyond which would be contemplated by the ordinary and prudent buyer, consumer, or user of that product in that community considering the product's characteristics, propensities, risks, dangers, and uses together with any actual knowledge, training, or experience possessed by that particular buyer, user, or consumer.

Section 9. Section 78B-6-703 is amended to read:

78B-6-703 . Defect or defective condition making product unreasonably dangerous -- Rebuttable presumption.

(1) In any action for damages for personal injury, death, or property damage allegedly caused by a defect in a product other than an ADS-dedicated vehicle or an ADS-equipped vehicle described in Subsections (3) and (4), a product may not be considered to have a defect or to be in a defective condition, unless at the time the product was sold by the manufacturer or other initial seller, there was a defect or defective condition in the product which made the product unreasonably dangerous to the user or consumer.

(2) There is a rebuttable presumption that a product described in Subsection (1) is free from any defect or defective condition where the alleged defect in the plans or designs for the product or the methods and techniques of manufacturing, inspecting and testing the product were in conformity with government standards established for that industry which were in existence at the time the plans or designs for the product or the methods and techniques of manufacturing, inspecting and testing the product were adopted.

(3) In any action for damages for personal injury, death, or property damage allegedly caused by a defect in the automated driving system operation of a level four ADS or level five ADS of an ADS-equipped vehicle or an ADS-dedicated vehicle, the automated driving system may not be considered to have a defect or to be in a defective condition, unless the plaintiff proves by a preponderance of the evidence that:

(a) a reasonable and feasible alternative design existed at the time the level four ADS or level five ADS was designed and manufactured; and
(b) the use of the automated driving system, at scale and in the aggregate, causes more injuries to persons than would be caused by humans performing a similar task, at scale and in the aggregate, without an automated driving system.

(4) There is a rebuttable presumption that a level four ADS or level five ADS is free from any defect or defective condition if the automated driving system:

(a) conforms to all applicable U.S. federal motor vehicle safety, bumper, and theft prevention standards in effect on the date of the vehicle's manufacture; and

(b) was authorized for use or operation in the state.

Section 10. Section 78B-6-708 is enacted to read:

78B-6-708 . State of the art affirmative defense against product liability for an automated driving system.

In an action based upon defective design, manufacture, or failure to warn related to the automated driving system of an ADS-dedicated vehicle or an ADS-equipped vehicle that is equipped with a level four ADS or level five ADS brought against the manufacturer or developer of the automated driving system, liability is precluded if:

(1) the manufacturer or developer complied with the state of the art knowledge of scientific and technical knowledge and other circumstances that existed at the time of manufacture; or

(2) the automated driving system when deployed reduces injuries to persons, in the aggregate, as compared to humans conducting the same activity.

Section 11. Effective Date.

This bill takes effect on May 6, 2026.

Draft language submitted by Waymo for discussion purposes. To be discussed alongside Utah SB 292 during the NCOIL Property & Casualty Insurance Committee on November 22, 2026.

SECTION 1. Definitions.

(a) AUTOMATED DRIVING SYSTEM (ADS). The hardware and software that are collectively capable of performing the entire dynamic driving task on a sustained basis, regardless of whether it is limited to a specific operational design domain.

(b) AUTONOMOUS VEHICLE. A motor vehicle equipped with an automated driving system designed to function as a level 4 or 5 system under SAE J3016.

(c) DEVELOPER. A person that designs, creates, or produces the software or algorithms that constitute an automated driving system.

(d) DISPATCH. To place an autonomous vehicle into driverless operation by engaging the ADS. "Dispatch" includes software-enabled dispatch of multiple autonomous vehicles that may complete multiple trips involving pick-up and drop-off of passengers or goods throughout a day or other pre-defined periods of service, and which may involve multiple agents performing various tasks related to the dispatch function.

(e) DISPATCHER. A person who dispatches an autonomous vehicle.

(f) DYNAMIC DRIVING TASK (DDT). All of the real-time operational and tactical functions required to operate a vehicle in on-road traffic, excluding the strategic functions such as trip scheduling and selection of destinations and waypoints, and including without limitation:

(1) Lateral vehicle motion control via steering;
(2) Longitudinal motion control via acceleration and deceleration;
(3) Monitoring the driving environment via object and event detection, recognition, classification, and response preparation;
(4) Object and event response execution;
(5) Maneuver planning; and
(6) Enhancing conspicuity via lighting, signaling, and gesturing.

(g) DDT FALLBACK. The response by an automated driving system to achieve minimal risk condition, given the same circumstances.

(h) ENGAGE. As it pertains to the operation of an autonomous vehicle, to cause an automated driving system to perform part or all of the dynamic driving task on a sustained basis.

(i) CONVENTIONAL DRIVER. A human driver who is onboard the motor vehicle and manually performing some or all of the actions necessary to operate the vehicle, including but not limited to braking, accelerating, steering, and transmission gear selection.

(j) MANUFACTURER. A person that manufactures, assembles, or produces an autonomous vehicle or the hardware components of an automated driving system.

(k) MINIMAL RISK CONDITION. A condition to which a person, conventional driver, or an ADS may bring a vehicle after performing the DDT Fallback in order to reduce the risk of a crash when a given trip cannot or should not be completed.

(l) NONECONOMIC LOSS. Nonpecuniary harm that results from an injury or loss to a person or property, including:

(1) Pain and suffering;
(2) Loss of society, consortium, companionship, care, assistance, attention, protection, advice, guidance, counsel, instruction, training, or education;
(3) Disfigurement;
(4) Mental anguish; or
(5) Other intangible loss.

(m) ON-DEMAND AUTONOMOUS VEHICLE NETWORK. A transportation service network that uses a software application or other digital means to dispatch or otherwise enable the pre-arrangement of transportation with autonomous vehicles for purposes of transporting passengers or goods, including for-hire transportation and transportation of passengers or goods for compensation.

(n) OPERATIONAL DESIGN DOMAIN (ODD). Operating conditions under which a given automated driving system is specifically designed to function, including, but not limited to, environmental, geographical, and time-of-day restrictions, and/or the requisite presence or absence of certain traffic or roadway characteristics.

(o) [[**PERSON.** A natural person, corporation, business trust, estate, trust, partnership, limited liability company, association, joint venture, governmental agency, public corporation, or any other legal or commercial entity.]] *[[Note: Definition only needed if not already addressed in the vehicle code.]]*

(p) SAE J3016. The Taxonomy and Definitions for Terms Related to Driving Automation Systems for On-Road Motor Vehicles published by SAE International in April 2021.

(q) STATE OF THE ART KNOWLEDGE. The technical, mechanical, and scientific knowledge of manufacturing, designing, testing, or labeling the same or similar products that was in existence and reasonably feasible for use at the time of manufacture.

(r) SYSTEM FAILURE. A malfunction in an automated driving system or other vehicle system that prevents the ADS from reliably performing the portion of the dynamic driving task on a sustained basis, including the complete dynamic driving task.

SECTION 2. On-Demand Autonomous Vehicle Network.

An on-demand autonomous vehicle network shall be permitted to operate pursuant to state laws governing the operation of transportation network companies, taxis, or any other ground transportation for-hire of passengers [or other relevant law governing transportation of goods, etc.], with the exceptions that (1) insurance requirements outlined in Section 3 shall apply, and (2) any provision of [the cross-referenced state laws] that reasonably applies only to a conventional driver would not apply to autonomous vehicle roadside assistance services or the operation of autonomous vehicles with the automated driving system engaged on an on-demand autonomous vehicle network.

SECTION 3. Financial Responsibility.

(a) A vehicle equipped with an automated driving system must at all times maintain proof of financial responsibility in the same form and at the same minimum limits required under [citation to the state's general motor vehicle financial responsibility law, including cross-references to appropriate financial responsibility sections for both insurance and self-insurance].

(b) A vehicle equipped with an automated driving system where the automated driving system is engaged must maintain proof of financial responsibility as follows:

> (1) For vehicles operating as part of an on-demand autonomous vehicle network, in the amount of $1 million combined single limit per occurrence for third party liability.
>
> (2) For vehicles operated for personal, non-commercial use, the minimum limits under subsection (a) of this section apply.

[Drafting note: If other coverages such as PIP or UM are required under the financial responsibility statute, then cross reference those statutes as requirements identical to all other vehicles. Example for a PIP state: Proof of financial responsibility under this subsection must also satisfy personal injury protection requirements under [statutory cross reference] when those requirements are not satisfied by insurance policies or self-insurance under subsection (a) of this section.]

(c) The requirements of this section may be satisfied by one or more insurance policies or self-insurance arrangements (collectively, the "insurance program"). An insurance program may include:

(1) An insurance policy issued by an insurer licensed in this state; or

(2) An insurance policy issued by an eligible surplus lines insurer in accordance with [cross-reference state surplus lines statute]; or

(3) Self-insurance as permitted by [statutory cross-reference]. [Drafting note: This may take the form of a bond or other instrument in some states.]

(d) The requirements of subsection (b)(1) may be satisfied by any of the following:

(1) The owner of the vehicle;

(2) The owner of the on-demand autonomous vehicle network upon which the motor vehicle is operated; or

(3) Any combination of (1) and (2).

(e) Insurance policies and self-insurance applicable under subsections (a) and (b) may coordinate with each other to determine which will satisfy the requirements of subsection (b). The satisfaction of financial responsibility under subsection (b) shall be deemed to satisfy financial responsibility under subsection (a) for all purposes.

(f) No higher limits or additional coverages shall be required solely due to the vehicle's use of an automated driving system except as provided in subsection (b).

SECTION 4. Driverless Operation Liability - Fast Track.

(a) A person who suffers injury or property damage directly caused by an autonomous vehicle while the automated driving system is engaged and performing the entire dynamic driving task has a right of action under this section and may bring an action against the autonomous vehicle owner, dispatcher, on-demand autonomous vehicle network, manufacturer, or developer.

(b) A plaintiff or claimant establishes liability under this section by proving, by a preponderance of the evidence, that:

(1) the automated driving system was engaged at the time of the incident; and

(2) the automated driving system was a proximate cause of the injury or property damage.

(c) Any liability established under this section may be mitigated in proportion to the degree that the claimant's or a third party's negligence, recklessness, or breach of duty of care contributed to the occurrence of the incident or the resulting harm [under [insert citation to comparative fault or contributory negligence statute].

(d) A plaintiff bringing an action or a claimant asserting a claim under this section is not required to prove negligence, breach of duty, or product defect.

(e) Notwithstanding Section 6 and any other provision of law, the total amount recoverable by a plaintiff or claimant under this section, including all damages, costs, and fees, may not exceed $100,000.

(f) A plaintiff or claimant may recover compensatory damages available under this section, subject to the limitations described in subsection (e).

(g) A claimant must elect between seeking recovery under this section or pursuing a product liability claim under Section 5 for any given incident. Electing to pursue or recover damages under this section shall constitute a full waiver and bar to bringing or maintaining a product liability action under Section 5 for the same incident.

SECTION 5. Limitations on Causes of Action Against Manufacturers and Developers.

(a) A manufacturer or developer is not subject to liability under a theory of negligence for personal injury, death, or property damage arising from the operation of an autonomous vehicle while the automated driving system is engaged.

(b) A manufacturer or developer may be held liable for personal injury, death, or property damage arising from the operation of an autonomous vehicle only under:

(1) Section 4 of this Act; or

(2) [Insert citation to state product liability act or statute, or, in the absence of such a law, "A common law action based on strict liability in tort as recognized

by the Supreme Court of this State, if the plaintiff establishes the elements required".]

A claimant must elect between these two remedies; pursuing or recovering under one strictly precludes and bars pursuing or recovering under the other against the same defendant for the same incident.

(c) Nothing in this section affects:

(1) the liability of any person or entity other than a manufacturer or developer; or

(2) the application of comparative fault under [insert citation to state comparative fault statute], if applicable, to reduce a plaintiff's recovery based on the plaintiff's own conduct.

(d) For purposes of this section, a claim alleging that a manufacturer or developer was negligent in the design, development, testing, manufacture, or deployment of the automated driving system or autonomous vehicle is a product liability claim subject to ["the common law actions based on strict liability in tort recognized by the Supreme Court of this State, if the plaintiff establishes the elements required" OR [insert citation to state product liability act or statute]], and not a claim for ordinary negligence. For the avoidance of doubt, a manufacturer or developer of an autonomous vehicle shall not be denied the protections of this section on the basis that such manufacturer or developer also acts in the capacity of a dispatcher, network, or owner. [Drafting note: States with product liability statutes will directly reference those code sections.]

SECTION 6. Limitations on Awards.

(a) Subject to subsections (b), (c), and (d) of this section, in an action relating to an autonomous vehicle, the amount of the award for noneconomic losses, if any, may not exceed $1,000,000.

(b) The limit described in subsection (a) does not apply to a claim for wrongful death.

(c) In an action relating to an autonomous vehicle under this Act, punitive damages may not be awarded.

(d) For a claim brought under Section 4 of this Act, the recoverable amount may not exceed the amount described in Subsection (e) of Section 4.

SECTION 7. Defective Condition – Rebuttable Presumption.

(a) In any action for damages for personal injury, death, or property damage allegedly caused by a defect in the autonomous vehicle, the automated driving system may not be considered to have a defect or to be in a defective condition unless the plaintiff proves by a preponderance of the evidence that:

(1) a reasonable and feasible alternative design existed at the time the autonomous vehicle was designed and manufactured; and

(2) the use of an automated driving system, at scale and in the aggregate, causes more injuries to persons than would be caused by humans performing a similar task, at scale and in the aggregate, without an automated driving system.

SECTION 8. State of the Art Affirmative Defense.

In an action based upon defective design, manufacture, or failure to warn related to the automated driving system of an autonomous vehicle brought against the manufacturer or developer of the automated driving system, liability is precluded if:

(a) the manufacturer or developer complied with the state of the art knowledge of scientific and technical developments that existed at the time of manufacture; or

(b) the automated driving system when deployed reduces injuries to persons, in the aggregate, as compared to humans conducting the same activity.

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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)

Wildfire Prepared Program Model Act

Sponsored by Rep. Jim Dunnigan (UT) – NCOIL Treasurer

To be introduced during the meeting of the Property & Casualty Insurance Committee on November 22, 2026.

Table of Contents

Section 1. Title
Section 2. Purpose
Section 3. Grant Program
Section 4. Premium Discount or Insurance Rate Reduction
Section 5. Effective Date

Section 1. Title

This Act shall be referred to as the "[State] Wildfire Prepared Program Model Act."

Section 2. Purpose

The purpose of this Act is to promote pre-disaster mitigation for structures and property to protect against fire.

Section 3. Grant Program

(A) The [State] Wildfire Prepared Program is hereby created within the [agency which regulates insurance in the state]. The [lead regulator], as program administrator, may make financial grants to retrofit structures and land of insurable property, as defined in Section 4(B)(6) of this Act, with a homestead exemption to resist loss due to wildfire events and to meet or exceed the "Wildfire Prepared Home" standard of the Insurance Institute for Business and Home Safety.

(B) The commissioner shall promulgate rules governing eligibility requirements for grants and the administration of the program, which shall include application forms and procedures for seeking a grant. The rules shall set forth that priority shall be given to applications submitted in clusters of the smallest meaningful unit of

collective action, as determined by the commissioner. Other grant criteria, including lower-income applicants and applicants who live in locations that have a higher susceptibility to wildfire events, shall be determined by the commissioner. The commissioner shall develop wildfire preparedness standards for certification that are consistent with and no less stringent than the most recent standards developed by a nationally recognized wildfire prepared standard-setting organization, such as the Insurance Institute for Business and Home Safety.

(C) To receive a grant pursuant to this Section, the grantee shall do all of the following:

(1) Obtain all permits required by law or ordinance for construction.

(2) Arrange and pay for inspections required by law or ordinance and the terms of the grant, which shall include inspection pursuant to Section 4(B)(2) of this Act.

(3) Comply with applicable building and wildland urban interface (WUI) codes.

(4) Maintain records as required by Section 4(B)(3) of this Act and the terms of the grant.

(D) The name of a recipient of a grant received pursuant to this Section, the amount of the grant, and the municipal address of the retrofitted insurable property shall be a public record.

(E) There is hereby established in the state treasury as a special fund the [State] Wildfire Prepared Program Fund, hereafter referred to in this Section as the "fund".

(1) The following shall be deposited into the fund:

(a) All grants and funds received or raised by the Commissioner under paragraph (6) of this subsection.

(b) Any discretionary appropriations made to the fund by the Legislature.

(2) Monies appropriated or transferred to the fund shall be deposited by the state treasurer after compliance with the provisions of xxxxxxx of the Constitution of [State].

(3) Monies in the fund shall be invested in the same manner as monies in the state general fund, and any interest earned on monies in the fund shall be credited to the fund.

(4) All unexpended and unencumbered monies in the fund at the end of the fiscal year shall remain in the fund.

(5) Monies in the fund shall be used to provide grants pursuant to this Section.

(6) The Commissioner shall use his or her best efforts to obtain grants or funds from the federal government or other funding sources for deposit into the fund to supplement any appropriations to the fund made by the Legislature.

(F) Implementation of the Program is subject to the receipt of federal grants or funds or from other sources of grants or funds.
(G) To be eligible to work as a contractor on a project funded by a grant under this Section, the contractor must meet all of the following program requirements and must maintain a current copy of all certificates, licenses, and proof of insurance coverage with the Program office. An eligible contractor must:

(1) hold a valid residential building contractor and residential remodeler license issued by the [insert reference to the appropriate state licensing/accrediting body];

(2) not be subject to disciplinary action by the [insert reference to the appropriate state licensing/accrediting body];

(3) hold any other state or jurisdictional business license, registration, or work permits required by law;

(4) possess an in-force general liability policy with $1,000,000 in liability coverage;

(5) possess an in-force workers compensation policy;

(6) maintain Internet access and keep a valid email address on file with the Program; and

(7) agree to follow Program procedures and rules established under this section and satisfy any additional requirements established by the Commissioner.

Drafting Note: States with vendor registration requirements may wish to require satisfaction of those obligations as an additional condition of eligibility.

(H) An eligible contractor must not have a financial interest, other than payment on behalf of the homeowner, in any project for which the eligible contractor performs work toward a wildfire prepared designation under the Program. An eligible contractor is prohibited from acting as the inspector for a wildfire prepared designation on any project funded by the Program. An eligible contractor must report to the Commissioner regarding

any potential conflict of interest before work commences on any job funded by the Program.

(I) Any project funded by the Program must be inspected and obtain a wildfire prepared designation. A program inspector must:

(1) meet all program eligibility requirements established by the Commissioner;

(2) not have a financial interest in any project that the evaluator inspects for designation purposes for the Program;

(3) not be an eligible contractor or supplier of any material, product, or system installed in any home that the evaluator inspects for designation purposes for the Program;

(4) inform the Commissioner of any potential conflict of interest impacting the evaluator's participation in the Program.

(J) This Section does not create any of the following:

(1) An entitlement for property owners to receive funding to inspect or retrofit residential property.

(2) An obligation for the state to appropriate funding to inspect or retrofit residential property.

Section 4. Premium Discount or Insurance Rate Reduction

(A) All insurance companies writing property insurance for any property located in [State] that has been designated as complying with the most recent version of the "wildfire prepared" standard of the Insurance Institute for Business and Home Safety shall provide a premium discount or rate reduction on the coverage if such a discount or reduction is actuarially justified and there is sufficient and credible evidence of cost savings that can be attributed to the construction standards.

(B) (1) To obtain a credit or discount provided in this Subsection, an insurable property located in this state shall be certified as meeting all requirements of the wildfire prepared program provided by the Insurance Institute for Business and Home Safety.

(2) An insurable property shall be designated as in conformance with the wildfire prepared program only after inspection and certification by an Insurance Institute for Business and Home Safety-approved inspector.

(3) An owner of insurable property who is eligible for a credit or discount shall maintain the Insurance Institute for Business and Home Safety designation documents, which shall be considered evidence of compliance with the wildfire prepared standards. Upon request, the certification shall be presented to the insurer or potential insurer of a property owner before the adjustment becomes effective for the insurable property.

(4) Any available credit or discount shall apply only to policies that provide wildfire coverage and may apply to the portion of the premium for wildfire coverage or to the total premium, if the insurer does not separate out the premium for wildfire coverage in the rate filing. The adjustment shall apply exclusively to the premium designated for the improved insurable property. The adjustment is not required to be in addition to other mitigation adjustments provided by the insurer and shall be in lieu of those other adjustments, including those in place prior to xxxxxxxx, if they are deemed to be duplicative actuarially.

(5) Nothing in this Section shall prohibit insurers from offering additional adjustments in deductible, other credit rate differentials, or a combination thereof. These adjustments, if offered, shall be available under the terms specified in this Section to any owner who builds or locates a new insurable property in this state to resist loss due to wildfire.

(6) For the purposes of this Act, insurable property means residential property that is an owner-occupied, single-family, primary residence, that is eligible to be retrofitted.

(C) The commissioner of insurance, in consultation with the State Uniform Construction Code Council, shall promulgate rules and regulations in accordance with the Administrative Procedure Act to implement the provisions of this Section. The rules and regulations may include but not be limited to the following:

(1) When insurers are unable to obtain actuarially valid data to provide a premium discount or rate reduction under Section 4(A)(1) due to inadequate resources or experience, optional provisions defining and delineating the criteria for discounts, credits, rate differentials, targets, adjustments in deductibles, or any other adjustments to reduce the insurance premium and how such discounts, credits, rate differentials, adjustments in deductibles, or any other adjustments are computed in determining their application in each premium quoted.

(2) Those items necessary for an insurer to compute or otherwise determine the actuarially justified amount of any premium rate reduction, discount, credit, rate differential, reduction in deductible, or other adjustment available to an insured.

(3) Provisions establishing the inspection and certification requirements for insureds who comply with the provisions of this Section.

(4) Recordkeeping requirements for insurers.

Section 5. Effective Date

This Act shall take effect xxxxxxx.

EXECUTIVE COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
EXECUTIVE COMMITTEE
2026 NCOIL SUMMER MEETING – BOSTON, MA
JULY 18, 2026
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Executive Committee met at the Westin Copley Place Hotel in Boston, MA on Saturday July 18, 2026 at 12:30 PM.

NCOIL President, Senator Paul Utke (MN), Chair of the Committee, presided.

Other members of the committee present:

Rep. Kerry Wood (CT)
Rep. Peggy Mayfield (IN)
Rep. Michael Sarge Pollock (KY)
Rep. Michael Meredith (KY)
Rep. Edmond Jordan (LA)
Rep. David LeBouef (MA)
Sen. Lana Theis (MI)
Sen. Bill Gannon (NH)
Asw. Pamela Hunter (NY)
Rep. Brian Lampton (OH)
Sen. George Lang (OH)
Rep. Ellyn Hefner (OK)
Del. Walter Hall (WV)
Sen. Cale Case (WY)

Other legislators present were:

Rep. Stephen Meskers (CT)
Sen. Tim McGough (NH)

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 Sen. George Lang (OH), 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. David LeBoeuf (MA) 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 April 19, 2026 meeting in Louisville, KY.

FUTURE MEETING LOCATIONS

Sen. Utke stated that looking ahead to the rest of 2026, the Annual Meeting will be in Sanibel, FL from November 19th – 22nd which will really be a great venue especially during that time of the year. The Meeting will also start with the 5th Annual NCOIL Open Insurance Legislators Foundation (ILF) Golf Outing on Thursday the 19th. Golf outing registration and sponsorship opportunities are now open on the NCOIL website.

ADMINISTRATION

Will Melofchik, NCOIL CEO, stated that the final attendance numbers for this meeting included 425 total registrants including 76 legislators from 32 states and of that number there were 16 first time attendee legislators from 11 states. Additionally, 12 Insurance Commissioners participated with 15 total insurance departments represented.

Mr. Melofchik gave the 2026 unaudited financials through June 30th of this year which shows revenue of $1,040,409.66 and expenses of $750,652.56 for an excess of $289,757.10 heading into this Meeting.

Sen. Utke then stated that the Audit Committee met on Wednesday and received the audits for both NCOIL and the ILF from Dianne Batistoni of EisnerAmper. She reported that in reviewing NCOIL and ILF financials she rendered an unmodified opinion meaning that the financials looked proper and up to industry standard practices. There was a positive change in net assets for NCOIL of approximately $250,000.

Hearing no questions or comments, upon a Motion made by Rep. Edmond Jordan (LA), NCOIL Vice President, and seconded by Rep. Michael Meredith (KY), the Committee voted without objection by way of a voice vote to accept the audits.

CONSENT CALENDAR

Sen. Utke noted that the consent calendar includes resolutions and model laws adopted and re-adopted therein, as well as ratification of decisions made and actions taken by the NCOIL Officers and staff in the time between Executive Committee Meetings.

The Consent Calendar included:

- The Workers' Compensation Insurance Committee readopted the Trucking/Messenger Courier Industries Workers' Comp Model Act and the Model Agreement Between Jurisdictions to Govern Coordination of Claims and Coverage.

- The Health Insurance & Long Term Care Issues Committee adopted the NCOIL Charity Care and Medical Debt Reform Model Act, and readopted the NCOIL Telemedicine Authorization and Reimbursement Model Act (until the Annual Meeting).

- The Property & Casualty Insurance Committee readopted: the Transportation Network Company Model Act (until the Annual Meeting); the Post-Assessment Property and Liability Insurance Guaranty Association Model Act (with amendments); the NCOIL Distracted Driving Model Act; the NCOIL Peer-to-Peer Car Sharing Program Model Act (until the Annual Meeting); the Property/Casualty Insurance Modernization Act; and the Property/Casualty Flex-Rating Regulatory Improvement Model Act.

Hearing no questions or comments, upon a Motion made by Rep. LeBoeuf and seconded by Rep. Ellyn Hefner (OK), the Committee voted without objection by way of a voice to adopt the consent calendar.

OTHER SESSIONS

Sen. Utke stated we had three great General Sessions focusing on autonomous vehicles, tort reform, and innovations in disease screening and testing methods. We also had a great lineup of featured speakers throughout the conference. Massachusetts Attorney General Andrea Campbell joined us at the breakfast and Congressman Jake Auchincloss and Hawthorn Group Chairman & CEO John Ashford each provided great insights at the luncheon.

NEW EXECUTIVE COMMITTEE MEMBERS

Sen. Utke asked if anyone would like to make any nominations to the NCOIL Executive Committee. Rep. Kerry Wood (CT) nominated Rep. Stephen Meskers (CT).

Hearing no questions or comments, upon a Motion made by Rep. Hefner and seconded by Rep. Michael Sarge Pollock (KY), the Committee voted without objection by way of a voice vote to add Rep. Meskers to the Executive Committee.

ANY OTHER BUSINESS

Rep. Wood noted that she thinks NCOIL should look into getting an Instagram page so that people can tag NCOIL in their posts.

Rep. Meskers stated he would like to thank everyone for their confidence and support and stressed that he's learned a lot from everyone at NCOIL and he is grateful for that. Rep. Meskers also stated that it may be worth looking into increasing the travel reimbursements NCOIL provides to legislators to attend NCOIL National Meetings in light of rising travel expenses.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Peggy Mayfield (IN) and seconded by Sen. Cale Case (WY), the Committee adjourned at 1:00 p.m.