30 DAY MATERIALS AND TENTATIVE GENERAL SCHEDULE
NCOIL SPRING MEETING
MARCH 9 - 12, 2023

As of March 8, 2023, and Subject to Change

The Westin San Diego Gaslamp Quarter Hotel
San Diego, California

NCOIL SPRING MEETING
San Diego, California
March 9 - 12, 2023
TENTATIVE SCHEDULE

THURSDAY, MARCH 9TH

IEC Board Meeting	4:45 p.m.	-	5:45 p.m.
Welcome Reception	6:00 p.m.	-	7:00 p.m.

FRIDAY, MARCH 10TH

Registration *Exhibits Open: 9:00 a.m. – 5:00 p.m.*	7:00 a.m.	-	5:00 p.m.
Welcome Breakfast	8:00 a.m.	-	9:30 a.m.
Networking Break	9:30 a.m.	-	9:45 a.m.
Joint State-Federal Relations & International Insurance Issues Committee	9:45 a.m.	-	11:15 a.m.
Workers' Compensation Insurance Committee	11:15 p.m.	-	12:30 p.m.
The Institutes Griffith Foundation Legislator Luncheon Understanding the Economics of the Insurance Market ***Open to Public Policymakers and Staff Only***	12:30 p.m.	-	1:30 p.m.

NCOIL – NAIC Dialogue	1:30 p.m.	-	2:45 p.m.
General Session NCOIL Special Environmental, Social, and Governance (ESG) Series Part 1: Introduction to ESG and Environmental Aspects	2:45 p.m.	-	4:45 p.m.
Networking Break	4:45 p.m.	-	5:00 p.m.
Life Insurance & Financial Planning Committee	5:00 p.m.	-	6:15 p.m.
Adjournment	6:15 p.m.		
CIP Member & Sponsor Reception	6:30 p.m.	-	7:30 p.m.

SATURDAY, MARCH 11TH

Registration *Exhibits Open: 8:00 a.m. – 3:00 p.m.*	8:00 a.m.	-	3:00 p.m.
Property & Casualty Insurance Committee	9:00 a.m.	-	10:30 a.m.
Networking Break	10:30 a.m.	-	10:45 a.m.
General Session Liability Insurance for Gun Owners: Is it Time?	10:45 a.m.	-	12:00 p.m.
Luncheon with Keynote Address	12:00 p.m.	-	1:30 p.m.

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

Financial Services & Multi-Lines Issues Committee	1:30 p.m.	-	3:00 p.m.
Adjournment	3:00 p.m.		

SUNDAY, MARCH 12TH

Registration *Exhibits Open: 8:00 a.m. – 11:00 a.m.*	8:00 a.m.	-	11:00 a.m.
Health Insurance & Long Term Care Issues Committee	9:00 a.m.	-	10:45 a.m.
Executive Committee	10:45 a.m.	-	11:15 a.m.

******Please note all speakers listed are scheduled to speak as of March 8, 2023. There will be modifications between now and the start of the Meeting.******

******Note: There will be a room (Imperial on 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, March 9th, 2023

IEC Board Meeting
Thursday, March 9, 2023
4:45 p.m. – 5:45 p.m.

Welcome Reception
Thursday, March 9, 2023
6:00 p.m. – 7:00 p.m.

Friday, March 10th, 2023

Welcome Breakfast
Friday, March 10, 2023
8:00 a.m. – 9:30 a.m.

1.) Welcome to San Diego
2.) **Hon. Tom Considine**
    -Introductory Comments from NCOIL CEO
3.) **Rep. Deborah Ferguson, DDS (AR)**
    a.) President's Welcome
    b.) New Member Welcome and Introduction
4.) **Will Melofchik, NCOIL General Counsel**
    -Agenda Overview
5.) **Sen. Paul Utke (MN) – NCOIL Secretary**
    -Announcement of 2nd Annual NCOIL Open to Benefit ILF Scholarship Fund
6.) Any Other Business
7.) Adjournment

Networking Break
Friday, March 10, 2023
9:30 a.m. – 9:45 a.m.

Joint State-Federal Relations & International Insurance Issues Committee
Friday, March 10, 2023
9:45 a.m. – 11:15 a.m.

Chair: Rep. Jim Dunnigan (UT)
Vice Chair: Rep. Brenda Carter (MI)

1.) Call to Order/Roll Call/Approval of November 19, 2022 Committee Meeting Minutes
2.) Presentation on Federal and State Data from Balance Billing Independent Dispute Resolution Programs
    Tom Naughton, Division President, Federal Services – Maximus
3.) What Qualifies as "Preventive Services?" A Policy Discussion, and Briefing on *Braidwood Management, Inc. v. Becerra*
    Emily Carroll, Senior Legislative Attorney–American Medical Association (AMA)
    Justin Giovannelli, Associate Professor, Center on Health Insurance Reforms, Health Policy Institute, McCourt School of Public Policy – Georgetown University
    Greg Baylor, Esq., Senior Counsel, Director of Center for Religious Schools – Alliance Defending Freedom (ADF)
4.) Update on Preparations for/Implications of End of Public Health Emergency
    Miranda Motter, Senior VP, State Affairs and Policy – America's Health Insurance Plans (AHIP)
5.) Any Other Business
6.) Adjournment

Workers' Compensation Insurance Committee
Friday, March 10, 2023
11:15 a.m. – 12:30 p.m.

Chair: Sen. Bob Hackett (OH)
Vice Chair: Rep. Hank Zuber (MS)

1.) Call to Order/Roll Call/Approval of November 18, 2022 Committee Meeting Minutes
2.) Presentation on Developments in California Workers' Compensation Insurance Marketplace
    Mitch Steiger, Legislative Advocate – California Labor Federation, AFL-CIO
    Kristen Marsh, Senior VP & Chief Legal Officer – Workers' Compensation Insurance Rating Bureau of California (WCIRB)
3.) Discussion on Proposed U.S. Department of Labor Worker Classification Rule
    Michael Lotito, Co-Chair, Littler Workplace Policy Institute and Shareholder – Littler Mendelson P.C.
4.) Presentation on Emerging Issues in Workers' Compensation
    Susan Donegon, Chief Regulatory Officer – National Council on Compensation Insurance (NCCI)
5.) Any Other Business
6.) Adjournment

The Institutes Griffith Foundation Legislator Luncheon
Understanding the Economics of the Insurance Market
Friday, March 10, 2023
12:30 p.m. – 1:30 p.m.

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

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

NCOIL – NAIC Dialogue
Friday, March 10, 2023
1:30 p.m. – 2:45 p.m.

Co-Chair: Rep. Deborah Ferguson, DDS (AR) – NCOIL President
Co-Chair: Rep. Tom Oliverson, M.D. (TX) – NCOIL Vice President

1.) Call to Order/Roll Call/Approval of November 18, 2022 Committee Meeting Minutes
2.) The Return of the Systemically Important Financial Institution (SIFI) Designation?
3.) Update on Enhanced Cash Surrender Value (ECSV) Developments
4.) Discussion on Issues Relating to Tribal Insurers
5.) Discussion on Development of NAIC's New Consumer Privacy Protection Model Law
6.) Preview of Environmental, Social, and Governance (ESG) General Session
7.) Discussion on Development of Model Bulletin on Issues Relating to Artificial Intelligence and the Insurance Industry
8.) Any Other Business
9.) Adjournment

General Session
NCOIL Special Environmental, Social, and Governance (ESG) Series
Part 1: Introduction to ESG and Environmental Aspects
Friday, March 10, 2023
2:45 p.m. – 4:45 p.m.

Moderator: Asw. Pam Hunter (NY) – NCOIL Treasurer

David Shin, Ph.D.
Assistant Professor
Kelley School of Business
Indiana University

Travis Antoniono
California Public Employees' Retirement System (CalPERS)
Investment Manager
Sustainable Investing

The Hon. Jason Isaac
Director, Life:Powered
Texas Public Policy Foundation

Phillip Ludvigsen, Ph.D.
Senior Associate
First Environment, Inc.

Dave Snyder
VP & Counsel, Policy Research
American Property Casualty Insurance Ass'n (APCIA)

The Hon. Todd Kaminsky
Shareholder
Greenberg Traurig, LLP

Sam Gutterman FSA, FCAS, MAAA, CERA, FCA, HonFIA
Member
American Academy of Actuaries

The Hon. Marlo Oaks
Utah State Treasurer

Networking Break
Friday, March 10, 2023
4:45 p.m. – 5:00 p.m.

Life Insurance & Financial Planning Committee
Friday, March 10, 2023
5:00 p.m. – 6:15 p.m.

Chair: Rep. Carl Anderson (SC)
Vice Chair: Sen. Mary Felzkowski (WI)

1.) Call to Order/Roll Call/Approval of November 17, 2022 Committee Meeting Minutes
2.) Introduction and Discussion of NCOIL Life Insurance is a Promise for Life Model Act
Sen. Travis Holdman (IN), NCOIL Immediate Past President – Sponsor
The Hon. Nat Shapo, Life Insurance Settlement Association (LISA); former Illinois Insurance Director
Karen Melchert, Regional VP, State Relations - American Council of Life Insurers (ACLI)
3.) Discussion on Developments in California's Life Insurance Policy Lapse Laws
Tiger Joyce, President – American Tort Reform Association (ATRA)
Dick Weber, Board Member – Life Insurance Consumer Advocacy Center; President and Lead Consultant – The Ethical Edge, Inc.
4.) Presentation on New Federal Retirement Security Law – The SECURE Act 2.0
Kathleen Coulombe, VP, Retirement Security & Principal Deputy, Federal Relations – ACLI
5.) Any Other Business
6.) Adjournment

CIP Member & Sponsor Reception
Friday, March 10, 2023
6:30 p.m. – 7:30 p.m.

Saturday, March 11th, 2023

Property & Casualty Insurance Committee
Saturday, March 11, 2023
9:00 a.m. – 10:30 a.m.

Chair: Rep. Edmond Jordan (LA)
Vice Chair: Sen. Vickie Sawyer (NC)

1.) Call to Order/Roll Call/Approval of November 18, 2022 and February 17, 2023 Committee Meeting Minutes
2.) Presentation on Improving Natural Disaster Resiliency Efforts
Roy Wright, President & CEO – Insurance Institute for Business & Home Safety (IBHS)
The Hon. Jim Donelon – Louisiana Insurance Commissioner
3.) Presentation on Insurance Issues Related to Catalytic Converter Theft
Eric De Campos, Director, Strategy, Policy, and Government Affairs - National Insurance Crime Bureau (NICB)
4.) Discussion and Consideration of NCOIL Insurance Underwriting Transparency Model Act
Rep. Matt Lehman (IN), NCOIL Immediate Past President – Sponsor
Frank O'Brien, VP, State Gov't Relations – American Property Casualty Insurance Association (APCIA)
Jon Schnautz, Ass't VP, State Affairs – National Association of Mutual Insurance Companies (NAMIC)
Wes Bissett, Senior Counsel, Independent Insurance Agents and Brokers of America (IIABA)
Robert Herrell, Executive Director – Consumer Federation of California (CFC)
5.) Any Other Business
6.) Adjournment

Networking Break
Saturday, March 11, 2023
10:30 a.m. – 10:45 a.m.

General Session
Liability Insurance for Gun Owners: Is it Time?
Saturday, March 11, 2023
10:45 a.m. – 12:00 p.m.

Moderator: Rep. Brenda Carter (MI)

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

RJ Lehmann
Editor-in-Chief and Senior Fellow
International Center for Law & Economics

Deborah Ramirez
Professor of Law
Co-Director, Center for Law, Equity and Race
Northeastern University School of Law

The Hon. Catherine Blakespear
California State Senate

Luncheon with Keynote Address
Saturday, March 11, 2023
12:00 p.m. – 1:30 p.m.

Financial Services & Multi-Lines Issues Committee
Saturday, March 11, 2023
1:30 p.m. – 3:00 p.m.

Chair: Rep. Forrest Bennett (OK)
Vice Chair: Rep. Tammy Nuccio (CT)

1.) Call to Order/Roll Call/Approval of November 18, 2022 Committee Meeting Minutes
2.) Presentation on Insurance Issues Surrounding Name, Image & Likeness (NIL) Industry
Pat Brown, Director of Risk Mgmt. & Insurance – Edmonds Duncan
3.) Discussion on Potential NCOIL Consumer Data Protection Model Act
JP Wieske, VP of State Affairs – Horizon Gov't Affairs
Andrew Barnhill, Head of Public Policy – IQVIA
Robert Herrell, Executive Director – Consumer Federation of California (CFC)
Jon Schnautz, Ass't VP, State Affairs – National Association of Mutual Insurance Companies (NAMIC)
4.) Discussion on E-Delivery of Insurance Documents and Potential Amendments to NCOIL Insurance E-Commerce Model Act
Mollie Zito, Associate General Counsel - UnitedHealthcare
Jeff Album, VP, Public & Gov't Affairs - Delta Dental of California
Robert Herrell, Executive Director - CFC
5.) Presentation on Developments in Direct Procurement of Insurance
Bill Bryan, Director – Providence Insurance Partners, LLC
6.) Any Other Business
7.) Adjournment

Sunday, March 12th, 2023

Health Insurance & Long Term Care Issues Committee
Sunday, March 12, 2023
9:00 a.m. – 10:45 a.m.

Chair: Del. Steve Westfall (WV)
Vice Chair: Rep. Rachel Roberts (KY)

1.) Call to Order/Roll Call/Approval of November 17, 2022 and February 17, 2023 Committee Meeting Minutes
2.) Continued Discussion on NCOIL Biomarker Testing Insurance Coverage Model Act

Asw. Pam Hunter (NY), NCOIL Treasurer – Sponsor; Sen. Paul Utke (MN), NCOIL Secretary – Co-Sponsor
Adara Citron, MPH, Policy Analyst - California Health Benefits Review Program
Scott M. Lippman, MD, Distinguished Professor of Medicine, Associate Vice Chancellor for Cancer Research – UC San Diego

3.) Introduction and Discussion on NCOIL Medical Loss Ratios (MLR) for Dental Health Care Services Plans Model Act
Del. Steve Westfall (WV) – Sponsor
Chad Olson, Director of State Gov't Affairs – American Dental Ass'n (ADA)
Robert J. Hanlon Jr. DMD - California Dental Association (CDA)
Jeff Album, VP, Public & Gov't Affairs - Delta Dental of California
Jill Rickard, Regional VP, State Relations - American Council of Life Insurers (ACLI)

4.) Introduction and Discussion on NCOIL Hospital Price Transparency Model Act
Rep. Tom Oliverson, M.D. (TX), NCOIL Vice President – Sponsor; Rep. Rachel Roberts (KY) – Co-Sponsor
Jonathan Wolfson, Chief Legal Officer & Policy Director - The Cicero Institute
Aaron Wesolowski, VP, Policy Research, Analytics & Strategy – American Hospital Association (AHA)

5.) Consideration of Re-adoption of NCOIL Pharmacy Benefits Manager (PBM) Licensure and Regulation Model Act (originally Adopted 12/8/18)
6.) Any Other Business
7.) Adjournment

Executive Committee
Sunday, March 12, 2023
10:45 a.m. – 11:15 a.m.

Chair: Rep. Deborah Ferguson, DDS (AR) – NCOIL President
Vice Chair: Rep. Tom Oliverson, M.D. (TX) – NCOIL Vice President

1.) Call to Order/Roll Call/Approval of November 19, 2022 Committee Meeting Minutes
2.) Future Meeting Locations
3.) Administration
a.) Meeting Report
b.) Receipt of Financials
4.) Consent Calendar – Committee Reports Including Resolutions and Model Laws Adopted/Re-adopted Therein
5.) Other Sessions
a.) The Institutes Griffith Foundation Legislator Luncheon
b.) General Sessions
c.) Featured Speakers
6.) Any Other Business
7.) Adjournment

JOINT STATE-FEDERAL RELATIONS & INTERNATIONAL INSURANCE ISSUES COMMITTEE MATERIAL

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
JOINT STATE-FEDERAL RELATIONS & INTERNATIONAL INSURANCE ISSUES COMMITTEE
NEW ORLEANS, LOUISIANA
NOVEMBER 19, 2022
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Joint State-Federal Relations & International Insurance Issues Committee met at The Sheraton New Orleans Hotel on Saturday, November 19, 2022 at 10:30 a.m.

Senator Paul Utke of Minnesota, Chair of the Committee, presided.

Other members of the Committee present were:

Rep. James Kaufman (AK)
Rep. Deborah Ferguson, DDS (AR)
Sen. Jason Rapert (AR)
Asm. Ken Cooley (CA)
Rep. Matt Lehman (IN)
Rep. Brenda Carter (MI)
Sen. Bob Hackett (OH)

Other legislators present were:

Rep. Tammy Nuccio (CT)
Rep. Rod Furniss (ID)
Rep. Edmond Jordan (LA)
Sen. Robert Mills (LA)
Asm. Jarett Gandolfo (NY)
Asw. Pam Hunter (NY)
Sen. George Lang (OH)
Rep. Carl Anderson (SC)
Sen. Mary Felzkowski (WI)
Sen. Mike Azinger (WV)
Sen. Eric Nelson (WV)
Del. Steve Westfall (WV)

Also in attendance were:

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

QUORUM

Upon a Motion made by Sen. Jason Rapert (AR), NCOIL Immediate Past President, and seconded by Sen. Bob Hackett (OH), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Sen. Hackett and seconded by Rep. Brenda Carter (MI), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 19, 2022 meeting in Jersey City, NJ.

PRESENTATION ON NATIONAL 988 SUICIDE & CRISIS PREVENTION LIFELINE

The Hon. Charles Curie, Consultant for Elevance Health and former Administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA) thanked the

Committee for the opportunity to speak and stated that just to give my background real quickly I was a Deputy Secretary for Mental Health and Substance Abuse Services in Pennsylvania for Governor Ridge from 1995 to 2001 and then I was appointed by President Bush and confirmed by the Senate to be Administer of SAMHSA within HHS from 2001 to 2006. I'm very pleased to be here today presenting on 988 and I'll be giving a little background on that but first I'll let my co-panelist introducer herself. Stephanie Pasternak, Director of State Affairs, Gov't Relations and Policy & Advocacy at the National Alliance on Mental Illness (NAMI) thanked the Committee for the opportunity to speak and stated that NAMI's mission is to build better lives for people affected by mental illness. We represent people living with mental health conditions and their family members. I've been with NAMI for about three years now and our areas of focus are raising public awareness, education, support, and advocacy around mental health and I'm joining you from our national office but I really must give credit to the heart of NAMI which is our grassroots network of 600 local offices in our 49 state organizations who offer programs free of charge in their local communities.

Mr. Curie stated that I also might add that throughout my 43 year career, I've had the opportunity to work with NAMI both at the state level and federal level and they are a tremendous resource for public policy issues for knowing evidence based practices and knowing the latest in behavioral health so you'll have some resources at the end of this presentation. Also, I might mention I currently am with The Curie Group, a group I formed 16 years ago, a consulting group and I'm here today working with Elevance as well. We're going to begin the presentation today talking about what is 988 - the new mental health crisis emergency number. And in considering it, 988 really is a culmination of efforts on the part of suicide prevention advocates over the past two decades. Suicide prevention really came into the forefront of public policy considerations during my tenure at SAMHSA with the publication of President Bush's new freedom commission of mental health. And that commission examined the mental health service delivery system and for the first time identified suicide prevention and suicide as a public health issue that needed to be addressed in some sort of formal way. And out of that, I refer you to look at that report, a model was identified that the Air Force had implemented in how to prevent suicide as their numbers were very high in terms of suicide in the 1990's. And they were able to implement a program around education, around involving people at all levels in the Air Force. Families as well. And it really brought the suicide rate down and many of those principles in that program are in that report and it also informed suicide prevention today. In 2005 we made suicide prevention at SAMHSA one of the specific stated priorities and since those days there's been very active participation on the part of a range of advocacy groups and the taskforce in particular that I know Ms. Pasternak participates in and NAMI's been a part of to really take a look at what's needed in order to address suicide prevention.

When we look at 988, the forerunner of 988 was a national suicide prevention lifeline. You may be familiar with the number 1-800-273-TALK. That was the number that's been highlighted through the years that if someone is suicidal or someone is considering or in the midst of a mental health or substance use crisis to call that number. What's interesting as I flew into New Orleans today is I'm reminded that we implemented that hotline in 2005 and the first test of that hotline was Hurricane Katrina in New Orleans and again, I made many visits to New Orleans during that period of time and kind of had flashbacks this time coming back thinking about we're actually talking about the origins of the hotline and how Katrina was really the first test of that and today we see 988. But after two decades of work one of the major pillars that the suicide prevention advocates

and public policy officials felt would set the stage to address suicide prevention in a real way is to implement 988, a three digit universal dialing code knowing that it would be much easier to dial 988 than to memorize the number. And it offers the promise of the new response at the local level in every state. But it's really an entry point. There's really much more to do. It's an opportunity to re-imagine the crisis services system and that's going to be a focus of our conversation today, is what needs to be in that system. What does our current crisis response look like? Well, because of the lack of available mental health resources and the increased demand around mental health right now and substance use, communities are facing more and more challenges. And again, 988 was not created to address necessarily the COVID challenges we're seeing now but it's actually very timely. As we take a look currently, two million times each year people with mental illness are booked into the nation's jails. Again, can that be avoided if we have another crisis response system? One hundred thousand people die of drug overdoses unfortunately in a 12 month period and each year annually there's between 45,000 to 50,000 suicides each year in our country. I want to contrast that with the time I was at SAMHSA the numbers were 28,000 to 32,000 during that five year period. It averaged right around 30,000 a year back in the early 2000's. Today, it's 45,000 to 50,000. What contributes to that? Part of that is the returning Veterans have contributed significantly to that rate. Also, I do believe we are reporting more accurately because we've made that part of the public policy approach to ensure that local jurisdictions are reporting it accurately and we're getting an accurate count. But unfortunately, the rate continues to go up. Also, with COVID, lately the data's been telling us one out of three Americans are experiencing a mental health issue. Contrast that with, during my time at SAMHSA and for decades it's been one out of five Americans have mental health issues. But again, we've seen that increase over the last year or two and COVID has contributed to that.

Ms. Pasternak stated that I'm going to jump in here because fortunately over the last few years there's sort of been a national consensus on what a mental health crisis system should look like and a couple years ago SAMHSA put out behavioral health crisis guidelines and it really boils down to three core services: 24/7 crisis call centers giving you someone to talk to; mobile crisis teams so someone to respond; and crisis stabilization options, somewhere to go. Breaking these three pillars down a little bit further, the crisis call centers are really contact centers because they are also available by text and chat, are staffed by trained crisis counselors and for 988 compared to the National Suicide Prevention Lifeline they're receiving more training on a wider variety of behavioral health related crises and they provide local referrals to follow up services and are able to dispatch mobile crisis teams if they're available in that area. Some people need more support than can be offered over the phone when they're in crisis and ideally, a mobile crisis team, which is usually a pair of behavioral health professionals, can come out and deescalate the situation. If they happen to need even more support they can transport them to either a local ER or a crisis stabilization option if that's available. Breaking down what crisis stabilization is, these are only available in a few communities across the country but generally, they're 23 hour facilities that are meant to be an alternative to an emergency room as emergency rooms tend to not have psychiatric professionals available to treat people in crises. They're also very loud, very bright, and not a very therapeutic setting for someone in crisis. So, these facilities have behavioral health professionals and generally at the end of the 23 hours folks are discharged back into the community but if someone needs an in-patient level of care than they can be transferred to an in-patient facility. And I want to stop on this last point. So, if you work with your local police departments, many of them have the priority of diverting people

away from arrest in our local jail system but you might hear them say, “well they’re in our jails because there’s simply nowhere else to go; there’s nowhere I can divert people to.” And this third pillar is so important because it really answers that question and Mr. Curie will address that.

Mr. Curie stated that in Maricopa County in Arizona when I was consulting there at the time, they have one of the first programs and a model program in which they set up a 23 hour crisis stabilization in a store front and they did it with not only the local healthcare and behavioral health system but with law enforcement and law enforcement actually helped establish it and shape it. And it did give police officers and first responders a place that if someone needed more of a response that they could handle a call out at a home but needed some care that would be a first opportunity. And what we might want to mention with the continuum of care is 80% of the calls can be handled by phone with trained professionals. So, that’s another reason it’s important 988 having the appropriate expertise in place locally. It does take that burden right off of 911 immediately and obviously 911 has its own response but 80% can be handled typically and we’ve seen that consistently through the years by phone. On the crisis mobile, again you can resolve 70% there as you can see from this figure and then then I’ll Ms. Pasternak describe the rest of the continuum. Ms. Pasternak stated that just so you know what you’re looking at here, this is what it looks like when a local community actually implements the full continuum of care. This is a graphic representation of what’s available in Tucson, Arizona. Arizona’s doing a lot of amazing things in crisis care. I won’t break down everything here but as you can see when people call in 80% of those calls are resolved over the phone. For the percent of calls that do need a mobile crisis team option, 70% of those are resolved in the field without going to any further facility. And then for most people that end up at a crisis stabilization facility the vast majority can be discharged back into the community avoiding any in-patient care stays and that saves hospital funds. It also saves money to our justice system and you see 911 and law enforcement up at the top there. These systems have to have close partnerships to work well and in Tucson the police officers can actually drop someone off at a local crisis stabilization facility and in ten minutes get that person seen by a provider instead of hours waiting in an ER with someone to be admitted.

Mr. Curie stated that the federal action to create 988 was from the National Suicide Hotline Designation Act which was passed and signed into law September of 2020 and it did create the three digit number for mental crises and suicide to be that universal telephone number available everywhere in the county. Again, similar to 911 in terms of the concept and the goal also was to re-imagine as we’ve been talking about that continuum of care. What does a crisis system look like? What does the continuum look like that a community needs? And base that on the data and the experience we have thus far in terms of what would be anticipated in that structure. Ms. Pasternak stated that I will just add that there was a funding option made available in the National Suicide Hotline Designation Act really looking at how 911 is funded today which if you don’t know, you a pay a small monthly fee on your phone bill. Usually, the national average is about $1 a month and this Act made clear that if states wanted to fund 988 in a similar way, that they have the ability to do that and that can cover costs associated with the three pillars of crisis care. Mr. Curie stated that I also might mention money has been made available from the Federal Government to states in order to implement 988. The Omnibus Act of 2020 with the American Rescue, there was a total of about $282 million available to states and then there was $35 million in the SAMHSA block grant that was made available to states and there have been waivers with the Centers for Medicare and

Medicaid Services (CMS) to be able to pay for crisis intervention. So, I encourage you to consider how is your state using those resources? Are they maximizing them? And are they being used to help build that continuum of care. Ms. Pasternak stated that I'll go through this really quickly just to explain how does 988 actually work practically. So, if someone calls or texts 988 what happens is they hear an automated message that says if they are a Veteran they can press one and be connected to the Veterans Crisis Line and that's actually administered separately by the Veterans Administration. Or they can press two if they are a Spanish speaker if they'd like to be connected to a Spanish sub-network. If they press neither of those automated options they are routed based on their area code to their nearest local call center and if a certain amount of time passes and that local center does not pick up there are a series of national backup centers run by Vibrant Emotional Health that will pick up those calls generally after two minutes if no one has picked up locally and the system is designed that way so that if a local call center is overwhelmed at a certain moment and simply can't pick up a call, there is a way to get them a response no matter what.

Mr. Curie stated that the reason that's so important is in 2020 before the implementation of 988, on the suicide hotline that was in place it was documented by the New York Times that 17% of calls were abandoned and this is something that with 988 we want to make sure is addressed in states because the last thing you want are individuals calling in because they're in a suicidal crisis or a mental health crisis and they're put on hold. You don't want that to happen and so the backup system's been very important. I also might mention that Beacon Health, working with Vibrant Emotional Health and Beacon's division of Elevance is backing up the text function of that as well. Ms. Pasternak stated that other things are expected to change with 988. It's an easier to remember number. Vibrant is estimating that in year one, for reference the 988 officially launched in July, that they will have a doubling of contacts and they have started to release actual monthly data and the data for August of this year compared to August of last year when only the ten digit number was available they noticed a 45% increase in contacts. Mr. Curie stated that they did anticipate that if you build it they will come and it's being borne out here. The other thing that we want to examine is how much diversion from 911 is happening in 988? I think that's another important metric to examine. Ms. Pasternak stated that when 988 launched this July you might have seen a local headline something like the new 911 for mental health is here and it's 988. There are some similarities but I want it to be clear that there's really major differences between these two emergency lines. With 911 the goal is really for the operator to collect enough information to figure out which service they need to dispatch to your location: fire, police, EMS, or a mixture of all those. 988's a little different. The call itself is an intervention. The call's picked up by a trained crisis counselor and their goal is to use the least invasive response possible. So, as we said, somewhere between 80-90% of crises can be actually resolved over the phone and it's fairly rare that they actually need to dispatch a service but we know that people are still going to call 911 when they're in emergency. That's the number they know. So, there's going to need to be standard operating procedures about transferring calls back and forth between 911 and 988. Mr. Curie stated that and when you think about it for a moment, 911 is called and what usually happens - they send out an ambulance and they send out perhaps fireman or police. They send all those resources out. Again, if 80% can be resolved over the phone without having that, we're hopeful that 988 will certainly streamline things and also ultimately not only save lives most importantly but also be cost effective overall.

So, what happened on July 16th? That was part of the law that would be implemented on July 16th when they flipped the switch so to speak. Effective July 16th and this in place right now, everyone can text or call or chat on 988 no matter where they live. Their call will be directed to the 988 suicide and crisis lifeline network which again came out of 1-800-273-TALK. And the lifeline again is focused on not just suicide. It's a range of mental health and substance use crises such as the opioid crisis and the Fentanyl crisis. This is a resource that's available and helping people really in any type of emotional distress. And again, we at least have the three digit number in place and we have the beginnings of it but again, there are some policy making challenges here that need to be considered and Ms. Pasternak will speak to those. Ms. Pasternak stated that at NAMI we've been calling July 16th a starting line for 988 but we are far from finished. If there's not further action at the federal and state levels there's some challenges we're going to have. Call centers are going to continue to operate with very limited public funding while experiencing an increase in call volumes. Mobile crisis teams are not going to be available in every community and where they're not available that burden is going to continue falling on law enforcement to be that first responder. Crisis stabilization options are only available in a few communities. If we don't build those out further we're going to continue to see the cycling that we know happens in the ER's and jails with no other options to turn to. And also 988 it'll be a national number but there's going to be a wide variation in the quality of that response community to community. Mr. Curie stated that as Ms. Pasternak was saying we really have a patchwork quilt right now across the country when it comes to crisis and the continuum in each local area. First of all, historically it's been underfunded and that's a concern continued today. Again, I mentioned earlier some of the funding streams that are available. Again, I think it would be important to ascertain in your state how those are being used. There's mobile crisis teams only in certain areas of the country and very limited availability. In fact, I think you're probably all familiar right now with the emergency room boarding crisis that's occurring and where literally you have people who have a mental health crisis going through emergency rooms in certain parts of the country. There seems to be a real spike among teenagers and young women but they're sometimes boarded in the emergency room for days. I've even heard as long as a week at a time and again, with no place to go. So again, the need is great there.

Ms. Pasternak stated that what NAMI and our partners in the mental health and really a cross section of advocacy organizations have been pushing for is for states to pass legislation that implements an infrastructure to support the new 988 line and those related crisis services. The key points that state legislation should hit on is identifying dedicated funding mechanisms that are sustainable and the monthly fees can certainly be a piece of the puzzle here. Define the requirements for 988 crisis services. What kind of training are people going to be required to receive to work in this system? Look at additional resources such as state general revenue funds and insurance coverage. And then importantly create oversight coordination and public reporting on 988 to ensure smooth implementation. I won't go through this but I'll just make folks aware that NAMI's live tracking 988 legislation and I'm sorry that link doesn't show up very well but it's reimaginecrisis.org\map. You want to see where your state is at with passing the model bill and other measures as well. Just giving you a sense of what's happened so far in state legislation - seven states have created a permanent 988 advisory body. Five states have enacted those telecommunications fees that we've just mentioned. California was the most recent to do so with AB988 and you'll notice throughout the five states that have them those fees are pretty low especially in comparison to 911 fees. In California it's going to start at eight cents for a couple years and then we'll be capped at

thirty cents moving forward. Thirty states have passed appropriations for at least one of the core crisis services. Another interim measure states are looking at is to do sort of a study of what's the state of play in crisis care in their state now. Where are there gaps? Let's put a taskforce together to make financing recommendations. And three states have passed 988 legislation that strengthens commercial insurance coverage of crisis care. Additionally, things that our states are grappling with outside of legislation I think I've mentioned most of this but I will say they're also trying to develop a culturally competent diverse workforce so that the call takers can respond to people from a variety of backgrounds and that they're also reflective of the communities that they are serving.

Mr. Curie stated that I think it would also be appropriate if you would like to request a briefing of your state officials. These are the mental health authority or CMS, whoever's managing the public health, and ask them about their sustainability plans. You know, what are their thoughts, what are they looking at? How to use the funding? Also, what are the overall plans they have in place for 988 implementation and the crisis continuum of care. Ms. Pasternak stated that the bottom line here is that states are really going to need to bring different funding sources together to make 988 fully work and that's going to of course include insurance coverage. At NAMI we've been also assessing the public opinion of mental health crisis care and it probably doesn't surprise you to learn that the American public is not very happy with the state of behavioral health crisis care and we partnered with a polling firm in June 2022 and found that four out of five people believe that people should receive a mental health professional to respond to them when they're in a mental health crisis rather than a law enforcement officer. The poll showed a lot of support for the call centers and the related response services and nearly three in four people are willing to pay a monthly fee on their phone bill to support this system. And so these are the top areas of concern for 988 moving forward. One is the overall availability in terms of capacity and determining those long term funding streams and how insurance coverage is going to play into this and workforce issues. Because you can fund the programs as much as you want but if you don't have the people to implement then you're going to have a challenge and we certainly have a workforce shortage. Second is elevating policy maker awareness of 988 and third is elevating the public awareness. We did a poll also right before 988 launched and found that only 4% of the general public had any awareness of 988's existence. In our more recent poll in October we found that that is up to 44% but everyone can benefit from this so,we certainly want a wider public awareness. And just finally to wrap up some tips on how to get involved - find out who's in charge of 988 planning in your state. Is there one of those task force or advisory bodies that's been set up already? Is it your state mental health agency that's taking the lead or your state public health agency? Or a few agencies co-leading? And importantly, within that is there a financing or insurance work group that you could send representatives to? Is there a separate advocacy coalition in place? A lot of times those are run by state NAMI organizations. And just in general, is your state agency that's responsible for Medicaid coverage and commercial insurance regulation at those 988 planning and implementation tables? And you can visit our 988 hub at reimaginecrisis.org for more information. And you can see our state map and we also have a short explainer video and again, the link isn't showing up great but I have also linked to where you can find your state's 988 data.

Asw. Pam Hunter (NY) stated that I absolutely agree that we are in crisis for many reasons but these are some of my thoughts and I've been thinking about this a lot lately. So, 988 I'm thinking it's like the treatment to the problem but how are we really taking care of the underlying issues that are really affecting our people across the country?

And not wanting to take anything away from something acute like I need to call 911 now to take care of the problem or I need to call 988 now to take care of the problem. But people are in crisis to the point that we spend lots of money on this and it just doesn't seem like we're really tackling the problem of the underlying issues to get to the point of not needing this. And it's getting worse. It's not getting better. So, that's my thought and I don't expect you to really have the whole answer but if we don't ever take time to really get to the underlying issues of why people are in crisis we're going to be in my state house and others across the country asking the feds and not for profits are still going to keep asking us to fund the programs that are so desperate in the community without really taking care of the underlying issues. I'm trying to understand the providers that provide these services. It's important for people to have consistent care and we talked about making 988 a sustainable but consistent care. If there are a lack of providers and say I'm talking to a mental health counselor and we're having a great relationship and sometimes they're the ones you find online but you might not get the same person again. How is that helping someone if they're not having a consistent relationship with someone and being able to have consistent conversations? That's my one question. Another is, how does this translate to young people? Because I have a 22 year old and I can tell you he has never heard of 988 and wouldn't know anything about this. They live online even though you could do this on the phone. And that demographic it seems to me is a huge group of people who have these issues so how are we targeting our younger people? And also just generally with demographics, is there some information that you have you can send to us saying you're compiling all this information and we see the age of people who are calling and non-veterans. I'm a Veteran myself and I get that whole separate thing but do you have the age of people who are calling and the demographics of people that are calling. Is it in the Midwest? Is it in the northeast? Where are the people calling from and what are the issues? That could help legislators tackle these issues easier.

Mr. Curie stated that I'll talk a little bit about the underlying problems. I think it's important to take a look at both mental health and healthcare in general. It would be important to begin integrating at the service level behavioral health into primary care and into pediatric care. There are screenings. We see that if you screen and identify early you can prevent exacerbation of mental health issues and this many times can be picked up again in those other medical settings where you don't necessarily have behavioral health capacity. That would be I think one consideration is where can you begin to integrate behavioral health capacity not only in terms of assessment but then a clear pathway to needed initial treatment. Asw. Hunter stated that I hear what you're saying and I definitely do not want to be argumentative about this at all but if you look at trauma in communities and you're looking at where people are, if someone is homeless or indigent your primary care provider is not taking enough time to figure out if you are stable to live or if you have enough food. I know how my son acts when he's hungry and that exacerbates and I just think it's broken and our young people are just dying. Mr. Curie stated that I think you're exactly right. Again, I think it's only a piece of the issue to begin to reach out in those integrated settings in all of our systems in health and human services. And today we have a great deal of knowledge on trauma informed care and I think we need to be thinking in terms of people are in trauma. And again, there's a lot of guidance on how you begin to ensure all the systems that are touching people are trauma informed and I think that's also a beginning point to look at.

Ms. Pasternak stated that I'll just add that we were here to focus just on the crisis care of the broader continuum but we certainly hope that if people do come into contact with the

crisis system that that's their first and last time doing so and that's going to take a more build out of outpatient services. I know crisis stabilization facilities where they are do try to take care of some of those basic needs in addition to mental health care. If someone's hungry they get food. If they need a shower, they get a shower there and if they need housing, they get connected to those right services that do address some of those underlying issues. Regarding your question about are we tracking demographics of who's calling, SAMHSA is. That's publicly available on their website but also states can go even further in what they track and New York's law actually in my opinion went further than any state's 988 law thus far regarding reporting metrics about who's coming into contact with mobile crisis teams - their race, ethnicity, if they identify as LGBTQ plus. And then what were the outcomes of those calls - are they being transferred to law enforcement? We certainly want to know that. Are they going to the hospital? Are they going to some other crisis care option? And that's supposed to be reported publicly monthly and I'm failing to remember the start date of that but that's in state law. Mr. Curie stated that I also might mention when we look at resources to address the types of issues you've described, one thing we did not mention is over the course of this year and next year, I think there's been close to half a billion dollars allocated to certify community based behavioral health centers, and that's available to the states. Again, we're going to have workforce challenges regardless of how much money is coming into the system but states need to examine how are those dollars being used to establish capacity for behavioral health in communities, especially communities that do not have the capacity right now and that was one of the purposes of community based health centers (CBHCs). Ms. Pasternak stated that sorry to keep belaboring the point but to jump on that regarding CBHCs, what I think what you're describing of people is they see one doctor and then the next week they see someone else and how are they supposed to have quality care if that's their experience. CBHC's are meant to help address some of these issues that are in the public mental health system. They receive a much more sustainable payment rate than traditional community mental health centers have received and early results show that they've been able to hire more people and offer more services and retain that staff to offer a higher quality of care.

Sen. Utke thanked Mr. Curie and Ms. Pasternak and stated that in previous meetings related to these topics we're talking a lot about the treatment or catching them in crisis but it's important to go back on the prevention side and actually drill down to the root cause and try to get them the help they need.

PRESENTATION ON IMPLEMENTATION OF THE FEDERAL CLINICAL TREATMENT ACT

Megan Lydon, MPH Policy Fellow at Bristol Myers Squibb thanked the Committee for the opportunity to speak and stated that today I'm going to be talking about improving access to clinical trials and the role of state Medicaid departments in accomplishing this. So, to start off and frame this issue, clinical trial diversity is an issue for individual patient access, health equity, and regulatory decision making. Right now, U.S. clinical trials are not very representative of U.S. demographics as a whole or patient populations and this is especially a problem among racially and ethnically diverse communities as well as patients with disabilities who are severely underrepresented in clinical trials. And this has long term ramifications on the safety and efficacy information of the products that are being tested in clinical trials. When we test a product we want to make sure that the patients who are being tested in those trials are representative of those who are eventually going to be using the drug or therapy after it's approved and prescribed by

their physician. And this is an issue that has also caught the attention of the U.S. Food and Drug Administration (FDA) and other global regulatory agencies for the reason of proper safety and efficacy information that is applicable to the U.S. population as a whole and the FDA in particular has issued a number of guidance on promoting diversity in clinical trials and has even highlighted it as a major factor in some regulatory decisions recently. This issue has also gained a lot of traction among stakeholders throughout the research system. Patients, survivors of diseases, physicians, research groups, as well as advocacy organizations like the American Cancer Society and the National Minority Quality Forum have all really advocated for the removal of some of these barriers to better increase access for patients, especially over the past decade as a lot of those disparities have become more pronounced.

So, in response to a lot of this, Congress passed the bipartisan Clinical Treatment Act (CTA) in 2020. The CTA directs state Medicaid programs to cover routine costs associated with clinical trials regarding cancer or other life threatening conditions and this routine cost piece is really important because these costs are not related to data collection or monitoring of the specific therapy or anything like that. They're related to the clinical management of the beneficiary so it covers drugs to treat the side effects of a specific trial therapy or follow up appointments with a doctor if they're having some sort of symptoms following their participation in a clinical trial. And because these are all related to the clinical management of the beneficiary in the Medicaid program this will have little to no impact on Medicaid budgets going forward and this legislation was really important because prior to its effective date of January 1, 2022 Medicaid was the only major payer that did not cover these costs. Medicare has covered them since 2000 and the Affordable Care Act (ACA) guaranteed coverage for commercial patients since 2010 and this is a huge issue because Medicaid insures approximately one third of the entire U.S. population, a little bit under that. And even though some states did have mandates prior to the CTA's passage many of these mandates of covering routine costs had more restrictions. Some of them only covered cancer trials or would only cover trials located in the state and even with that, that still meant millions of Medicaid patients had no access to this benefit. It is especially important because many patients, especially low income patients, cite financial barriers as one of the greatest obstacles to participate in a clinical trial and accessing really innovative life saving therapies when they've exhausted their standard of care options. So though this was passed by Congress it is up to state Medicaid departments to implement the CTA and this is done through state plan amendments or spa's. These spa's allow Medicaid departments to make changes to their programs while still complying with federal requirements and claiming matching funds and CMS has created a number of different templates, three specific ones for the CTA to implement these in individual states. And each of these templates identify specific population groups or pathways within a state's Medicaid department.

The first is categorically needy or those that qualify for cash assistance, medically needy or those who normally do not qualify for cash assistance because their income or assets are too high but their medical needs or their bills put them under that threshold, and then alternative benefit plan groups which relate to a specific delivery system or area of the state. And one important thing to note is that not all states will have all three of these pathways. Some states do not have the medically needy pathway, and alternative benefit plans mostly just apply to ACA expansion states so not all states will have implemented spa's for all three of these categories it will just vary depending on the state and its Medicaid department. As of yesterday this is the patchwork of spa implementation across the country. As you can see, states have made a really

important first step forward in implementing these spa's and getting them on the books for the Medicaid patients in each of the states and it's especially interesting to note that it's quite a patchwork across the country. There is a regional distinction or specificities in specific areas of the country but as you can see the majority of states have gotten spa's on the books for their patients and this is especially impactful for patients who are seeking trials located out of state or patients in rural areas who might not be able to access the academic medical center in their state. They might be closer to one in a different state so this has really helped to increase access for patients across the country and states have been a great partner in this so far. One thing to note though is despite the implementation of spa's and what a positive step forward it was, many barriers still remain to accessing and participating in clinical trials. Clinical trials can be very disruptive to daily life and there are a number of practical obstacles that patients may face, especially lower income patients or rural patients might face particularly in accessing clinical trials. One being research is often conducted at large academic medical centers which may be far away from where someone lives so they have to cover the cost of potentially getting themselves there or lodging there especially if there are multiple site visits required throughout the duration of a trial. That can be an additional barrier especially for rural patients. Other costs of missing work or covering childcare or other caring responsibilities can be another financial obstacle for patients that is not covered in that routine cost piece of the CTA.

Next, moving on to medical and research institutions, these can be very complex to navigate especially for those who do not have much familiarity with the system and this could be a barrier that prevent patients from getting in the door for a trial. There could also be low trust in PhRMA or medical research or different levels of health literacy that impact how a patient understands clinical trials, the results, and the benefits that they can potentially get from participating in a trial. And finally, one thing to note is clinical trial sites are just getting back up and running fully after the COVID-19 pandemic and with this new benefit generated by the CTA some staff may not be familiar with processing Medicaid claims yet and this could lead to some potential delays for patients. And then finally, a really important piece going forward is public and provider awareness, in particular providers or physicians are really important in letting their patient know that a clinical trial is occurring and assuring that there is a clinical benefit to their participation. And they're often the ones that are referring their patients to these trials so physician awareness is a huge important variable in implementing the CTA and pulling through for patients. One survey done about a year ago found that just one in five physicians were aware of the CTA so this was before its full effective date and then another similar survey hasn't been conducted since but it's something to note when we are thinking about how these patients can fully access the benefits afforded by this legislation. And finally, public awareness of the CTA is really important because especially for patients with cancer or other life-threatening conditions, if they've exhausted their standard of care options it's really important they can benefit from innovative therapies as quickly as possible so knowing about these trials and knowing that they have the coverage of routine cost is really important and is a really great opportunity for state legislators and other people throughout the medical system to be partners in raising awareness through social media newsletters and Town Halls just to make sure that patients and their loved ones are aware of this benefit for whenever they do need it.

Next, a couple of things could change Medicaid eligibility and thus impact trial access and diversity. First, as many of us know the unwinding of the COVID-19 public health

emergency (PHE) will likely be coming in the next couple of months. During the PHE, Medicaid enrollment increased by about twenty million enrollees to about ninety million total enrolled around the country and once the PHE expires and the redetermination requirements are reenacted if someone hasn't aged into Medicare or found some other type of health coverage they could not only lose their health care but they could potentially lose their access to clinical trials as well. There has been some discussion recently of moving these patients to State exchanges. I think that is still in the experimental phase to better understand what that would look like state-to-state but this is something to consider as the aims of the CTA could be impacted by these changes in redetermination requirements and underrepresented populations may continue to face some barriers in this area. And then one proposed rule is expected to have somewhat of the opposite effect. So this is a proposed rule from CMS that would better streamline enrollment and verification requirements for Medicaid and children's health insurance program (CHIP) patients and this could have a really positive impact on clinical trials especially considering how long trials often last. They can be weeks, months, or years and if a patient is turning off and on Medicaid and they are unsure if they're going to have access to a benefit and if they're going to have the routine costs covered, by streamlining eligibility and enrollment they can be more certain that financial uncertainty and surprises won't occur throughout the duration that they are involved in the trial. So finally I just want to leave you all with an anecdote about the importance of the CTA. This is a headline from one state. This one patient had stage four cancer and tried all the standard of care options and had exhausted a lot of options and her provider deemed them a perfect candidate for a specific trial for her condition. But she reached out to her State health plan, this state also had implemented an spa covering categorically needy beneficiaries, and was denied coverage of routine cost three different times. One was for the trial being out-of-network. One was for a paperwork issue and one was for the plan did not cover experimental treatments. And in particular that first and third reasons are explicitly outlined as a benefit of the CTA that the State had on the books. There was just a lack of awareness at all levels that just really highlights the importance of this for patients and making sure that the patient themselves are aware of it and that providers are aware of it and that the health plans are aware of this to make sure these patients can access trials as quickly as possible for long-term health benefits.

Rep. Deborah Ferguson, DDS (AR), NCOIL Secretary, asked if these are placebo controlled trials? Because one of the big discussions in the medical community is whether placebo controlled trials are ethical and particularly if you're asking Medicaid to pay for it. Can you address that? Ms. Lydon stated that the CTA will cover all trials related to cancer or life threatening conditions. It will cover the routine costs associated with that for the patient. Obviously, it will not determine what arm of the trial a patient is going to be entering or what trial specifically they are going to be entering. So, the CTA is really just aiming at covering that financial barrier that patients face as an obstacle to get into the door at clinical trials so it will cover all kinds of trials but once they're in the door the cost will still be covered but it doesn't have any sway on what trial a patient is involved in.

UNDERSTANDING THE HEALTHCARE PROVISIONS IN THE FEDERAL INFLATION REDUCTION ACT

Alexander Dworkowitz, Partner at Manatt, Phelps & Phillips, LLP, thanked the Committee for the opportunity to speak and stated that I'm going to provide an overview

of the Inflation Reduction Act's (IRA) healthcare provisions. I'll start with an overview then quickly go through the three main pillars of the law and then end with a perspective of what does this actually mean for states. So, there are three main pillars of the law when you think about the drug pricing provisions. Number one is for the first time, the federal government under Medicare can negotiate the prices for drugs that are paid for under both Medicare Part B and Medicare Part D. Second, also for the first time, manufactures are required to pay rebates to the federal government if they increase the price of their drugs at a rate faster than the rate of inflation. And third, the Medicare Part B benefit has been changed substantially. The biggest change being there's now a $2,000 out of pocket cap on what beneficiaries can pay for their Part D drug spending. We don't have to go through all the details here but this is just to note that this is not the first time that the federal government has intervened in impacting the price of drugs under Medicare or Medicaid. Also I wanted to note that some of the points on the right hand side here we have from 2019 and President Trump proposing using international reference prices to impact the price of drugs and then we have the U.S. House of Representatives passing in 2019 HR3 which also took into account international prices for drugs. That's not exactly how the IRA works but certainly was an influence on this law. So, I'll start with the first pillar, the drug price negotiation program. So, what HHS can do, or will do, is establish a maximum fair price (MFP) for selected drugs and each selected drug will have a ceiling price under the law. The law actually has a very detailed formula about the most the federal government can pay under Medicare for these drugs but importantly the federal government has leeway to go below that maximum price. So, the law says this is the most Medicare can pay for a drug but CMS has discretion to go even lower. An important point is that this doesn't apply to all drugs. There are really three main restrictions here. Number one, we're talking about drugs that cost Medicare a fair amount of money. These are drugs that cost the Medicare program at least $200 million dollars per year. Second, these are drugs that have been on the market for a while. So, if you have a new drug that's approved next year, it won't be eligible for negotiated price for at least nine years. And it depends on whether it's an oral drug or a biologic. Biologic's can go up to thirteen years. And third, these are about drugs that do not have competition. These are drugs that do not have an available generic or available biosimilar. And finally, two other points on this slide. The MFP will kick in on the Part D side in 2026 for a few numbers of drugs and on the Part B side in 2028. And also note even though we talk about this as Medicare negotiation it actually is a Medicaid negotiation too because the law was drafted saying the negotiated price impacts the Medicaid best price. So, for any of you who are familiar about how Medicaid drug payments work that essentially means that Medicaid has to get the lowest available price on the market subject to certain exceptions. So, the federal government negotiates a lower price for a drug under Medicare and Medicaid programs get the benefit of that low price and it works the same way with the 340B program.

There's a lot here so we don't have to go through all these slides but just note there's a detailed process in the law that talks about how the government has to go about picking which drugs are subject to negotiation. There's a long timeline. Though it's probably a little hard to see here I think one key date is September 2023. So, less than one year from now that's when the Federal Government will come up with its list of drugs that are subject to negotiated price for the first time. Those drug prices won't take effect until 2026 but within a year from now we're all going to know these are the first ten drugs that the government's going to negotiate and step in and set a price for. This point I essentially already covered but the key here is that if there's a marketed generic or marketed biosimilar that competes with a brand drug in question that brand drug is not

going to be subject to a negotiated price. So, that creates sort of different dynamics and it's not what we're used to because there's actually a bit of incentive now if you're a brand manufacturer that you want a generic to compete with you because if you have a generic competing with you, you're free from this program so it's going to be interesting to see how this all plays out.

Inflation rebates is the next pillar I mentioned. There's a lot of details here but just fundamentally it's a simple concept. The idea is that if you as a manufacturer increase the price of your drug at the rate faster than inflation you have to pay back to the federal government the difference of that increase. So, say your drug is $100 and inflation is 5%. You're allowed to increase it up to $105 without any penalty but if you go up to $110, you're now overcharging by $5 and you have to pay the government back that extra $5. So, you're not making any money off that additional increase. This is based on the Medicaid drug rebate program which has been around since 1990. So, there are a lot of similarities between how the Medicaid rebates work and the new Medicare Part B and Part D rebates will work but a couple important differences I want to point out are that in that first line generally Part B and Part D will not impose rebates for generics and biosimilars. Under Medicaid there is no such escape hatch. And also that line about whether rebates are owed if there is no price increase. Yes, there's no rebates owed right if the manufacturer does not increase the price of a drug at all there will be no rebates under Medicare at all but under Medicaid there will be rebates. For most brands at least the minimum rebate is 23.1% of what's called the average manufacturer price.

Part D redesign is the third major pillar. I think this chart, to the extent you can see it, really gets at the key differences here. To the left is the current benefit of how things look under Part D and the right is what it's going to look like in 2025. The deductible's the same, about $500 will be increased for inflation, and then there's not too much of difference under that next coverage phase. The beneficiary has to pay 25% and that's going to remain the same. There's a bit of difference in the manufacturers have to kick in 10% for coverage of the drugs in that coverage phase but that's going to look pretty similar. It's the top that looks really different. So, we're getting rid of the coverage gap phase entirely and then you look at the top the way it works currently is that the federal government is paying most of the costs above the out of pocket threshold. That that orange bar is now shrinking a lot so the Federal Government above the catastrophic cap isn't paying much anymore. Instead that's being shifted to the plans and to some extent the manufacturers. And the other key difference is that, again on the left side, you see that little slim dark blue on the left. That's the enrollee costs - they owe 5% above the catastrophic cap under the current rules and then in 2025 that will go down to zero. The difference between 5% and zero is not a big deal, right? Well it actually can be a very big deal because if you think of a drug that's priced over $100,000 or $200,000, 5% of that is a big difference versus zero. The catastrophic cap is going to be $2,000 per year indexed for inflation but that's coming down. So, clearly there's going to be a real impact on Medicare beneficiaries that have really high drug costs under Part D.

A few other changes to note. There's now cap co-pays of no more than $35 a month for insulin and $0 for vaccines. As I mentioned before that because the plans are going to really absorb the costs above the catastrophic cap that money's going to have to come from somewhere. So, the incentive really is that you increase premiums. The law prevents increased, well I shouldn't say prevents premium increases, but caps them at 6% until basically 2030. So, what that means is that the Federal Government is going to have to come up with the additional money but after 2030 we're going to see the ability

to increase premiums at a higher rate. Finally, I just want to note the marketplace changes. These are not drug price provisions but the law is keeping it effective, the additional marketplace subsidies under the American Rescue Plan Act. You can see sort of in the middle there, that's what happened prior to 2021 in terms of subsidies for buying plans for the exchanges and to the right side from 2021 now through 2025, those percentages are lower. So, what does this mean for states? It's not the easiest question to answer because a lot of this involves prediction and I can't promise what's going to happen but there's speculation as to what might happen and it's worth taking that into account. One of the big questions is what does this mean for the commercial health insurance market. This is a law that's designed to reduce costs under Medicare. It's not a law that's designed to reduce costs under the commercial health insurance market and there's a concern that there might be a bit of a cost shifting going on. Drug manufacturers are going to have lower revenues from the Medicare program and where are those additional revenues going to come from? They may make efforts to seek higher revenues from the commercial health insurance market. This may happen through higher launch prices for drugs. Also, when you know think about the way these new Medicare rebates work, the manufacturer's only paying rebates to the government for Medicare units so if you imagine you have a drug say 80% of it is sold in the commercial market and 20% is sold to Medicare enrollees or say Medicare and Medicaid, it's a drug that generally is used in the commercial health insurance market not Medicare and Medicaid. Think about what that means for a manufacturer. You may say, well we can still increase the price of our drug, we won't get any additional revenues on the Medicare and Medicaid side but we will get additional revenues on the commercial side and that's 80% of the business for this drug, so that's fine. So, that's the potential for what may happen. I don't know if that's actually what's going to happen but it's something that some have speculated could occur.

The second point here is how this might impact state legislation. So, to the extent there's efforts to control drug prices at the state level you could see this law being a model in some ways. An easy point is the $35 insulin copay cap. Many states already have this or something similar. It's possible that other states might be encouraged to do something similar for their commercial health insurance market. Another point I think is the state of drug price affordability boards. Most states don't have them but some do. I know boards are intended to reduce the price of drugs generally in the commercial market and one of the challenges for those boards is understanding if they're going to come out with a price that commercial health plans should not pay more than that price. Where is that number going to come from? They don't want to make it up out of thin air. Well, now we have a federal law that's going to give them that price. These are going to be published federal prices where the federal government's going to say that we are not going to pay more than X for this drug and so you can say as a state, we're going to follow that. We're not going to pay more than X for that drug either and then also think about the inflationary rebates. As I mentioned they do not apply to commercial drug units. Initially they did but this was struck by the U.S. Senate Parliamentarian due to Congressional rules. So is there going to be an effort by states to try to address that by perhaps requiring inflationary rebates on the commercial side as well? And finally, the fact that the Medicaid PHE is going to come to an end soon and we have these higher subsidies and the exchanges through 2025 perhaps that's going to lead to more of a shift to marketplace enrollment in the next few years.

Sen. Utke stated that as you went through all of that what I thought in the back of my mind is when it comes to healthcare and the costs that you're talking about and some of

it's being shifted, it's kind of like the balloon when you squeeze it on one section which we're going to reduce, who's picking up the balance? And so with that at this point what do you envision the success of this will be or what will be the result or what do you think we'll see down the road? Mr. Dworkowitz stated that it's a very good question and it's hard to know exactly. I think one big question is, is this going to actually impact drug development? Are there going to be fewer drugs brought to market due to the lack of anticipated returns from the manufacturers? I don't know. I've heard good arguments on both sides. It may be not so much overall drug development is impacted but maybe certain niches are impacted because of certain incentives under the law. In terms of the cost shifting it's certainly plausible there could be some cost shifting to the commercial market. But we'll see. It may be that there's a version where this does result in lower costs in Medicare and there's not a profound impact on the remainder of the market but it's just hard to know that.

Asw. Hunter stated that we had a conversation I think last year relative to 340B and the savings and you're at Manatt in New York so you understand where we are with the 340B program and the savings. So I get the fact that the reduction needed to happen, it's too expensive. But several years ago we had a panel with actuarial folks, doctors, and the insurance plans and still we could never get to how is the pricing for drugs priced. You have the people at the table, and no one can say and I get the role of shareholders but the savings that Medicare recipients are getting is important. You're talking about seniors, people with fixed incomes. people who are disabled. The 340B program which gives savings especially to federally qualified health centers (FQHCs), you see in New York what's happening. The state wants the savings back. Is the federal government then in turn going to supplant dollars to these places and it's not just urban centers, but rural areas where healthcare is not accessible in order for programming? We have hospitals who are getting these 340B savings and they don't need it. The last panel probably wouldn't agree with what I just said but FQHCs need these savings. If they're not getting that and the federal government doesn't supplant it they cannot deliver the services to the people who desperately need it. I don't want that to go and it's very confusing. People don't understand 340B but this is happening right now and it will affect every single state who has FQHC's who are not watching this. This is very concerning to me and also, the middle can't absorb the increased costs because they're defraying costs from Medicare. That's important. Seniors shouldn't have to, but the middle shouldn't have to take care of that either and I think that needs to be watched in a way that the working poor cannot afford to have these increased costs and these high deductible plans.

Mr. Dworkowitz stated that 340B is a complicated program. There's some weird dynamics going on with this law and 340B because in theory you can say if you're a 340B covered entity and if you are a FQHC, I like this because the negotiated prices that Medicare gets pass on to me for those drugs so you say oh that's great. The complication is that the savings are not supposed to go to the covered entities. Everything is supposed to go to the Medicare program. So, even though I might be buying the drugs as an FQHC for a lower price, Medicare's going to come in and pay a lot less because the law's designed to capture those savings so I may be getting actually less in terms of revenue for those particular drugs. Again, those are only negotiated drugs but that dynamic is definitely at play here.

DISCUSSION AND CONSIDERATION OF RE-ADOPTION OF MODEL LAWS

Sen. Utke stated that per NCOIL bylaws all Model laws must be readopted every five years or else they will sunset. The models scheduled for re-adoption today are on the app, the website and they start off in the binders on page 350. The models are the Exhaustion of Administrative Remedies Model Act, and the Producer Compensation Disclosure Model Amendment to the Producer Licensing Model Act. Hearing no questions or comments, upon a Motion made by Rep. Carter and seconded by Sen. Hackett, 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 Sen. Hackett and seconded by Rep. Matt Lehman (IN), NCOIL Immediate Past President, the Committee adjourned at 12:00 p.m.

Please see this link for more information on the Committee topic "What Qualifies as 'Preventive Services?' A Policy Discussion, and Briefing on *Braidwood Management, Inc. v. Becerra*": https://www.kff.org/womens-health-policy/issue-brief/explaining-litigation-challenging-the-acas-preventive-services-requirements-braidwood-management-inc-v-becerra/

Please see this link for more information on the Committee topic "Update on Preparations for/Implications of End of Public Health Emergency": https://www.kff.org/coronavirus-covid-19/issue-brief/what-happens-when-covid-19-emergency-declarations-end-implications-for-coverage-costs-and-access/

WORKERS' COMPENSATION INSURANCE COMMITTEE MATERIAL

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
WORKERS' COMPENSATION INSURANCE COMMITTEE
NEW ORLEANS, LOUISIANA
NOVEMBER 17, 2022
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Workers' Compensation Insurance Committee met at The Sheraton New Orleans Hotel on Thursday, November 17, 2022 at 2:00 p.m.

Senator Bob Hackett of Ohio, Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Deborah Ferguson, DDS (AR)
Asm. Ken Cooley (CA)
Rep. Brian Lohse (IA)
Rep. Joe Fischer (KY)
Rep. Rachel Roberts (KY)
Sen. Paul Utke (MN)
Sen. Paul Wieland (MO)
Sen. Jerry Klein (ND)
Rep. Kevin Hardee (SC)
Del. Steve Westfall (WV)

Other legislators present were:

Rep. James Kaufman (AK)
Rep. Tammy Nuccio (CT)
Rep. Kerry Wood (CT)
Rep. Matthew Gambill (GA)
Rep. Carolyn Hugley (GA)
Rep. Rod Furniss (ID)
Rep. Rita Mayfield (IL)
Rep. Cherlynn Stevenson (KY)
Rep. John Illg (LA)
Sen. Robert Mills (LA)
Sen. Kirk Talbot (LA)
Rep. Kevin Coleman (MI)
Sen. Kevin Blackwell (MS)
Sen. Scott DeLano (MS)
Sen. Joseph Thomas (MS)
Sen. Paul Lowe (NC)
Sen. Shawn Vedaa (ND)
Sen. Bill Gannon (NH)
Rep. Brian Lampton (OH)
Rep. Forrest Bennett (OK)
Sen. Roger Picard (RI)
Rep. Carl Anderson (SC)
Sen. Mike Azinger (WV)
Sen. Eric Nelson (WV)

Also in attendance were:

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

QUORUM

Upon a Motion made by Rep. Deborah Ferguson, DDS (AR), NCOIL Secretary, and seconded by Sen. Paul Utke (MN), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Joe Fischer (KY) and seconded by Sen. Jerry Klein (ND), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 15, 2022 meeting in Jersey City, NJ.

PRESENTATION ON FENTANYL AND ITS IMPACT ON THE WORKERS' COMPENSATION MARKETPLACE

Phil Walls, RPh, Chief Clinical Officer at myMatrixx thanked the Committee for the opportunity to speak and stated that by way of introduction I have been a pharmacist for the past 45 years. While I was in school I started giving talks to church groups and other groups on drugs of abuse so that means I've been speaking on subjects like this for almost 50 years now which makes me feel really old. Back in the 1970s, one of the primary drugs that I was speaking on of course was heroin. That was when our veterans were returning from Vietnam and unfortunately a number of them had become addicted to heroin. Today what I want you to think about as I go through this presentation is that the primary cause of death today with a heroin overdose is fentanyl, not heroin. So keep that in mind as we go forward. I'll help explain how that's the case and we're going to talk about Fentanyl and the fact that this is a prescription medication unlike heroin which is an illegal substance and it's a schedule 1 controlled substance. Fentanyl is a legal prescription drug. It's schedule 2 and yet it has made this journey from being a legal prescription drug to an illegal street drug. So how did that happen? I'll give a little bit of background on that. I'm going to start off with some definitions in talking about opioids and opiates and drugs like fentanyl. I'll talk about an individual named George Marquardt which is a name you may or may not be familiar with. I'll also talk about a term that if you don't know today you will become familiar with - illicitly manufactured fentanyl (IMFs). We'll talk about potency of these drugs and overdoses and then discuss special considerations for first responders and this is when we'll really get into workers compensation.

Opioids is a broad term that basically applies to all of these painkillers that we're going to be talking about today. Specifically though opioids are the ones that came from the opium poppy. So these are a natural product. We hear all the time today that cannabis is a natural product. Well that's true of many drugs, morphine and codeine in particular. Both of these are derived directly from the poppy plant. In pharmaceutical science we take drugs that occur naturally and we alter them and usually that's to do one of two things - make them safer or make them more potent. And in the case of opioids when we convert an opioid into something that's now man-made, a semi-synthetic opioid, that is referred to as an opiate. This includes drugs like hydrocodone, which we see so often in workers compensation. Hydrocodone, oxycodone, even heroin. Heroin was created shortly after morphine was isolated from the poppy through a process known as a chelation. You're probably all familiar with vinegar and what vinegar smells like. Well that's acetic acid. So a chelation is basically creating these drugs with acidic acid. It changes them. In the case of morphine it created diacetyl morphine or diamorph which was the brand name and became heroin. Heroin was a drug created by a company known as Bayer. Bayer is of course still around today. At the time they did this they were not Bayer Pharmaceuticals. They were the Bayer Carpet Dyeing Company. To make carpet dies more vibrant they would use this chelation process. Well, one year there was a shortage of raw materials to produce carpet, so they had to look for something else to do and they tried this process of morphine and produced heroin. Shortly after they produced aspirin. So it's the same Bayer pharmaceutical company we know today.

And then we have synthetic opioids which is unique in that with these opioids, we do not have to start with the opium poppy. So that means that they're a lot easier to produce. The most common ones that we know of are methadone and fentanyl. So where did fentanyl come from? It's an extremely potent drug. Morphine is quite strong and all the other derivatives are quite strong. So why did we need this drug known as fentanyl? Well a doctor, a Belgian physician, first synthesized fentanyl in 1960 and what he found in producing this drug was that it had all of the good benefits of the opioids and then it had two unique factors. One is that it's extremely rapid acting and has a short duration of action. So for anesthesia these are very good qualities. You know you want to give the patient something that is going to put them under for a short period of time and then wear off quickly so you don't have that delayed recovery period. So from that perspective fentanyl was a very good drug. It also has fewer side effects than the other opioids, a lot less nausea and vomiting for most patients. So, his intention was to create a drug that was going to be an improvement over the existing opioid and he did that. Then the drug found further use when they created duragesic patches. So they took a drug that was extremely rapid acting and short-acting and turned it into a long-acting version. Why did they do that? Well, they wanted to go for those characteristics that produce less nausea and vomiting. So the fewer side effects. By putting it on a patch that is slowly released they were able to create an opiate that had these characteristics and yet would stay in a person's system for a long period of time.

Now a couple comments about the duragesic patch. It's effective for 72 hours. At the end of 72 hours there is still a significant amount of fentanyl left in that patch, enough to kill a child or pet. So with disposal of these patches, people have to be very careful and they have to be instructed. One, the sticky sides should be folded together and then it should be placed in something where it's not going to be retrievable. Throwing it out in the garbage is not a good idea. The U.S. Food and Drug Administration (FDA) years ago told communities to quit flushing drugs down the toilet because we were starting to see significant quantities of drugs in public water supplies and that's not a good thing. Then they sort of had to backpedal and they came back and they said, "okay there's some drugs that are so dangerous that actually we want you to flush them down the toilet." The opioids, all of them including fentanyl, made that list. They are so dangerous they have to be gotten rid of and they have to be gotten rid of in a way that no one can find them. So then pharmaceutical companies as they always do continue to find new uses for an old drug and that's when in the early 2000s they came out with something known as the actiq lollipop. It was a fentanyl lollipop. Now why on Earth would we put something as potent as fentanyl in a lollipop? Well it was designed again for a good purpose. Most drugs are designed for good purposes. It's just that then they're use is changed and used in ways that it shouldn't be. With fentanyl the idea here was end of life cancer patients. They know they have a short time to live. They do not want to be in hospice. They do not want to be in the hospital. They want to be at home and yet most caregivers are not trained in how to take care of these patients especially when it comes to injecting something like morphine.

So the idea with fentanyl is that the fastest way to get a drug into the human body other than an injection is absorption through the oral mucosa. So by the patient sucking on a lollipop the fentanyl would go to work very quickly and so it made sense to do it this way but only for that use. Unfortunately we saw the actiq lollipop in workers compensation. It was never intended for low back pain. It was an off-label use of a drug that was not a good off-label use. So being purely synthetic, what that means is that this drug can be

made by one person in a lab or in their parents basement. If any of you ever watched the series Breaking Bad, it's about production of methamphetamine. Apply that same thought to fentanyl. It is just that easy. A young man named George Marquardt was a high school dropout and self-described genius that did this. He went into his parents basement and started producing fentanyl. Now, the implications of this may not seem that striking but heroin is hard to produce. There's a huge market for it. So in the black market there's a lot of money that is made on the sale in the transport of heroin but you have to have the opium poppy in order to produce heroin. Fentanyl being entirely synthetic does not have that restriction. It is very easy to reproduce. So if we stop thinking for a moment about the dangers of this drug and we stop thinking about the illegality of this black market and think as business people which one would you want to start with? The heroin and the opium poppy or a few chemicals that can be obtained fairly easily? Well George's idea was well if I can produce this I can take over the opioid market and that's exactly what he did. He ended up serving time and there were a number of deaths that were tied directly to him.

I think the number of deaths today tied to fentanyl is almost uncountable. It's tragic. But because it's so easy to produce and I started off saying that the majority of heroin overdoses are caused by fentanyl because fentanyl is replacing heroin on the streets. It is so much easier to produce. Now, a lot of it is coming in from China and a lot of it is coming in from overseas but a lot of it is also produced in this country. Now in just a little while I'm going to show you a map on how this is affecting first responders. You're going to see a predominance on the East Coast. This is because within the U.S. the type of heroin that is always been on the east coast is very different from the type of heroin that is in the western part of the U.S. The Western half U.S. deals with what is referred to as black tar heroin and it's exactly that. It is a black tarry substance. The heroin on the east coast is pure; it's a white powder. It's a lot easier to substitute fentanyl, which is also a white powder, for heroin on the East Coast than it is the West Coast. So that's why there's been this shift. Unfortunately though it is spreading throughout the U.S. so it's no longer restricted to the east coast. And now regarding IMFs, there are 42 IMF analogues on the market. So what's an analog? It's just a slight variation in that original structure to make it a little bit different. The one that you might read about right now from The Centers for Disease Control and Prevention (CDC) is known as para-fluorofentanyl. It's not better, it's not stronger, it's just different. It has already been identified by the Drug Enforcement Administration (DEA) and made a schedule I controlled substance. The problem with IMF's and many chemicals like this is these black market chemists are able to come up with things before the DEA can actually declare them illegal because they don't know they exist yet so that's a challenge in and of itself.

Fentanyl itself is 50 times more potent than heroin and 100 times more potent than morphine. There's actually another legal form of fentanyl on the market known as a carfentanil and it's a schedule 2 controlled substance known as an elephant tranquilizer because that's its primary use in veterinary medicine. It is 100 times more potent than fentanyl. Now if I'm doing the math correctly that means 10,000 times more potent than morphine. When carfentanil hit the streets overdose deaths rose dramatically because of this potency. It almost cannot be cut enough to get it down to a safe level to use in place of heroin so that's a challenge. With overdose deaths related to opioids, with most of my talks when I talk to a workers compensation market I'm talking about prescription opioids and it's been frustrating over the last few years because we've actually seen a significant decline in the use of prescription opioids. But we're seeing an increase in

opioid overdose deaths. That's because of the increase of the use of illicit opioids. I don't know this for a fact so I'm going to go out on a limb here - we went through a period of time in not just workers' compensation but in this country where many people were receiving opioids inappropriately. We know that many of those patients became addicted to those prescription opioids. Then we launched some very good campaigns to educate prescribers, pharmacists, nurses, and everyone involved in the care of patients that we should use fewer opioids. And we've done that but we did it without thinking about the people that were already addicted to prescription opioids. So sadly in my opinion a lot of people that were addicted to prescription opioids turned to street opioids when their supply was cut off and the result we're seeing is a significant number of people are dying from opioid overdoses. 2013 is where we started to see the switch from heroin to the synthetic opioids, primarily fentanyl. It's still a problem today.
Let's now talk just for a moment about signs and symptoms of an overdose. The person's going to be unresponsive. Their lips and their nails are going to appear blue because they can't breathe. With a situation like this, first thing to do is call 911. If you have access to naloxone, administer it. Do not worry about whether or not you know for sure that this person has an opioid overdose because naloxone brand name Narcan all it does is block the effect of opioids. In many ways it's tragic that it's a prescription-only drug in most states because prescription drugs are made prescription only because of safety concerns. Well naloxone if it's administered to someone who is not in an opioid overdose basically it's not going to do anything so there's no concern over the safety for these individuals. Actually, there's more concern over safety if the person is indeed in an opioid overdose. Why? Because when you give them naloxone it immediately blocks all their opioid receptors and basically takes them out of an opioid overdose and puts them right into opioid withdrawal. They come out of it almost immediately for most opioids, not fentanyl. And when they come out of this overdose many times they're combative. These patients have been known to actually hurt the person that saved your life because they come out and they're agitated and fighting. They have gone straight into withdrawal which is not a good situation. So that's why I'm saying first thing anyone should do is call 911 even if you have naloxone and you can save their life you still need that support as soon as you administer that naloxone.

Now with first responders, when are they going to possibly encounter fentanyl? Well pretty much anytime. It could be a traffic stop or an overdose call - pretty much anything that a first responder is called to do. How can they be exposed to it – it could be skin contact, inhalation, ingestion, contact with mucous membrane such as the eyes, nose etc. Or it could be an accidental needle-stick. There has been a significant debate about skin contact and whether or not fentanyl can actually be absorbed through the skin. Forget the debate, it doesn't matter. First responders are being exposed to fentanyl and if they're exposed to enough of it, it can kill them. Whether it's absorbed through the skin, that debate can go on for years and quite frankly I don't care. More than likely what's happening is maybe they were exposed to their skin but if there's enough of it that they're exposed in that way they probably also inhaled some of it and it is so potent that's all it takes. There was a very famous case a few years back about an officer who brushed off a white powder on a colleague's jacket and he went into an overdose situation because of that. That's where most of this debate started. I think by brushing it that was all it took - a few of those particles from the powder went into the air and he inhaled it more than likely. When this occurs they're going to need access to naloxone. Most states have taken really good steps towards making naloxone more readily available. Before I retire if I had one wish it would be let's make naloxone over the counter. It's a safe drug. Remember what I said, if you give it to someone that's not

in an opioid overdose it's not going to really do anything. Is there a chance of an allergic reaction? Yes, there's a chance of an allergic reaction to any drug on the market whether it's over the counter or prescription so I don't think that's a reason not to make it over the counter. We need more available access. An argument I hear about that is, "well if people have access to the naloxone it might cause risky behavior when it comes to opioids." We already have risky behavior when it comes to opioids. Making naloxone more available I don't think in my opinion is going to necessarily lead to more risky behavior than what we're already seeing. Now, this is a map that's a few years old and in 2015 it shows the incidence of fentanyl encounters and as I said you can see a predominance more towards the eastern part of the country but over time that is changing unfortunately.

In addition to access to naloxone our first responders also need access to personal protective equipment (PPE) such as masks and gloves and things of this nature. So any municipality should be providing this to anyone that's involved. There are kits on the market that a first responder can use to test a substance to see if it's fentanyl or not. Don't spend your money on these kits. Train our first responders that if there is a substance of an unknown origin assume that it's fentanyl. Just taking the time to test it is going to expose these first responders to the possibility of fentanyl so don't go through that process and assume it's fentanyl until we can find out later once it's sent off to a lab. Start with PPE. If someone is exposed to it make sure they have access to naloxone. With naloxone the overdose is heroin and morphine - the prescription opioids that we're familiar with. A shot of naloxone or even a nasal spray is going to bring that person out of an overdose. Fentanyl and the IMF analogues are so potent that it's probably going to take repeat injections of naloxone in order to bring them out of an overdose so having one kit available or one vial may not be enough. They need to have access to quite a few because fentanyl is just that potent and powerful. After the incident that our first responder has gone to, anything that's potentially exposed needs to be handled very carefully and needs to be marked as fentanyl contaminated or possibly fentanyl contaminated until we know otherwise. It's vital that nobody else gets exposed through that. I've got some more resources here but if you just Google fentanyl you're going to find a lot of information on it. A few sites do better jobs than others. The CDC in particular has a lot of very good information on fentanyl and naloxone and opioids in general so I would encourage you to start with that.

The Hon. Tom Considine, NCOIL CEO, thanked Mr. Walls for his presentation and stated that it was great. With the testing I totally understand the rationale on the first responders, but I watched something that was advocating the testing oddly enough for use at parties so that if kids are thinking they're going to use ecstasy they should use the testing on ecstasy to make sure it's not laced with fentanyl. Do you have any views on that? Mr. Walls stated that is a very good point and my thoughts today were to focus on workers compensation which sort of led me to the first responders but you're absolutely right. Fentanyl is so cheap and easy to produce that it is showing up in all sorts of different things such as recreational drugs and even in things that you would not even think would be related to a drug so in those instances absolutely you're right to test just to know.

Rep. Rita Mayfield (IL) stated that my state has had a large increase in opioid overdoses - is there legislation that we could work on that can reduce access to fentanyl or carfentanil or to any of the other ingredients that are going into these items that they're trying to cut as heroin? Mr. Walls stated that is a good question. Fentanyl is unique in

that we're not seeing prescription drug diversion the way that we saw with Oxycontin and some of the others because we're not taking prescription drugs and putting those on the street. We have a chemist and to use that comparison again to Breaking Bad it is just like that TV series where an individual once they can get the chemicals can produce fentanyl through a fairly easy process. I'm not sure if there should be restriction to the purchase of chemicals. I'm a pharmacist and certainly not an attorney and I don't know what type of restrictions exist today. I'm sure there would be barriers because many of these chemicals are used for many different processes so by trying to ratchet down on them to keep them from being turned into fentanyl we're probably going to upset some other industries that are using them for a perfectly legal reason so I don't know about that. The biggest thing is that the DEA has a tough job and they also have an excellent website. Their job is almost insurmountable so anything that we can do in my opinion to fund them and give them more access to resources the better.

Rep. Ferguson stated that I just want to make sure I understand clearly - you're saying rather than turn your opioid prescriptions into the sheriff's department or take them to the Walmart disposal Rx system, you're saying to put them down the toilet instead? Mr. Walls stated that I'm glad you brought that up. The DEA has created something known as the DEA take-back day. You mentioned Walmart's program and a number of different pharmacies participate in that. Until the DEA did that it was actually illegal for a pharmacist to take back a controlled substance. We legally cannot do that because there's no paper trail there. When the DEA created the take-back day that is the best and safest disposal method. I'm so glad you brought that up. Short of that if it's not possible, the FDA says okay if there's no alternative then flush it down the toilet.

Sen. William Gannon (NH) stated that my state of New Hampshire is one of the most afflicted with opioid problems and it has been for the last five or six years. Is the production predominantly coming from out of the country or is that anecdotal that I hear? Mr. Walls stated that the last time I looked, China was the primary source. Now that has changed. There was a period of time where China did not even treat fentanyl as a controlled substance the way that we do in the U.S. That may have changed but I would be surprised if they're not still a predominant supplier.

DISCUSSION ON LOUISIANA WORKERS' COMPENSATION SYSTEM

Kristin Wall, President & CEO of the Louisiana Workers' Compensation Corporation (LWCC), thanked the Committee for the opportunity to speak and stated that I'm really honored to be here again as I spoke to this Committee in 2017 when NCOIL was last in New Orleans. I don't do a lot of speaking to groups but I really enjoyed it and I also really appreciate and understand what all of you do. You are setting the policies for your state. We are following all of the policies that you set. Workers compensation is done differently in every single state so the chances we get to learn from one another are importance because great things are being done in every state and there's some things that we should be learning from one another. If you think back to workers comp, it came about in the early 1920s with the Industrial Revolution and people started creating these workers comp funds and that was kind of the first generation that came about and they really were trying to support the competitive economy because back then if workers got hurt they sort of moved on to the next one and that's not right. State funds came in and they said we we've got to do something and we must make workplaces safer. I was listening to Phil talk and I was thinking about how that's changed just over the 30 years

that I've been doing this - now safe workplaces involve things like what are first responders being exposed to.

We underwrite a lot of municipalities and fire district's with first responders of all kind so with safety now and what we're supposed to do now, we do that in addition to falls from heights, slips and falls and things of that nature. So it really has evolved. We strive to provide fair access to insurance as the worst case is when you can't get insurance and there's nobody to take care of an injured worker. Taking care of injured workers is why we're all here. We operate on a self sufficient basis and we have a relentless focus on the injured worker and I have seen that in all the state funds. I'm a big part of the national organization that we have and that's what we all have in common is that we understand that's the most important thing that we do. And again, that's evolved as we have people now who are addicted to opioids. Simply cutting them off might not be the right thing to do. We have to make sure we do those types of things very carefully or else we might actually be causing greater harm. Some common features of state funds are that they are self-supporting and pay dividends. Some people are paying dividends across the country. Some are organized like mutual insurance companies. Some are more state agency driven subject to regulatory requirements and then operate in both residual and competitive markets. I will tell you that there was a big crisis in the 1980s and 1990s and it hit a lot of states. I can give you some particular insights into Louisiana, and Maine was also really in crisis. There was this instability crisis where the states that had state funds tended to weather it better because they had this mechanism of they were providing this insurance and were very focused on safety and injured workers. But a lot of states had what we call assigned risk pools and I'm sure a lot of you have been around long enough to know about that. We had them in Louisiana and it really wasn't working very well. That's when all the other insurance companies across the country sort of put in money to find out how it's going to run and how insurance is going to be delivered. It kind of comes down to no one is really accountable and that's what happened. Rates were increasing all across the country. Coverage was becoming unaffordable. And then there was this new self-insured market that started popping up in the 1990s and the economy really did suffer.

John Leonard, former president of the Maine Employers' Mutual Insurance Company (MEMIC) said, "if you've seen one state fund you've seen one state fund" meaning that we're all different. But we do have a variety of characteristics. We're created by our legislators. Many of us operate as the insurer of last resort. Insurance companies in general terms don't want to provide insurance to a business that pays them say less than $1,000 or $2,000 or $3,000. It's a commercial product and you have to deliver it as a commercial product but it comes at a steep price. So in general there's not always an available market for the smaller ones and then also there's not always an available market for those who have very high hazards. Some of the state funds are writing the line of other states. Some have subsidiaries. A few are monopolistic. I know some of you are from monopolistic areas as well. In 1991 in Louisiana 1991, the state of play was that rates had increased by over 260%. That's a lot. Employers were leaving the state because workers compensation was becoming one of their largest budget items. So you can create an economy where if you don't design it right, it's not attractive to stay. Ninety percent of our employers were in the assigned risk pool back then and most insurers began leaving to avoid all of these heavy assessments. So we really were left in a crisis. We didn't have carriers in to operate. So the LWCC was created. Most people thought it was the dumbest thing ever to create this company with absolutely no money and most people thought it was going to fail but it was there to provide workers

comp to Louisiana's employers who began issuing the policies in 1992. I was there, I remember it. And we were set up happily by our legislature. They did a really great job. As a private company, a domestic company, and a non-profit mutual insurance company they put all of the right fundamental pieces in place. We're not a state agency. Our trade-off if you will is we write all business good, bad, and small - we write everything. But we get to price it. We get to have the freedom of rate. Rates have to be actuarially sound and there's an awful lot that goes into that.

So with LWCC and kind of looking back over the eras that we had I mentioned that people didn't think we would survive but we did. And then as we sort of began to come out of those survival years we said we really need to learn how to do this well if we want to keep doing this so we were really in striving mode and focusing on getting better and better and really understanding the intent behind the legislation. Then we came and we moved into our thriving years. Things were good and things were getting better and more recently we realized that we really need to have pride - pride in our state, pride in the associations that we have with one another, and pride in our systems. And so we've been very much involved in that as well. If you look at LWCC we say we're a specialist, meaning that this is all we do. We only write workers comp. We're a private mutual as I mentioned. We've now been recognized for 17 years a Ward 50 company. There are about 3,000 property and casualty companies across the country and we make it into the top 50 every year. We have an AM Best rating of A which we're very proud of and we operate this competitive and residual market of state and federal risk. So there was market collapse but there's no longer a market collapse. We really like competitors in our state. We want a healthy state environment and I'll show you in a minute kind of how that all worked out because the carriers had all left and instead of having those rates going up by 260%, the rates have come down by 60% so we charged 60% less for the business than when we started.

I work with an incredible group of teammates and we are very purpose driven about everything we do. We are, we say, a model workers comp provider and the champion of Louisiana. What do I mean by that? We are dedicated solely to Louisiana - Louisiana employers, Louisiana workers and most of the people who treat our employees are Louisiana physicians. So it really does create an ability to get to know the environment that you're in. I mentioned the rate decrease and we've also been able to give back some of the premium our 20,000 policyholders have given us. In fact in current standing we've given back over $1 billion dollars. So that money when you have excess profit if you will, you can look at that and you can release that back to the people who gave it to you in the first place so we're very proud of that as that goes back to those Louisiana businesses and gets reinvested back into Louisiana's economy. We have paid over $2.6 billion to injured workers. I noticed that I say injured workers. We don't say claimants. That's not okay in our business because you want to treat them like you want to treat your other family members. And we also invest in Louisiana so we've got invested $518 million in mortgage securities and that helps support the Louisiana housing market and we've overseen the treatment of return to work for over 34,000 employees and serviced 186,000 work-related injuries.

So here do we have a good market? I would say we absolutely have a good market. This is a three-year snapshot on the slide and as you can see it's a really great healthy competitive market. We work hard at being competitive as well so there's nobody that takes an easy at bat or a bunt or anything like that. I know some of you are from different states and I don't know if you can read these states down at the bottom of the

slide but it goes from Pennsylvania over to Washington to the far right and then the dark green is Louisiana and LWCC. But what you have here is sort of a rating of funds. I mentioned AM Best and they rate your funds. An A is the highest rating that you can get for a single state, single line carrier. Some of the funds in this group aren't trying to be rated and they're very different. If you look over to the far right, Ohio, North Dakota, and Washington are monopolistic state funds. That's not a competitive environment. That state fund takes care of everyone and they have 100% of the market accordingly. So you can see the ratings but you can also see the percent of the market that each of your state funds has. So you'll see Maine over here at close to 70% so they write a big portion of the market. LWCC is 30% of the market and we try to balance that out as we don't want to get too big but we need to be big enough to have critical mass and to do a good job and to do all the things that we need to do. I'll note again that we're a purpose driven business. Insurance is primarily a purpose driven industry and workers comp is I believe the biggest purpose because we're taking care of people and our mission is to elevate Louisiana and celebrate it. So we've got a movement called Louisiana Loyal which if you're in Louisiana hopefully you'll be seeing and hearing more about that. I'm not going to play the video here but there's a lot of activities that are going on to support that. And finally, here's our destination statement - we showed you where we've been and where we are but where are we going? And if you were to take a look at that statement you can see that we're very proud to partner with all of our agents and we're about giving compassionate care to workers and we want to make sure we are giving unique benefits to our policyholders in the form of dividends and safety. But ultimately we want Louisiana to be a great place to live and work and we're doing our part and we're going to work hard at that and we are going to keep growing incrementally, but carefully. The statement ends by noting "as a result of our efforts, Louisiana citizens' lives will be improved, the state economy will be elevated, our state payroll share will return to 10%, and our state market share will return to 32% by 2027, while maintaining profitability."

Angela McGhee, SVP of Underwriting & Chief Actuary at LWCC thanked the Committee for the opportunity to speak and stated I've been in the industry for about 25 years so I have a little bit of experience pricing. I'm going to take you back just a little bit too just covering some basics of workers compensation and what it covers. It's designed to provide benefits to workers who were injured on the job. Sometimes those injuries are clearly tied to the work that a person is doing. For example if somebody falls off a ladder while they're working on a roof that was obviously in the course and scope of their job and would naturally be considered a worker's compensation claim and that would be covered under the traumatic injury portion of workers compensation. But workers comp also has an occupational disease component and the one that you might be most familiar with is asbestos. Before we realized that asbestos was as harmful as it is this was a disease that some workers contracted while they were working with it. That would be covered under the occupational disease portion of workers compensation. But there's some requirements for it to qualify - it has to be due to causes and conditions that are characteristic and peculiar to the workers trade and it also has to result from those conditions present in the employment and not from other conditions to which the employee might be exposed. So you might think about for example the flu - if someone is working in a doctor's office and a patient comes in and they have the flu they might get the flu from that person but we're all exposed to it and it's everywhere we go so it's not really peculiar to that person's trade because they're exposed to it elsewhere, not just in their occupational work.

So how are presumptions different from workers compensation? There are about 30 states, maybe a little more that have presumptions for workers compensation for certain occupations. So what the presumption does is take the burden of proof out of the employee's hands and it puts it on the employer or the insurance company's hand to deny the claim. So for an injury to qualify for occupational disease the employee has to prove that disease was caused by the exposure. The presumption takes that completely out of the picture and that disease is assumed to be caused by the work that the employee was doing. For occupational disease disability is generally required meaning that they can't work. So for a presumption disability might be required or like in Louisiana disability is not required. Occupational disease is generally applicable to all employees who are covered under the workers compensation act. Presumptions are generally only applicable to employees who are in a certain occupation. And occupational disease has this characteristic of and peculiar to the trade that we talked about. A presumption has none of that. It doesn't have to have any kind of direct cause tied to their occupation. So what's the problem with that? Well workers comp is based on causation - the whole point of workers comp is to tie it back to what they were doing in the workplace. So the presumption actually contradicts the whole basis of workers comp because it's assuming that it was tied to their work. So generally what happens with the presumption is it takes benefits or injuries that would have been treated under their general health care and it shifts over to workers compensation.

So, what's wrong with that? Well, Ms. Wall mentioned workers comp rates have to be actuarially sound. So what that means is that you can't have any kind of subsidization across different types of occupations. So every occupation has a certain rate in each of your states including Louisiana and those rates have to be actuarially sound which means it has to be tied back to the expected cost for that particular occupation. So, we can't subsidize across industries so as businesses increase benefits or employees are eligible for higher benefits they end up with higher rates because it costs more. So the types of presumptions vary a little bit as well as the groups that are eligible for presumptions but they're generally applicable to first responders. That's the most common area where we see presumption, in particular for firefighters. They may cover a variety of diseases but cancer and heart and lung disease are probably the most common but we also see things like post traumatic stress disorder (PTSD) and even COVID-19. In Louisiana just like work comp has evolved, the presumptions for firefighters have evolved significantly since work comp started. Back in 1914 when work comp was created, cancer was covered under occupational disease. So that would have been for anybody including firefighters. Ultimately in 1968 Louisiana opted to create a heart and lung presumption so any heart attack or lung issue that a firefighter had would be presumed to have been caused in the workplace and therefore treated under workers compensation rather than general health care. Cancer was later added but the cancer had to be disabling so the worker had to be unable to work to qualify for the presumption and it was limited to only a handful of different types of cancers that had been shown through research to be significantly tied to firefighter exposures and it was applicable during the time the employee was working in the fire service and up to five years post leaving the service. About nine years later more cancers were added to the presumption. In 2006 a new presumption came in where hearing loss was covered.

In 2017 we had a significant change - the disabling requirement was removed and essentially every type of cancer was incorporated into the presumption including things like prostate cancer that are generally more common in retired men of that age where the presumption applies post leaving the service. But the disabling piece was actually

the more significant part because now things like skin cancer including things that you might just go into the dermatologist and have it removed, that's all work comp now. In 2019, PTSD benefits were added. In 2020, indemnity benefits for hearing loss claims were added and then in 2022 we actually just went through some significant legislation where although LWCC was able to help educate some of the stakeholders as this bill was being written and passed, the cancer presumption was increased from five years after the firefighter leaves the service up to ten years. So as long as they have ten years of work with the service they're covered during the time they're working and ten years after they leave. One of the significant changes besides the offset of the additional costs that are obviously going to be incurred as a result of more cancer claims being pulled into the work comp system is there was a reduction in the medical costs. Louisiana has a very old medical fee schedule. Many of you are from states where your work comp fee schedule is likely tied to Medicare. A lot of states may say okay all my work comp cost will be a 150% or 200% of the Medicare schedule.

In Louisiana our med fee schedule is actually 90% of whatever the provider charges for outpatient. So for all outpatient claims I know you've all seen your explanation of benefits (EOB) from your insurance company and you see the very high number and then you see the reduction for the insurance negotiated costs. Whatever that number is, we pay 90% of that in Louisiana so the medical costs in Louisiana are very significant and they average about double what general health care pays. So it's huge when you add benefits like this to work comp. There has to be an offset and that's what was done here and so they opted to charge for any medical cost we would now pay 150% of Medicare. So that offset some of those additional claims costs that are coming into the system. So these cancer presumptions, just like state funds, if you've seen one you've seen one. These cancer presumptions are very different across states. I'm going to walk through some of the different characteristics. On the left in the light green is the less generous provision in the presumption and on the right is the more generous meaning they get more generous benefits. So, this starts from just having a presumption. There's actually about 10 states where there is a presumption for cancer in firefighters but it's actually removed from work comp and covered under some kind of different provision so they have a special policy or provision that provides benefits for those.

In Louisiana we started as being an occupational disease and we are now obviously presumed to be covered under work comp or caused by the workplace. In some states there's also a service eligibility requirement so the firefighter may have to work a certain amount of time before they would be covered under the presumption. Some states actually have no minimum and they're covered day one by the presumption. In Louisiana we're on the ten year side so they have to work ten years to be eligible for the presumption. There's a presumption application period. There are a handful of states that only provide that presumption while the firefighter is employed meaning once they leave the service the presumption no longer applies and there's actually one state that provides this presumption for life. In Louisiana we started at up to five years post leaving the service and we're now ten years post leaving the service. It also varies depending on the type of cancer. Some states have the low end of four different cancers that are covered all the way up to all types of cancers. Louisiana has obviously been moved all the way up to the all types of cancers now. There is an ability to rebut - in Louisiana, if the firefighter has cancer there is really no way for the employer or the insurance company to rebut or argue against that to deny the claim. Some states have the ability to do this through tobacco use. If the firefighter used tobacco or there's some

kind of family history the employer may be able to rebut that claim. And then there is the disability requirement that we talked about - Louisiana started as being unable to work and we now have no disability requirement. There are also a handful of states where there's really only coverage if the firefighter passes away from the cancer.

Sen. Hackett stated that in Ohio we don't cover mental health unless there's an accident - is that how you do it here in Louisiana? Ms. McGhee stated that it depends on the state and in Louisiana it's like PTSD. In Louisiana for firefighters we have a PTSD presumption which would mean if they're on the scene of an accident and they suffer from some kind of mental issue afterwards then that would be covered automatically for first responders. Sen. Hackett asked if Louisiana separates PTSD from any other mental health condition that they think was brought on by that? In Ohio you have to have an injury first. Ms. McGhee stated that here it's presumed. So, for firefighters it's presumed to have been caused by that accident. If it was another occupation then I think you would have to tie it back to that particular incident in order for them to have some kind of coverage for that. Sen. Hackett then stated that we just passed in Ohio the cancer exemption but we did put in for people who are smokers a ten year exclusion that they had to have quit smoking for the last ten years before we pay on lung cancer - how does Louisiana handle that? Ms. McGhee stated that there's none of that here. Even if they're smoking they are eligible. It doesn't matter what the firefighter has done during their employment or pre-employment - it's covered here.

DISCUSSION ON WORKERS' COMPENSATION LEGISLATIVE AND REGULATORY TRENDS

Tim Tucker, Washington Affairs Executive, External and Government Affairs at the National Council on Compensation Insurance (NCCI) thanked the Committee for the opportunity to speak and stated that I'm going to go through some of these issues that you've all been working on in the states in somewhat of a rapid-fire fashion in the interest of time. The good news is that all the things I'm going to go through are available at ncci.com through the numerous resources we have. This year has been somewhat typical in the volume of legislation and regulations you all have been working on in your respective states. We've seen about 800 bills be considered countrywide and 450 in NCCI states. About 100 of those were actually enacted and of course a 120 of those dealt with COVID-19 and workers compensation. Briefly I'll touch upon COVID-19 and work comp, mental injuries, marijuana legalization, single payer health insurance initiatives and their impact on workers compensation, and worker classification. With the onset of the pandemic back in 2020 we saw states take various approaches to the presumptions similar to that which we've seen for firefighters and other first responders previously for COVID-19. In this past year several states have extended the deadline for those presumptions and extended them into the future. Others have expanded the presumptions. Initially in some states they were solely for first responders. They've been expanded in some cases to other occupations as well. There's been some activity around that. And of course new presumptions have been considered. Some states who did not act at the onset of the pandemic have looked back and some have actually retroactively enacted legislation to cover injuries caused by exposure to the COVID-19 virus.

We talked a little bit about infectious diseases. Some states have taken a very broad approach and actually have gone and amended the occupational disease provisions of their workers compensation acts to include various infectious diseases as compensable

under their state workers compensation statutes. Something new this year and not surprising is that states are taking a look at the impact of the COVID-19 vaccines and potential compensable scenarios for workers. Several bills were introduced that established presumptions for adverse impacts to the vaccination. There've been a number of bills that specify the injuries from the vaccine are compensable under work comp laws. And two states actually enacted legislation that creates a private right of action against the employer if they mandate vaccinations for their workforce. Regarding mental injuries, we've seen an uptick in this area as far as legislative and regulatory proposals. Out of 60 bills, 45 relate to PTSD. A handful of states have actually enacted those proposals. Regarding state activity related to marijuana legalization, as you all know the impacts of marijuana legalization reaches a lot of different areas including the workplace. Some states this year such as Rhode Island enacted legislation that approved the use of recreational marijuana for recreational purposes. Two states last week by ballot initiative, Maryland and Missouri, made marijuana legal for recreational purposes. And then of course the issue that some state courts have been grappling with is the reimbursement for medical marijuana in workers compensation.

I think that's a trend we'll see more of as courts are working through that now both at the state and federal levels. There is certainly more to come here as the state's comparatively on the marijuana reform issue are far ahead of the federal government. For years there's been different proposals to legalize or otherwise address the treatment of marijuana under federal law. The real tension in Congress now is the scope of those reforms. It is one of those odd bipartisan bicameral issues that enjoys support. The devil happens to be in the details of whether to go with a comprehensive approach such as a Cannabis Administration and Opportunity Act that was put forward earlier this year which has a host of provisions from expungement of criminal records to the creation of a regulatory framework, to a taxation mechanism. Just this week the House Oversight Committee had a hearing on marijuana reform at the federal level. There does appear to be some bipartisan support for doing something, perhaps even in the upcoming lame-duck. The principles that were laid out in a joint memo released over the weekend by both the House Republicans and Democrats put a framework together that addresses those issues I just mentioned - expungement, taxation and a regulatory framework. There is a chance there could be a narrow reform such as a Safe And Fair Enforcement banking act that creates the safe harbor for banks and insurers and others who are working with legitimate cannabis-related enterprises. I mentioned the hearing this week so we'll see if there's enough time and momentum to get something across the finish line before the 118th Congress comes in in January.

I'll be very brief on single-payer. Obviously states have looked at this in varying degrees for decades now. The one stumbling point that always seems to come up is how to treat workers compensation medical costs and whatnot. States generally have kicked the can down the road and created a board or a commission within the proposed framework to deal with workers compensation so it really does present a challenge when you're looking at these universal single-payer systems. I will also note that for a number of years Medicare-For-All has been introduced in Congress which would create a single-payer universal plan and the provision within the Act does require workers compensation carriers to reimburse the Medicare For All program for services rendered to injured workers. So, that is something that needs to be considered when policymakers are looking at moving towards a single-payer healthcare system. And then of course worker classification continues to be a significant issue and states have taken various

approaches. I know several states have carved out transportation network companies or other gig type employments and treated them different than other independent contractors. And some states have created a framework that would provide certain benefits and services to those gig workers. At the federal level the Biden Administration has proposed regulations that would really create a more stringent framework for the classification of workers making it more difficult to classify workers as independent contractors. That is open for comment now. It really looks a lot like Assembly Bill 5 in California from a number of years ago which created a framework for employee classification. So we'll see what happens. I expect that there will be legal challenges to the Biden Administration's independent contractor rule.

One thing I wanted to follow-up from our July meeting where we presented to you – my colleague indicated at that time we were just beginning our annual rate filing season. We are about three-quarters of the way through that. You can look to see how your state compares to others. I will tell you with the exception of Hawaii, in all NCCI jurisdictions we have filed rate decreases so far this year. So we have about 32 of 38 states filed and those with the exception of Hawaii indicate decreases. I also want to put a few things on your radar for the upcoming year. NCCI will continue to examine the impact of COVID-19 both in terms of the impact of long- COVID as well as the existing trend of claims. Earlier this week NCCI and some of its partners released a report on the claims activity around COVID-19. A couple of numbers that stand out - there's been $1.1 billion in COVID claims paid to date. That represents a 117,000 claims with an average claim of just below $10,000. So you can see that there's been quite a bit of activity around COVID-19 claims that has impacted the industry. Another thing to keep an eye on is obviously trends in claim frequency and severity. While we've seen some severity tick up a little bit it largely has been offset by the continued decade or more long trend down in frequency. And then lastly and not surprisingly something that we've always kept our finger on is the impact of medical costs and workers compensation both in terms of course inflation but also utilization. So those are some things that I think we'll be looking at and determining how they impact workers compensation going forward.

ADJOURNMENT

Hearing no further business, upon a motion made by Del. Steve Westfall (WV) and seconded by Sen. Kelin, the Committee adjourned at 3:15 p.m.

Please see this link for more information on the Committee topic “Discussion on Proposed U.S. Department of Labor Worker Classification Rule”: https://www.littler.com/publication-press/publication/department-labor-proposes-new-rule-independent-contractor-status

NCOIL – NAIC DIALOGUE MATERIAL

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
NCOIL – NAIC DIALOGUE COMMITTEE
NEW ORLEANS, LOUISIANA
NOVEMBER 18, 2022
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) NCOIL – NAIC Dialogue Committee met at The Sheraton New Orleans Hotel on Friday, November 18, 2022 at 10:45 a.m.

Assemblyman Kevin Cahill of New York, Chair of the Committee, presided.

Other members of the Committee present were:

Sen. Jason Rapert (AR)
Asm. Ken Cooley (CA)
Rep. Tammy Nuccio (CT)
Rep. Rod Furniss (ID)
Rep. Matt Lehman (IN)
Rep. Brenda Carter (MI)
Sen. Paul Utke (MN)
Sen. Jerry Klein (ND)
Sen. Shawn Vedaa (ND)
Sen. Bob Hackett (OH)
Rep. Brian Lampton (OH)
Del. Steve Westfall (WV)

Other legislators present were:

Rep. James Kaufman (AK)
Rep. Deborah Ferguson, DDS (AR)
Rep. Kerry Wood (CT)
Rep. Carolyn Hugley (GA)
Rep. Brian Lohse (IA)
Rep. Jonathan Carroll (IL)
Rep. Michael Sarge Pollock (KY)
Sen. Robert Mills (LA)
Sen. Lana Theis (MI)
Sen. Paul Wieland (MO)
Sen. Kevin Blackwell (MS)
Sen. Mike McLendon (MS)
Sen. Walter Michel (MS)
Sen. Joseph Thomas (MS)
Asm. Jarett Gandolfo (NY)
Asw. Pam Hunter (NY)
Sen. Jay Hottinger (OH)
Rep. Carl Anderson (SC)
Rep. Jim Dunnigan (UT)
Sen. Mike Azinger (WV)
Sen. Eric Nelson (WV)

Also in attendance were:

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

QUORUM

Upon a Motion made by Rep. Matt Lehman (IN), NCOIL Immediate Past President and seconded by Sen. Paul Utke (MN), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Asm. Ken Cooley (CA), NCOIL President, and seconded by Sen. Jerry Klein (ND), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 15, 2022 meeting in Jersey City, NJ.

INTRODUCTORY REMARKS

Asm. Cahill stated that before we get started I just want to point out that this is probably in my experience here which is now nine years the largest attendance that we've seen at NCOIL and the largest attendance of insurance commissioners that we've seen at NCOIL. So thank you very much for making this such a successful meeting. And the other thing that's important to note is the difference between now and years past - we actually get along now. And that's really a nice thing too. It's a much more productive relationship when we're on the same side then it is when we're arguing. Before we get started I'm going to ask each insurance commissioner to please introduce yourself.

The Hon. Glen Mulready, Oklahoma Insurance Commissioner, thanked Asm. Cahill and stated that I would just echo your comments as I sat in those seats over there for quite a few years and in my dozen years of involvement with both organizations I don't think our relationship has been better so kudos to you and we look forward to more. The Hon. John King, Georgia Insurance Commissioner thanked the Committee for the opportunity to speak. The Hon. Jim Donelon, Louisiana Insurance Commission, stated that he also previously served in the legislature and he appreciates the opportunity to speak today. The Hon. Troy Downing, Montana Insurance Commissioner, stated that these meetings have been very productive and he appreciates the opportunity to speak today. The Hon. Jon Pike, Utah Insurance Commissioner stated that this is the second time I've been to one of your conferences and I appreciate the collegiality and the collaboration. The Hon. Lori Wing-Heier, Alaska Insurance Commissioner, thanked the Committee for the opportunity to speak today. The Hon. Chlora Lindley-Myers, Missouri Insurance Commissioner, thanked the Committee for the opportunity to speak and noted that she is also the incoming President of the NAIC and it's great to be here.

UPDATE ON WORK OF NAIC INNOVATION CYBERSECURITY AND TECHNOLOGY (H) COMMITTEE

Asm. Cahill stated that the NAIC's H Committee is a new committee and that's not something you typically do. You are a very conservative group and you move very deliberately. When you form a new committee it means something. So you can give us a little bit of an update and particularly we would like to hear a little bit about algorithmic bias and how insurers can manage and mitigate risk of unintended bias and illegal discrimination when developing and using artificial intelligence and machine language.

Cmsr. Downing stated that obviously this is something that was given a lot of thought and consideration in the need for creating a new letter committee which was a big deal within the NAIC but we saw that need as we see obviously insurers are increasingly using technology and big data and artificial intelligence and machine learning. And that affects us as regulators and it's really clear that as regulators we are never going to keep up with innovation and industry but we need to be thoughtful about this and have good conversations and understand what is happening and what's coming around the corner to the extent that it falls under our umbrellas as regulators to ensure all the things that

we do are followed. Solvency is important as is making sure that we're protecting against unfair discrimination - all these things that come up in this brave new world. And that has been interesting too. I'm going to just talk a little bit about what we're seeing in Montana as we get a lot of pressure from folks looking at doing these regulatory sandboxes so that they can get some form of regulatory relief to try something innovative. And innovation is important and it's coming. We want to make sure that we're open to innovation but make sure that it fits squarely into what we care about as regulators and I've had a number of conversations with the folks in industry and otherwise wanting these regulatory sandboxes and you get a lot of innovators that are not insurance professionals which is an interesting quandary. And one of the messages that we've been saying to these folks coming to us in Montana is yes we're open for innovation. We want to foster innovation. But what do I care about? I care about solvency. So, are you doing something that requires some kind of relief in what would make us uncomfortable as regulators in terms of solvency.

And then the other thing is unfair discrimination. Obviously insurance is by nature discriminatory but we need to look at what is unfair and what's illegal discrimination. And a lot of times when presented with that, we haven't really heard of any product that needed that space and I know there's some other states that have these sandboxes but we had somebody come up that wanted some relief in the workers compensation market basically to try some product but got around some prohibitions on rebates because they wanted to be able to help get injured workers back to work more quickly. And we've had some interesting stuff there. But I'm digressing a little bit on what we're saying here. In terms of the H Committee, this is something that touches almost everything that we do and so we're trying to be collaborative and as you had mentioned earlier about these collaboration forums, we just had one this summer to bring in folks from all the different committees to help understand industry and understand everything on collaborating and what we need to do as regulators in terms of protecting against unfair discrimination. And in other words if we have bias in algorithms, how do we deal with that? And it's been an interesting conversation as we try to explore what that means. Is an algorithm biased or not? And how do you understand when you're using a black box if you're getting results that you don't like. And a big thing that's come up in some of these conversations is what do you need to do in terms of the data going in that's being used in these artificial intelligence algorithms. Is there bias in the data going in? Is there bias in the data coming out? Or is it giving us something that we need to make a public policy decision on independent of that? And so there's a lot of conversations on whether we need to do data calls from insurers and whether they can figure this out on their own on whether non-correlated pieces of data are meaningful when you can't find causality but you can find correlation. And there's a lot of big concepts and conversations that are going on here. And I will say because I sit on the H committee that a lot of thoughts from a lot of different perspectives are going into this and understanding where we can come to a consensus and what that's actually going to mean. And I'm going to hand this off to Cmsr. King because he had some comments on this as well but I just want to say that this has been a really interesting project and it's going to continue in its importance in the insurance industry and what that means when you start seeing more and more artificial intelligence, big data, machine learning, and all these giant databases that we're all creating even just sitting here with our phones pinging our location data and everything else. And we all need to understand what we need to do with regulators and the things that we care about and like I said one of the big things that we're looking at here is whether there is illegal or unfair discrimination in some of these projects.

Cmsr. King stated that we come at this from a number of perspectives and I come from obviously public safety and from the military background so I look at a lot of this from how do we secure the data because this issue is affecting all industries. It's not exclusive to insurance and so we're being very methodical and very disciplined about not rushing to failure. And what I'm really glad that this committee's doing is basically getting a common understanding of just agreeing on the terms of reference as we start absorbing and going after problems. We have a number of Commissioners who have different perspectives and we listen very carefully to our legislators. We listen very carefully to our consumers that we are sworn to protect and we're being very deliberate and we are taking input from the industry with advocates. And so we're starting our education because we come from different backgrounds and we bring different lenses to this committee and I'm really glad that we have an incredible level of diversity that we really are being very disciplined and not rushing to start putting regulations out into the industry without truly understand the problem that we're solving. So I'm very glad to be part of it and obviously I come from the security and from the military perspective so that is the lens that I approach this very important topic and I think it's not only in insurance but it's affecting every industry throughout the U.S.

Asm. Cahill stated that in an earlier discussion between us before this meeting we were talking about entities asking questions for which the answers don't exist related to something else but that's one of the hazards when we're talking about artificial intelligence and machine learning as we think we can fill the gaps but doesn't that increase the opportunity for what in accounting would be called the carryover error that if you make a mistake here it can balloon into something massive at the end? And isn't it also possible that we're not asking the right questions? Is something being considered along those lines to put guard rails up around those issues? Cmsr. King stated that we are considering those and those exact comments are being vetted in the committee's discussions. The way that some of us look at machine learning is increasing the speed and the analysis but it ultimately is going to have to be human beings applying their own common sense. But the machine learning and a lot of this technology is to increase the amount of speed but also the breadth of information being brought at assigning of risk. Cmsr. Downing stated that there's so many important questions to be asked there and like I mentioned earlier one of the big questions is correlation enough or do you need causation? And understanding really how the data comes together and whether we need to have explanations of that or not. I mean these are the conversations that are being had right now because some of that's not really clear and there's a lot of stuff that we deal with on a daily basis that is completely based on correlation and not causation. So they're interesting questions that we ask here as we try to figure that out. And what does that mean to have transparency into these black boxes? What are we looking at? Do we need the connections of these data pieces and how that comes to that final result? How do they interact? And in the modern era I don't know if a lot of people are aware of this but predictive analysis on just basic human behavior is so good. I was talking to somebody at Google a decade ago on their predictive search analysis where they with 97% accuracy knew what you were going to ask for before you typed in a letter. And it scared people so they detuned it. We're getting better and better as we generate more and more data and what does that mean to us as regulators? These are the conversations we're having. I'm not offering any answers here. I'm just saying that these are big interesting problems of understanding really what that means and then in my personal opinion I'm not talking for NAIC or anybody else, if you have a big enough and broad enough data set that gives you an answer and it's not an answer that you want because you think it's affecting somebody that you want to protect then that

becomes a public policy decision. And we start dealing with not assuming that the algorithm was intrinsically wrong, intrinsically biased, intrinsically bad but that was a result and then you decide what the public policy decision is on those results and then we act accordingly on those results. I'm not saying that the whole idea of artificial intelligence or machine learning is wrong. Sometimes it's very right. We just don't like the answers and I think there are valid public policy decisions to be made on that.

Asm. Cahill asked what is the risk of becoming overly confident in these types of things? Cmsr. Downing stated that I think that's always a risk and I think we need to be diligent on understanding what these results are and have ways of vetting. And one of the things that I mentioned is having very rich, very broad data sets to see what results you're getting to see how we understand what is happening there and what's not and I think that as we start to see those results it's going to foster a lot more questions and we're going to continue discussing that and start trying to understand what's happening there.

Dir. Wing-Heier stated that I agree with what they're saying. This is a new area for us. This is something that we delving into putting our toe into and trying to find results or a path forward. What I would ask of legislators as a whole is when you're working with your department or your divisions of insurance going forward, when you see a request for a behavioral scientist or data analytics expert - these requests are real. We need someone to help us. Our departments don't have these experts on staff and maybe the California's and the bigger ones are recruiting now but the smaller ones, this is all new for us. And so we are looking for the expertise to help us through this and so when you see these requests please talk to your departments. We're not going to get out of this or through this to understand this without some help internally on our staffs.

Asm. Cahill stated that I think that's a very important point that the race has already started and you're not quite at the gate yet with the tools that you need so it's important. Cmsr. Donelon stated that at a previous NCOIL meeting several years back the issue of big data being used to increase rates for some of identical risk, called price optimization, was discussed and it was a very accurate predictor of who would shop with a rate increase versus who would be asleep at the switch or maybe not notice the increase. And I for one and I think most other regulators said no to that on a policy basis. Not on an accuracy or an anti-marketing basis. Just on a public policy basis. And we had a robust discussion. Asm. Cahill stated that I think Cmsr. Downing made that point that at some point in the discussion it becomes policy. It changes over from information or even massaging information to making a decision about what you do with the information.

DISCUSSION ON THE IMPACT OF WILDFIRE RISK ON THE INSURANCE MARKET

Asm. Cahill stated that he would like to turn this topic over to NCOIL President, Asm. Ken Cooley (CA). Asm. Cooley stated that we see this through the lens of California where we have so many forests and we have an ongoing drought and the scale of fires have just been sweeping through the state and becoming much more urban. A lot of places are getting caught up in that. And so it becomes a matter of how is the risk being managed - the fire risk affecting these communities? And then you get the carriers concerned about their exposure to fire and it starts becoming an issue of the cost of their homeowners insurance, primarily people concerned about the impact of that on rating. CA Cmsr. Ricardo Lara is struggling with how to deal with that. Having just come off the

campaign trail I hear from lots of people concerned about the cost of their homeowners insurance and it is a significant struggle to just figure out how to deal with it within our rating system. Of course California is not a file and use state, it's as a prior approval State and so the conundrum of how to set rates when there is a significant fire risk that you can't identify geographically and maintain affordability is a great challenge for folks. So what do you see happening at the NAIC on that broad topic?

Dir. Wing-Heier stated that the NAIC is looking at not just wildfires but other catastrophic risks that are putting a strain on reinsurers and the primary insurer and the ability to pay the claim. Wildfires are certainly at the top of the list but so are hurricanes. And the storms that are going to the Midwest that are the tornadoes and such are having catastrophic claims from the east coast to the west. And so the NAIC Center for Insurance Policy and Research (CIPR) has developed a modeling center of excellence which is going to help regulators become more efficient in dealing with the filings we're getting. And looking at the solvency of insurers with respect to these catastrophic risks, the conflagration is a big piece of that and again we're putting our program together so that we all have the tools and our staff has the tools to look at what these claims are doing and the impact they're having on the industry throughout the whole nation because you could have the fire in California but that doesn't mean that we're not going to feel it in Alaska. It will get to us. And on the other hand we don't have the property laws California do. We could burn twice the number of acres but we don't have the property so we don't get the attention because the claims aren't paid. There are no claims. So in looking at that, we're trying to come up with the tools to look at the hurricanes and the storms to see what we can do to look at the solvency and then how are they handling the claims? When are the claims being paid? Are there resources on the ground for consumers? And also what we're calling the hardening. Can we communicate to consumers with effective tools and resources of what they can do to harden their home so that the loss isn't quite so severe if there is a loss at all? This could include anything from is it worth as a return on your investment to put on a metal roof and clearing trees and things like that.

Cmsr. Pike stated that there are some pretty stunning things to see here in terms of the amount of damage that can occur. A fire in California can have consequences across the entire U.S. in terms of air quality and so forth. During our summer meeting in Portland, OR we had the Climate Risk and Resiliency Task Force convene a panel on wildfire mitigation and a wide array of perspectives were heard and we heard about several different mitigation efforts. One is called wildfire prepared home. It allows homeowners to apply for and achieve a designation if they can show that they have taken certain steps and measures to qualify them for a meaningful reduction for them in their homeowners insurance. Some of these relate to what type of roof you install, installing certain types of vents and using fire resistant materials for decks, windows, doors, and clearing away combustible materials. And there's varying levels of that obviously from 5 ft to 30 ft to 100 ft from the structure. But there is a lot of data being formed there and there's lots of mapping being done and that could be good or bad in my state. Rep. Jim Dunnigan (UT) knows that we've heard from a few insurance agents who have said they're concerned that there will be both on the reinsurance side and on the insurance side either a reduction in the products offered or a higher premium that people will be priced out of the market. And Rep. Dunnigan and I met with our property-casualty advisory committee and it was interesting to have different representatives there from companies such as Allstate and others. And some people are saying "well it's not a problem yet" but then we heard from one agent who said "it's a problem with

this company who may not write in these areas because of wildfire mapping that's now kind of started." So it's going to be interesting and I think we're going to have to make sure that as we have these opportunities there's a program in Boulder, CO we'll talk about this afternoon in the wildfire session where again one of the keys is that if you're going to attain some certification and therefore be able to purchase appropriate coverage it can't just be you, it's got to be your community that's taking appropriate measures. And that gets tricky. So it'll be interesting to see where that goes but I think what the NAIC is trying to do is identify the risks and identify the different mitigation possibilities and work with states as best we can. And as it relates to solvency risks, wildfires have been now identified as one of the major drivers of U.S. insurance company losses. I'm sure you all are aware of that. Last year our solvency workstream of the climate resilience task force recommended that a wildfire peril be added to the risk-based capital framework for catastrophic risk exposures and that recommendation was formally adopted by the capital adequacy (E) task force earlier this year. So we'll be requiring companies to annually report their modeled wildfire risk for informational purposes only. This will help to ensure that companies are adequately reserving the capital necessary to maintain their financial conditions when wildfires do occur. And after collecting that data for a period of time and measuring against benchmarks the NAIC will consider an appropriate capital charge to be applied.

Rep. Lehman stated that I want to touch on something Cmsr. Pike said and that was you start talking about the reinsurance market and I know I'm hearing from multiple reinsurers that had a meeting at the end of the last quarter what's referred to as the mid team increases and then also capacity issues which obviously then flows down to the carriers. You look at carriers ending their third-quarter with crazy numbers and unless you have a fantastic fourth quarter they're going to be going in the next year with a rate increase on the horizon – potentially a big rate increase. I'm from a state that doesn't have wildfires. I'm from a state that doesn't have flooding from hurricanes. But we feel the pain of what happens on the coasts. My colleagues in Florida have always said we're paying for the weight of ice and snow and we have no exposure of weight of ice and snow. But I would venture a guess that the payments out for weight of ice and snow pale to what's paid out for fire and wind and flood. So are we going to see any sort of division and will there be any push back on how do I get around me paying for these expanding and growing claims in the places that have zero effect on me? And we're seeing among carriers. This is the first I've seen this - one of my clients bought a house in Montana and I said this company writes in Montana so I submitted and they said no it doesn't score well on the wildfire class rating and we don't have any homes in Indiana that are on a wildfire class rating. So it was interesting to me this is all now being developed. But do you see a path ever that this is going to become somewhat a division issue when some of us have these rates go up so high?

Cmsr. Donelson stated that being from the state of the worst hurricane vulnerability in America, I hear this question an awful lot and I'm able to explain to my folks in non-hurricane prone areas that they do not pay to subsidize for those who live in coastal Louisiana. For example, catastrophe coverage on the coast is 40% on average of the premium cost for policyholders there and 20% in the northern reaches of our state although they get hurricane damage often times as hurricanes make landfall on the coast and move through our state. In fact in Ohio at least as of two or three years ago, the all time insured loss event for Ohio was a hurricane that went through our state and it went through to the Northeast and out to the ocean. So, I don't think that is a factor. There are those however who are advocating now for nationwide the pricing of property

& casualty products and spreading the risk on that basis. I'm not there. I think that would undermine the most valuable part of what we all do and that is to set policy and regulate insurance at the state level and if we go down that nationwide pricing system that will certainly lead to greater and probably total federal takeover of the insurance regulatory world.

Asm. Cooley stated that this wildfire risk is something where there's a lot of tools in the toolkit. Cmsr. Lara is requiring carriers to present rating approaches that acknowledges people are hardening their houses. But there are a lot of public elements. This last year I got $20 million dollars to improve Northern California firefighter training coordination with rural fire departments to kind of strengthen the firefighting response. I got $8 million dollars for a new fire house in Western Amador County which is very close to suburban Sacramento County and is a large community that's kind of out in the rural part of the county basically to improve firefighting in an area where there's a known fire risk. Obviously Cmsr. Lara is looking at this hardening of properties. We're working with our utilities to prune around their power lines that thread their way across the state because that's been a source of ignition. So, I do think we're going to end up using every tool in the tool kit and analyze to try to understand where is some element of risk that we can move on aggressively? Whether it's the insurance pricing mechanism or hardening of homes that has started. In Florida with some of the Hurricanes we started hardening homes and changing the way we vent things and so we're trying to do that in the wildfire space as well. It seems like this is one of those big issues that'll take us awhile to work through the system. I carry around on my keychain three words that my staff had inscribed there because they're certain challenges I've had to take on where these words are very relevant. It's relevant to this conversation as well. All good things in life have to work through three words: impossible, improbable, inevitable. I think in this wildfire space we end up dealing with what seems almost an insurmountable challenge and you just need to try to put all the different pieces together as best we can and try to bend the curve through industry and human effort and creativity.

DISCUSSION ON DEVELOPMENT OF NEW NAIC DATA PRIVACY MODEL LAW

Dir. Lindley-Myers stated that we've been researching privacy issues and engaging with not only consumers and their representatives but also the industry and other regulators and this is definitely a priority for the NAIC. We have had this on our radar. We already have models laws on this and so we're re-looking at the models that are out there. Some of the things that were discussed are: the industry's need for a uniform approach to privacy across all jurisdictions; privacy rules that apply to technology; and standards that may not be appropriate for insurers. And so we're looking at that. Existing NAIC privacy models were adopted decades ago and while they serve the industry fairly well there are new things and new technologies that are out in the marketplace that we need to address when we look at privacy. I certainly wear a Fitbit and some wear an Apple Watch which looks at your health and a lot of times that information may be passed on. I may want that information passed on but others may not and so we're looking at all of those issues. The existing NAIC privacy models, probably the last time we looked at them was about five years ago. And the new privacy standards, we want to make sure that they exist and they don't impede the ability of the companies to compete in the financial services industry and that existing companies understand what the new nuances are and that they are able to provide that. The fact that there are data sets and algorithms that are out there and complex models that are out there are things that we need to look at. So the privacy protection working group is drafting a new NAIC model

act to replace the two existing models which is the insurance information and privacy protection model act which is model #670 and then the privacy of consumer financial and health information regulation which is model #672.

Some of the more important issues which we'll be addressing in some manner is the consumer's ability to request data especially if there's a third-party who's collecting information on behalf of the insurer. We don't want the insured or the consumer to have to barter frankly to get that information back. To figure out what is going on we want to make sure that the information that is out there for the consumer is portable and it has a portability such that telematics data from one insurer to the next is taken into account. I'm with insurance company A this year but maybe next year I change to somebody else. I don't want some of the things that I built up under insurance company A to be lost when I go to C or D. And so those are the things that we're looking at. The next step for the privacy protection working group is to develop a draft. The hope is to have a draft and circulate the draft at the beginning of 2023. We're hoping to look at that at the Tampa meeting next month. We are also welcoming always the input of NCOIL members regarding this issue. Some of the things that you're hearing maybe we don't hear. We have always been served well by Sen. Paul Wieland (MO) who is here today and he has worked with us through the insurance committees in Missouri. And so in particular, we want to get an overview of what is out there and understand how we are able to capture the information that people are wanting to be captured and disseminated and then understand those that don't want certain information to be captured and disseminate how we can control that.

Asm. Cahill stated that one of the issues you mentioned Dir. Lindley-Myers is that this may be an area of uniform regulation. Dir. Lindley-Myers stated that we're hoping. Asm. Cahill stated that let's throw a couple of other words out there - uniform, national, federal. Dir. Lindley-Myers stated that well if you're asking uniform, national, and then what? I would say that the thought is that it is always compatible with a consumer. Whether I live in Missouri or I move to California or Montana it is still my information and the sharing of that information I want to have some control over that. And I want the legislatures of all of those different jurisdictions and venues to protect my information in those places. Asm. Cahill asked if you are looking at some of the models from other countries? The European model is a lot stronger than anything we've ever thought of doing in this country. Dir. Lindley-Myers stated that we are looking at those things but when you get to the U.S. it is truly a sense of freedom and I want that sense of freedom and not the structure in the rigidity of perhaps some of the European models. But those things are still being looked at.

DISCUSSION ON PROPOSED AMENDMENTS TO NAIC LIFE INSURANCE ILLUSTRATION MODEL REGULATION

Cmsr. Donelon stated that I have been asked to give a brief report on where we are with this at the NAIC. In fact I've been a member of the A committee since the second year I was commissioner many years back and Dir. Judith French of Ohio, Chair of the A committee, conducted a call of the A committee on this subject this week. And to give you a brief update, generally life insurance illustrations provide an overview of the benefits entitled to a policyholder, the premiums required to maintain that benefit, the expenses related to the policy issue and maintenance and the benefit and premium periods. But there are challenges when it comes to developing illustrations of indexed universal life (IUL) products. The value of an IUL product can change in relation to the

performance of an associated index such as the S&P 500 who's future values are uncertain. The NAIC IUL illustration subgroup is looking at both a short-term and long-term solution to this issue. As a short-term solution the NAIC is discussing revisions to actuarial guideline 49A titled “the application of a life illustrations model regulation to policies with indexed based interest to policies sold on or after December 14th 2020.” The subgroup has received several comment letters from interested parties and is discussing the merits and drawbacks of those recommendations. Potential long-term solutions are being discussed and would like to address future product designs without having to actually update the actuarial guidelines every time. One idea is to open the NAIC life insurance illustrations model regulation, model 582, for limited and targeted revisions. These are likely aspects of model 582 that do not fully capture the complexity of IUL product design but potential remedies may lead to over-complication of the illustrations. The subgroup is trying to strike a balance. For next steps, at our next meeting in Tampa next month the subgroup will receive comments from stakeholders on a potential direction for a long-term solution whether it involves revising model 582 or some other alternative. This subgroup will also discuss short-term and long-term options at the life actuarial A taskforce session in our coming national meeting in Tampa.

Asm. Cahill asked if there is an idea when there may be some possible adoption of any changes? Cmsr Donelon replied no and stated that I don't think Dir. French does yet either.

DISCUSSION ON ADOPTION OF NAIC PET INSURANCE MODEL LAW

Cmsr. Downing stated that after four long years of work the NAIC adopted the pet insurance model act, number 633. The purpose of this was to establish an appropriate regulatory framework to pet insurance that can be adopted in the states and I will say that Montana's legislature is bringing this in our next session starting in January. With this model we are removing pet insurance as a limited line and basically creating this is as a full property & casualty line and the reasoning this went through NAIC was there's a lot of growth in the pet insurance market and we found that premiums were far exceeding the costs and that these policies were overly complex. The model addresses some consumer protection issues relating to renewals, required disclosures of waiting periods, policy limitations and conditions, and benefit schedules. And there are also robust disclosures that allow consumers to affirmatively choose a policy that is best for them and in a world with dozens of available options. Another one of the points in the model is a free-look period. The Model allows a maximum of a 15 day free look period after which the consumer can examine the policy and request a refund if no claims were made. There's some language about pre-existing conditions and this limits how the insurers can deny a pet insurance claim related to pre-existing conditions of covered pets and it puts the onus on the insurer to prove the pre-existing condition limitation applies. There's some interesting parts about wellness programs and you can't have a wellness program being marketed as an insurance product and you can't have a wellness program being a requirement for the insurance. So there's some language about that . And there are some training requirements that codify training for insurance producers to ensure that they’re appropriately prepared to present information to consumers. This was just adopted recently and will be introduced in Montana.

Asm. Cahill stated that we have really discovered over the past couple of years that there's a great deal of interest in this body and this area of legislation and I have a theory that I don't think it's necessarily how much we love our pets and how much we care

about them. I think it's that we recognize the microcosmic way we can examine these issues without getting the emotionality that's involved when it's concerning people. So I think it's important that we stay on the same page together and we don't want to do duplicative work.

DISCUSSION ON FEDERAL INSURANCE OFFICE (FIO) ACTIVITIES

Asm. Cahill stated that FIO has been asking a lot of questions lately. They've been gathering a lot of data and in particular collecting data to assess climate-related financial risk. Let's keep our discussion about that. I think it's clear that there's statutory authority for FIO to ask for this information. The question that I want to get to is what do you think about the exercise so far?

Cmsr. Mulready stated that just less than a month ago FIO published a notice and request for comment and they are looking to collect data. Just a quick overview of what FIO did is it put out to the different states a request for information which as far as I know I don't think a single state has collected such data at that granular level. And I think the question a lot of us were asking is why? What are we going to do with that? But I can tell you that a number of states responded as we did that we don't collect at that granular level and we can't meet your 30 day timeline. They really had an ask that was impossible to meet. And they immediately then come out to collect data from ten different states. So they have now focused on ten states and as I look at my colleagues here there's three of us that are on that list including the state of Oklahoma that are especially vulnerable to climate related disasters. But I think our feedback would be this isn't the normal cooperation and collaboration that we would have with them. Typically they would be working with us to gather data from companies and we certainly would prefer that and so we will be submitting a formal comment to FIO on this and there's a draft in the works right now and I don't want to get ahead of ourselves about commenting about that but we're not thrilled with the way that process came about.

Asm. Cahill stated that I understand the delicate balance that you're trying to take place here. You recognize that you have an obligation to work with this agency whether you want to or not. You have an obligation to do so. On the other hand it's difficult to cede territory to an entity that doesn't necessarily demonstrate that they know what they're talking about. When it comes to the jurisdiction of the agency, my understanding is that it is really the gathering of data but I must believe that that's not an unbridled authority to gather any data they want or to tell entities or regulators or even insurers that they have to create that data to be gathered. They're not just gathering data, they're now telling you what questions you have to ask and that's using your resources. So maybe one of the things that is necessary is to open up better lines of communication with them even if you don't like them and even if you don't think that they have the authority. Maybe we need to start working a little closer with them. What do you think about that idea? Cmsr. Mulready stated that I don't disagree. I'm not an attorney but those that are have reviewed that and believe and maybe indeed there is statutory authority. However, there was not a good faith effort put forward to work in the normal channels that we would work with them on collecting data like this.

Rep. Lehman stated that I remember when FIO came into existence as part of Dodd-Frank in 2010. At that time the concern was we're moving into federal regulation of insurance. I think that we've been watching very closely the last decade and asking if FIO is staying in their lane and to be honest for the most part they have. There's not

been that takeover of regulation. I think the real question every time FIO speaks is it to ask the question, why? What are you going to do with it? What is your endgame in all this? And I think what my challenge to NCOIL would be is we want to be a partner with NAIC in making sure FIO stays in their lane. So anything that the NAIC needs help with or that we can coordinate with or show up at please let us know. I want to continue to fight to make sure we are on the same page of McCarran-Ferguson. Dir. Lindley-Myers stated that we couldn't agree with you more. I absolutely agree with Cmsr. Mulready that we feel that there was a right way and a wrong way to approach the subject and FIO chose the wrong way and it is something that we are hopeful that NCOIL will continue to work with us on. FIO chose the wrong avenue in trying to secure this information. Had they come to us to collaborate we could have worked out, what is it that you want, why do you want it and to what end are we collecting this information? So we could not agree more that this is something that we would need the collaboration of NCOIL with.

Asm. Cahill stated that we've had this discussion many times most recently yesterday when we were talking to the legislators attending their first NCOIL meeting - we do consider it a very fundamental part of our organization to support the primacy of the state regulation of insurance. And I think that will always remain very central to what we do and there's also a recognition that there's a need on the worldwide market that there has to be some sort of uniformity in response to the rest of the world. And if that is the intended purpose of FIO and if that's what their mission is then then go forth. But we are very much interested in supporting the NAIC and your efforts to make sure that we all continue to be the place that people go to first and foremost. Dir. Lindley-Myers stated that is certainly our hope as well.

Cmsr. Mulready stated that I echo Rep. Lehman's comments and we agree 100%. I think especially when you're in something like this where you're talking about a lot of resources and hours to put into that both on the regulator side as well as the company's side to develop something like that, it is important to ask why and what is the end game here and what you going to do with this? Asm. Cahill stated that taking it from the opposite end of the spectrum here and the very liberal end of the perspective and the progress end of the perspective - my experience with the federal government's regulation of health insurance under the Employee Retirement Income and Security Act (ERISA) is that there is no regulation of health insurance under ERISA. The rights and responsibilities between insurers and consumers in New York from the New York State regulation of health insurance are vastly superior to those who are regulated under ERISA. So I think it's important that we maintain that state primacy.

Asm. Cooley stated that in a family, the family members can at times spar but the family sticks together. I think we are dealing with consumers and it is a task of lawmakers to watch the laws in their state. We pass the baton to you, the regulators, to oversee the marketplace. You're overseeing rates and what the system pays for. Carriers end up holding the bag if somebody stumbles as we have our whole guaranty system. I just think we need to stand up for the state based system of regulation. It's not just state-based egotism. It's a customer-focused system of regulation that is granular reflecting the unique character of each state and we do need to maintain solidarity on this system and insist we are a society of laws. And the road through significant public policy change affecting insurance runs through the 50 states capitals and I think on that we need to be backing you up and supporting you and it's a very consequential evolution happening here. We need to not lose track of it.

Asm. Cahill stated that I want to thank you all. This will be my last time chairing anything at NCOIL. It has been a great pleasure. It's been incredibly educational, particularly my time with the Commissioners. I've really enjoyed hearing your perspectives on things. You speak with great humble authority over every subject matter that you talk about. It has been a great honor to serve with you and I thank you all.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Tammy Nuccio (CT) and seconded by Rep. Lehman, the Committee adjourned at 12:00 p.m.

LIFE INSURANCE & FINANCIAL PLANNING COMMITTEE MATERIAL

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
LIFE INSURANCE & FINANCIAL PLANNING COMMITTEE
NEW ORLEANS, LOUISIANA
NOVEMBER 17, 2022
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Life Insurance & Financial Planning Committee met at The Sheraton New Orleans Hotel on Thursday, November 17, 2022 at 3:30 p.m.

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

Other members of the Committee present were:

Rep. Deborah Ferguson, DDS (AR)
Asm. Ken Cooley (CA)
Rep. Kerry Wood (CT)
Rep. Rod Furniss (ID)
Rep. Jonathan Carroll (IL)
Rep. Matt Lehman (IN)
Rep. Joe Fischer (KY)
Rep. John Illg (LA)
Rep. Brenda Carter (MI)
Sen. Walter Michel (MS)
Sen. Jerry Klein (ND)
Sen. Shawn Vedaa (ND)
Asm. Kevin Cahill (NY)
Sen. Bob Hackett (OH)
Sen. George Lang (OH)
Rep. Jim Dunnigan (UT)
Sen. Eric Nelson (WV)
Del. Steve Westfall (WV)

Other legislators present were:

Rep. James Kaufman (AK)
Rep. Reginald Murdock (AR)
Rep. Tammy Nuccio (CT)
Rep. Matthew Gambill (GA)
Rep. Carolyn Hugley (GA)
Rep. Rita Mayfield (IL)
Rep. Mary DuBuisson (LA)
Sen. Robert Mills (LA)
Sen. Kirk Talbot (LA)
Rep. Matthew Willard (LA)
Sen. Lana Theis (MI)
Sen. Paul Utke (MN)
Sen. Kevin Blackwell (MS)
Sen. Joseph Thomas (MS)
Sen. Bill Gannon (NH)
Asm. Jarett Gandolfo (NY)
Sen. Jay Hottinger (OH)
Rep. Forrest Bennett (OK)
Sen. Roger Picard (RI)
Sen. Mike Azinger (WV)

Also in attendance were:

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

QUORUM

Upon a Motion made by Rep. Matt (IN), NCOIL Immediate Past President, and seconded by Del. Steve Westfall (WV), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Joe Fischer (KY) and seconded by Rep. John Illg (LA), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 15, 2022 meeting in Jersey City, NJ.

DISCUSSION AND CONSIDERATION OF NCOIL PAID FAMILY LEAVE INSURANCE MODEL ACT

Rep. Anderson stated that he would like to turn things over to Sen. Paul Utke (MN), sponsor of the NCOIL Paid Family Leave (PFL) Insurance Model Act for some brief remarks. Sen. Utke thanked Rep. Anderson and stated that he is proud to sponsor this Model and is very confident you will see versions of it being introduced in legislatures around the country this coming year including my home state of Minnesota where we actually passed something like this last year in the start of our Senate but that's as far as it got so we have to come back and start over. You can view the Model on the NCOIL website and on the app and it also appears in our binders on page 87. Just to briefly summarize the Model, it establishes PFL as a class of insurance and would authorize state insurance departments to receive and approve PFL policies in their states. The Model authorizes insurers who are licensed to transact life insurance or disability insurance business in the state to issue policies covering PFL and this would empower employers to be able to give PFL to their employees. The Model is also very flexible in that it can be used in states that have mandatory PFL requirements for their employers and it can be used in states that don't have any PFL requirement, but the employers want to offer it as an enhanced benefit to their employees as we see an ever increasing competitive employment market. I look at this as an extra tool in the toolbox for the employers. It's a tool that can be used to retain or recruit new employees. We're seeing more and more what we have out there as far as a shortage in our labor market and this may be one of the tools if it fits your business model that would be great for them. Also the Model is drafted in such a way that it can be adopted just as an authorization statute and then have as a regulation the standards that would go into that policy or you can put the entirety of it into your statute when you propose it. Virginia went the authorization route, and they are now working on the regulations as an example. Thank you, Mr. Chairman and I look forward to the Committee's support of the Model.

Karen Melchert, 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've been before you now four or five times with this proposal beginning back in March 2020 when we first brought it forward. I'm grateful for the support of Rep. Deborah Ferguson, DDS (AR), NCOIL Secretary, and Sen. Utke in sponsoring this. We do believe that this is a tool for states that have a mandatory PFL requirement and for those that do not who wish to expand the benefits to their employees. The ACLI supports the Model and requests the Committee's support as well.

Rep. Jim Dunnigan (UT) asked Ms. Melchert if the ACLI has had any discussion with insurers to see if they're interested in this and if they going to be able to come up with an actuarial analysis. Ms. Melchert stated that we have and we have several companies that are preparing products to be filed in Virginia once the regulations are finalized so they have been able to put that together. We've been working on this for several years so they've been working on developing these products while we've been trying to get this off the ground starting with Virginia and then we have a handful of states that we have

teed up for 2023 and once those are approved and the regulations are adopted then we expect them to be filing policies at that time too. And they're already doing this to some degree in the states where there is a mandate where the state has outsourced it to other insurance companies to help run so they've got experience out there for this product in particular just not necessarily as an insurance product on its own but operating this type of program in states where it's been mandated already. Rep. Dunnigan stated that I'm curious about pricing and if you have seen any pricing models. Ms. Melchert stated that I have not seen any pricing models myself but I can certainly get some of that information for you from the folks that are looking at that from an actuarial perspective. I'm told it's similar to a disability income insurance product. Rep. Dunnigan asked if the employer has a short term disability policy, how does this interact with that? Ms. Melchert stated that this could be attached as a rider. It can't now because there's no authorization for it but it could be included in your disability income insurance policy as an added on benefit as a rider for an additional premium but not a significant additional premium from what I'm told. Rep. Dunnigan stated that one of the things I like about this is it's an offering instead of mandate and instead of the government coming and saying you have to do it. - you're saying here's a tool if you want to do it.

Rep. Ferguson stated that I think this is a great Model and I am glad that Sen. Utke brought the Model forward. Not only is it a good private insurance option for states that have mandated family leave but I'm from Arkansas and we don't have mandated family leave and I did some checking with my insurance department and found that it will require some statutory change for us to allow this and I look at it much like disability insurance but in Arkansas we will have to run a bill so that the insurance company can actually allow these companies to operate in the state. So you might want to check with your insurance Commissioners and see if you need that. But as noted, it has really become a very competitive employment market where people are looking for time off and they're looking for 401k's. To attract employees now you look for more ways to empower that and certainly in medical offices you employ a lot of young women that have babies or have family they need to help take care of so this is very attractive to me for those reasons.

Rep. Brenda Carter (MI) asked if the Model allows States the flexibility to opt-in or opt-out or to modify the Model if needed to fit their State requirements. Sen. Utke stated that the flexibility remains with the state and each state can take as much or as little as they would like to make this work for them.

Sen. Bill Gannon (NH) stated that I don't know if you're familiar with the model we did New Hampshire. We passed the legislation about a year ago. The state has state family medical leave for our employees and businesses in the state can sign on and join that. Sen. Gannon asked Sen. Utke if he is familiar with how NH is doing that and would the Model be better? Sen. Utke asked Sen. Gannon to clarify if NH has a state-mandated portion of PFL. Sen. Gannon replied that NH has one for state workers and then businesses in the state can join onto that program. Sen. Utke stated that in this case the employer can buy this as an insurance policy and I think what I've seen in some of the mandated states is that you come down to a certain level and the smaller employers are exempted and if you happen to be one of those small employers then this was that piece that you needed to recruit your employees that you're after. In the private sector, you could go out and purchase this. There are other employers where none of this works for them. You may only have a few employees and you can't afford your employees to actually take off three or six months as much as you want to help them

out. So, the flexibility is in the employer's hands which is great. They can use it however it best fits their business model. Rep. Ferguson stated that there are several differences among the states. Obviously there are states like mine where it would just be up to the employers to buy it. There are states where it's mandated and they do it with private insurance. But really New Hampshire is a great model because you're empowering private companies to be included in your plan which makes it more affordable for them so I hope that's something that we'll look at in Arkansas.

Hearing no further questions or comments, upon a Motion made by Sen. Utke and seconded by Rep. Jonathan Carroll (IL), the Committee voted without objection by way of a voice vote to adopt the Model.

DISCUSSION ON UNIFORM REGULATION OF INSURER INVESTING

Rep. Anderson provided some quick background on this topic before the panel began. We had a session on private equity's influence and impact on the insurance marketplace in July which generated discussion on whether or not there should be increased regulatory scrutiny of private equity-owned insurers. This session today is meant to continue that discussion and bridge the gap by offering information as to why such scrutiny should be based on the activities and investments of the insurers and not ownership structure.

Michael Porcelli, FSA, Senior Director at AM Best Rating Services thanked the Committee for the opportunity to speak and stated that you're probably not aware of AM Best. We're a rating agency. We rate insurance companies. It's really all we do. We were established in 1899. I'll give you a sense of what AM Best does. We rate insurance companies. We've been doing it for almost a 125 years. We are exclusively a rating agency for the purpose of rating life and property and casualty insurers. We rate companies from the U.S. and all around the globe. We have 135 rating analysts located in five different offices. We rate 3,300 insurance companies worldwide. We also have research publications. We became a Nationally Recognized Statistical Rating Organization (NRSRO) in 2007 right before the financial crisis. And so how do you rate insurance companies? Well, we have a criteria that we use and I want to show you it's a building block approach. When we rate insurance companies we publish and issue a credit rating and also a financial strength rating. Basically in a rating committee we vote on an issue creating a credit rating in the map to the financial strength rating. Financial strength ratings are what people traditionally associate with AM Best and they're actually a bit more granular and we have a mapping for that. We also issue debt ratings. Here are our building blocks and the foundation of the building blocks is actually the balance sheet strength, So the first thing we do is we assess the balance sheet of the company. We then make adjustments up or down for their operating performance, up or down for the business profile, and up or down for the risk management practices and then what we ultimately wind up with is that issue of credit rating that I was talking about. The highest you can get on balance sheet strength is an A+ and then the movements up and down can get you all the way up to an AAA. There are some companies that are AAA in our portfolio.

For new companies and the kind of companies that were talking about here, they are actually limited on their balance sheet strength to an A. And what's the basis for that? It's going to be the projections that they provide for us in our management meeting that we have with the company. And here's an overview of what that looks like for the point

of view of the building blocks and some of the components in here and the main thing that you're going to notice is that we don't actually include the form of ownership. So if you are a mutual, a fraternal, a stock company or whatever it may be, if you're owned by private-equity, you're not going to see anything here that goes in and penalizes you or rewards you for your ownership structure. But what is important to know is that there are certain things that come along in our analysis that are driven by your ownership structure. For example, I don't think it's a secret that companies we've been labeling private equity insurers typically have more asset risk so they usually have some sort of expertise in certain asset classes. So what does AM Best do to get themselves familiar with it? The answer is we have a capital model and we apply capital charges and we have a published Best's Capital Adequacy Ratio (BCAR) score that we use. We also have an investment working group. So we've had many companies come to us and say you know we got this asset class we believe that we can achieve superior returns with. What we have to do is we have to take that asset class and put in front of our investment working group and the reason for that is to make sure that we're applying the proper capital charges.

There are a few other things that you're going to see with private equity firms. There could be a reliance on reinsurance. There could be different financial flexibility based on the level of commitment from the parent. Those are all components of how we rate companies but ultimately I think one of the things that we really have to get our arms around is the fact that the time horizons for the capital involved in life insurance and annuity insurance is longer than what is traditionally associated with private equity. Private equity firms tend to look at three to five year types of time horizons and everyone in this room knows that the life insurance business and the annuity business are not three to five year businesses. So my concluding remarks are that I don't believe that there are any barriers to actually enter the life and annuity insurance business. It's actually a fairly simple to do. If you can go and raise some capital, come to us, get a rating, and put together a management team you could be in the insurance business. It's not the barriers to entry that matter, it's actually the barriers to exit because getting out of the insurance business is actually much harder to do given the long-term nature of the liabilities.

Jennifer Webb, AVP, Assistant General Counsel and Head of State Gov't Affairs at Pacific Life thanked the Committee for the opportunity to speak and stated that I plan to take the next several minutes to provide a high level review of regulation of life insurer investing and to note a key National Association of Insurance Commissioners (NAIC) workstream that Pacific Life and several other companies believe is particularly important. State policymakers are charged with safeguarding the ability of insurance companies to keep their promises to policyholders by ensuring their financial health. One of the tools that regulators use to measure financial health of a company is risk based capital (RBC). The RBC requirement is a statutory minimum level of capital that's based on two factors. One is the the insurance company size and two is the risk profile of its financial assets and operations. In other words the company must hold capital in proportion to its risk. The purpose of the RBC requirement is to identify weakly capitalized companies before there's a problem. It's in effect an early warning system so think like a check engine light. For my remarks today I want to focus on the second factor of the RBC calculation, the risk profile of a company's financial assets, and how regulators determine RBC charges.

Generally speaking, state regulators use an activities based approach to determine RBC. That's to say they look at the types of financial instruments that insurers are investing in and the types of products the insurers offer to look at the risk level. Given that there's more private equity-backed companies that are entering or have entered the life insurance space, it was previously discussed at the July meeting that ownership structure is coming under scrutiny in relationship to riskiness. While there has certainly been attention paid by policymakers to the growing presence of private equity firms in the life insurance space this is not in my opinion the current focus at the NAIC because RBC calculations apply to all companies no matter their ownership structure. So what is being discussed around RBC calculations currently? Last year the NAIC took an important first step in updating the life RBC framework with the adoption of revised capital factors for bond investments. These changes introduced more granular RBC charges for bonds by expanding the number of NAIC designations from six to 20 similar to the rating scales that the rating agencies use. This was always acknowledged by the NAIC and the industry to be the first phase of a longer-term initiative exploring the differentiation of RBC treatment across diverse asset risks. The NAIC has chosen to begin the next phase of this project with a focus on asset-backed Securities or ABS. Generally speaking ABS its kind of like a mortgage-backed security except the underlying assets are something other than mortgages. The NAIC is currently focusing on CLO's or collateralized loan obligations which are a type of ABS generally composed of highly leveraged corporate loans. The timing of this work is important because insurers have become the biggest U.S. investors in the CLO market topping banks, pension plans and hedge funds. In fact, insurers currently hold 60% of all single A and Triple B rated CLO's which are riskier than the triple A and double A holdings and certain firms tend to hold higher concentration of CLO's with this credit quality on their books. The NAIC has taken note of these developments and has developed a high priority workstream around CLO's and RBC charges. While RBC is intended to be a blunt instrument at the same time it is critical that any capital charges are appropriately calibrated across different types of asset classes to accurately reflect risk. If the capital charges don't match the risk for an asset this could be problematic from a financial solvency perspective.

Currently for RBC, CLO is treated the same as corporate bonds but they do not share the same risk characteristics. To be clear CLO's are not bad - Pacific Life invests in them. If used well they provide insurers with high quality options to tailor cash flows for different investor return needs. However, CLO's come with long-term risk sensitivities. They're not well captured in the current RBC framework. Simply puts CLO's are not the same as a corporate bond and CLO's did not perform the same and stress as corporate bonds. And under a stress test performed by the NAIC's Securities Valuation Office (SVO), these assets are shown to suffer losses that are not consistent with corporate bonds, again potentially posing solvents risks. This is why the NAIC is working to model CLO's similar to the process they currently use for mortgage-backed securities and make sure the RBC charges are appropriate. Pacific Life supports the NAIC's work and is working with a diverse group of companies who are aligned to modernize the RBC framework. This group includes Equitable, New York Life, Northwestern Mutual and Western and Southern among others. The ACLI has also expressed support for this project. Finally, I'd like to briefly note that beyond the CLO modeling the NAIC has several other workstreams going on in their Macroprudential Working Group that are looking at insurer investment activities including financial disclosures, investment management agreements and other items. And Pacific Life supports this holistic approach. In conclusion, Pacific Life supports the NAIC's current review of RBC

treatment of CLO's, and this review will continue to ensure that capital charges are appropriately calibrated for the risk of the asset class. Once adopted, these risk charges will apply regardless of ownership structure to all U.S. insurers.

The Honorable Jim Hodges, former Governor of South Carolina and now Executive Director of the National Alliance of Life Companies (NALC), thanked the Committee for the opportunity to speak and stated that the NALC is a group of small to mid-sized life insurers from all across the country so we come with the perspective of smaller life insurers, midsize like insurers, who are sensitive to try to preserve capital options. I do want to make a few general comments before getting into our feelings about these specific proposals. I think we're pretty well aligned with the NCOIL statement on this issue and I'll elaborate a bit on that later but I can't help but notice that some of this arises out of comments from Members of Congress who expressed some concern about private equity investment in life insurance. I can't help but be a bit amused by that because if you look at the financial crisis back in 2008 and 2009, life insurers did pretty well - state regulated life insurers. The banks that were federally regulated didn't do so well and our friends in Washington seem to want to scrutinize the level of scrutiny we provide to those entities that regulate life insurers. And I might say that in my twenty plus years around state regulators, state legislators have done a pretty good job of keeping insurers solvent so I think when we receive inquiries and suggestions from Washington we need to be careful about it. They don't understand insurance very well and they've shown that. They have their own struggles with regulation and they have shown that. And we have done a good job at the state level. You all have done a good job. State regulators have done a good job. But there always seems to be this sensitivity when Washington says something that there's a fear that there'll be some imminent federal regulation if we don't jump. I don't think this is a case in which we jump and I think you all have appropriately had a measured approach to this.

From a small company perspective, I think I would say this - we feel as though every investor ought to be treated the same. I think you have a good system in place whether its private equity or other sources of capital. Everyone should be treated the same. There should not be a specific class to single out for a lot of reasons. One is it makes no sense and there's no evidence that that's needed. But the second piece is when you are a smaller company, and we all know we want more small companies growing around the country and a number of you are from states that probably have a limited number of life companies, we need to preserve options for capital. And the more unnecessary regulations we put into place that really aren't serving policyholders or companies than the more we limit potential investment options to allow these small companies to invest in your communities and to grow their businesses. And that is a major concern of ours that we preserve meaningful capital options and that we do nothing that unnecessarily harms or scares away potential sources of capital for our companies. And a final comment here - there have been periods in the last decade where regulators when there are companies that were in trouble, regulators encouraged private equity enterprises to invest in insurance companies because they felt like that was capital that could be used to try to prop up and help ensure those insurance companies remain successful. We don't want to get into that situation again where we create unnecessary obstacles to that investment and we want to preserve options that are available for companies to try to grow and prosper. And we believe that the framework is already in place in our state regulatory regime to properly evaluate these companies that are choosing to invest and to scrutinize the decisions that they make in terms of how they invest those dollars and to protect policyholders. So those are the comments of the NALC and we feel strongly

that the current system is working pretty well and as you seem to have indicated in your statement, finding a way in which any changes that we make are consistent for all of the entities or enterprises that invest in insurers makes the most sense.

Rep. Anderson asked Gov. Hodges to clarify if he meant all investors should be treated the same or all insurers should be regardless of ownership structure. Gov. Hodges stated that he thinks all insurers regardless of ownership structure is probably the better way of saying that but ultimately if you are looking at putting capital into an insurance company and you got an additional level of scrutiny that others don't have it is going to discourage those who might put capital in. That's the point I was trying to make.

Sen. Gannon stated to Rep. Anderson regarding the clarification he just asked for - why wouldn't we treat all investors equal? Rep. Anderson stated that I wanted Gov. Hodges to make his point clear. I wanted him to clarify that he was talking about the insurers so that we got the right wording because we want to make sure the minutes are right.

Rep. Dunnigan asked Mr. Porcelli what is AM Best's view on these investors that come in and participate in the insurers? Mr. Porcelli stated that the view is always driven by our methodology and because the methodology is actually not reflecting the ownership structure it's never really about that and just like my co-panelists here have said, our view has been all along that it's not that you're a mutual or you're a private equity-owned firm. It's really about the activities that fall out of that. So just like we talked about with the RBC model, our capital model that we use is very similar. If we see that unnecessary asset risk is being taken on we're in a position to go and adjust our capital model and adjust the ratings outcome and that's the kind of thing that we're going to look for. Rep. Dunnigan asked if a private equity company came in and purchased or bought in and they're trying to get a short-term gain would you be able to recognize that and adjust your rating under its portfolio? Mr. Porcelli stated that to be as clear as I possibly can, if looking at short-term gains in the life or annuity business, we're going to meet with the management team, we're going to ask them questions so that we could sniff that out. We are a data point. We are not the only datapoint but certainly the fact that we meet with every management team as part of our rating process and as part of our methodology makes us relevant in this. And I can tell you that we would be able to without a doubt sniff that out and the reason for that is because in our process we need to see what kind of capital commitment is there and by capital commitment I don't just mean the capital that's put in today, but also the long-term capital commitment. In addition, because so many of us have years in insurance it really candidly is hard to find a management team that comes to us that are people we haven't heard of before. It just comes with being in the business for 30 years. Rep. Dunnigan asked Ms. Webb if she had anything to add. Ms. Webb stated no as Mr. Porcelli did a good job in his response.

Rep. Anderson thanked everyone for speaking and stated that if anyone thinks NCOIL should continue to discuss this topic please reach out to me or NCOIL staff. The Hon. Tom Considine, NCOIL CEO, stated that this topic is not on the agenda for the NCOIL-NAIC Dialogue tomorrow and I mean this totally respectfully but here was no NAIC representative at the table today and to the extent that time permits tomorrow under any other business I just wonder if any of our NAIC colleagues are in the room because I just wonder if they'd have any feedback that they could tell us tomorrow at the dialogue about this issue - is it something that they agree with about that regardless of ownership structure the rules should be the same for everyone? And further if they have any thoughts on that CLO issue.

PRESENTATION ON LIFE INSURER INVESTMENTS IN SOCIAL INFRASTRUCTURE AND COMMUNITY DEVELOPMENT INITIATIVES

Kelly Edmiston, Ph.D., Policy Research Manager at the NAIC Center for Insurance Policy and Research (CIPR) thanked the Committee for the opportunity to speak and stated that I want to talk to you about some of the work that the CIPR at the NAIC has been doing around social infrastructure investment which I think more in terms of community development types of Investments. I want to thank you for the opportunity to speak to you about this research initiative. I was a Community Development Economist at the Federal Reserve Bank of Kansas City for many years so I've been working in the space for a long time and I'm very happy to see the insurance industry taking an increased interest in community development and social impact investing more generally. So, when we're talking about social impact investments we're talking about the S in environmental, social, and corporate governance (ESG). We're talking about investment having intentional direct and measurable positive effect on social outcomes. And for the insurance industry, the life insurance industry in particular, we're looking at investments that not only have a positive effect on social outcomes but also that generate competitive risk-adjusted return. In October of last year the CIPR published a report and it's on our website called "Can insurance company investments help fill the infrastructure gap?" And there we were talking about physical infrastructure and economic infrastructure and our conclusion was and is that they can. We find that the financial performance of the infrastructure backed investments were superior to other non-financial corporate investment across several domains but not every domain. They're long-lived assets. They helped diversify portfolios. They can hedge against inflation. They generally produce competitive returns and they have an appealing risk profile. So even within a single rating if across all organizations rated double-A for example the infrastructure backed financial investments tend to have lower default rates, greater recovery rate upon default, and more stable ratings.

But in this work we did not consider social infrastructure and we since turned our attention to a similar question within social infrastructure. The question being whether the insurance industry can help build a social infrastructure gap specifically in community development space, and more specifically in the affordable housing space, not with their foundation investments but with their general account or balance sheet investments. In terms of what is social infrastructure? It's in some sense not economic infrastructure, not physical infrastructure. It's infrastructure that increases the quality of life in a community. It could include many assets like hospitals and schools and community facilities but our effect is largely on tangible community development investments or assets. And so these are assets that remain critical for low and moderate-income communities which typically are already struggling and we're specifically talking about issues of affordable housing and community resilience to natural catastrophes as those are particularly significant in this regard. At the CIPR we're working closely with the impact investing team at the Robert Wood Johnson Foundation (RWJF) in this endeavor. As researchers we're agnostic and I want to emphasize that for CIPR it's a research effort but the hope of RWJF is that and the reason they came to us is that if insurance as large institutional investors can they infuse additional capital in the space and to help close the gap between community needs and the availability of social infrastructure and community assets.

Then based on CIPR's previous work in the physical and economic infrastructure space which I just mentioned, RWJF approached us about similar work that can be done in the social infrastructure community development space. And so beginning this summer we embarked on an exploratory phase of this research basically to see if there's any there-there. The idea is to see if this effort to help close the social infrastructure or community development investment gap would be feasible for insurers. Can they make a positive social impact with their general account investments that generate an appropriate risk-adjusted return and meet the necessary regulatory requirements? And then can they do that at scale? This initial exploratory effort which we're wrapping up currently was to survey the landscape and to generate a list of questions to be addressed which we would then approach with a deeper and more sophisticated research effort that we hope to do over the next couple of years. It was a learning effort and through events and one on one meetings we've engaged with insurance industry stakeholders including the investment strategists, regulators, financial intermediaries, trade organizations, and also community development practitioners who are on the ground doing these types of things. I'll spend just a brief few minutes discussing what we found thus far and where we plan to go with the research. Insurers have already undertaken impact investing efforts so it's not totally new by any means but the primary consideration of insurer investors of course is to fulfill their fiduciary responsibility by enhancing the general accounts risk adjusted return. And social impact investment of investors within the industry have generally found that they generated competitive risk-adjusted returns with these investments. Moreover, like investments in the physical and economic infrastructure space, these social impact investments can bring increased diversity to existing portfolios.

We've also discovered additional value added with these investments. Insurance of course is a risk based business and addressing social issues through their investments could potentially mitigate some types of underwriting risk. There was a report out by Nuveen just yesterday and they were discussing the fact that inequality is a systemic risk to their portfolio and to the entire financial system and investing in companies and assets that provide solutions to those problems can mitigate those risks as well. Furthermore, most insurers want to be good corporate citizens especially in their own backyards. And finally, insurers or major employers with vast numbers of clients and stakeholders are increasingly demanding socially responsible investing. We've discovered a number of vehicles for these investments and that was a big part of the project and no doubt there are more vehicles that we have yet to discover and as the insurance industry is financially innovative no doubt there will be new structures developed along the way. Chief among these that we have is the low income housing tax credit. I don't have time to delve deeply as it's a rather complex investment but in general terms it's the chief avenue for the federal government to subsidize the construction of affordable housing. They allocate a number of tax credits to each state which in turn allocate tax credits to developers and so developers can't use these tax credits because they're not nonprofits. So what happens is investors put money into syndicators to purchase the credits and so they can buy these tax credits generally for less than a dollar and then get dollar-for-dollar tax reductions or tax credits with these instruments. One of the benefits of the syndication, the funds that they invest in, is that other than monitoring the financial performance as investors get regular detailed reports on the financial performance, these investments are largely hands off for the investors. The syndication fund is a limited partner and they take responsibility for monitoring the investments for compliance. These investments are quite popular and have performed well financially

for investors. Investors could directly invest equity in a development that's less usual or less common but in general would be done through an intermediary.

I just want to mention a couple more community development financial institutions or CDFIs that offer an opportunity or an avenue for making debt investments in affordable housing projects. The insurer investor can invest directly in the CDFI which then does the due diligence in defining and monitoring affordable housing development for which to issue debt. I might add that several of the CDFIs have been rated by major rating agencies and the 11 who have been rated by S&P Global Ratings are investment grade generally along the lines of an A-. And then municipal bonds is another avenue for investing private activity bonds, that is bonds that are issued by municipalities by states and local government for private activities that have a community benefit. And potentially in terms of scale an insurer could buy an entire bond issue. And finally there are other intriguing alternatives like there's a community development fund that's a standard institutional investor only mutual fund that uses its proceeds for impact while generating respectable return for its investors. Keep in mind I've just scratched the surface of opportunities for investing with social impact. The CIPR looks forward to delving deeper with their research effort into this social impact investing space as investment alternatives for the insurance industry. There remain many questions to be addressed. Our intent is to better understand the risk return profile of these investments, to uncover and analyze the various investment strategy structures that are available for social impact investing and how they should be evaluated and to understand the regulatory concerns that may arise and how they might be addressed. And so, I thank you again for the opportunity to share the work of the CIPR at the NAIC in evaluating the feasibility of bringing social impact investing to scale in the insurance industry.

Pat Reeder, Vice President & Deputy General Counsel at ACLI thanked the Committee for the opportunity to speak and stated that the ACLI came to me six months ago and they asked me to operationalize our affordable housing initiative and I'm here today to talk to you about what we're doing and I want to make sure we emphasize that the initiative that we're working on is an initiative of the life insurance industry broadly. How we can bring our scope and scale and our investing expertise into the affordable housing area? But we are not alone - it isn't just individual companies that are putting great resources and a great deal of intellectual capital into this space. And we have an example here today. So I'll give the history of what we're doing and why we're doing it. The life insurance industry has been engaged in our communities for 175 years. It's one of the cornerstones of what the life insurance industry does. And you all know that. You've been engaged in this in your professions and you understand what the life insurance industry does. And a lot of the work in affordable housing and community development has been done by their foundations. They have a lot of charitable arms and they put a significant amount of money and work into affordable housing through their foundations and through just their broad engagement with the communities where their employees are. But if you go to the summer of 2020 and the death of George Floyd, the insurance industry and many industries and organizations got together and said we need to do something. They were motivated and our CEOs were very wise.

The ACLI had a statement. We spoke into this as it's important that you speak into these issues and that you have your voice be heard. But our CEOs were wise and they said that's not enough. We don't want to just talk about this, we want to do something. We want to do something that is supposed to be stainable and that is meaningful and that is going to actually make an impact. And from that the CEOs instructed us to

develop an initiative that's called our Economic Empowerment and Racial Equity Initiative. It's got four pillars. One of the pillars is closing the racial wealth gap. And the idea is that the insurance industry is really good at certain things and are CEOs told us very clearly don't get ahead of your skis - let's not try to do things that we're not good. While there are important social issues that are out there and we can make a positive impact on our society in our communities, let's not try to do things that we're not good at. So we said what are we really good at? The life insurance industry is really good at protecting people's financial futures. The life insurance industry is really good at long-term investing. And so we'd look into those things and we said how do we use those things to close the racial wealth gap? And that gave rise to the development a subsidiary of ACLI and an initiative called 360 Community Capital and 360 Community Capital is a nonprofit organization that is being established and set up by ACLI member companies. In April of this year the ACLI board of directors voted unanimously and they said go operationalize this. This is important and make it happen. And from that, 42 of our member companies not only voted to do this, they put money up to get this operation started.

So what are we trying to do? We're going to start with the premise that we want to find ways to take insurance companies' general account dollars and put those general account dollars to work in affordable housing. Affordable housing is so foundational to closing the racial wealth gap we thought we would start there. It doesn't end there but we need to start somewhere. It's the idea of boiling the ocean or whatever phrase that you like. I always talk internally about start by starting and so that's what we're going to do to start with affordable housing because that's so foundational. And we're going to use general account funds and we're going to start with debt as life insurers love debt. We're going to start long-term. Life insurers love long-term and liquid debt. We're really good at that and we've been doing that a long time. We're going to need these investments to be investment grade. For general account dollars, the general account investing for a life insurer needs to be able to pay claims when due. That's the purpose of what those investments are. But we want to find affordable housing investment that do the good that Dr. Edmiston talked about and also meet our needs to our policyholders and our members and so that's going to be of investment-grade and it's got to be market rate returns. Again, we have this obligation. Our companies do tons of work in the foundation space and in the charitable space but this is market rate and we believe there's a market out there in affordable housing. Affordable housing is a term of art in the community development space. Affordable housing is a measure of area median income. So it's sort of what is the income of the people in a certain community – the average median income. Affordable housing has different ranges but affordable housing is usually defined as 60% to 80% of average median income.

But there's another piece of affordable housing that's really important. It's going to be a part of this initiative and that's what's often called workforce housing and workforce housing is typically defined as 80% to 120% of average median income. Think of your shopkeepers, your teachers. And so if we can find ways that the life insurance industry can work on what they called naturally occurring affordable housing or NOAH which we think of with rehab in terms of houses and apartment complexes and condominiums that are rehabbed for the purpose of affordable housing where the rent will be set in such a way that they will be able to be maintained as affordable housing units. So affordable housing but also workforce housing and we think that's the way that we that we can do that. We think this is going to be hard. The CDFI world has been doing this a long time and there's an ecosystem out there as there's a lot of low income tax credits and banks

with community development investing requirements. There are cities and municipalities that are putting money into this and all that's very important. So we must find out how do we use these insurance company general account funds? How do we create those opportunities? And it's going to take some time and it's going to be hard. We will be working with the NAIC because you heard about the RBC and the charges. Again, life insurers are investing in their general accounts so that they can pay claims so they can make good on their promises. What we're trying to do here is to find a way that we can do those investments and we're making good on their promises but we're also going to be investing into our communities and affordable housing.

One last thing I'm going to talk about is to provide a very specific example of what New York Life is doing. We get asked a lot - why affordable housing? And is that all you're going to do? What if one of our CEO's said well what if we build these great affordable housing units and it's in a food desert? What about that? And as I said before we need to start by starting and we think affordable housing is foundational and we think it'll do two things. One - it's going to track other money. If you start building affordable housing units that are in this space you're going to be able to get other areas that may come in and they may take care of the medical services or they may invest in the transportation or they may invest in the fresh fruits and vegetables. And the second thing is we think that once we get started we're going to be able to create some momentum, that's our goal. To me that's our success case. That we build momentum. That more people come in and say wait a minute we don't just need to do affordable housing, we want to work on the schools. We want to work on the grocery stores. We want to find ways to do this with general account dollars because we think that can move the needle. And again we have an example of what New York Life has done. New York Life has not just been a participant and an intellectual capital driver of what the life insurance industry has been doing, they're doing something specifically for themselves too.

Doug Wheeler, Senior Vice President of Government Affairs at New York Life thanked the Committee for the opportunity to speak and stated that as Mr. Reeder just mentioned, we are a very proud partner of the 360 Community Capital Project. New York Life in the Spring of 2021 announced a billion-dollar impact investing initiative and primarily so far we've deployed pretty much the billion dollars. A lot of it's been mostly the tax credit for housing tax credit areas because that's the low hanging fruit. And the initiative was really focused in three areas: affordable housing, small business investment, and community development. And again, so far a lot of focus has been around affordable housing and we've obviously seen some challenges and that's one of the things Mr. Reeder alluded to in terms of working with the NAIC to make sure we're using balance sheet dollars as we have to get returns, and we have to make sure the capital charges and all those accounting issues and some of these other issues at the NAIC get addressed. And I have to tell you we are completely in mission align with NAIC. We have had meetings with leadership and other Commissioners. We met at a recent NAIC meeting and almost 20 Insurance Commissioners attended. There was so much interest because when we do these investments, first of all it's all 50 states. It's in all of your states and all of your communities and this is about again bridging the wealth gap and serving undercapitalized and underserved communities and when you provide affordable housing and when you invest in small businesses you're creating jobs. And as Mr. Reeder just mentioned that leads to the building of schools and hospitals and for New York Life, we have 12,000 agents across the country. These are people that now actually have jobs and want to build wealth and build communities and so for us it's an opportunity to sell our products and provide financial security and again bridging that

wealth gap is a win-win for everybody. And so again the NAIC is completely aligned with us. They're working with us and certainly we appreciate their efforts. We participated in part of the CIPR's work as well and again this is something that is a win-win for everybody and it's obviously a win-win in your communities as well.

Sen. Mike Azinger (WV) stated that he listened to all three speakers and he thinks that the intent of the mission described is to make the insurance industry "woke." Is that accurate? Mr. Reeder stated that's actually not how I would describe it. Sen. Azinger stated to Dr. Edmiston that you mentioned the banking industry and ESG. ESG is just "woke" critical theory infused in the banking system. And I listened to you mostly. You used the most code words of critical theory of all of the three speakers. To me, that's what it sounds like what you're doing - am I incorrect there? Dr. Edmiston stated I think so and the reason is CIPR, which is the research center in NAIC, is agnostic on this. Sen. Azinger stated that I don't think you're agnostic. Sen. Azinger stated that we are agnostic. The question came to us: is this something that the insurance industry can do? And so, we're asking the questions. Can they generate more reasonable or adequate or whatever necessary risk-adjusted return and do the social impact investment at the same time? And is that going to meet regulatory and statutory accounting standards? Sen. Azinger stated that's all "woke Marxism." Dr. Edmiston stated that we're completely agnostic. Sen. Azinger stated that's not agnostic. I've read enough on it. I won't belabor it. Dr. Edmiston stated that we're researchers. It's either we're going to find that it is acceptable or we're going to find that it isn't. I don't care personally as that's not my job. I'm a researcher. It's up to the insurers. Sen. Azinger stated that you're a threat to the free markets and the free markets of insurance.

Rep. Forrest Bennett (OK) stated that I've heard comments similar to Sen. Azinger's from my colleagues back home in Oklahoma but would you not agree that the efforts that were described today also have the side effect of eventually creating a larger base of people who are able to afford life insurance products and other things like that? These other societal benefits, as bad as some people think they are, create a wealthier and healthier environment for our economy, correct? Mr. Reeder replied, yes - that is one of the purposes of what we're trying to do.

Sen. Gannon stated that I look at things more from a financial aspect and so for me, the district I represent in Southern New Hampshire is middle America so when my people hear you talk they're not thinking "woke" or racism. They're thinking you're going to cost our community because you're going to put in workforces or affordable housing in my twelve little towns who can't afford the tax increases and that's going to result in tax breaks to these workforce housing units. You're going to add students to our schools which are already overburdened. The average family in my little district is paying about $10,000 to $15,000 in taxes for little cape houses and they can't afford taking on additional responsibilities. In New Hampshire, our cities want it and our more liberal towns want it. If they want to take it, that's great but they're trying to now hoist this on to my small communities who can't afford the burden to our educational system. We're averaging around $21,000 per student so if you're putting in workforce housing where they're not either going to get a ten year tax break or they're going to pay less money, they're not putting into the educational system and you're putting a burden on an overstressed property tax in my case. Mr. Reeder stated that I think the idea of what this is trying to do is that you're trying to enhance the economy all over because if you think in the workforce housing space, you're thinking of the people that work in the stores of your community shop. Those are the people that work there. The teachers that you're

worried about that are overburdened and overstressed, that's certainly real all across the country but if they're working one job instead of three because they have a predictable rent as opposed to a rent that they don't know when it's going to go up, those are the kinds of things that we think that we're going to have what I will call knock-on effects into the community. And so I recognize and appreciate your concern but we think that the results of what could be done by these investments can have great effects in the community.

Sen. Lana Theis (MI) stated that she appreciated all of the presentations and stated that my struggle is where do you balance the fiduciary responsibilities of actually investing in known returns on investment to what you believe will have an effect on community planning which may or may not actually meet itself out successfully. There's no doubt that this is a higher risk because you're looking longer-term and believing that you can effect a change that may or may not happen. Where the fiduciary responsibility balance there? Mr. Reeder stated that's a great question and I'm really glad you asked it because one of the key pieces of this initiative is investing - these aren't donations. These are investments and those investments need to be investment-grade and they need to have a market return. That isn't easy - the needs to be investment-grade meaning risked similar to other risks that are out there similar to corporate bond, similar to the A and B references we heard in the prior panel, that's the kind of investments that this initiative is looking at and for the very reason that you're talking about. There is this obligation - the fiduciary obligation. Again, these members are making investments so they can pay their claims. If they could do social good that's great. But they're making investments to be able to pay their claims. And so that doesn't change with these investments. What we're trying to do that hasn't been done before is to find investments that meet that obligation that you're concerned about that are investment-grade that provide market returns so that companies can make good on their promises and do the social good. It is not an or it's an and. And it's a good question and that really is an important guidance that we have and our members have given us.

Sen. Theis stated that so you're saying literally all things being equal or are you saying there's a cost that we're willing to take? Mr. Reeder stated that it is all things being equal. These are going to be investment-grade and market return. That's what our members have said and we've done our due diligence and we've been doing the work to say those opportunities are out there. They're sometimes harder to find and we're going to do that work because we think that's work worth doing but again it is an and it is not an or. Mr. Wheeler stated that it's a great question. We have an impact investing team within our investment shop at New York Life. It's investment first so it must meet the requirements and criteria for our investments regarding returns and other things. The social good is the check. That's the added plus to the investment and obviously it's nice to have and we want to do more of it but it's investment-grade first. It has to generate returns because as we've said over and over and over again these are balance sheet dollars to pay claims down the road at some point in time. But we look at certain investments and using these CDFI's, those are the folks in these communities and are the ones who helped build the deals and those are the ones that know where the needs are and they come to us and they say okay here's the proposal and we have to make the economics work. That's the first thing. And obviously if it goes to fruition and there's a social good, again that's an extra check. We want to do a lot of it. Our industry wants to do a lot of it but it's investment first because that's our fiduciary responsibility. Dr. Edmiston stated that the investments have to meet the standard regulatory requirements

and statutory accounting requirements that are in place now. No one is talking about changing the regulatory requirements for these types of investments.

Sen. Theis stated that I get the concerns that some of us have that you're adding an extra element into the algorithm for the consideration for what to do with the investment. The algorithm has a lot of unknowns associated with it. We've seen in the investment markets they're ongoing right now. There are some very major issues associated with adding something in that is purely fiduciary as you're moving forward. So I have significant concerns with someone's idea of what is a social good as opposed to strict dollar responses and I understand the arguments for both sides but I have extraordinary concerns when we're not just simply looking at the primary fiduciary responsibility and instead adding more in. And while I understand that we're speaking within our current regulatory system there's a lot of flex in that regulation as you look at what's the best and you invest in the best and right now we're saying we're going to redefine what the best looks like and that I think is a concern that a lot of us have.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Fischer and seconded by Sen. Bob Hackett (OH), the Committee adjourned at 5:00 p.m.

616 Fifth Avenue, Suite 106
Belmar, NJ 07719
732-201-4133
CHIEF EXECUTIVE OFFICER: Thomas B. Considine

National Council of Insurance Legislators (NCOIL)

Life Insurance is a Promise for Life Model Act

Sponsored by Sen. Travis Holdman (IN) – NCOIL Immediate Past President

Draft as of February 8, 2023. To be discussed during the Life Insurance & Financial Planning Committee Meeting on March 10, 2023.

Table of Contents

Section 1. Title

This Act shall be known and cited as the "[State] Life Insurance is a Promise for Life Act."

Section 2. Legislative findings and purpose

Under long-established life insurance norms, carriers make a promise for life: They assess the applicant's known risk, match premiums to benefits by treating like risks alike, then treat risks of the same class and equal expectation of life at policy issuance the same throughout the duration of their policies, according to the terms set at issuance. Treating like risks alike encompasses the traditional and accepted anti-tontine principle that persisting policyholders may not receive higher surrender benefits in relation to their premiums than received by prior surrendering policyholders of the same risk class.

Sections 4 and 5, consistent with these established standards, do not change, but rather support the implementation of, bedrock insurance law and policy. Section 4 affirmatively requires the insurance commissioner to take regulatory action against what is already illegal: Unfairly discriminatory enhancements to cash surrender benefits on seasoned policies which—for the purpose of inducing termination of the very purpose of life insurance, the death benefit—offer identical risks more in return for the same premiums than received by prior surrendering policyholders. Section 5 ensures informed underwriting and risk classification making in an information age, without asymmetries and adverse selection, by codifying the insurer's historical access to pertinent risk information. Section 6 creates new consumer protection law (in most states) in the information age by prohibiting insurers from requiring genetic testing for applicants.

Section 3. Definitions

(a) "Cash surrender value" means any amount that is paid by the insurer in return for the policyholder's surrender or termination of the death benefit of the policy.

(b) "Genetic information" means information regarding the presence or absence of variations or mutations, including carrier status, in an individual's genetic material or genes that are scientifically or medically believed to cause a disease, disorder, or syndrome, or are associated with a statistically increased risk of developing a disease, disorder, or syndrome, which is asymptomatic in a person at the time of genetic testing or screening.

(c) "Genetic testing or screening" means any method of obtaining genetic information from the proposed insured for an application for life insurance.

Section 4. Enforcing fair discrimination in cash surrender benefits

The insurance commissioner:

(1) Must disapprove an endorsement or other amendment filed by the insurer that issued a life insurance policy if such a change would provide additional cash surrender value or otherwise modify the method of calculating the policy's cash surrender value established at issuance;

(2) Must rescind any regulatory approval or acceptance of an endorsement or other amendment described in subparagraph (1) above that was granted before the effective date of this law, as having been inconsistent with law at the time the approval was granted; and

(3) Must otherwise prohibit and prevent insurers from engaging in any other method of providing additional cash surrender value or otherwise modifying the method of calculating cash surrender values after policy issuance.

Section 5. Ensuring accurate risk classification

An insurer may require an applicant for a life insurance policy to provide any information known to the applicant or anyone else providing information on the application that is

pertinent to the longevity risk posed by the insured, including genetic information resulting from any screening or testing regarding the individual's susceptibility to future health conditions.

Section 6. Protecting consumers from unreasonable testing requirements

Notwithstanding section (5):

(a) A life insurance policy shall not be underwritten on the basis of a requirement that the applicant or insured individual undergo genetic testing or screening; and

(b) The issuance of a life insurance policy shall not be conditioned on the requirement that the applicant or insured individual undergo genetic testing or screening.

Section 7. Rules

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

Section 8. Effective Date

This Act shall take effect xxxxxxxx.

Please see this link for more information on the Committee topic “Discussion on Developments in California’s Life Insurance Policy Lapse Laws”: https://www.jdsupra.com/legalnews/california-decisions-kick-off-parade-of-2541221/

Please see this link for more information on the Committee topic “Presentation on New Federal Retirement Security Law – The SECURE Act 2.0”: https://www.acli.com/-/media/acli/public/files/pdfs-public-site/advocacy/SECURE_2_Point_0_Data_Infographic_Final_110422.pdf

PROPERTY & CASUALTY INSURANCE COMMITTEE MATERIAL

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
PROPERTY & CASUALTY INSURANCE COMMITTEE
NEW ORLEANS, LOUISIANA
NOVEMBER 18, 2022
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Property & Casualty Insurance Committee met at The Sheraton New Orleans Hotel on Friday, November 18, 2022 at 3:00 p.m.

Representative Bart Rowland of Kentucky, Chair of the Committee, presided.

Other members of the Committee present were:

Asm. Ken Cooley (CA)
Rep. Tammy Nuccio (CT)
Rep. Brian Lohse (IA)
Rep. Matt Lehman (IN)
Rep. Jonathan Carroll (IL)
Rep. Joe Fischer (KY)
Rep. Michael Sarge Pollock (KY)
Rep. John Illg (LA)
Rep. Edmond Jordan (LA)
Sen. Robert Mills (LA)
Rep. Brenda Carter (MI)
Rep. Kevin Coleman (MI)
Sen. Paul Utke (MN)
Sen. Paul Wieland (MO)
Sen. Michael McLendon (MS)
Sen. Walter Michel (MS)
Sen. Jerry Klein (ND)
Sen. Shawn Vedaa (ND)
Asm. Kevin Cahill (NY)
Asw. Pam Hunter (NY)
Sen. Bob Hackett (OH)
Sen. Jay Hottinger (OH)
Rep. Brian Lampton (OH)
Sen. George Lang (OH)
Rep. Forrest Bennett (OK)
Rep. Carl Anderson (SC)
Sen. Mary Felzkowski (WI)
Del. Steve Westfall (WV)

Other legislators present were:

Rep. James Kaufman (AK)
Rep. Deborah Ferguson, DDS (AR)
Rep. Reginald Murdock (AR)
Rep. Kerry Wood (CT)
Rep. Carolyn Hugley (GA)
Rep. Rod Furniss (ID)
Rep. Rita Mayfield (IL)
Rep. Michael Meredith (KY)
Rep, Rachel Roberts (KY)
Rep. Cherlynn Stevenson (KY)
Sen. Lana Theis (MI)
Asm. Jarett Gandolfo (NY)
Rep. Jim Dunnigan (UT)
Sen. Mike Azinger (WV)
Sen. Eric Nelson (WV)

Also in attendance were:

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

QUORUM

Upon a Motion made by Sen. Mary Felzkowski (WI), and seconded by Rep. Edmond Jordan (LA), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Michael Sarge Pollock (KY) and seconded by Rep. Joe Fischer (KY), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 16, 2022 meeting in Jersey City, NJ and the Committee's September 29, 2022 interim Zoom meeting.

DISCUSSION ON IDAHO'S EFFORTS TO LOWER THE UNINSURED MOTORIST POPULATION

Rep. Rowland stated that we'll begin today with a discussion on Idaho's efforts to lower the uninsured motorist population. Over the past year we've had several conversations on how states can utilize different methods to lower the uninsured motorist population. Today we're going to hear from Rep. Rod Furniss (ID) who will brief us on some of the legislation he has sponsored in Idaho. That legislation appears in your binders on page 275.

Rep. Furniss stated that this is my fourth NCOIL meeting and I just want to say how kind the leadership and administration has been to me. It's been a wonderful experience for me to get to know NCOIL. I've been an agent since 1986. I spent 25 years with Northwestern Mutual and then became an independent agent in their office. We have P&C agents and all kinds of agents. It's been a wonderful ride for me. We work mostly with c-suite executives and we do self-funded health plans now across the board. Let's talk about Idaho and what they've done there to minimize the uninsured motorist population. HB179 is found in your books on page 275. The fiscal note is on page 278. I'll speak on the pros and cons of the bill we passed three years ago. HB179 is not a perfect bill but it's not bad and it needs to be updated and we hope to do that this year after three years of data. Before the bill, Idaho had no enforced mandate. We had a lot of this ingenuity to have insurance, but we didn't have anything to check on it or any way to find out if you had complied with the law except when you got a ticket or were in an accident and that's a little too late to find that out whether you're the insured or not. The Speaker of the House asked me to champion this bill and they've been trying to do it for ten years. It was only due to technology changes that we were able to put this together and get through it. The Senate passed it and the Governor signed it.

The challenge was to make the clerks at the Department of Motor Vehicle (DMV) office not the bad guys and to continually check insurance after the registration. Many states require insurance and registration but then there's no check after that. How do you know they have insurance after the registration? So we started to work on that. HB179 uses an online program we already had for commercial vehicles and a program that our police officers could access all vehicles to see if they had insurance. But this was only if the insurance company in Idaho cooperated at that time and downloaded their data into our data bank. Many did not, some did. None of the insurers downloaded on a timely fashion. So a lot of the information the police officers were getting was outdated and unreliable. HB179 mandated that companies dump their data into our system at least monthly. If you're keeping track of this bill and you want to know how to write it better I

would suggest you don't say monthly and that's one of the changes we're going to make. We're going to have them dump at least bi-monthly and we're going to set a date on that day they dumped - probably the 15th and the first of the month so that we can keep track of that data. So what this program does is it matches the vehicle identification number (VIN) number with the insurance policy to see if they have coverage. In the bill it says the department shall establish a program to match information from the online insurance verification system with the motor vehicle registrations to determine whether the owner of the motor vehicle has established financial responsibilities. If they don't have financial responsibility then their registration was canceled. How do we do it? By the insurers reporting the data to the verification system and the department performing a periodic match at least semi-annually or semi-monthly. It says monthly in the bill of the information from the online insurance verification system of Motor Vehicle registrations to determine whether the owner of the motor vehicle has established financial responsibility. At the first test we did when we actually ran the tests we had 363,000 vehicles that were uninsured in the state of Idaho. What we found out there was a lot of false positives in that first test. So as we held the data constant and we look down the road two months, we got that number down to about a 100,000 vehicles and that's where it is today. We think there's about a 100,000 vehicles in our state that go uninsured. So what happens? The way the bill works is we match at the first month, we match at the second month. If your car doesn't show up as insured in the second month you get a letter in the mail that says unless you can show us you have insurance by the end of 30 days your registration will be canceled.

Now, in the bill it tells you that you have an opportunity to go in and tell us why your car isn't insured. Is it stored ? Did you sell it? Is it insured under a business policy? So the person receives a letter that gives them instructions and it allows a person to tell us if your vehicle is stored or covered in some other way. And they can do that. A lot of agents have gotten on board and helped us with this program where a person may wait until the 29th or 30th day before their registration was canceled and on that day they go in and they can explain to us and upload a document that says I'm insured and the registration won't be canceled. If the registration is canceled, the bill says that they have to pay a $75 fee plus re-registration to get it re-registered. That's about a $300 hit to a family if they let that go on. We picked $75 because we didn't want to be onerous but I will submit to you that it's not enough and that it needs to be higher. Probably in our state $150 is where it needs to be. And in this bill it says that the fees go to the highway department. I would also recommend, and we'll fix it this year, that part of that fee goes back to the county where that ticket was issued or where the registration was canceled so that the county gets money to re-register those vehicles so we don't have an unfunded mandate back toward the county. So the three months gives us time to tell if that vehicle's been sold or if it's been purchased by someone else but what we've seen are some false negatives in that because the insurance companies aren't downloading it. Maybe they're hitting and missing on the download. We may see times when we'll see a big increase in uninsured motorists in Idaho because the insurance companies haven't downloaded in a timely manner. Some companies download almost every day. Some companies download every other week. Some companies don't download until a month-and-a-half and when that happens all their clients get letters that say they're uninsured and they begin calling their insurance agent.

So it's important that the companies download on their right days. The fiscal note for Idaho is $345,000. You'll see in that fiscal note we put some money in to advertise this program. We wanted people to know about it. It took about three full-time employees to

run this program and the next year we took in $408,000 in fees and so it was almost a wash on the cost of the program to run it. There are states that have vendors to do this kind of merchandising or keeping track. In Idaho we figured we can save about 75% by keeping it in-house versus hiring the vendor so that's what we did. You'll see on the fiscal note we have postage, we have computers, we also had to do a major change to the computer system that cost about $30,000 to make sure that we can match those VINs appropriately. Interestingly enough when we matched those VINs we found 10,000 VIN numbers that weren't accurate. The VIN was wrong. The owner was wrong. We were able to clean that system up by implementing this program. The next year the program actually went higher in cost and we think that was due to the growth in Idaho. Some of the other things that we saw was we saw the state police are really lenient on uninsured motorists. They need to be tougher I think. If they pick someone up and they don't have insurance they'll give them a warning and they'll even give them a second warning sometimes. By the third time though they give them a ticket. We were seeing 1,000 tickets a month in Idaho for uninsured motorists which means they were picking up a lot more people. After the program went into place we were seeing 500 tickets a month so it almost cut those tickets down by half and what it did was it made Idahoans aware that insurance was important. Agents became aware and were helping clients register their vehicles if they went without insurance until the 89th day and it became a program that Idahoans could understand. Now it's not perfect and we still have some people call in that are upset about it because they haven't read the letter they get about storing their vehicles and in Idaho if you have a Corvette you can only drive those four months a year so you have to store it and you'll take the insurance off and so that client has to go in and say it's stored so that the registration maintains itself. But what we're hoping is for example, Liberty Mutual you can go in on your app and you can store that vehicle and when you store it we're hoping that pretty soon we'll get a marker from the insurance company that says this car is stored. If that were the case then people wouldn't have to go into the Idaho system and mark it as stored and we hope technology will keep up to us.

Sen. Mike McClendon (MS) asked if they end up in the database where it shows they don't have their insurance, does that go against your credit score at all? Rep. Furniss replied no - it doesn't hook to their credit score at all. All of it is internal in Idaho. We just notify them that we know their car's not insured or we believe it's not insured. We tell them to go on our website if it is insured or stored and upload the data to prove it and that's it. That's as far as it goes. We did have a lot of fights with insurance companies when I first started putting this together. They didn't want to disclose their data. They were afraid we were going to mix the data. They had to make sure that they felt okay about sending their data to us on a regular basis.

Rep. Brian Lampton (OH) asked if the bill is compulsory or optional in terms of the carriers having to report? Rep. Furniss stated that they have to report, it's not optional. They would have liked it to have been optional but no it isn't. Rep. Lampton stated that you said you started at 300,000 and then it went down to 100,000 - does that mean 200,000 car registrations were canceled? Did it effectively reduce the number of uninsured cars? Rep. Furniss stated that what it did is when we first ran the test on that month there were 363,000 cars that said they were uninsured at that particular time. But as we left that data stagnant for the month of January and we checked on that data in February and March they went down to 100,000 after that. So what it told us was that at any one time there might be 363,000 cars uninsured but they were in the process of getting them insured or they were insured and the insurance company hadn't

downloaded the data to us so there's a lag of about two months there. Rep. Lampton asked if you have any overall data about the actual results of if there was a reduction? Rep. Furniss replied yes - by the third test we ended up sending out about 35,000 letters after the second month. So it not only came down to 100,000 it actually came down to about 35,000 by the time we sent the letters out.

Sen. George Lang (OH) stated that he is curious about the notification process and the accuracy of it in terms of address changes, cell phones change, and emails change. I'm curious about the accuracy of the notification process and maybe any backup plans? Rep. Furniss stated that is a good question. When the insurance company sends up that data on the VIN number we also get the most current address so we've had very few letters come back because of that information that we have but we think we could cut those costs down by quite a bit if the insurance companies would download twice a month rather than once a month. We think it would almost cut the false positives in half if we could get a better connection. Sen. Lang asked if the primary source of contact is direct mail. Rep. Furniss replied yes - we didn't e-mail but in the bill you'll see that if they want to they can e-mail proof of insurance back to the department and we'll accept that.

Rep. Rowland thanked Rep. Furniss and stated that if anyone has any thoughts or suggestions on this topic please reach out to Rep. Furniss or NCOIL staff.

PRESENTATION ON DEVELOPMENTS IN THE SURPLUS AND EXCESS LINE INSURANCE MARKETPLACE

John Meetz, Senior State Relations Manager for the Wholesale and Specialty Insurance Association (WSIA) thanked the Committee for the opportunity to speak and stated that our association represents brokers, carriers and service members operating in the surplus lines industry. So, today we plan to give you a bit of a crash course on the industry, give you some updates on some recent market and regulatory developments. One quick point I want to make as you may hear me say surplus lines, you may hear me use the New York term excess lines. You may hear the word non-admitted. I'm going to try to stick to E&S as a catch-all for all those things but for our purposes today just understand that those are fairly interchangeable words. So each state has established public policy that provides a legal framework for obtaining insurance when the standard or admitted market is unable or unwilling to write a particular risk and that was not an accident. Your predecessors, your colleagues, and many of you were involved in those decisions to set that public policy. So what kind of risks are we talking about? Really three main categories. Typically, they fall into high-capacity, unique or emerging risks. And here's a few examples of high-capacity risks. Obviously you can see skyscrapers, large property, terrorism, political risk, special events, festivals. Here's a few examples of unique risks, medical research, product recalls, pollution cleanup. And here you see a couple of examples of emerging risks. It is entirely likely that someday the cannabis industry will be insured through admitted products - same with autonomous vehicles. But until the admitted industry obtains the experience necessary to do that the E&S market will step in and make sure those industries are insured.

So, I want to take a minute and talk about how our industry is regulated and really emphasize that yes it is regulated contrary to what you might sometimes hear. In the admitted market each state regulator has the opportunity to regulate any carrier selling products sold within its borders. But E&S carriers are regulated by their state of domicile for the purposes of solvency and the licensed surplus lines broker is responsible for

most of the compliance in the transaction. They are responsible for complying with all the relevant state laws. They're responsible for placing coverage with a financially sound insurer, reporting that transaction and any relevant data to the home state, collecting and remitting premium tax, and again assuring that each transaction is in compliance with all of the applicable state laws. So why are E&S insurers able to write risks that are rejected by the admitted market? Well again, each state has established public policy that provides for freedom of rate and form for E&S policies and our members are able to do their job because they uniquely tailor the terms of a contract to the needs of the consumer. So as we say if you've seen one E&S policy, you've seen one E&S policy and I think preserving that principle is probably the most important takeaway from my presentation today. But I want to reiterate that doesn't happen as a first resort. So insurance can only be placed in the E&S market after it's been rejected by the admitted market. And how does that happen? Most states have a process for verifying a diligent search among admitted insurers has taken place. The traditional method for that is a producer must obtain three declinations from admitted insurers but some states are actually moving away from this recently. And why? Well, it can be burdensome. It's actually quite redundant for a producer to ask the same underwriter over and over if they're willing to insure a risk that they know darn well that the underwriter won't write. And what we found is actually that the wholesale distribution system actually has more to do with keeping business in the admitted market.

In 2010, Congress passed the Non-admitted and Reinsurance Reform Act commonly referred to as the NRRA. This was a critical law for our industry because before it was passed there was no clarity over which state has authority to tax and regulate multi-state E&S transactions. So, the NRRA established that the home state as defined by the law of the insured has the sole authority to tax and regulate each of those transactions. So that brings me to my final point and why I'm here. Last year the National Association of Insurance Commissioners (NAIC) surplus lines task force appointed a drafting group to update their Not Admitted Insurance Model Act to correspond to those changes that occurred in the federal law in 2010. So their work is coming to a close and we expect that model to be adopted either later this year or early next year. The good news is neither we nor the NAIC is giving anyone here any marching orders. This is not an accreditation standard and even if it were, basically every state has adopted some form of law to correspond with the changes that occurred in the NRRA. But this may be an opportunity for you to take a look at your state E&S laws to see if any updates are necessary and we are happy to assist any legislators if you're willing to undertake that process. I want to thank Commissioner James Donelon of Louisiana as he chairs the NAIC surplus lines taskforce and his staff for drafting. They did exemplary work on revising this model and did it in extremely quick fashion especially relative to some other model laws. So we just want to thank them for all their cooperation and hard work on that.

Howard Green, Director of Gov't Affairs and Strategic Initiatives at the Excess Line Association of New York (ELANY) thanked the Committee for the opportunity to speak and stated that ELANY is a nonprofit organization that was created by statute in New York to facilitate compliance with New York excess line laws. So, I want to get a little perspective on some of the things that we've been talking about and what I'm going to talk about. Everything I'm going to talk about is the way it is in New York because we're a New York organization so it's focused on New York but I think highlights the market nationally in many ways. The E&S policy count in New York is very small in comparison to the admitted market and the premium is as well. If you see it standing by itself it

seems a little more substantial when you look at the total market. It's a small part of the market and it's dominated by higher risk insureds and unique coverage needs. So let me give an example of what I'm talking about and of the way that the E&S market sort of focuses on certain things in New York that admitted carriers don't want to do. We commissioned an independent study to analyze the New York homeowners market. We thought that was a pretty easy thing for most people to identify with and to get their arms around. In 2017, there were 20,000 E&S homeowner policies issued in New York. In New York there are 2.86 million residences. That means if you look at New York residences only seven tenths of 1% of residences are actually insured in the E&S market place. Again, in New York there are two factors that the study found that drive homeowners risks to the E&S Market - one is increased wind exposure in coastal areas and the other is high valued homes. E&S homeowners policies are concentrated on Long Island. It's more than 60% and if you see a map of New York then you'll see that Long Island has the most exposed place in New York State to storms coming off of the ocean.

Most of what's in the E&S market are within 1,000 feet of the coastline. Most homes and almost 80% of E&S premium insures high value homes. Specifically, the E&S market has had more than a 90% share of wind storm risk homes and that is those homes that are within 1,000 feet of the coast. In contrast, as you move to homes that are more than one mile from the coast the admitted market has 99% of the market. The average insured value per policy in the excess line market of a home was about $855,000. So that kind of demonstrates what we were talking about in terms of exposure to wind in coastal areas and high-value homes. Let me give a specific example and that is the example of Long Beach, Long Island which is a place that got devastated during superstorm Sandy back in 2012. If you look at the chart up on the screen and you look to the right, you'll see total policies in Long Beach and as of the time of superstorm Sandy in 2012 there were 989 E&S homeowners policies written in Long Beach and that was about the same a few years later. But by 2021 it was down to 419 and that is well less than half. What happened in a relatively short period of time? Well, what happened is that after superstorm Sandy devastated Long Island, homes were raised higher up to avoid flood risk. They were raised which means brought down to the ground, disposed of, rebuilt, and all of this was done with wind and flood risk mitigation designs. So what happened? As a result, many Long Beach homes became much more risk-averse and therefore much more insurable in the admitted market and we've seen the admitted market move back into Long Beach and the E&S market recede in terms of its role there. That's exactly the way the market is supposed to work. How is E&S placed? It's placed through licensed E&S brokers and there are two types. One is a retail broker and retail brokers represent the insured and go straight to the E&S insurer and go straight to the market. Wholesale brokers are brokers as you could guess where they're licensed to deal with placing with E&S insurers but they don't deal with the insured, they deal with retail brokers who are not E&S brokers. So, as you'll see from the chart the transaction share for wholesale brokers is overwhelming, it's 83%. The premium is a little different while it's still favors wholesale brokers it's more of a 60/40 split.

And why is that? Well retail brokers tend to be large brokers that represent large risks and they have a need for capacity so they will have risks that are too large for any one insurer to write. An example would be you'd have a $700 million skyscraper, you're not going to get one insurer to write that. Nor do I think you'd want that. So you go out to 14 insurers and you put together a program and each insurer might take $50 million. Retail brokers will do that and they'll access the E&S market directly. Wholesale brokers on

the other hand serve the retail brokers on their deep difficult accounts, the retail brokers. Most retail brokers around the state and in the country are not licensed for E&S and so they have to go through wholesale brokers. Now in 2021, 8,162 retail brokers utilized wholesale brokers to place E&S risks. That is out of 48,000 total New York licensed brokers in New York so maybe about 17% even access the E&S market through wholesalers. Out of those, 70% of the brokers who did that placed less than ten policies into the E&S market and that is a pretty strong indicator to us that these retailers only go to the E&S market when that's what they have to do to serve their clients to get insurance but can't get in the admitted market and there's a lot of incentive for them not to do that. They don't want to split their commission which is what they have to do if they bring in another broker. They have relationships with their admitted carriers. Maybe they have direct bill. There are various reasons why they don't really want to go to the E&S market but it's what they do when they have to do that. Now market growth in the E&S market is often found in new emerging product categories and one example of that would be cyber liability and the numbers are pretty startling. The first year, a full year of reporting on cyber in New York we had 3,649 cyber liability policies filed. This year in the first nine months alone we're approaching 12,000 policies. That's become a much hotter area in terms of insurance. It's in the E&S market typically because it's not a settled area yet and the admitted carriers tend not to want to write that as much. Certain products are consistently in the E&S market and construction is the prime example in New York – 17% of the total New York E&S market is construction in terms of policies; 20% of the E&S premium. And that's because if you look around the New York City metro area you can't help but see all the skyscrapers and when they are built, they're built in spaces and at great elevation so it's more dangerous and more complicated and in New York there's strict liability for gravity related falls when working on a construction project so the risk is greater and these risks come to the E&S market.

Just as a quick aside, E&S insurance is almost 100% P&C so when we're talking E&S we're almost always talking P&C insurance. So some conclusions. The New York E&S market serves the need for which it was created as it insures risks which licensed insurers choose not to write and the small size of the E&S market, plus the nature of the risks as demonstrated by the numbers that I've provided sort of proves this conclusion. Our future expectations and aspirations for the E&S market would be that E&S will continue serving hard to insure populations. The market will be viewed through the prism of granular data and what we mean by that is looking at the market not just in general terms but specifically what's insured in the E&S market and what's insured in the admitted market. That's when you get a much better understanding of why things are going to the E&S market and why things stay in the admitted market. Regulatory uniformity is important which we believe will reduce costs and benefit insureds and that goes past New York. And then also sort of an overriding objective that's not just New York which is that public policy should maintain its focus on differentiating between the E&S market and the admitted market and I'll give one quick example and finish off like this. In the last couple of years during the pandemic New York had some emergency regulations which impacted insurance very directly and the New York State Department of Financial Services actually was very careful to maintain the differentiation between the E&S market and the admitted market when interpreting those regulations.

Sen. Bob Hackett (OH) stated that I have actually two questions. How many of the companies in the E&S are international companies? Because we see it a lot in reinsurance. Mr. Meetz stated that I'll have to get back to you with an exact number. Sen. Hackett stated that the reason I ask, and I carried legislation on this in Ohio, is that

Ohio used to require for an insurance company with international presence 100% collateral and we changed that in Ohio because Ohio's a big insurance state and we had the potential of losing some decent amount of business. So we left it up to the insurance commissioner - she still can look at the international company and say they're not sure on that and still require 100% but usually we try to treat the international companies well because we all know it in the room that a lot of the big conglomerates are international companies. Next, the admitted carriers don't have secondary insurers that they use so they're usually going to the reinsurance market, right? Mr. Meetz stated that they utilize the reinsurance market, sure. The international insurers have a decrease in the amount of market share in the U.S. The NRRA dictates the terms by which they are regulated through the NAIC's International Insurance Department (IID) list so that's how that works. Mr. Green stated that I would just add that in New York and I believe nationally Lloyd's of course is a huge player. Sen. Hackett agreed and stated so is Zurich. Mr. Green stated but most of the bigger ones in New York I believe are U.S. companies.

DISCUSSION AND CONSIDERATION OF MODEL LAWS

a.) NCOIL DELIVERY NETWORK COMPANY (DNC) INSURANCE MODEL ACT

Rep. Rowland stated that at this time we'll move into item number four which is a discussion and consideration of the NCOIL DNC Insurance model act. We have three model laws to discuss today and I will begin with this one which I'm proud to be the sponsor of. We've been discussing this issue for nearly a year now and we've made great progress and I think today this model is finally ready for a vote. You can view the model in your binders on page 279 but before we proceed I would like to note two minor technical changes to the model. The first is in Section 3(b). Language will be included just to make clear that the insurance required to be maintained insures the driver of these delivery network vehicles. This is really just a belt and suspenders change and is consistent with the intent of the model. The change is also exactly the same language that we have in the NCOIL Transportation Network Company (TNC) model which has been adopted in almost every state. The second technical change is in section 3(e). A clarification will be made that coverage can be obtained by eligible surplus lines brokers or insurance companies. I will just note that this model is a great example of NCOIL being at the forefront of an emerging issue and being able to move swiftly to provide states guidance. You'll certainly see this model introduced across the country next year. I will go ahead now and hear from our interested persons who would like to speak and then we'll turn it over to the legislators.

Frank O'Brien, VP of State Gov't Relations at the American Property Casualty Insurance Association (APCIA) thanked the Committee for the opportunity to speak and stated that I am very pleased to be before the committee today in full support of this DNC model. This model is the product of the NCOIL process which includes extensive consultation with state lawmakers and the use of a stakeholder process that had all of the parties at the table which produced the draft in front of you today. It is a draft which maintains NCOIL as the pre-eminent place where you go if you want to have model legislation that appropriately regulates the shared economy space. This is the latest but I don't think that it will be the last. So with that Mr. Chairman I commend you and I commend the members of the committee for your actions on this and I look forward to its approval.

Jon Schnautz, Assistant VP of State Affairs at the National Association of Mutual Insurance Companies (NAMIC) thanked the Committee for the opportunity to speak and stated that in deference to the committee's time I'll be really brief and echo everything

Mr. O'Brien said. We are also fine with the changes that you mentioned and thanks to you and Del. Steve Westfall (WV), co-sponsor of the Model, for carrying it.

Sen. Lang stated that I'm a little confused about when the coverage would start for this. Would it start when the delivery or the call for service is requested or would it start when an app is turned on saying hey I'm ready for a job? Mr. O'Brien stated that with your permission, Mr. Chairman, I'd like to ask Brad Nail to come to the table as he was the person who led the stakeholder conference on this particular issue and I think it's only appropriate that he be at the table because it was his leadership that produced a lot of the results here. Rep. Rowland agreed and stated that a lot the conversation around the model was around the delivery availability period.

Mr. Nail of Converge Public Strategies stated that I think the easiest way to answer that is that a key component of the model is that the personal lines insurer that insures the vehicle, because it's personal auto, can exclude coverage. So the model needs to make sure that the DNC provider has coverage in place whenever that personal lines has excluded coverage so it may be when they have just turned the app on to indicate that they're available or it may be when they're providing the actual delivery and there are a number of different companies in this space that operate in different ways so it's hard to have a one-size-fits-all to describe that but the end result of the model is that coverage will be in place whenever it is not provided by that personal lines insurer.

Rep. Jim Dunnigan (UT) asked typically when will a personal line coverage end? What triggers it? Mr. Nail stated that it depends on how they write it. They may choose, this is supposition on my part, that they will not cover when you are actually on the road making a delivery because that's commercial activity that they don't want to cover so the concept of having to cover when you're just available to provide that the personal lines insurer may go ahead and cover that time period. They may not change their policy language. Rep. Dunnigan asked what if they don't? Then is a person without coverage or who covers it? Mr. Nail replied no and stated that if the policy language is unchanged then they have coverage through their personal insurer, as they would any other time. If the personal lines insurer excludes coverage then the DNC has to have coverage to step in. Mr. Schnautz stated that the key language there is in section 3(a) and that is really a default rule. If no other coverage is in place then the DNC has to provide it during those applicable periods. It doesn't rule out that the private passenger auto policy might provide coverage through endorsement or otherwise but if it doesn't the obligation falls on the DNC.

Sen. Hackett stated that I agree and appreciate that but Uber and Lyft operate a certain way and you saw the problem with the insurance industry with the TNCs that either model didn't work so we had to develop a model because they didn't want it to go on to personal auto when it was a business activity. Well now you have companies that contract like Amazon will contract and they have everything already set up. They're not always happy if someone turns the app on so it's hard to get the legislation right and usually we create a framework and then they go to the states to get it right in each state depending on the states but can't we get this right here to protect the companies like the Amazon types and also the Uber and Lyft types because they are totally radically different in how their business models work. Mr. Nail stated that I think we did get it right here. What we've done is I think it's pretty clear that when they're making the delivery, that's the commercial activity it's got to be covered. When some of these folks operate like an Uber and Lyft where they might be driving around that is addressed here and

then for the folks that have more of a scheduling process where you don't really just drive around indicating that you're free right this second but you're scheduled for a later time I think that's addressed in here as well in the delivery available period definition where the coverage is only required while you're actually driving a car and available to make that delivery. Sen. Hackett stated that so the coverage isn't there when they turn the app on. What if the driver on the weekend turns his app on to see when his schedule is next week – is the coverage there when the app is on? Mr. Nail stated that you have to be driving a car while you're doing that and then coverage would apply.

Sen. Lang stated that I'm pleased with that answer you just gave but what if there is a company out there, because these are mostly independent contractors if not fully independent contractors, who's business model is I'm going to pay you twice what my competitor pays but in return I expect you to supply all of your own insurance and whatever else there is. I'm just curious if we're interfering with the free market in any way. Mr. Nail replied no - this model allows for the driver to provide their own coverage so it has flexibility in that respect.

Seeing no other questions or comments at this time, upon a Motion made by Rep. Michael Sarge Pollock (KY) and seconded by Rep. Tammy Nuccio (CT), the Committee voted without objection by way of a voice vote to adopt the Model.

b.) NCOIL DOG BREED INSURANCE UNDERWRITING PROTECTION MODEL ACT

Rep. Rowland stated that we will now move on to our next model - the NCOIL Dog Breed Insurance Underwriting Protection Model Act, sponsored by Asm. Kevin Cahill (NY), NCOIL Vice President, and co-sponsored by Rep. Nuccio. I'll turn things over to Rep. Nuccio for some remarks.

Rep. Nuccio stated that I'm proud to sponsor this model alongside my colleague Asm. Cahill. What's great about this model as you'll hear from the people who are going to be speaking about it today is that when we started discussing this a few meetings ago it was very contentious and it seemed that a model may not be able to actually be achieved and adopted. However, in that time we've had a lot of meetings and everyone has come together to reach a compromise and it's a great example of NCOIL serving as a forum where people with different views can engage respectfully with each other to discuss good legislation that meets the needs of all sides. You can view the model in your binder on page 285. As you can see, we settled on removing the data collection portion of the model and chose to focus on the restriction of the use of dog breed in homeowners and renters insurance policies. We also changed the effective date so that insurers will have more time to comply with the model's provisions. I appreciate everyone's work on this and I look forward to continuing to work on it in my own house chamber in Connecticut. I think it's also very likely that we'll see this model legislation introduced in other states as well. I won't take up any more time Mr. Chairman at the substance of the model has already been thoroughly discussed over several meetings and we've reached a point of agreement amongst ourselves, Asm. Cahill, and all of the interested parties including industry and advocates. Thank you and I look forward to the committee's support.

Ledy Vankavage, Sr. Legislative Attorney at Best Friends Animal Society thanked the Committee for the opportunity to speak and stated that I really appreciate having this opportunity to speak on this issue and thank you for your leadership and the leadership of Asm. Cahill and Rep. Nuccio. I hope that this issue didn't drive you away from the

chairmanship because we think you've been a very good chairman and we really appreciate everyone coming together to work on a framework that we can replicate throughout numerous states and keep dogs with their families because people love their dogs and we want the focus to be on the behavior of the dog and the behavior of the owner, not their breed. So, again thank you and thank you to my colleagues at APCIA and NAMIC and again thank you so much for your patience and we appreciate everything you've done to keep dogs out of shelters.

Mr. O'Brien thanked the Committee for the opportunity to speak and stated that once again this is also an example of how the NCOIL process works. Those of you who have been attending these hearings know that this was an issue that could not have gotten any more contentious. Having said that, with the work of Asm. Cahill and Rep. Nuccio we were able to come to a workable solution on this. We believe that this model appropriately balances the need for insurers to assess the risks and price it accordingly while on the other hand understanding the public policy issues surrounding our relationship with our canine companions. And with that Mr. Chairman APCIA urges the committee to support this particular model.

Mr. Schnautz thanked the Committee for the opportunity to speak and stated that NAMIC very much appreciates the data collection provision being taken out. That was our concern with the model as it stood a few months ago and without that we have no further concerns. We appreciate the work on this.

Brittany Benesi, Sr. Legislative Director, Western Region, at the American Society for the Prevention of Cruelty to Animals (ASPCA) thanked the Committee for the opportunity to speak and stated that I would like to thank this committee for the work that has gone into the development of this model and for your receptiveness to input along the way. While ASPCA ultimately believes that breed should be excluded entirely from underwriting decisions, we feel that this model is an excellent place to start and look forward to working with state legislators and helping keep people and pets together and in their homes. I respectfully ask for your approval of the model today.

Jessica Simpson, Sr. Public Policy Specialist at the Humane Society of the U.S. thanked the Committee for the opportunity to speak and stated that I echo my colleagues remarks and just want to thank the committee for your continued work on this important model legislation. And especially Asm. Cahill and Rep. Nuccio for your continued dedication to ensure that people are able to remain with their pets and have appropriate coverage in their insurance. And with that I ask for your approval of the Model today.

Rep. Carl Anderson (SC) noted how great it is to see how both sides have worked together to come to a compromise.

Seeing no more comments or questions, upon a Motion made by Rep. Nuccio and seconded by Rep. Forrest Bennett (OK), the Committee voted without objection by way of a voice vote to adop the Model.

c.) NCOIL INSURANCE UNDERWRITING TRANSPARENCY MODEL ACT

Rep. Rowland stated that at this time we will move to the discussion around the NCOIL Insurance Underwriting Transparency Model Act sponsored by Rep. Matt Lehman (IN),

NCOIL Immediate Past President, and at this time I want to turn it over to Rep. Lehman for some opening comments.

Rep. Lehman stated that I'm not going to go deep in the Model today because we have been at this for a while now. We've been having discussions for a long time now about the changing world of technology and rating models are changing and how information is exchanged to our clients is changing and that's being used to affect their premiums and so we really need to get to the "why?" And the whole genesis of this a year ago was to get to a place where there's some transparency so that when a person comes into an office - and I'm an insurance agent and we always put ourselves out to be professional advisers. We'll analyze your risk. We'll tell you what's the best way to protect that risk and protect those assets and then we go out and find the best product at the best price for you. When those prices change right now the answer I'm getting from my carrier's is, "we don't know." And so my response to my client asking "why did my rate go up 18%?" is "I don't know." And as we're sitting here I got an email from one of my underwriters because I got a renewal - two vehicles to retirees driving their vehicles around town. One vehicle stayed flat. The other one went up $40. And I just simply reached out to underwriting and said, why did it go up $40? The response was the liability symbol changed and therefore the rating changed. Would you give me $40 for that answer?

That's what I'm getting. And the frustration here is we have to get past the "I don't know." So what we began to look at was how do we get some transparency built into this? And this Model was introduced and has taken 1,000 turns. If you look on pages 287 to 290 we've used as much red ink as Washington D.C. It has moved. However, I am hearing from a lot of people that there is still work to be done. There's still things that need to change. There was an issue around duplicative reporting, that if we're doing this under the credit scoring model which requires me to disclose certain things don't make me do it again. And we can work on those nuances. I think this really comes down to two issues. One is the issue of declinations. If someone is declined for not getting insurance, should they be given a response as to why? Again, 30 years ago I could tell you why - you're a horrible driver or you have five speeding tickets or you had eight crashes in the last year. And then credit came along. We said well part of it is your horrible credit risk. Now it's just no we're declined. So that's an issue. Also, what number of factors should we say? Is it ten, is it five? What do we need to disclose? The credit model we passed I think is working in states and it requires four things you have to tell the insured. If you look at the banking industry, if your credit score changes they're required to notify you of the factors, and I think it's four, that caused your rate to change. So there's a model out there that says just tell me why.

So I don't know if that's the answer but really what it comes down to is, if the language we're looking for to answer the question of "why" is out there we've not found it yet. And I don't know if it's ten factors or five factors or just a true transparent explanation that I can pass on to my client and my client can somewhat understand it. The other thing I'll say is I've heard from the industry that we've got to play some defense here against what's happening in Washington State which has taken a much stricter position on these issues and has simply prohibited the use of certain things. Here at NCOIL we're saying you can use it but you just have to disclose it in certain ways. And I think that as much as the broker world is saying "I don't know," the department of insurance is saying "we don't know" and my biggest fear is when regulators say "we don't know," the answer is "no." And I do think there's technology out there and I do think these models are very sophisticated and I think they're actually probably fairly accurate but there just needs to

be some transparency. And so I am concerned with the alternate and that's why I really want to focus on not what you can and cannot use but more on the transparency so that we do see what you are using. So I don't think we have found the magic language yet. I'll defer to the Chair on this but before I would ask for this committee to move, I want to hear from the industry and I want to hear some of these questions answered - how do we become transparent to our constituents? I had someone ask me - are people complaining about this? And yes, I've had people complain to me about the lack of transparency. But what troubled me more was the departments have said the complaints are coming against the agent because we're hearing "my agent's not telling me why I had a price increase." And so I think before this thing starts rolling down hill to where we can't get to a good place, I do want to continue to work on this and get to the right place. So I want to hear what you feel about the model and your concerns with the model and then what your plans would be moving forward to help us create the elimination of the "I don't know."

Mr. O'Brien stated that I find myself in a much more agreement with everything that you have said than I expected to be when I sat down here. Speaking for the members of APCIA, we are 100% with you in terms of the need for transparency and for the need for insurers to be able to coherently and efficiently communicate to the producer community as well as to our policyholders or customers if you will, the reasons why something is happening to their particular policy. We agree with you wholeheartedly that answers such as "it's what the computer told us" are unacceptable. We agree that "insurance speak" such as "there was a change in symbol or there was a change in this or that" - that is quintessential "insurance speak" and is not appropriate in terms of communicating that to a customer. Maybe the agent understands it and would be able to translate it for a normal human being. That certainly is I think something that's doable. We would like to be in a position to support and we think that we are in a position here at NCOIL with the basis of the model that has been proposed in the substance in the sponsor's substitute draft which is reflective of some suggestions that the agents in APCIA and others provided to the sponsor. We think that we are a long way there. Unfortunately at this particular point in time we think that there are some additional changes that need to be made. For example, Rep. Lehman noted the Fair Credit Reporting Act language. We think that that's a relatively simple fix all things considered. We think that is a fix going forward. There is some controversy surrounding whether declinations should be included. My association is agnostic on that particular issue but there are some other provisions particularly around very lengthy and somewhat confusing sentences concerning the ten factors which we think needs more work and more thought. I've said this to a number of people and I don't want it to in any way denigrate the product that were attempting to produce here but the cake isn't baked on this yet. I think this cake needs to stay in the oven a little bit longer and I think that we can as an industry and as a group of public policy makers produce the type of result that will position NCOIL as a leader on this particular issue as NCOIL has been positioned as a leader on the two models that you all just approved and I think that there's an opportunity to do that here and we look forward to working with this committee. We look forward to working with Rep. Lehman on what could be one of the most important aspects of public policy related to insurers and how we relate to our customers that we may be working on in the next few years.

Mr. Schnautz stated that first, Rep. Lehman I do want to say with respect to your red ink comment you are absolutely right you have made a lot of changes that I think come directly from long and I think for you painful conversations that we've had that I

appreciate. I think you've also identified the remaining issues that we have very succinctly. The idea that we have been pushing here from the beginning is that the key here is value. Companies can, large companies at least, probably build systems to make whatever sort of disclosures you would want them to make. The question is those are not cost-free systems. We have some idea from the Washington regulation, which it's not fair to compare to this, but we know those can be very costly for both big and small companies and so the question is what is the cost of that which ultimately will be borne by policyholders versus the value to policyholders. And that's the needle that we're trying to thread. I will say on the declinations issue that is one of our remaining issues. The reasons are several. One is, the comments you made at the beginning of this were all about premium increases. That has been the most acute discussion here in terms of what the issue is and we think that's appropriate as there's an existing contractual relationship there and some explanation makes more sense. To give an example of the interaction between a couple of the provisions that are still in the bill that we think are problematic, let's take the declinations provision and the fact that it's still included and the ten factor sentence that Mr. O'Brien referenced. I think it's a reasonable reading of that to say that if a potential policyholder is declined, that's a binary choice of you write them or no you decline them, that company to comply with that would have to go through every relevant factor that it used in that decision, rank them, try to figure out what the top ten are and then report them to that policyholder. And doing that is not a very simple thing because it may not be a binary issue of just one of those factors. It could be a combination of all of them and I think that sentence is so prescriptive that particularly in the context of declinations it creates a notice that would be very hard to produce and probably of very little value. Because frankly it's not going to change the company's answer on whether they'll write the coverage. The person's going to have to go find coverage elsewhere. So I think that's a good illustration. And the credit interaction issue I think that one is fairly easy to address and I don't think anyone here wants it to be duplicative and we agree with that. So we would look forward to the chance to continue to work on this. We've been working on it for a while. We think we've done that in good faith to try to reach something that we could not only not oppose but possibly even support because I think Rep. Lehman you're right this is an emerging issue and it is a tough one to crack and the industry would benefit from greater public confidence than what it is doing and we want to find the right answer there.

Wes Bisset, Senior Counsel at the Independent Insurance Agents & Brokers of America (IIABA), thanked the Committee for the opportunity to speak and stated that we are big supporters of Rep. Lehman's efforts and I'll walk you through some of the reasons why and hopefully not reiterate many of the comments that Rep. Lehman made. We do see a need for this model. The underwriting rating process in the personal lines world has become increasingly complex and opaque. In recent years companies are using advanced analytics and vast new types of data and complex models that just weren't in place even a few years ago and the result that these models sometimes produced are counterintuitive. As Rep. Lehman said, it used to be much more intuitive in the insurance personal lines underwriting context. If you had a lot of accidents you can imagine why your rates went up. Or if you have teen drivers coming on your policy there was a natural tie-in and much easier to understand. But when there's a large rate increase that is counterintuitive it leaves people wondering why and in some cases could potentially lead to an outcome where people are wondering if the price they have been quoted really represents the risk that they ultimately presented. And agents struggle sometimes to provide explanations for customers who are kind of wondering exactly why their rate went up 20% or why they were non-renewed and it can lead to false

conclusions that we don't want to have occur. So basically, all the model would do would be to establish some basic transparency in this process if requested by the customer, if a consumer was non-renewed, or if their rate increased a certain percentage, that they can then ask the insurer for a list of the primary reasons for why that decision was reached.

So hopefully it would do a few things. It would hopefully facilitate a basic understanding of the reasons for that increase. If the information had been utilized was incorrect or inadequate or incomplete the consumer then go back and take action and potentially improve their outcome. And hopefully in a big picture way all of this would help restore faith and trust in the insurance rate making process. And some might look at this and say this is radical and coming out of left field but honestly this is not a new or novel context. There was a big data revolution about 20 years ago when companies began using information based on credit histories and credit reports in underwriting. And actually 20 years ago at this this very meeting NCOIL adopted a comprehensive model that established the regulatory framework for how credit information and history's could be used by the insurance industry. What's ironic is at that time there were companies who were really skeptical of the NCOIL credit model and they've become big supporters and believers in that in the years since. But among the many provisions in there, there was one that Rep. Lehman mentioned that requires that if an adverse action is taken that the reasons for that be explained in "clear and specific language." That's been broadly adopted and it may be NCOIL's most successful model. And all the proposal does here is essentially keep up with the times as data is changing and in kind requires the same type of adverse action notice given the new underwriting and rating factors that are being employed. And the other issues were behind the banking industry on this - for many years federal law in the form of the Equal Credit Opportunity Act and regulation B has required disclosure of the specific principal reasons for adverse actions that occurred in connection with an application for an extension of credit. And that applies to the federal regulators who said you're not even allowed to use a complex algorithm if when an adverse action is taken you can't explain the reasons for that action.

So there is a need for a proposal like this. There's a particular need for a reasonable and legislative based model of this nature. We already have individual states taking action. We have the NAIC contemplating action in this particular context. So having an appropriate narrowly tailored model is incredibly important especially because requirements like this should be established by statute and not by unilateral regulatory action. So having a transparency based approach we believe is the right direction being big supporters of the state system and of the risk-based pricing models and framework that we have. The only thing I'd say is whether you ultimately consider this today or in the future we'd urge you to move forward on this even if you conclude this is not something you want to bring back to your home state and act on maybe now or even in the near future. But there is sufficient interest among the states and they're going to be looking to do things like this and it would be helpful to have a reasonable narrowly tailored model and not have those states acting on this in an ad hoc way. I'll close by saying that to keep up with the times in the emergence of new data sets and in complex models we think it's reasonable and narrowly tailored in its current fashion. So whether it's today or in the near future at an interim meeting or in San Diego whenever you take this up, we'd urge your support and I hope if it is delayed that any delay would not be an effort by some who have concerns to essentially kill this all together and that it's truly in good faith to come to the table and negotiate and make this the best product it could be.

Sen. Hackett stated that first of all I want to thank Rep. Lehman as you have worked so hard on this. What Rep. Lehman said is we've moved into the modern age and these formulas are a lot more intricate than what we had in the old days. The problem I think some people have is we're worried about the cost of this and I agree with Mr. Schnautz saying you should look at cost versus value and I agree with that. We want to control costs and we don't want to create a business environment that's really costly. I've always said as insurance chair that the good legislation is legislation that is good for the consumer, good for the producer, but also good for the company and so that's why this is a really difficult issue. And I do get on the insurance companies to say that we have to get this resolved and it's the smaller insurance companies that are objecting the strongest because they're looking at what it's going to cost them to put this into place. I defend Rep. Lehman to the end because he has worked on this so hard and it's a really difficult issue and he's working hard to get it a solution on it and we're close and the only message I give the insurance companies is we must get this resolved in the next couple of months because if we sit on it much longer some states are going to go act on their own and they're going to be a lot more strict than we will. So we must be careful in the message we send but cost is such a major issue that we worry about creating additional regulations and additional costs. And I'm not a producer in P&C but I'm a producer on the financial side and I realize that this industry has changed drastically and I do think it's for the better because it's more accurate. I think it's great that the insurance industry wants to get this resolved but we want to get it resolved quickly. We should postpone it but let's get it resolved quickly.

Mr. O'Brien stated that Sen. Hackett, I agree with everything that you've said. Mr. Bissett and I agree with most everything you've said but we need to get this right. We have worked very hard on this. We do understand that part of what we're talking about is the credibility of the insurance industry in the product that it delivers and people want to know that they have been dealt with fairly. And in terms of dealing with people fairly they don't want to know what happened, they want to know why it happened, and they want to know in such a way that is understandable so that they can make an appropriate decision. We want to be in a position where we can take this legislation and put it in place in our companies so that it can be put in place as a standard practice in such a way that it is cost-effective and produces a result that's going to generate the desired result which is people know what's going on. We commit to the sponsor. We have said to the sponsor and we commit to the committee and commit publicly that we are all in on this and that our concerns and our request for a delay are in no way dilatory or intended as an artifice to end up with a result that produces nothing. It's important to get something done and something done right.

Rep. Anderson stated that first of all I want to say thank you to Rep. Lehman for all of his hard work and he has a heart of a champion because he cares about everybody and everything that is going on and that's why we are hearing him talk the way that he's talking today. And thanks to all of the speakers here today from industry agreeing this is important. I heard from some of my colleagues back in South Carolina today from the insurance side of things and this is what they said - please remove the premium increase language from the definition of "adverse action" because it's unnecessary and confusing to lump together premium changes and declinations. South Carolina already has laws on both of these subjects. Secondly, please do not make a violation of this proposal to be punishable under the Unfair Trade Practice Act. I just want us all to consider all of these things and I'm sure that around this table there are others who have heard from insurance companies in their area.

Rep. Rita Mayfield (IL) stated thank you Rep. Lehman for bringing this language. When I saw this bill I got extremely excited. In addition to sitting on the insurance committee in Illinois I also sit on the consumer protection committee and this bill as written even with the objection of industry would pretty much fly out of the consumer protection committee because of the way it is written. We want more transparency. Policyholders deserve transparency. As Mr. O'Brien stated they want to know why something has happened. And I do believe that as an industry you owe it to them to provide them with that why. They don't want to hear about complex algorithms or anything else. They just want a simple explanation and I believe that can be given to them. So thank you for this. If it does not precede you will see it in Illinois in a form probably something that you would not like. So it would be great if we could get uniform language as opposed to 50 different versions.

Sen. Lang thanked Rep. Lehman for all the work that you have done. I am in the insurance business as well. I own an agency that's a life and health agency and I know it's not the same as P&C but I also own a captive insurance company that's in the P&C world and it's a very narrow market we insure. So my experience is not similar to Rep. Lehman's but in my experience a client that gets declined pretty much knows the reason why they've been declined. I would like to follow up on Sen. Hackett's comments about a cost increase. We know this will add cost. We know this will add complexity to the system. My question from the industry is - are there any estimates on what it would cost on a per individual basis across the board? And are there any estimates what it would cost the industry if all 50 states were to adopt this on an aggregate basis? And furthermore as it relates to that cost is it fair to assume that the insurance companies would eat that cost which would result in negative impact on them because of their fiduciary responsibility to their shareholders if they're a stock company or to their policyholders if there are mutual company, would it be fair to assume that whatever those increases are would be passed along in the form of increased premiums which would most likely have a negative impact on our nation's working class people more than just about anybody else?

Mr. Schnautz stated that I referenced early on the only cost estimate that I'm aware of that is related to something close to this were cost estimates that the industry did on the Washington regulation. In fairness I don't think you can take those numbers and apply them to this. I could give you some indication of what those were but I don't want to leave any impression that they are somehow transferable this. For large national companies those costs were generally in the tens of millions of dollars and for smaller companies in the single millions of dollars. The answer to where those costs are borne is insurance companies don't print money. Everything has to be paid for somehow through the available sources of revenue to the company. I think that's the best way I can answer that. But again to be fair the Washington regulation is different. We know this would cost something. We don't know specifically per policy or anything like that. Mr. Bissett stated that those are great questions and I think there's a few things to contemplate. The short answer is I don't know. But the things to potentially contemplate would be is this offset by savings that carriers are enjoying because of the complex modeling and the increased accuracy that would occur and one thing that might be worth exploring too would be what types if any of meaningful cost occur as a result of companies complying with the adverse action requirements under the credit scoring model from 20 years ago. There's probably data out there that we can look to. It would also be interesting to look at how and what costs there are if any on the banking industry

as a result of their compliance with very similar requirements over the last few decades. Those would be things that we can perhaps explore and take a look at.

Del. Westfall stated that in 12 days I'll be an insurance agent for 43 years. I try to answer these questions daily. It is a problem but I just don't think we're there yet. I talked to a lot of insurance companies besides the ones I represent and they're not against this in my opinion but just want to get it a little better than what it is. If we pass it now as it is and we take it back to our states we would have to tweak. I would have to and I don't think I'd have the ability to really do it as well as the committee could do. I'm all for taking this next year and trying to pass it in West Virginia. I got a pretty good record of passing bills out of NCOIL. I do a lot of them. But I'm not comfortable with this one right now with the way it is. I think we need to work on it a little bit more. I think it's going in the right direction but I'd just like to see it tweaked a little bit more.

Sen. Robert Mills (LA) stated that for background, I'm strictly a consumer of insurance. My business background is that I'm a member of the Insurance Committee in the Louisiana Senate and we've talked about this exact issue for some time there and I was amazed to find out that there's over 100 external consumer data points that you can buy on an individual and in my mind as a consumer, if you ever said you don't know the answer I take it at that value and I say well, what are my options? I'm much more concerned as a consumer about having an option than I am with an explanation and particularly if the explanation's going to cost me money in my next policy. I apologize I don't know about the banking rules relative to something similar to this but I surely want to study that. That's going to take some time and I'm going to ask for some time on this as well. I live in probably the most litigious state in the nation and I know that if you put just two of these external data points out as to the reason that you were either giving an increase or a declination I've got thousands of lawyers just giggling at the idea of one by one knocking those off and we're going to be tied up in the courts every time with the lawyers in my state and I'm nervous as a cat about putting these external data points out in the public realm. I know that they exist. I can live with that. I just want to know what the rate is. Give me my options. Let's go forward. And I so I would suggest we defer this.

Sen. Mary Felzkowski (WI) thanked Rep. Lehman for all his work but I have to respectfully decline on this. I've been an agent since 1985 and we do a lot of P&C. I do mainly commercial but home and life auto. You are literally asking companies to put out models that I agree are going to cause a whole lot of litigation. But also think of this. If an agent's putting a policy and it's getting declined it kind of means they are not doing their job to start. You know what you're underwriting guidelines are from your companies and if it's a tougher risk you should be having those conversations. So the declination of coverage I think should be out of there. In addition, we're one of the most highly regulated industries in the nation and when rate increases happen those rate increases are approved by the insurance department. And I'm just going to look at the one company I've got, there's 1,000 factors that go into the algorithms - everywhere from where you are to what are the weather patterns and far are you from your responding fire department? Credit score is a large part of it but there's other things that are part of it and I think the minute you start seeing that they're using X, Y and Z to rate, all of a sudden it's going to be which one is discriminatory and which one is not and this is bad and that's not and I just think we're going down the rabbit hole on this and we absolutely don't need to. And my final question is why? Is it so agents can say to you that your credit score dropped ten points? Or that the weather patterns are changing in Oklahoma

and we're seeing much more damage in that area? So we're going to add the cost of doing this but what are the consumers actually going to do? Now I'm going to know why I'm being charged more and it's going to cost me more to know that. But we can't change weather patterns, we can't change a lot of other things. We have a robust insurance market in this nation. You can shop your insurance and find out if you can get a better deal with more coverage and through other people. I just think we're going down a rabbit hole and that doesn't need to happen.

Rep. Lehman thanked everyone for their comments and stated that the only push back I have on a couple of comments is when you mention about the departments already approved rates, they're saying we don't know how to approve these because we don't have the expertise to dig into these models. We just don't. And I think when you mentioned 100 data points, we're not talking 100 data points. We're talking 1,000 data points. In Indiana, I asked a very simple question - how many data points has a carrier asked to use and how many have you approved? They said we had a carrier that asked to use 1,400 data points and we approved about 620 of them. And I'm thinking which is more appalling, that there's 620 things about me that are driving my rate and some of it is as simple as you live in a tornado alley but what else is in there? Or is it more appalling thinking about the 700+ that were denied. So when you talk about going down the rabbit hole, we're already in the rabbit hole. We went in that rabbit hole when all of sudden technology said I can put up a little box in your car and tell you how many times you stopped and turned left and you calculate your rate and everything else. So we're there. It's just going to be how do we craft this to be efficient, fair and transparent? This is my 37th NCOIL meeting. One thing I've learned in those 37 meetings is to get it right. So I want to get this right. I have already talked with our bill drafting people in Indiana. I'd like to work on a bill. I think it's that important. And I am asking for your help and I've got respect for everybody at that table because you've always been upfront with me and been fair with me and I look forward to finding that the answer of "I don't know" becoming "I can tell you why." And I think that's what we owe to our clients. And so with that Mr. Chairman, I am willing to hold this. I will look to see what we do in Indiana. By March it will have been through the IN House of Representatives so I think we'll have something that has been vetted by the committee, vetted by the industry, vetted by consumer groups, and vetted by those who really want to see some transparency. So with that I appreciate everyone's comments and I'm open to more discussion so please reach out to me but at this time Mr. Chairman I ask that we hold this until San Diego.

ANY OTHER BUSINESS

Rep. Brenda Carter (MI) stated that I'd just like to say that this past year I worked on a bill that deals with liability insurance requirements for firearm dealers. I think with everything that's going on recently surrounding that issue NOCIL should have some sessions regarding liability insurance and its relationship to firearms and firearm dealers. If anyone would like to speak to me about it please don't hesitate to reach out to me.

Hearing no other questions or comments, Rep. Rowland stated that it's been an honor to chair this committee for the past two years. I was looking around earlier and was impressed with the large number of legislators present today and I can remember the days when there might have been only ten or twelve of us in here so it's a testament to the way that this organization is growing and I wish you all the most success.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Hackett and seconded by Rep. Lehman, the Committee adjourned at 4:30 p.m.

616 Fifth Avenue, Suite 106
Belmar, NJ 07719
732-201-4133
CHIEF EXECUTIVE OFFICER: Thomas B. Considine

National Council of Insurance Legislators (NCOIL)

Insurance Underwriting Transparency Model Act

Sponsored by Rep. Matt Lehman (IN) – NCOIL Immediate Past President

To be discussed and considered during the Property & Casualty Insurance Committee Meeting on March 11, 2023.

Sponsor's substitute as of March 1, 2023

Table of Contents

Section 1. Short Title

This Act shall be known and cited as the "[State] Insurance Underwriting Transparency Act."

Section 2. Purpose

The purpose of this legislation is to provide personal auto and homeowners insurance consumers with clear and useful information explaining the basis for when a material change is made to a consumer's policy.

Section 3. Scope

(a) This Act applies to personal automobile and homeowner's policies that are underwritten on an individual basis for an individual, family, or household.

(b) This Act does not apply to notices required by the federal Fair Credit Reporting Act (15 U.S.C. 1681 et. seq.).

Section 4. Definitions

(a) "Insured" means an individual entitled to coverage under a personal automobile or homeowner's policy.

(b) (1) "Material change" means:

(A) a nonrenewal or cancellation of;

(B) an increase of more than ten percent (10%) over the expiring premium for;

(C) a reduction in coverage of; or

(D) another adverse or unfavorable change in the terms of coverage or amount of;

insurance in connection with a personal automobile or homeowner's policy.

(2) The term does not include the following:

(A) An increase in the insurer's filed rate plan and automatic inflationary increases.

(B) An additional premium due to a change initiated by the insured, such as:

(i) adding or removing vehicles or drivers;

(ii) adding an endorsement;

(iii) adding additional coverages;

(iv) adding covered premises; or

(v) increasing coverage limits or deductibles.

(C) An additional premium due to a change in risk exposure as a result of the insured's participation in a usage based or telematics insurance program.

Drafting Note: Terms such as "automobile policy", "homeowner's policy", and "insurer" are intentionally not defined in this Model so that the specific definitions of each state's insurance code shall govern.

Drafting Note: States may wish to consider expanding the scope of the Model to make it applicable to declinations so that those who are declined coverage are required to be issued an explanation pursuant to the process set forth in Section 4 of the Model.

Section 5. Transparency Requirements

(a) An insurer that makes a material change to an insured's personal automobile or homeowner's policy shall provide a written notice to the insured that:

(1) explains the principal factors for the material change; or

(2) states that the insured has the right to request and obtain an explanation of the principal factors for the material change.

(b) An insured who receives a notice of a material change described in subsection (a)(2) may submit to the insurer a written request for an explanation of the principal factors for the material change.

(c) Upon receiving a request for an explanation under subsection (b), the insurer shall provide a written notice to the insured explaining the principal factors for the material change.

(d) An insurer shall provide a copy of a written notice provided under subsection (a)(1) or (c) to the insurance producer, if any, who:

(1) represented the insured in obtaining coverage from the insurer, or represented the insurer in regard to the providing of coverage to the insured; and

(2) is not an employee, an exclusive agent, or a captive agent of the insurer.

(e) A written notice provided under subsection (a) or (c), or a written request submitted under subsection (b), must be provided by first class mail, or electronic delivery as set forth in [insert citation to electronic delivery section of State insurance code].

(f) A written notice provided under subsection (a)(1) or (c):

(1) must be sufficiently clear and use language sufficiently specific to enable the insured to identify the basis for the insurer's decision to make the material change;

(2) must include a description of the principal factors most heavily weighed by an insurer in making a material change, listed in no particular order; and

(3) may provide a point of contact through which the insured may discuss the reasons for the material change.

Drafting Note: States may wish to consider requiring a specific number of principal factors to be included in the notice provided to the insured (or applicant if a State has expanded the Model to include declinations).

(g) The following statements do not meet the requirements set forth in subsection (f):

(1) the material change is based on the insurer's internal standards, policies, or models;

(2) the insured failed to achieve a particular score on the insurer's scoring system;

(3) one containing generalized terms, such as "poor credit history", "poor credit rating", or "poor insurance score."

(h) The requirements set forth in this Section do not replace and are in addition to the requirements under [insert citation to state cancellation/termination notice requirements].

(i) Nothing in this Act shall prohibit an insurer from voluntarily providing the disclosures required by this Act.

Section 6. Rules

The Commissioner shall adopt rules to effectuate the provisions of this Act. Those rules shall include monetary penalties consistent with those assessed for other similar violations of this State's insurance code. Violations shall be enforced solely by the Commissioner. A violation of this Act shall not create a private cause of action.

Section 7. Effective Date

This Act applies to a personal automobile or homeowner's policy that is issued, delivered, amended, or renewed after [one year following enactment of this Act].

The following State laws will be discussed during the Committee topic “Presentation on Improving Natural Disaster Resiliency Efforts” as examples of different approaches states have taken.

Louisiana HB 612

Louisiana HB 451

Oklahoma HB 1720

GENERAL SESSION
LIABILITY INSURANCE FOR GUN OWNERS: IS IT TIME?

The following material will be used as the basis for discussion during the general session titled “Liability Insurance for Gun Owners: Is it Time?”

San Jose, CA Ordinance No. 30716

California SB 8

https://www.insurancejournal.com/blogs/law-and-economics/2023/01/03/701434.htm

FINANCIAL SERVICES & MULTI-LINES ISSUES COMMITTEE MATERIAL

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
FINANCIAL SERVICES & MULTI-LINES ISSUES COMMITTEE
NEW ORLEANS, LOUISIANA
NOVEMBER 18, 2022
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Financial Services & Multi-Lines Issues Committee met at The Sheraton New Orleans Hotel on Friday, November 18, 2022 at 9:00 a.m.

Representative Edmond Jordan of Louisiana, Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Rod Furniss (ID)
Rep. Matt Lehman (IN)
Rep. Craig Snow (IN)
Rep. Joe Fischer (KY)
Rep. Bart Rowland (KY)
Rep. Brenda Carter (MI)
Sen. Jerry Klein (ND)
Sen. Shawn Vedaa (ND)
Asw. Pam Hunter (NY)
Sen. Bob Hackett (OH)
Rep. Brian Lampton (OH)
Rep. Forrest Bennett (OK)
Rep. Tom Oliverson, M.D. (TX)
Rep. Jim Dunnigan (UT)
Sen. Eric Nelson (WV)
Del. Steve Westfall (WV)

Other legislators present were:

Rep. James Kaufman (AK)
Rep. Tammy Nuccio (CT)
Rep. Kerry Wood (CT)
Rep. Carolyn Hugley (GA)
Rep. Cherlynn Stevenson (KY)
Rep. Rachel Roberts (KY)
Rep. Michael Sarge Pollock (KY)
Rep. Brian Lohse (IA)
Rep. Jonathan Carroll (IL)
Sen. Robert Mills (LA)
Sen. Lana Theis (MI)
Sen. Paul Utke (MN)
Sen. Walter Michel (MS)
Sen. Michael McLendon (MS)
Sen. George Lang (OH)
Sen. Jay Hottinger (OH)
Asm. Kevin Cahill (NY)
Asm. Jarett Gandolfo (NY)
Sen. Bill Gannon (NH)
Sen. Mary Felzkowski (WI)
Sen. Mike Azinger (WV)

Also in attendance were:

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

QUORUM

Upon a Motion made by Rep. Brian Lampton (OH) and seconded by Rep. Jim Dunnigan (UT), 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 Sen. Jerry Klein (ND), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 14, 2022 meeting in Jersey City, NJ.

DISCUSSION AND CONSIDERATION OF NCOIL INSURANCE REGULATORY SANDBOX MODEL ACT

Rep. Jordan stated that we've been discussing this issue since our summer meeting of last year and now we are ready for a vote. Before that I'll turn things over to the sponsor of the Model, Rep. Bart Rowland (KY) for some brief remarks. Rep. Rowland stated that he is proud to sponsor this Model and he appreciates everyone's work on it throughout the process. You can view the model on the website and on the app and it also appears in your binders on page 134. This really was a collaborative and deliberative process as we started with a draft that looked a lot like the Kentucky sandbox law that was passed a couple of years ago but we made some changes based upon feedback from both legislators and interested parties. To reiterate for those who may be new to the discussion, this Model and the similar sandbox laws across the country permit the Department of Insurance to waive certain regulatory and statutory requirements with the main goal of reducing hurdles for companies that want to introduce new concepts and products at the same speed as insurance technology develops. Several states have adopted these types of laws and I believe that with the NCOIL Model passing it will serve as a spark for more states to do the same thing.

J.P. Wieske with the American InsurTech Council (AIC) stated that the AIC supports the Model and the work that's been done and we look forward to hopefully a favorable vote on it in the states. Rees Empey, Director of Government Affairs at The Libertas Institute thanked the Committee for its work and stated that this is two years in the making and he is thankful to be part of this process and looks forward to a favorable vote and hopefully some states adopting similar models. Wes Bissett, Senior Counsel with the Independent Insurance Agents & Brokers of America (IIABA) stated that I just want to echo the comments made by the two gentleman a moment ago and thank Rep. Rowland for his leadership on this both in Kentucky and now at NCOIL. We really appreciate the works that has gone into this and would also urge a favorable vote this morning.

Del. Steve Westfall (WV) stated that West Virginia passed a version of the Model a couple of years ago following Kentucky's lead and I'm glad to see that other states possibly can do this. I think it's a great thing for insurance.

Hearing no further questions or comments, upon a Motion made by Rep. Joe Fischer (KY) and seconded by Sen. Bob Hackett (OH), the Committee voted without objection by way of a voice vote to adopt the Model.

DISCUSSION ON THE DEVELOPMENT AND USE OF ENVIRONMENTAL, SOCIAL AND GOVERNANCE SCORES

Rep. Jordan stated that we'll now move on to the discussion on the development and use of ESG scores. This is a topic that I'm very interested in and I hope NCOIL will continue to discuss this going forward. Today's speakers will be able to provide us with a high-level overview on how their respective organizations use ESG scores.

Peter Giacone, Sr. Managing Director at Kroll Bon Rating Agency (KBRA) thanked the Committee for the opportunity to speak and share the views of my firm. For those who are not aware, KBRA is one of the newer rating agencies that serves the capital markets. We were founded 11 years ago by Jules Kroll. Some people confuse us with Kroll the investigation firm. We are not affiliated with them in any way shape or form. We are a Nationally Recognized Statistical Rating Organization (NRSRO) which makes this effectively the equivalent of providing the sort of service to the capital markets such as S&P, AM Best, Moody's, and Fitch. So we are peers of those companies and have over the last few years we've expanded our practice quite dramatically. When I joined the company about seven years ago we had 170 employees and we are now up to over 500. We are a global firm covering every major asset class in the credit market and everything in the structured finance side that you can think of as well as on the corporate and financial institutions and government side as well. We have a huge public finance practice. We rate many of the state's sitting in this room today as well as many of the municipalities within those states. And finally the area that's near and dear to my heart - the insurance practice. And that's the part that I'm responsible for. I'm the global head of insurance ratings for KBRA, which means that we provide financial strength ratings currently for over 150 companies. Most are published with some that are unpublished and you can go to our website and take a look at those anytime. And the coverage of our firm across the capital markets is quite extensive and in fact the U.S. Securities and Exchange Commission (SEC) because we are an NRSRO and regulated by the SEC, this most recent every year the SEC put out a report and in that report they talk about the state of the rating agency market and they list all of the companies and this most recent year they made a change in the way they described the market.

One is they used to have sort of the big three rating agencies, S&P, Moody's and Fitch, and everybody else. This year they sort of fine-tuned their categorization to say well we have the big three and that we have medium-sized firms and those are AM Best, KBRA and DBRS and then you have everyone else after that. So we rate probably over $2 trillion dollars of paper in the capital markets so we are a major player there. Some folks still have not heard of us but we are a rapidly growing firm and the opportunity to come in here and speak to you today about the approach that we've taken on ESG is one of the reasons we have grown so fast because our growth in ESG and the approach to it is very similar to the way we approach credit ratings more generally which is on a more holistic basis and providing a different perspective. Looking at our insurance practices I mentioned we have 150 ratings that covers everything from small fraternals out in the Midwest all the way up to Lloyd's of London and I mention Lloyd's of London because they added us as a fourth rating agency to provide a different perspective on credit. So moving to ESG, it is a big topic. It is in the news pretty much everyday and we set out to look at how KBRA as a firm was going to address this issue because our constituents are our policyholders in the case of insurance financial strength ratings and more broadly investors in the case of the credit ratings that we provide. We went out and asked them specifically, investors, and said this ESG thing seems to be pretty big - what would you like us to do? What would be helpful to you? And the first thing they said to us is no scores. You're credit analysts. You are not in the business of coming up with value-based judgements around ESG. We don't need another set of scores out there. What we need is maybe for you to incorporate something into your credit ratings but please don't provide another score.

So we took that to heart and our approach to ESG is to look at it through the lens of ESG management and by the way I should mention that this is for the record that all of our

methodologies and a lot of the comments I'm making today regarding ESG and our credit ratings more broadly are all available free of charge on our website KBRA.com and I encourage everyone in this room who covers the insurance industry at least to go to register with the website. You can get notifications for free of everything that we're doing and you can check off when you register what areas you are interested in and not just insurance but other areas and certainly ESG. So if you're interested in what we're publishing on these topics please go to website and the vast majority that stuff can be obtained free of charge including our approach to ESG. And we've been publishing a lot on this topic. So, stepping back, how do we look at ESG? Again, we look at it from an insurance company perspective and broader across our whole firm is based on ESG management. So whether it's environmental, social, or governance all of these things we believe are management issues for organizations whether they be municipalities, whether they be insurance companies, to manage as they do any other risk. So when we think about our approach to this we go through a very diligent, a very detailed due diligence process and we asked our companies, what does climate change impact have with respect to your business? When it comes to social, we tend to focus on stakeholders. What are your stakeholders demanding of you? What are they asking of you? Who are your stakeholders first of all and what are they maybe asking on these issues? And when it comes to governance we've tended to focus mostly on cybersecurity because all three of these frankly are very broad topics and we've tried to focus on just the three as I've described. So when we talked about environmental we tend to focus mostly on climate change. When we go to social issues we tend to think more in terms of stakeholder and transition risks. And when we go to governance we tend to focus primarily on cyber.

But again, we do not do scores. We don't think it's our job as a rating agency to make value-based judgments on these topics. These are very important topics. I'm not disputing that. I think most of the market would agree. But our job is to talk about credit. So when I put a single A rating on an insurance company, that is a very specific meaning. It means the probability of default over a specified time period. And you might ask well where'd you come up with those numbers? Eighty years of corporate default data is where I came up with that. I didn't just make it up. I went to the statistics and I came up with that and so the whole market understands when I say single A what that means and what that implies with respect to the probability of default. Now if you step back to an ESG score and there are lots of them floating around up there in my competitors none of whom are here today but I can talk about them. A lot of them have come up with these scoring rubrics and have assessed those scores and perhaps most damaging to the market they have actually then taken those scores and then linked them to the credit rating process. And that we feel is improper and inappropriate for the simple reason that there is no data to support most of those scores. There's certainly no 80 years of corporate default data and we think it's very misleading and if you ask me quite honestly I think a lot of those scores are just frankly made up and so we're not in the business of making up scores. We're in the business of assessing credit risk and providing those signals to the market based on real data and real research and real analysis.

So we've tended to step back. We don't say these issues are not important, they are, but when it comes to insurance companies specifically and even more broadly we incorporate them in the context of ESG management and with insurance companies specifically ESG risk management. And if you go to our website and you pull any of the published reports that we have on any entity that is rated by KBRA there will be a

section in that report at the back or maybe in the front depending on how relevant it is that talks about ESG but qualitatively. And specifically what aspects of those three topics might have a linkage in some degree, shape or form to credit risk and what our assessment of the credit of that company or entity is. So, I'm going to turn it over to my colleague here who has some things about what they do at Marsh to kind of help get some ideas and get some concrete assessments of these things together which I think is certainly helpful to the market but from a rating agency perspective, we don't feel it's our place to make value-based judgments. It's not for us to decide and tell you well here's how many folks of color or how many women you should have on your board in order to achieve a certain credit rating. That's not our business. Maybe having diverse boards is a very good thing but I certainly don't have enough data or analysis to make an analytical judgment on what impact that has on credit except potentially in specific cases and if in the course of those conversations when we're doing our diligence if we feel there's something that is relevant to credit, we'll disclose it on our rating report for the whole world to see and then folks can make their own judgment. Investors and policyholders can make their own judgment based on the information we provided on ESG and how that entity is handling and addressing and looking at that and we share that with the market in the spirit of transparency and then let the investors and policyholders make their own judgments as to whether that's efficient or not.

Dave Carlson, Managing Director of U.S. Manufacturing and Automotive Industry Practice at Marsh McLennan thanked the Committee for the opportunity to speak and stated that in addition to his manufacturing and automotive work he also leads ESG in the U.S. and Canada and he's very pleased to be here today. You might hear me today and think that I'm contrary to what Mr. Giacone is saying, but I'm not. And I'm going to get to that point. Marsh McLennan is the world's largest insurance broker and risk management advisor. As such, we have found that ESG climate sustainability is a boardroom level discuss that crosses every level of risk. As such, we found and find it paramount for us to be able to help our clients on that journey. Some are in a different place. Others are in another place. And we just have to find that common ground to ensure that we're providing risk management services that align with what our aspirations for our clients are. So today I'm going to talk about our ESG risk rating tool, what it means, why we built it and really try and give an idea of how that works and what it could be utilized for. So very quickly we're going to talk about the insights on ESG - score outputs, controls, reporting resilience framework, benchmarking. Then some differentiation - why is this tool different than other rating tools? And then the insurance applications. So what I want to highlight is what the output of the tool looks like. Many people want to see something that they can tangibly hold and really what the ESG rating tool does is it takes an aggregation of 160 questions under 18 components and gives a relative score of an E an S and a G. It also gives an aggregated score. Under that we put in a risk management framework that we've highlighted with controls of reporting of resilience. Resiliency is something that's become incredibly important to organizations after COVID as COVID exacerbated many things: supply chain issues, insurance issues, liquidity. And as an organization around risk we felt that resiliency was critical for our clients and so we added these components to help our clients understand how they could actually manage these risks that are identified.

This is an example of the output. Again our clients see this when they take the rating assessment survey. There's 160 questions and I'll get to what built the survey but then they get a dashboard that highlights red, green, yellow. Everybody loves red, green, yellow as it's very easy and it's very visual and they can understand kind of where they

are as far as world-class or something else. Perhaps there's places where they need to build a little bit more resiliency and other places meaning red where they really have no controls whatsoever and that's ok. This is a new topic. I got a degree in environmental engineering and science in 1994 and I'm still getting the opportunity to use this. So we're starting a push in the world around this topic that has many aspects and an impact in the insurance world. And these are not new things and let me give an example here. When you see for instance natural catastrophes such as floods, fires and other things - that risk has been around a very long time. There is insurance for property - asset protection, contingent business interruption, business interruption. These aren't new topics, but when put in the context of ESG we're seeing that many rating agencies are scoring them. Banks, creditors, capital providers, insurance companies. Hence why this standard is becoming more prevalent. Hence why organizations are saying we need to know where we stand. I will tell you right now the score is irrelevant in my opinion. It's the actions that companies take when they find gaps that's what's most important. A score could be anything. Numbers can tell you whatever you'd want them to tell you. You can tweak them any way you want but the reality is it's the actions that an organization takes to improve their resiliency from a risk management perspective.

Basically this is a benchmarking analysis that we look at and we do it across industry, we do the cross global region and really right now the Continental Europe in the European Union (EU) is much further ahead than the U.S. and other parts of the world. They've been much more vigilant in this and standards like SASB and others have been created over in Europe. And you might have heard of the task force on climate financial disclosures or TCFD. One of our sister companies actually helped craft a lot of the frameworks of that standard. But the reality is there are many global registration standards out there and not one common theme and that's I think to what Mr. Giacone was saying is which one makes the most sense for you as an organization? I don't have an answer for that but I know in the U.S. many of you heard about the SEC rule that's proposed that would require large publicly traded companies to disclose on greenhouse gasses and other emissions and their scope one through scope three emissions. Again what that really means to an organization - in time we'll find out. But we just like to highlight that when you benchmark you collect data and it's only as good as what you put into it and how you analyze the data. So this is an example of how we analyze the data. Here's where I think some of what Mr. Giacone was talking about is important. Our tool was created around the different standards around the globe. There are sums like MSCI, Sustainalytics, Refinitiv, S&P Global, Arabesques-ray, and then there's our rating tool. What we try to do is take all of those and put them into one context. So for instance MSCI scores AAA and CCC. Okay, so they have a numeric or an alphanumeric. Then we have others that have a numeric scoring from 100 to zero. Then ours is ten to zero. So you can see there's already some ambiguity there. We get it. We understand. But from a risk management perspective when you look at risk analysis tools you know failure modes analysis, frequency, severity, likelihood of occurrence - companies are used to that. They're used to risk assessment tools in the insurance marketplace. Hence why we built ours the way we did. So I'm not going to go through everything as that's a lot of information but there are many standards and we tried to create ours in a way that was a comprehensive look.

So when we look at the insurance applications. ESG underwriting information is promoting standardization of information requirements to the risk tool as a tool to communicate should the client wish to. The framework allows clients to narrow their ESG conversations in areas relevant to them and their industry. When the insurance

company starts to ask questions around it they're going to need to have an answer. Ignorance will not be bliss. And so we're trying to help our clients have some type of answer. One example is on directors and officers liability, we have a unique product that we've created for ESG that has direct relations to directors and officers and potential litigation around greenwashing as another form ESG could have. There's over 1,800 claims globally that have been sent out or had been filed and it's things as easy as books and records and others that can be very expensive to organizations that have no endorsements and there's no coverage. We've created a specific coverage for that to help our clients and there are two law firms and I think eight different insurance companies now that will accept it. If you submit your score from taking the rating tool the insurance companies will actually provide loss control services free of charge to help you correct those corrective actions. So we're starting to see this push very similar to other forms of insurance. With differentiated outcomes carriers can leverage the rating tool to provide enhanced outcomes as I was just saying. They can discount a premium finance. They can open greater assets and allow higher retentions and other forms of higher towers and greater reforms and additional capacity as well because you're a good risk in their view. And then finally, there is improved understanding of a ESG risk profile. It's a correlation between ESG performance and underwriting performance and it improves the industry's risk understanding of what ESG is and what it is not.

With completing the tool, it's a survey. It's 160 questions and there's 18 themes. We've tried to make it as robust as possible and again this is just an example of the 18 themes and where we're trying to highlight for clients where they have places that they can improve and whether it's an E an S or a G. And then documents that clients use many times are their annual reports and their corporate social responsibility ESG sustainability reports. This is just an example of how people would take it. You actually review the full question set, you complete the key document. This document then gets sent to Marsh McLennan to get assessed. We then contact the client and we do a risk assessment review with the client and then we start to create a strategy around how they address their ESG. It's very simple and very common to any other risk assessment tool. These are many of the what we call the ten different recognized international standards such as the International Organization for Standardization (IOS), European Union Taxonomy for Sustainable Activities, World Economic Forum, and the Global Reporting Initiative. Just to highlight the different agencies that are out there and again to Mr. Giacone's point, we do have all this on our website and people can go and look at our climate sustainability hub and they can review all this content at their leisure. Now I'm done with my general comments and I do appreciate everybody's time but many people ask - the question sets themselves are broken into many different themes and we try and color code and try and highlight everything in an insurance context. Everything we're trying to rate is through an insurance perspective so I just wanted to highlight that there's a method to the madness behind that. I truly appreciate the time today and hopefully that gives everybody an understanding of the risk assessment tool that is out there that we've created to serve our clients in the insurance and risk management world.

Rep. Matt Lehman (IN), NCOIL Immediate Past President stated that you finished your presentation by saying a risk assessment tool and yet I saw where Liberty Mutual gives me a discount so is it becoming a pricing tool as well? And then you said companies are asking where they stand but compared to what? What other industries outside of insurance are going down the path of tying this to a rating or some sort of financial incentive? Mr. Carlson stated that those are good questions. First, it's not a discount, it's performance-based so they'll use the rating and they could potentially give premium

reductions or create capacity so you can get more insurance if they think you're a good risk. Again it's very similar to think of the world of workers compensation if you have safety management systems and you have a low employee experience modification rate and robust casualty programs, most markets would be willing to provide higher capacity and maybe take low retentions. That's what the tool does. The tool just creates an awareness of where that organization is. And to your second question, probably one of the most accepted standards is the TCFD. Most companies want to know where they stand with that but there are many others that I mentioned and that's the whole point - there is no consistent standard yet. Now the U.S. is trying to pass the SEC rule which will create a reporting requirement that will be a framework around the TCFD so if there was one standard that's probably leading out there TCFD is probably one of them

Sen. Bill Gannon (NH) stated that a small district so when my people here these ESG numbers we're thinking you're saying to people you're going to have to divest in your oil and your natural gas and all these terrible dirty things but our natural gas prices have doubled in the last year in New Hampshire. Our transportation costs are going up. Right now we have 300 years of natural gas in Pennsylvania in the ground. I'm thinking if I could get a big pipeline I could take care of a lot of my problems in New Hampshire. But what you're doing with these ESG scores and you can help me if I'm wrong is you're telling my constituents, middle American families, that we're going to have to get away from natural gas and as I understand it's much cleaner than most fossil fuels. And that's what is heating and turning our turbines in New Hampshire. To me and to my constituents you're saying you're going to have to just suck it up and double electric and heating prices. And you're sending all these businesses into that field. Tell me where I'm wrong so I can tell my voters that. Mr. Carlson stated that I love your passion first of all for your people. The reality is that's not what we're saying. There is an opportunity in every risk. What we're saying is there's a responsible way to transition and it has to take time and it needs to be methodical and it needs to take care of the people. There's an S in there, right? That's societal. That's people. So it's not just let's go out and change the world - we know you can't flip a switch. An example would be electric vehicles - every major automotive company in the world is trying to go towards electrification. Why? To meet certain standards and reduce what they believe are climate-changing greenhouse gasses. The reality is we still need fossil fuels, we still need internal combustion engines. We can't do all the charging that works in the world without electricity. We don't have enough capacity in the U.S. to do it right now. If we flip the switch and add five million electric cars in the market, we wouldn't have enough charging stations or electricity to do it. So the reality is we need a transition plan and it's got to be methodical and it's got to work for everybody. That's the reality. This rating system is nothing more than showing people where they stand against 160 questions. What they choose to do with it, how they choose to do it, and how often and what they try and correct is up to them as an organization.

Sen. Gannon stated would you say that we're going too fast though as my energy costs have doubled for my people to heat their home. And we see all this natural gas in Pennsylvania and we want it so do you think you're going too fast in this direction? In your electric cars and electric vehicles I have a little place Naples and they all lit on fire after the floods receded from the saltwater. I'm worried that we're going a little too fast in all these directions where all these cars are catching on fire that got the salt in them. I'm worried that the salt's going to corrode and get into my electric cars in New Hampshire and long-term we're going to have a lot of problems and we're going a little fast. Mr. Carlson stated that I won't say we're going too fast. I think there's aspirations in every

industry and every market has a different aspiration in a different way that they're approaching it. Some can move quicker than others.

Rep. Forrest Bennett (OK) stated you said something about if you take this assessment you can submit your scores to insurance companies and some of them will give you sort of a roadmap to fill those gaps. Can you give us some more specific examples of maybe companies that have done that and what the benefit has been? Mr. Carlson stated that it's really not anything new it's a new risk and they're putting in a new context. So for instance if you were submitting a score and one of the insurance companies said, okay we see you have a gap let's say in fire protection standards and you might be in a place that has high wind storm and high fire rates and it's been going on. They could say we can help you create a more robust resiliency plan around your property program with better fire suppression equipment. Maybe they can help you with something like an engineering assessment in a different part of the country in a different part of that state to find a place that isn't as prevalent as far as those risks. So those are the kind of things that they're doing. It's not a completely new look at a property risk. It's taking property risk and looking at it through the lens of that environmental impact a little bit better. So that's what they're doing, they're just trying to offer loss control services to fill gaps and help them.

Mr. Giacone stated that on that point from a credit rating agency perspective it isn't that new, these are issues where if you talk to any Florida insurance company we rate a lot of them and we have questionnaires and our approach on the rating side is not very different. It's very similar in that we go through and we have a diligence discussion with the management team and we ask them a series of questions. And again, it's not all value based judgment not to say that that's good or bad it just is and we ask how does that relate to your overall risk management framework? And how does it fit into the way you run your business? So, if I'm having my manager meeting with a Florida company and ask if they thought about climate risk they say yes we've been thinking about it for 40 years because we have hurricanes that blow through here every now then you might have noticed. So it's not necessarily that it's new but it is getting a lot of attention and like any other emerging risk that an insurance company needs to manage we get risk registers. We get heat masks and we get own risk and solvency assessments (ORSA). I think the people here probably are familiar with that. Risk assessment a great tool. These things around ESG are now embedded within particularly for larger companies and to the extent they are relevant to individual companies are embedded within the risk management frameworks. And so we asked questions about that and get that information and get it out to market so then people came make their own judgment. So it's not about directing traffic it's not making policy decisions. That's for the people in this room and for folks sitting in the legislative houses and in executive offices of various governments to make regarding the determination as to what the public policy will be. Our job as a rating agency is kind of like an umpire on the field at the game. We're just going to call what's there, what we see that's relevant from a credit perspective but steer clear from making any sort of public policy pronouncements or judgments and driving companies to do one thing or another because companies, and you all know this, are very idiosyncratic and they're very different. A variable annuity writer in the Midwest is very different from a natural catastrophe property-casualty writer in Florida. And so painting with one brush and saying here are the standards you need to do in order to get a single A rating is not right and we don't want to drive that sort of behavior. It's not our job. Our job is to call credit as we see it and to the extent we think ESG might be relevant to credit we"ll talk about it. It'll be in our report. We'll disclose it.

But it's early and as my colleague here was saying there's a lot out there. There's a lot of disclosure that's just barely evolving. We don't even have a common language about many of these issues because there's so many different tools. The tools you guys are describing sound great. That's certainly one. And sooner or later a standard or two will emerge kind of like we have with risk based capital (RBC) as the standard for everybody in this room that is familiar with. That's a single common benchmark at least within the U.S. in terms of how life and P&C companies get viewed from a regulatory perspective. We don't have anything like that today so the notion that it would come from rating agency just doesn't make any sense. This is great and important stuff and we love being part of the discussion. We think it's a very important risk management aspect but again it's not going to be a one-size-fits-all approach and we're going to evaluate these risk factors in the same way we do any other credit relevant risk factors within the context of the companies and how they operate.

Rep. Bennett stated that I appreciate that and it kind of speaks to my follow-up in that you talk about common language. As policymakers it seems that we're speaking two different languages on this issue oftentimes. And one of the things that I hear, such as from Sen. Gannon who's passion I appreciate, is that you are forcing this and from what I'm hearing from you is that at this point it's very much a voluntary thing and an opt-in kind of thing and I wonder if you see that changing at all or if at this point it really seems to be an opportunity for companies who think that perhaps it will give them an edge in the future to take advantage of that now. Mr. Carlson stated that's exactly my point and you said it very well. This is a voluntary standard. Creating a corporate social responsibility report or an annual sustainability report is a voluntary standard that organizations take upon themselves. There may be industry standards and best practices that they feel they need to follow but many feel kind of like what happened with Sarbanes-Oxley after Enron. This was something that was developed; it was a tool. There was management liability insurance but Sarbanes-Oxley came along and became the sledgehammer. Many are equating that to what ESG is. They're looking at that and saying down the road it could become a business advantage. It could become a business enablement tool for us to become more resilient as an organization. Again, from a risk management perspective I'm not telling anybody how to manage their utilities or they're coal usage. What we're doing is we're helping with the risk assessment tool to identify risk and how you mitigate it. You either transfer it with an insurance product or you retain it. That's what you do with risk. And that's all we're saying and some people may benefit from that and have an advantage over their peers and others may have a wait-and-see attitude.

Mr. Giacone stated that I would add the level of conversation around these topics has grown dramatically. I recall even as recently as three years ago having management meetings and saying there's a thing out there called ESG, what are you guys thinking about? And they asked what does ESG stand for? They didn't even know what we were talking about. Now that is not the case. So, it's an emerging risk and like any other risk that an insurance company needs to face, they either need to retain or pass it on, but it is also an opportunity. That's the nature of the insurance business is looking at not just the past history but looking ahead and saying what are the risks and the opportunities that my organization may be facing and how are we going to react to them? What frameworks are we going to put in place to address them? And those things are all constantly evolving and with our descriptions of risk management more generally, ESG flows right into that because it's part of the same conversation. You can't talk in terms of risk management for many companies without at least referencing

what's going on with respect to ESG and how you're addressing it. And again, the conversation will continue evolving and we'll see where it goes from there. I think transition is a big part of the conversation. It's probably the single most common area and topic of discussion - how are you dealing with the transition? What are your stakeholders demanding? What do your investment guidelines say to these things? Do you want to buy oil and gas stocks? Do you not want to buy oil and gas stocks? And you can make that judgment either way and maybe buying oil and gas stocks might be a good thing to do and I'm not going to sit here and tell you one way or the other but you should be thinking about it the way you manage your investment portfolio. I care about that as a credit analyst, I care whether you are managing your investment portfolio to take advantage of emerging risks. That's very important because that speaks directly to your ability to pay policyholder claims. So, if you're blind or not keeping your eye on the ball in terms of your investment portfolio or any of the things we're talking about today, over time that could become an issue but we're not anywhere near the stage of drawing any bright lines here. It's up to companies and policymakers to figure out what to do next.

Sen. Lana Theis (MI) thanked Mr. Carlson and Mr. Giacone for their presentations and stated that I spoke yesterday on some issues related to ESG. I am incredibly uncomfortable with us identifying risks with something that is so extraordinarily subjective and when you do things like saying coal is bad and electric is good and we're going to grade you on that and then we're going to tell everybody that's a good thing to have this analysis done just in case at some point in time somebody wants to take a look at it moving forward, we're not actually directing traffic but we're going to figure out exactly how traffic is going so just in case at some point in the future we really want to direct it. That's what this sounds like to me and to the point that it is optional, it's not. You have so many of the major investment firms driving this and requiring it for our organizations. I have a huge concerns about it. Insurance historically has been famous for looking at actual risk. You look at a statistically significant history and make your identification of risk based on what is statistically significant and historical. But nope we're going to make assumptions about what's good and bad and we're going to prognosticate on what's going to happen in the future and some of it has some evidentiary basis, yes that's true, but we don't know for sure what that actual impact is and we're going to go ahead and use that as a part of our insurance rating or our bond rating and I have extraordinary concerns. In a state where our fuel costs have gone up so dramatically they're trying to shut down a pipeline that's essential to our peninsula. I have major concerns and where we are considering perhaps wrapping our arms around this we need a lot more information and we need it not to be subjective.

Mr. Carlson stated that I agree that subjectivity is a challenge and we've talked about the lack of a universal standard. But quantifiable risk data is important and I know that we shouldn't opine on things that are so subjective and it is hard to say what does 1.5 degrees C really mean in Argentina versus Texas? I understand what you're saying. Our position in risk management is to try and quantify those things that are already quantifiable, meaning property risk, casualty risk, places that you can look and say we understand that. Now how the insurance world wants to underwrite against that we don't control that. I understand what you're saying completely and many clients aren't interested and that's great that they are on their path. Those that are, I think what they're trying to do is just get an understanding of where do they sit and it is a position of their organization that they do want to address it however they choose to address it. But I do welcome and appreciate your comments. Mr. Giacone stated that I agree as well.

That's exactly the point - it's not our job to do that to link it to credit risk when there's no data there. To your point, you're absolutely right and we agree and that's why we're taking the approach that we do. We're not saying good, bad, or indifferent. We're just looking at it and saying what does this mean, if anything, and can we draw the line here? And if you read any of our reports you'll see quite honestly there's nothing there and there's nothing to say for exactly the reasons you describe. We do not have the data yet. But I think highlighting the issue is important because it is so much in the market. Our constituents are asking us and investors are asking us whether we can have a different public policy debate about whether that's appropriate or not but we don't want to be in the middle of that. We're just going to get the information, put it out there and then let the constituents decide on their own.

Mr. Carlson stated that I'll give you an example from risk management that it's not about telling clients whether to forego greenhouse gas usage like coal and oil. What we do is we just released a report and we found a correlation between the experience modification rate of workers compensation and a good S score. So we're taking quantifiable data that is not ambiguous, and we're saying we see where companies have really good safety management systems typically have a really good S score and have low experience modification rates. When you take that to an insurance underwriter they like that. They understand that. That's quantifiable. That's what we're trying to do with the data. We are certainly not trying to tell a company how to invest and how to use gas and how to transition - that's not our role. Our role is to use risk management in the context that our clients can understand it. Sen. Theis stated that I understand what you're saying but you're green or yellow puts an opinion on what's good or bad with all of the questions that you're asking, many of which are highly subjective and have no foreseeable relevance in actual risk assessment. So why are you asking the questions in the first place? Mr. Carlson stated that the survey is taken by the client, so those are their responses to the questions. Sen. Theis stated but you're asking the questions. Mr. Carlson replied absolutely, based on 18 different global standards that they're willing to take - they don't have to take it. I understand what you're saying, but if you look at something like greenhouse gas, if they can quantify it and they want to respond to that they can. If they can't quantify, we tell them don't answer. If you don't have an answer for it, don't answer. And then it just becomes something that they may or may not want to address. Again, it's a risk management perspective and when an organization is trying to transition their business they just need to understand that. I understand your trepidation. I'm an environmental guy but I work in the manufacturing automotive industry and I see this every day. I completely understand where you're coming from. There's a place for common ground but there is a lot of data that hasn't been developed. There's a lot of information that needs to be developed and there's a consistency that does have to occur. I completely agree on that level.

Sen. Mike Azinger (WV) I'm just going to say what this is - this is just "crypto Marxism" and I assume this is all based on climate change - is that accurate? Mr. Carlson stated not all of it is based on climate change. Sen. Azinger stated the terms you're using such as greenhouse gas and others, is that not climate change language? Mr. Carlson stated that some of it is. Sen. Azinger asked if that is the foundation where you're coming from with this - the climate change philosophy? Because that's what ESG is societally as I understand it where you invest your money for example the state of West Virginia pulled out of BlackRock because you there's a punishment system for investing into oil and gas and fossil fuels. Is that something that you're talking about here? I'm just trying to understand where you're coming from because I know what ESG is peripherally. I've

studied enough to know the terms you're using and it's climate change, right? That's what you're talking about? So, a lot of us believe maybe not here but many American citizens believe climate change is a hoax. It's impossible for mankind to raise the temperature of the Earth so much that it creates everything out of kilter. And this to me I think is moving toward the punishment system for those that don't fall in line with the climate change philosophy. That's where this ESG is going and this is critical theory infused into the business world, infused into the culture. And it's a controlling system that's where this is headed. It's already in the banking system and that's where it's heading in the banking system. If you don't invest so much of your money into certain companies you get a bad score and that's where this is moving towards. So I just want to clarify that's what this is. I'm not calling you a "Marxist" I'm just saying that climate change is the home of "new Marxism" that's what it is.

Mr. Carlson stated that I'm a realist and I'm also an optimist and I understand your points but I just want to say that for our organization it's about risk management whether our clients agree and whether they believe it or not. If they're asking for us to provide risk management advisory services we have built this tool to address not only just that but there are many risks within ESG that have lived under corporate social responsibility. Corporate social responsibility was built when there was slave labor going on and there were a lot of other things going on in the global responsible organization level. I'm not saying slavery and climate change are comparable, I'm just saying that there were risks that were out there that organizations wanted to address and ESG has many risks that already exist like the E. There are a lot of natural catastrophes and hurricanes. What we are trying to do is help clients get a grasp on what the insurance underwriting world is starting to tell us as a broker that we're going to start baking this into our underwriting because we're going to underwrite our portfolios. So in order to help clients assess the risk this is what they've asked us to do. So it's really just from that perspective. I'm not here to say one way or the other what climate change is or is not. That is something that I pride myself on - not trying to say who I believe in or what I believe in. It doesn't matter what I believe. It's what my clients ask that matters. Sen. Azinger stated that it does matter what you believe in.

Rep. Jordan stated that I appreciate the passion on this but we need to move on as there are other topics on the agenda today. If anybody has any questions on this moving forward you can reach out to NCOIL staff.

PRESENTATION ON RETENTION AND RECRUITMENT OF INSURANCE TALENT

Rep. Jordan stated that our next topic is the recruitment and retention of insurance talent. I think that everybody here knows how difficult it is at this time to retain and recruit talent within the industry so I'm glad that NCOIL is discussing this and I look forward to discussing it further. I also want to thank former New York Superintendent of Insurance Greg Serio, now with Finseca, for putting this topic on our radar last year in Scottsdale.

Noelle Codispoti, CPCU, ARM, Director of Emerging Talent Programs for the National Alliance for Insurance Education and Research, thanked the Committee for the opportunity to speak and stated that the Alliance provides educational programs to insurance industry professionals across a wide spectrum of job roles including underwriting, brokerage, life and health, and consultancy. I came to the insurance industry through college. I majored in actuarial science and risk management. I was

very fortunate as a first generation college graduate to have someone in high school share with me the opportunities that existed in the risk management field specifically as an actuarial student and if you have not been aware insurance doesn't necessarily always get the sexy type of job description that most other industries do to young folks and certainly not an appealing exposure in movies or press. So, after spending a few years in the insurance industry I dedicated the past 15 years of my career to helping young people and folks in different industries find what I believe and what many others in this room also believe is quite a rewarding and stable career. What we have found is that the industry as a whole is facing, like other industries, many key challenges and on the screen you'll see here six of what I believe are the most important. Back in 2009 and 2010, Deloitte and McKinsey respectively produced reports regarding the aging talent within our industry and the significant talent gap that was going to emerge 15 years down the road and longer because of those entering retirement. I'm fortunate to be involved in organizations like the Griffith Insurance Education Foundation which I know many of you are familiar with that brought the industry together to figure out some ways to help solve this talent gap which projected around 400,000 available job opportunities in the years 2022 to 2025 which we very quickly are in.

We also found some key challenges regarding generational gaps and what younger workers wanted to experience in their careers versus what some of their more experienced generational counterparts were creating as work environments. Certainly over the past few years COVID has created challenges with going to the office or as I like to look at it as an opportunity to create a balance for younger generations that are looking to maybe not go to an office every day. The great resignation has also created some challenges although I read an article today that we may be entering the period of great remorse where folks are not actually finding the jobs that they thought they could. So that is one that I'll have to study a little bit more when I get back. I mentioned the visibility and certainly not many knowing that a career in insurance and risk management actuarial science exists when they are young. And that's probably one of the biggest challenges - the perception that our industry faces. And another challenge being the diversity of our industry and really lacking an opportunity for young people to see themselves in careers in the industry whether that's from a gender or race perspective or other versions or other characteristics of diversity that we may consider. We've also found that the insurance industry and many of the companies have been lagging behind in terms of creating work environments that are considered equity or inclusive. So many firms have spent many years creating workplaces that promote the opportunity for folks to feel like they belong and are listened to and they created environments that people want to be part of. From my perspective the most important issue for a company to tackle before we start considering recruiting new talent into the industry is that of retention and creating work environments that people don't want to leave. We have suffered as an industry from the idea that people come and people go. They just job hop and it's okay to pay a recruiter to bring somebody else new in which I think is a waste of money for any company to have to do that when in fact we could look internally to ensure that we are creating environments where people want to stay.

So some of the things that we look at or talk to companies about is making sure that the environment is equitable and making sure that all employees have the opportunity to be successful and that really looks at a number of different variables whether that's opportunities for learning and development, networking through engagement and professional associations and ensuring that we have the right technology in place so that our jobs don't seem cumbersome, and providing access to information and

communicating that the information that is needed to do one's job is readily available at employees fingertips. We also think that the best way to create an environment where people want to stay and ultimately a better environment where we can recruit people into the industry is making sure that people feel safe and respected – that's really an inclusive environment. The opportunity to share feedback and know that that feedback is going to be received and listened to is important and people need to know that it's okay to understand someone's point of view but not necessarily agree with it. And we also need to look at what we tolerate within our organizations and how people are treated - whether we are allowing that behavior to continue or whether that's on a recognition perspective, promotion perspective, and ensuring all employees are being paid favorably and fairly. We also think it's very important to make sure that employees have a voice much like your constituents. You all listen to what they have to say and bring those ideas and opinions to the jobs that you all do. Likewise we think companies should treat their employees in much the same way ensuring that everybody has a voice and when someone does use their voice to express new opportunities and new products or opportunities for growth within an organization that employers are doing that. And many studies have been done to show that diverse teams, whether that is ensuring different socio-economic, race, religion, or gender backgrounds, perform more profitably and have higher cash flow so we do want teams or companies that we work with to ensure that their teams are representative of the people that they serve and the people that they want to bring into their organizations.

So what we're doing and what many organizations within the insurance industry have done is create programs to allow for engagement of younger generations and individuals who work with other industries to consider a career in risk management and insurance. Particularly at the Alliance, we took one of our industry designations, certified insurance service representative, which is an intermediate level education program and it covers everything from personal lines, commercial lines insurance, life and health, workers compensation, and the risk management process, and we reconfigured it so that a technical education teacher within a high school can teach these courses to high school students and expose them to the wonderful and sexy careers that exist. When students are in this designation they are employable out of high school and we have many independent insurance agents and midsize brokers and insurance companies ready to hire these high school students upon high school graduation. We also see it as an opportunity to showcase the students their post-secondary opportunities. Nearly 100 colleges and universities within the U.S. have a risk management or actuarial science major or minor certificate and we want to make sure that students are aware of that as an option. We do expose them to the career paths as I've mentioned but it's a very core of this regardless of whether a student pursues a career in risk management or insurance. Our program does give some consumer education to the students specifically on those personal lines, auto and homeowners, and we've been very pleased to hear feedback from our students that they can also go back to their parents who actually are the purchasers of those products right now and help their parents understand the policies that they've been purchasing. We enhance all of that exposure with an opportunity to engage with the industry so we are fortunate to partner with organizations like the Independent Insurance Agents and Brokers of America (IIABA) and their state associations to get folks in the classroom and then also we offer work-based learning opportunities whether that's a summer or after school internship, a shadow day or just the opportunity to have a speaker come in and share what they do.

These are the components of our program. We offer eight learning modules through a learning management system. We have video lectures where we bring in what I will call mid-level talented actors and actresses who have yet to make the big screen to deliver the scripts that we have written and incorporate it with graphics and live footage. We also really help the teachers who are teaching this as they do not have to have an insurance background although several of our teachers have worked as agents before or in agencies before so there is some knowledge. But we do all the lesson plans, learning guides, and test assessments and answer questions and then we provide also professional development for those teachers in the event that they also want to earn their designations through us. Right now our program is located in these seven states. We are an Austin, TX based company and our program did start in Texas. We're currently in eight school districts there. Michigan was the other state we started in initially back in 2020. This year we expand it to seven of the Birmingham city schools in Alabama. We're in Georgia, Oklahoma, Illinois, South Carolina and hopefully Wisconsin. And so our hope is that not only are we bringing students into the industry but making better consumers of them. I'd also like to point out that we're not the first organization to think about how do we expose young people to careers in insurance. In college and for ten years of my life I was part of an organization called Gamma Sigma, which is a collegiate business fraternity that promotes the idea of risk management to college students and this year they chartered their 100th chapter at a university which is pretty amazing. The Griffith Insurance Education Foundation has also been doing this for many years through their ambassador program which they administer through the college students and my colleagues at IIABA through their invest program for nearly I think three or four decades have also been using industry professionals to go into high school classrooms to expose students to careers in insurance and many other organizations exist such as HBCU Impact which typically goes into historically black colleges and universities and was started and co-founded by an individual in this room. So there are still many important initiatives going on in this space and I have to stay that in my 20 years in the industry as a student and as an underwriter and in working to get students in, it has been one of the most rewarding things that I have done and I have been proud to wake up every day to know that we have an opportunity to really change the course for some of these young people and I appreciate the opportunity to share that with you today.

Sen. Mary Felzkowski (WI) stated that I am a past board member of the Alliance and we have been working through the National Association of Professional Insurance Agents (PIA) and others to get young people in this industry. I really love this program and I really would like to talk to you about how soon it's going to come into Wisconsin. Ms. Codispoti stated that is great
and we were on the phone with PIA when we first started talking about it. We're also working with the PIA in Indiana and they'll be starting in the Fall but I like to make sure that we're in there before I put the actual block on the screen to say we're in that state. Sen. Felzkowski noted that all of her employees have professional insurance designations such as certified insurance services representatives (CISR).

Rep. Brian Lampton (OH) stated that I appreciate these efforts. I know in our area in Ohio all employers everywhere are desperately looking for good workers. Could you describe some of those entry level jobs that are available in the insurance industry, not just in sales? Ms. Codispoti stated that I think from my perspective there are really a few - you have the entry-level accounting executive or account administrator at agents and brokers who are helping the producer or the account executive manage the clients. So

whether that's through issuing certificates or managing the policies, that's one. And we have seen many of those individuals start those jobs and then advance through the agent system. Another one specifically at an insurance company would be kind of like an underwriting assistant. We've seen many opportunities within call centers whether you're working in a personal lines insurance carrier to be able to help those individuals who are calling in with their claims after a natural disaster or an auto accident. And then on the claims adjusting side I think that oftentimes even for those of us that are considering a career as an insurance it's one of most overlooked paths and some of the technology that the insurance companies are coming out with to evaluate claims and serve their policyholders is pretty cool and I think we have an opportunity to engage young people from a technology perspective and their interest in some of those roles as well. The only one I would say from my perspective that still needs that four year college degree is that path to being an actuary as a very high-level mathematics degree is needed. But otherwise on the Bureau of Labor Statistics you would see most of these jobs that I've mentioned a minimum requirement would be a high school diploma.

Rep. Brenda Carter (MI) stated that I'm very excited about what I'm hearing from you and I just learned from a very reliable source that there will be a lot of retirements in the next ten years. I'm from Michigan so I would like to know where are the programs and then how do we engage our universities to get them to look at this? Ms. Codispoti stated that Wilson Talent Center was the first school in Michigan we worked with and they had high school students graduate with the CISR designee and they are among the best and brightest students I've seen. What we do is put in place a software that allows us to manage for each school the engagement with the industry. So it would be a lot for us to manage those schools in each of those states with the individuals that want to get involved. So we're putting in place and paying for software so that each school and the industry can engage together and know what's available. Many of those students in Michigan specifically though are pursuing additional education at Ferris State which has very strong risk management programs. In fact both Olivet and Ferris State are also part of our university program and they use our curriculum which is completely free to them and actually at Ferris State I think we will have quite a number of students graduating with our more advanced degree or advanced certification. Rep. Carter stated that she looks forward to connecting further with Ms. Codispoti.

Rep. Jordan thanked Ms. Codispoti for speaking and for the great work you do and the work of your agency so you guys are really doing some positive things and hopefully we can bring some of that to Louisiana. If anybody has any other questions on this moving forward please reach out to NCOIL staff.

PRESENTATION ON INSURANCE DEVELOPMENTS IN THE FEDERAL HOME LOAN BANK SYSTEM

Rep. Jordan stated that our next topic is a presentation on insurance developments in the federal home loan banking system. This is an issue that could be on NCOIL agendas next year in the form of model legislation but for now we'll be provided with an overview of the issues so that we can be aware of them.

Eric Haar, Director of Gov't and Industry Relations at the Federal Home Loan Bank (FHLB) of Dallas thanked the Committee for the opportunity to speak and stated that some of you may be familiar with the FHLB system and others may not. We do lend money to insurance companies and we're going to talk about a possible legislative

remedy to a situation we have found ourselves in. So a quick review of the FHLB system - we were created by Congress back in the 1930s and originally there were 12 regionally placed FHLBs spread around the country and there was a voluntary merger a few years ago so there are now 11 of us. It is a government sponsored enterprise (GSE) and is very well-regulated at the federal level by the Federal Housing Finance Agency (FHFA). And what the FHLBs do is we lend money to insurance companies, banks and credit unions. Typically an insurance company will borrow money from their regional FHLB and then they will use those proceeds to purchase mortgage-backed securities or treasury instruments for the benefit of the insurance company. We fund our loan demand not through taxpayer dollars even though we're a GSE, we borrow money in the global capital markets so we sell debt just like treasury sells debt or a corporation might sell debt to investors and then we take those hundreds of billions of dollars that we borrow in the global capital markets and we lend it out to insurance companies, banks and credit unions. No taxpayer money is involved in the FHLB system. We have operated for 90 years safely and soundly. A couple other components - each FHL bank as we're known is a cooperative. That means insurers and other financial firms will choose to join their regional FHLB. No one forces them to do that. They will join the cooperative and then they have access to FHLB lending if they are a member. Members purchase a nominal value of par value stock it doesn't go up or down in value but that's part of how we capitalize the FHLB system. Each of the FHLBs is profitable through its course of business and what we do with most of our earnings is we turn around and we pay a dividend, a cash payment to each of our members every quarter. So no individual or group of investors is getting enriched by the success of the FHLB - the money flows back into those local communities. We also fund a grant program with 10% of our earnings that has done a lot of good in support of affordable housing and community development initiatives since 1990.

A big takeaway for this group is that the FHLBs are under federal statute. We are a secured creditor. So we lend money and we are fully collateralized every time we lend a dollar. We cannot abide a credit loss or a dollar loss on any of our loans. That is mandated by a regulator. It's important because we're a GSE and it allows us to lend money to insurance companies at very favorable rates. So we lend a dollar, we take collateral that backs up that loan and then that is the kind of relationship that ensues. This is FHLB system-wide lending to insurance companies, banks, credit unions, nationwide since 2006. Nearly $1 trillion dollars in loans outstanding during the Great Recession. But the numbers ebb and flow just based on the needs of our members and we maintain a system that serves the borrowing needs of our members. This is insurance company membership by year beginning in 2006. You can see that the steady increase in membership is both life insurers and property & casualty companies. Many of them have seen the value in joining their FHLB. They're not all borrowing from us on any given day of the week. About 50% of our members are active borrowers on any typical day. The others maintain their membership in the system because next week, next month, next year they might have a need for our liquidity and so they retain their membership in the system. This is insurance company lending from the FHLBs by year in billions of dollars you can see the steady increase and it’s $146 billion as of the second quarter of this year. Each FHLB has a different membership profile. So we lend to banks and thrifts, credit unions, and insurance companies. About 19% of the FHLB of Dallas’ membership base is comprised of insurance companies but the system-wide nationwide average is 8.5%. We’re kind of an outlier on the high side but I want to give you an accurate picture it's around 8.5% of each FHLB membership comprised of insurance companies.

So here is where we come into the need for legislation. A FHLB lends money to a bank or a credit union and if that institution fails we have protections under federal law. We are able to step in and access the collateral that they pledged to us without delay or a hindrance. That allows us to quickly resolve the transaction and the receiver, the Federal Deposit Insurance Corporation (FDIC) National Credit Union Administration, they do what they do to wind down the entity. But because insurance of course is regulated at the state level we don't have the same federal protections that we have if we lend to a bank or a credit union. So in receivership there is a chance that we might be stayed or delayed or prohibited from accessing the collateral that an insurance company has pledged to us. Now we believe that in time we would access our collateral but because there could be a one, three, six month or longer delay in us accessing the collateral that's been pledged to us we have to make an accommodation with regard to that and so what we do is we have lending terms less favorable for our insurance company members in states where we do not have legislation passed at the state level protecting the FHLB in the event of a receivership or a rehabilitation. So the FHLB system has proposed legislation at the state level. I remember eight and nine years ago when I worked for the FHLB of Topeka going to many National Association of Insurance Commissioners (NAIC) meetings where this was a new issue at the time and talking through this issue and I worked on legislation then. Now that I'm at the Dallas bank we're working on it in our five-state region and other FHLBs have addressed this in all of the states where they're operating. Some of the FHLBs are still working on it. I believe it's relevant to everyone in this room. What we would like to do is clarify that a receiver will not delay or deny or stay a FHLB from accessing collateral that's been pledged to us and then we promise to create a framework for the receiver to resolve the transactions as quickly and as equitably as possible.

And then that allows us to lend money on more favorable terms. Not to give you a bunch of numbers but if we lend money to a bank and they pledge treasuries to us, any of these types of treasuries for this duration, we will lend for example 98 cents on the dollar of collateral pledged to us. So they pledged a dollar in collateral to us and we give them 98 cents. But if it's an insurance company in the state where we don't have protections they pledged a dollar in collateral to us we will give them 95 cents on that dollar. So the collateral terms are less favorable and that is just not good for any of the parties involved. So we have proposed a framework and I won't go through all of the numbers that you see here and my attorney colleague at the bank drafted this and I'll be happy to provide this to anyone who might like it. But within ten days the FHLB will provide a timeline for resolution. We will provide options to the receiver with regard to possibly renewing a loan or restructuring loans if the insurance company is not failing but they're going into rehabilitation. And then we have some promises, some assurances that we will have access to the collateral pledged to us not a nickel more that's owed to us but only what we have loaned out and we will not be delayed in a receivership for that purpose. And then a few other legal components to the proposal. A couple definitions here and then I share this final slide with you if you see a dark color blue state that is a state where legislation has been passed that takes care of this issue for the benefit of insurance company borrowers and the FHLBs that are domiciled in those regions. If you see light blue that means there is legislation that is active or to be proposed in 2023. In addition to what our regulator has said, let's get conformity and uniformity on this issue across the 50 states and territories. We believe it's just good business for insurance companies across the country and to the benefits of the FHLB system which is not necessarily the priority of this group it's the insurance companies and their policyholders.

But we believe it's a mutually beneficial and very important relationship. I'll be happy to return in March as you indicated if that's the wish of the group. Rep. Jordan thanked Mr. Haar and stated that NCOIL staff will reach out in advance of the Spring meeting.

DISCUSSION AND CONSIDERATION OF RE-ADOPTION OF MODEL LAWS

Rep. Jordan stated that per NCOIL bylaws all Model laws must be readopted every five years or else they will sunset. The models scheduled for re-adoption today are on the app, the website and they start off in the binders on page 140. The models are: Model Act to Support State Regulation of Insurance by Requiring Competition Among Rating Agencies; Model Act Prohibiting Consumer Reporting Agencies from Charging Fees Related to Security Freezes; Credit Report Protection for Minors Model Act; and the Credit Default Insurance Model Act. I note the amendments to the Rating Agency Model are being proposed by Sen. Bob Hackett (OH). Accordingly, we'll handle that model separately before moving to the others.

Sen. Hackett stated that I'll be brief as these amendments are straightforward and non-controversial and appear in your binders on page 140 and 141. This model was originally adopted five years ago to promote competition among rating agencies as there was a problem identified that some statutes require insurers be rated by one specific rating agency rather than simply required a rating from a rating agency that meets certain requirements. That is why the model sets out to define a "competent" rating agency at that time. The model recognizes that decisions about which rating agency to choose should be based on management's evaluation of the perceived strengths of each rating organization as a relates to their markets and business models. There shouldn't be a requirement in statute that requires insurers be rated by a specific rating agency. However an issue recently arose that we think requires some simple amendments in the model. Essentially what happened was that all the major rating agencies and those that are listed in the model have been approved and registered as a Nationally Recognized Statistical Rating Organization (NRSROs) by the SEC. And this wasn't the case when the model was originally adopted. And remember as NCOIL we're a fierce protector of the state system of insurance regulation. So we didn't think it was proper and still don't to essentially defer to the federal government what is deemed "competent." So according to the amendment to the model now it makes clear that a "competent" rating agency is one that is either an NRSRO or one that is a nationally recognized rating organization that maintains business practices that includes requirements set forth in the model. This way the model recognizes the business reality that all rating agencies that insurers use are NRSROs but it leaves open the avenue for any other nationally recognized rating organization to operate in a certain manner and be deemed "competent." Sen. Hackett thanked NCOIL staff for help in developing the amendment and stated that he looks forward to the committee's support.

Paul Brown, Director of Government Affairs for AM Best, thanked Sen. Hackett for sponsoring the amendments to the model. And we also want to thank NCOIL staff for getting us to language which we think improves the model very much and we would just urge the committee to adopt the model as amended.

Burke Coleman, Chief Regulatory & Compliance Counsel at Demotech, a Columbus, OH based rating agency and now an NRSRO. I just want to thank the committee and Sen. Hackett for originally sponsoring this model in 2017 and now sponsoring it again for readoption with the amendment. Demotech believes this is an important model to

promote competition among rating agencies which in turn promotes competition in the broader insurance marketplace and enables consumers choice. So thank you to the committee and thank you Sen. Hackett for your work on this and we appreciate it.

Hearing no further questions or comments, upon a Motion made by Rep. Joe Fischer (KY) and seconded by Rep. Lampton, the Committee voted without objection to re-adopt the Model as amended. Hearing no questions or comments on the remaining Models, upon a Motion made by Rep. Carter and seconded by Del. Steve Westfall (WV), the Committee voted without objection by way of a voice vote to re-adopt the remaining Models.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Holdman and seconded by Rep. Oliverson, the Committee adjourned at 4:45 p.m.

The Virginia Consumer Data Protection Act will serve as the basis for discussion for the Committee topic "Discussion on Potential NCOIL Consumer Data Protection Model Act."

Georgia HB 1308, Texas SB 2124, and the NCOIL E-Commerce Model Act will serve as the basis for the Committee topic "Discussion on E-Delivery of Insurance Documents and Potential Amendments to NCOIL Insurance E-Commerce Model Act."

HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
NEW ORLEANS, LOUISIANA
NOVEMBER 17, 2022
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee met at The Sheraton New Orleans Hotel on Thursday, November 17, 2022 at 10:00 a.m.

Assemblywoman Pam Hunter of New York, Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Deborah Ferguson, DDS (AR)
Asm. Ken Cooley (CA)
Rep. Tammy Nuccio (CT)
Rep. Rod Furniss (ID)
Rep. Thaddeus Jones (IL)
Rep. Matt Lehman (IN)
Rep. Joe Fischer (KY)
Rep. Rachel Roberts (KY)
Rep. Cherlynn Stevenson (KY)
Rep. Mary DuBuisson (LA)
Rep. Edmond Jordan (LA)
Sen. Robert Mills (LA)
Sen. Lana Theis (MI)
Sen. Paul Utke (MN)
Sen. Paul Wieland (MO)
Sen. Michael McLendon (MS)
Rep. Jim Perry (NC)
Sen. Vickie Sawyer (NC)
Sen. Jerry Klein (ND)
Sen. Shawn Vedaa (ND)
Asm. Kevin Cahill (NY)
Sen. Bob Hackett (OH)
Rep. Carl Anderson (SC)
Rep. Kevin Hardee (SC)
Rep. Jim Dunnigan (UT)
Sen. Mary Felzkowski (WI)
Sen. Eric Nelson (WV)

Other legislators present were:

Rep. Reginald Murdock (AR)
Rep. James Kaufman (AK)
Rep. Kerry Wood (CT)
Rep. Matthew Gambill (GA)
Rep. Carolyn Hugley (GA)
Rep. Brian Lohse (IA)
Rep. Rita Mayfield (IL)
Sen. Julie Raque Adams (KY)
Rep. Michael Sarge Pollock (KY)
Rep. John Illg (LA)
Sen. Kirk Talbot (LA)
Rep. Kevin Coleman (MI)
Rep. Lori Stone (MI)
Sen. Kevin Blackwell (MS)
Sen. Scott DeLano (MS)
Sen. Walter Michel (MS)
Sen. Joe Thomas (MS)
Sen. Paul Lowe (NC)
Sen. Bill Gannon (NH)
Sen. Jay Hottinger (OH)
Rep. Brian Lampton (OH)
Sen. George Lang (OH)
Rep. Forrest Bennett (OK)
Sen. Roger Picard (RI)
Sen. Mike Azinger (WV)

Also in attendance were:

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

QUORUM

Upon a Motion made by Sen. Bob Hackett (OH) and seconded by Sen. Paul Utke (MN), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Sen. Jerry Klein (ND) and seconded by Asm. Kevin Cahill (NY), NCOIL Vice President, the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 14, 2022 meeting in Jersey City, NJ.

INTRODUCTION AND DISCUSSION ON NCOIL BIOMARKER TESTING INSURANCE COVERAGE MODEL ACT

Asw. Hunter stated that today we are introducing and discussing the NCOIL Biomarker Testing Insurance Coverage Model Act (Model). I am the proud sponsor of this Model and I have also introduced this in the State of New York. A copy of the Model appears in your binders on page 33 and it's on the website and the app as well. For those of you who were at the Summer Meeting in Jersey City this past July you may remember we had a General Session dedicated to this topic. That session was a great opportunity to learn more about the issue before developing a Model. I'm looking forward to discussing the Model today and hearing everyone's thoughts about how it may be improved. Similar legislation has been either introduced or signed into law in states such as Arizona and California and Illinois and again I've introduced this in New York. One last thing before we get started, this Model will not be voted on today. We're still in the development and information-gathering phase. Depending on how things go today we may be voting on this Model during our next meeting in March.

Dr. Marc Matrana, Director of Precision Cancer Therapies (Phase 1) Research Program, Endowed Professor of Experimental Therapeutics and Associate Director of Clinical Cancer Research at the Ochsner Cancer Institute, thanked the Committee for the opportunity to speak and stated that he is a practicing medical oncologist and sees cancer patients every day and he also directs Precision Medicine at Ochsner Health. I've been instrumental in passing legislation here in Louisiana around comprehensive biomarker testing and precision medicine in general. We've actually passed about half a dozen laws to really protect the interests of cancer patients, make cancer care safer, cheaper, and better for our patients all around. But really the question is what is biomarker testing? What do we mean by biomarkers? Well at the most broadest level, a biomarker is anything we can measure in the body to help us make a better decision for a patient but when we were specifically talking about cancer the biomarkers that we often use are things like genes. So, we can sequence a gene and it can tell us if a cancer patient will respond better to drug A or drug B. This is not some new experimental thing. This is actually a standard of care. If I don't do this testing and if I don't prescribe the right drug for the patient my patient is going to have a far worse outcome. In fact, they're going to have a shorter life expectancy. I'll probably get sued for malpractice or I certainly should. But the problem is that not every insurance company is paying for guideline based proven comprehensive biomarker panels and this is unfortunate because patients really need this. In the state of Louisiana through the cancer advocacy group of Louisiana, we were able to successfully pass a number of bills that guarantee that our patients will have access to this type of testing.

To give you a few examples - with lung cancer you're going hear about this from one of our patient's here today but there are 14 different genes that we know of today that drive lung cancer. Most of those are associated with a therapy and if you get on the right therapy for the gene that's driving your lung cancer you're going to have a far better outcome. You're going to be able to go to work and be a productive member of society rather than having to take chemotherapy. You're going to live far longer. Maybe a decade longer than counterparts who don't have those same mutations that never got tested for them or are not on the right therapy. And so the legislation that we are proposing here is not to approve anything that's experimental, it's not to approve anything that's not proven. It's to simply approve guideline base testing that's going to save lives and at the same time save a lot of money. In 2003 it cost $2.7 billion dollars to sequence the first human genome. Want to guess what it cost today - $200. It took 13 years to sequence the first human genome. I can do it in a couple of days with a machine that's about the size of a small fax machine or a small printer. We've made dramatic improvements in the cost of testing and by getting the testing for patients we're then able to put them on better, more effective therapies. They are able to go to work every day, pay taxes every day and be productive members of society. We no longer have them sitting in hospitals dying of their cancer. It saves vast amounts of money when we get the correct testing and we get the patient on the right therapy.

I told the CEO of our hospital just a couple of weeks ago that we're not going to call precision medicine precision medicine in a few years - we're just going to call it medicine. Because that's what it is. Every one of us are our genes and once we really uncover this in a big way this will be the basis of all medicine. As you mentioned Asw. Hunter, Arizona, Illinois, Louisiana, and Rhode Island already passed these bills and they're being considered in other states as well. We can make decisions based on genetic information that can tell us if our patient needs a standard dose of drug, a half dose, a double dose, or a completely different drug. Before we were shooting in the dark - take two aspirin and call me in the morning and I hope it works. Maybe it won't and then we'll try something else. Now I can take a tube of blood and within days have an answer of exactly what will work for each patient. What won't this legislation do? It won't require unnecessary unproven tests. It's going to tie coverage to U.S. Food and Drug Administration (FDA) approved and cleared tests, things that are clearly labeled and indicated for these tests. It's going to tie this to Centers for Medicare & Medicaid Services (CMS) coverage determinations and nationally recognized scientifically sound practice guidelines that are written by the best physicians America has. And again, it won't increase costs, it simply won't. It will save a lot of money across the board.

Tammy Middletown, Volunteer at the GO2 Foundation for Lung Cancer thanked the Committee for the opportunity to tell her story and advocate for other patients. Ms. Middletown stated that she is a lung cancer survivor from Alexandria, Louisiana and a volunteer with the Go2 Foundation. In December of 2018 a CT scan showed a large tumor in my left lung during an Emergency Room visit. It was suspected to be lung cancer. At that time, I chose to go to Anderson Hospital in Houston, TX for additional treatment and diagnosis. In the beginning I had two tissue biopsies that failed to identify my type of cancer. One for my right adrenal gland and one for my left lung. My oncologist decided to pursue next generation sequencing biomarker testing on a liquid biopsy of my blood. This confirmed a diagnosis of stage four ALK positive non-small cell lung cancer. Based on this diagnosis, I was immediately started on a course of radiation and the targeted therapy developed specifically to treat ALK positive lung

cancer. Treatment started a month after the initial tumor was found. Soon after starting targeted therapy my health began to improve. I was stable until April of 2021 when a new spot appeared on the right adrenal gland. Again I had another tissue biopsy that did not yield any actionable information. My oncologist pushed to do another set of next generation sequencing biomarker testing on another liquid biopsy. This revealed that there had been no additional mutation burdens and we could locally treat the new spot with radiation. That meant I could stay on the targeted therapy that I had been on for two years at that point. After that round of radiation I've continued to be stable for a total of three years and nine months. This is all on the same initial treatment that I started with in January of 2019.

Next generations NGS biomarker testing allowed my cancer to be diagnosed quickly so that I can start treatment with a protocol that is effective for ALK positive lung cancer. In April of 2021 NGS biomarker testing guided treatment decisions that has allowed me to continue on my original therapy rather than hopping from one treatment to another. This buys me time for research to happen and cures to be found and it gives me hope. It also keeps other treatment options on the table for me in the future. Access to the information from comprehensive biomarker testing allows me and my oncologist to always make the best decisions for my treatment. As an example, because of the specific genetics of my cancer we knew that immunotherapy which is a powerful treatment for lung cancer would have zero effect on my cancer. On this journey I've discovered that access to good cancer care is a roll of the dice. I have been fortunate to access care at the center with the resources to fight for me, to get the right testing and the treatment that I need. That is not the case for every patient. Cancer care should not be a roll of the dice. All patients should have access to the testing needed to best direct their care. On their behalf I advocate for other patients to have access to the same testing I've had and they need.

James Gelfand, President of the ERISA Industry Committee (ERIC), thanked the Committee for the opportunity to speak and stated that ERIC is a national trade association that represents employers on benefits issues. Our large employer member companies sponsor health insurance benefits for tens of millions of Americans all across the country. Our members primarily offer self-insured plans where ultimately the employer is on the hook for the cost of healthcare for our employees, their families, and retirees as well. Some of our members also offer fully insured options to some or all of their beneficiaries. In all of these cases the benefits are designed to maximize value for beneficiaries. We are fiduciaries to these plans and we have a duty to design and implement health insurance benefits that provide high quality care, that meet the needs of our beneficiaries and that do so in a way that is value driven and responsibly spends plan funds. Overall, ERIC members pay about 85% of healthcare costs on behalf of our beneficiaries. And it's widely acknowledged that employer sponsored benefits are the most comprehensive and have generous coverage generally available. Health insurance is a voluntary benefit that employers offer to attract, retain, and support employees. Between 160 and 180 million Americans get their health insurance through a job and 110 million of those get their health insurance through a self-insured plan. For large employers they could instead choose to pay a fee under the Affordable Care Act (ACA). The fee is $2,500 per person which is much less than what the average cost is to actually insure our employees.

For small employers with fewer than fifty employees there's no penalty for dropping insurance and as costs continue to rise small businesses are dropping coverage and

their employees and their families end up either on taxpayer-subsidized ACA plans, on Medicaid, or uninsured. But employers do want to offer coverage and most small and medium-sized employers would prefer to buy fully insured state-regulated plans because it's the most simple arrangement, they pay the insurance company and their employees are taken care of. However many of these companies opt for self-insured Employee Retirement Income Security Act of 1974 (ERISA) plans mostly to escape the extremely high cost of State mandated coverage rules. I used to work for a U.S. Senator from Maine and at the time Maine was one of the states with the most health benefit mandates in the country. As a result we had chased away all but one insurance company. The cost of insurance were ludicrously high. The individual and small-group markets were basically dead in our state. After the ACA passed, Maine reduced some of these burdens to bring the market back and indeed many states are now cognizant of the need to allow flexibility in coverage but many state legislators are frustrated at their inability to regulate self-insured plans. At the same time they propose and pass laws that push more people into self-insured coverage. I know that there are State advocacy groups that have a grand vision of eliminating the risk of preemption for some or all health plans but this would be strongly opposed by many stakeholders in D.C. So until that happens legislators and regulators who want to keep control over health benefits in the state might consider how increasing mandates and therefore increasing costs could lead to fewer covered lives within the States purview.

Let's talk for a minute about those costs and the cost of health insurance which stems directly from the higher cost of healthcare that is delivered. Those costs continue to grow. They've devoured the wages of working families putting more pressure on both workers and employers. I remember over a decade ago when we were all shocked that General Motors was spending more money per vehicle sold on health care than they were on steel. Then I remember being shocked again several years later when the Kaiser Family Foundation confirmed that health insurance now cost the average family in a given year more than the cost of a motor vehicle. And no doubt this year or next new statistics will come out that shocks us further. Most of these unsustainable costs increases are attributable to hospital cost, some to drug cost, some to paying providers, some of the middleman administrative entities. But the thing to keep in mind is as healthcare costs expand to take up a greater and greater share of the economy the healthcare industry is making more and more money while families are forced to face those consequences. Eventually if we continue down the path of ever-increasing healthcare costs without finding a way to reign them in, we will end up with something akin to Medicare-for-all because employers will not be able to continue to sponsor plans. On the specific subject of mandating coverage for biomarker testing, ERIC believes that this mandate would likely increase costs, would drive waste in the healthcare system, and would further enrich the medical industrial complex without really benefiting patients.

We appreciate that there are members of NCOIL who see the great promise in biomarker testing and we see that promise too but mandating coverage will actually move us in the wrong direction. And don't take it from me, take it from the California health benefits review program at UC Berkeley. They wrote “under existing law, plans and policies are required to cover medically necessary diagnostic lab services and ongoing disease management services. Additionally, biomarker testing is broadly covered by California’s Essential Health Benefits (EHB) Benchmark plan. They further wrote that broadly speaking all enrollees with health insurance subject to a proposed bill in California have coverage for biomarker testing that is supported by medical and scientific evidence and is determined medically necessary. In other words, when

biomarker tests are useful, and that is, when they provide accurate and actionable information for patients and providers, those tests are already covered. They may be covered due to existing law such as the ACA's EHB requirements or they may be covered under ERISA plans because they're medically necessary, they provide clinically useful information, and that information leads to better and more efficient care. Both employers and health insurers want better and more efficient care. They can save money by providing effective treatment sooner by avoiding treatments that would harm patients or would be a waste of time and money. And by ensuring optimal care they can often stave off more serious and expensive interventions later. They can learn in advance what problems are likely to arise and address them in the plan of care prior to those problems metastasizing. Employers and insurers make these kinds of investments all the time and they do so voluntarily because it's the best way to drive value in the health plan or insurance coverage. But the Model proposed would broadly require insurance to cover biomarker testing when the testing is supported by medical and scientific evidence which is defined to mean that the test is FDA-approved, developed to inform pursuit into an FDA-approved drug, is covered by Medicare or supported by a national provider group or multi-stakeholder group.

Basically, this means that the test works. It doesn't mean that the test is actually useful. For a test to be useful the patient's provider would need to learn actionable information. If you got a certain result from this test what would you change in the course of treatment or the care plan? And if the answer is that something would in fact be changed then the test is likely already covered under current law and best practices. That sounds like a test that's medically necessary. It's needed for a provider and a patient to make a consequential choice about care. So under current law and policy when might a biomarker test not be covered today? Well, going back to the California analysis, they projected that if the mandate was enacted the primary change would be the test will be conducted more often when they weren't really called for. They described this as test use for screening purposes rather than tests that would be due to indications and lead the clinical responses. They projected that the use of biomarker testing would increase at about a $1,000 a pop but that it wouldn't likely improve health. Reading between the lines they anticipated that providers would start ordering more of these tests in order to obtain information that wasn't actually useful or actionable. But of course the providers would now be reimbursed for ordering those tests. So, they would make more money but the patients and the employers would pay that money and health would not necessarily be improved. I don't need to tell you that a lot of tests on the market today are deeply problematic. Worse than just not being useful, many tests provide information that is unreliable. These tests are causing patients to make drastic and incorrect choices about their healthcare. They're scaring patients. They're charging thousands of dollars in order to tell patients something that may be wrong or misleading.

In my previous role working for a patient advocacy group we were extremely concerned about certain genetic tests that were being pushed by for-profit companies. Those tests were providing questionable results to patients. Patients were then acting on those test results and making decisions that would have long term and drastic effects particularly on their fertility, their biomes and their overall health. At the time we advocated that test results from these genetic tests should always be put into context and should always come with counseling from an expert and should fully disclose in a way that was comprehensible to those with low health literacy their potential to be inaccurate. And I can't imagine mandating that insurance pay for those tests which would result in many more of those tests being delivered especially knowing how it might affect patients.

Employers don't support mandates for this kind of reason. If a treatment service or product is going to improve health and especially if it's going to bring value by improving health and lowering cost of course we want to cover it but broad mandates often don't distinguish and recommendations from a provider group or a consensus group don't necessarily meet these objectives nor does attest mean FDA-approved. Mandates could lead to waste in the healthcare system and when we waste money on one treatment that money is no longer available to spend on useful and needed treatment for this particular patient or for others. In conclusion, I would just mention perhaps the most important takeaway from the California analysis of the proposed legislation was that there were many patients who should have gotten biomarker tests and they didn't get them but the reason was not because insurance companies refused to pay for those tests. It was because the doctors didn't prescribe them. What that demonstrates is a lack of awareness of these tests and a lack of education and that's something that can and should be addressed but that a mandate for insurance coverage will not address.

Asw. Hunter stated that my first question is Dr. Matrana - we're talking about costs and sometimes associating costs with someone's life is hard to swallow. Asking how much your life is worth is difficult. But you talked about how much a test cost and now it costs $200. Can you briefly elaborate how you got to that so that we know when we go down this path it's not trying to figure out that the doctor isn't doing what they're supposed to be doing because they're not prescribing the test, compared to these are new initiatives in trying to help treatment in furthering someone's quality of life. Dr. Matrana stated that the cost of this type of testing has dramatically gone down in the last few years and comprehensive biomarker testing for oncology, what we call in NGS for example, is just a few hundred dollars now. Believe it or not sequencing every gene in the whole genome sequencing is even cheaper and can be about $200. But the cost savings is not so much in the testing, it's in getting the right patient on the right therapy at the right time and because of the way cancer tests and the drugs work we now have many drugs that are approved not based on the type of cancer a patient has but based on the mutation that's driving that cancer. So, for example just a few weeks ago a drug was approved for any cancer patient who has a RET mutation. We don't know if they have a RET mutation unless we do comprehensive biomarker testing. And that's not a singular example. There are half-a-dozen drugs and next year there will probably be a dozen and the next year there will probably be two dozen that specifically prove not based on the type of cancer but on the mutation the patient has. So if we're not testing every cancer patient for these mutations we are missing these mutations and missing the opportunity to get them on the right therapy that will dramatically improve their outcomes and allow us to avoid much more costly and toxic therapy for these patients. The idea that these tests are already covered is an interesting one and I would just add to that prior to this legislation being passed here in Louisiana a great deal of my time was spent arguing with insurance companies on coverage for patients to get guideline based testing that a patient absolutely needed for me to make treatment decision for how to treat their cancer. After the legislation went into effect I spend far less time doing that and I spend far more time treating patients.

Asw. Hunter asked Dr. Matrana if in his experience he has seen widespread providers just not asking for these tests? Dr. Matrana stated no that's not the case at all. I think providers understand the importance of these tests. Are there singular examples of providers out there who might not be ordering based on the guidelines, of course. But what we've done in our health system for example is we've actually taken the decision to order these tests or not out of the doctor's hands so they don't even have to worry about

this. At the time cancers are diagnosed by the pathologist we have an automatic system, an algorithm, that identifies which patients need the testing and which patient would not benefit from it so they're automatically tested based on an algorithm that is guideline and scientifically-based so that we don't even have to worry about whether the doctors are doing the right thing or are they ordering something they're not supposed to.

Rep. Deborah Ferguson, DDS (AR), NCOIL Secretary, asked Dr. Matrana if he could respond to what Mr. Gelfand stated regarding FDA approved versus the guideline based testing - are you using a different guideline as an oncologist? Dr. Matrana stated that the absolute gold standard of cancer care the world over is the National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology and a lot of coverage is based on the NCCN guidelines. The NCCN is a group of the largest cancer centers in the world and they all send their top experts to write the guidelines which outside of Europe which has their own guidelines, the whole world uses to treat cancer and we based our practice off of those guidelines they don't get any better than that. Rep. Ferguson asked if those have gone through the FDA process. Dr. Matrana stated that most of them have but not necessarily everything in the guidelines are FDA-approved as a lot of times the approval may lag a little bit from what's based on the guidelines. The guidelines are based on pure scientific evidence and FDA approval may come later down the pike.
Sen. Paul Lowe (NC) stated that if it's cheaper, then what is the challenge for states not using it or having this legislation? Dr. Matrana stated that what I have been told is, and I'm not an expert in this, often insures are not looking at cost savings over five to ten year periods for cancer patients. They're looking at it over a much shorter period because they don't expect that the cancer patient will remain employed with the same employer and therefore they would be changing plans. And so they want something that might save them money in six months rather than a cancer patient living for five years and they're going to save money over the five-year period. Sen. Lowe stated that so they're not looking for them to live, that's what you are saying? Dr. Matrana replied yes, that's correct.

Rep. Tammy Nuccio (CT) asked if there is a compromise here between having for lack of better words a free-for-all to be able to order a test whenever you want or to establish guidelines that put in medical necessity and accuracy of the test? Dr. Matrana replied absolutely and I think the Model looks at guideline based FDA-approved and tied to CMS coverage determinations. So yes we would not support legislation that would just allow any doctor to order anything at any time. We would want the appropriate test to be ordered as my colleague said that would obviously have a benefit towards patients and change the outcome of what we do for patients which is what biomarkers do.

Rep. Nuccio asked Mr. Gelfand if he agreed with that and also noted that this is the first time she has seen anybody here from ERIC so thank you for being here because ERISA plans are the majority of insurers and anything we do it a state-level absolutely does not impact the majority of people. I can't tell you how grateful I am that you're even at that table. Mr. Gelfand stated that I think from the ERISA plan perspective we'll be much more interested in things that are medically necessary. I think also other things to take into account would be perhaps getting other organizations and perspectives involved such as the Patient Centered Outcomes Research Institute (PCORI) and discussing using these tests versus not using these tests. Rep. Nuccio stated that I agree with you about getting other perspectives involved, particularly federal perspectives. But I'd be interested in understanding how we could develop medically necessary and accurate

enough testing to be able to put it through because there is a cost-savings benefit to being able to identify these treatments earlier and not going through the Step Therapy of ten different things before we get to something effective. And there is also a quality-of-life issue beyond just the financial aspect of it. So I know we're not voting on this today but I think the work that we should be doing is finding that compromise between medically necessary and accurate and from there figuring out how we can make it work for both.

Hilary Gee Goeckner, Director of State & Local Campaigns, Access to Care, at the American Cancer Society Cancer Action Network (ACS CAN) stated that as the legislation is written there are clear guardrails for the circumstances under which testing is appropriate and this does not include screening but this is diagnosis, treatment decisions, and ongoing monitoring. These are all to impact treatment decisions. And then the clear medical and scientific evidence must be met in order for a test to be covered.

Sen. George Lang (OH) stated to Mr. Gelfand, if the testimony we heard from Dr. Matrana is accurate, is it not possible that the markets will force these changes themselves without having a government mandates? In fact it's going to save money and as you mentioned, it only really affects the small mom and pop shops because the large self-funded groups are subject to ERISA and they would not fall under these mandates. So, if these claims are right is this something the market would naturally do without the government interfering? Mr. Gelfand stated that if the kind of savings projected in some of the literature I've seen is accurate, there's no question that insurance companies and risk plans would on their own demand these tests be covered. I think what's happening right now is that they're indeed seeing that some tests are indeed providing savings and are improving care and those are being covered and then there are some that may not be proven yet and as a result they may not be covered yet. And so over time that'll change if more evidence comes out but yes we do think the markets will resolve this issue.

Asw. Hunter thanked everyone for their comments and stated that in advance of the Committee's next meeting, please send any thoughts or comments on the Model to me or NCOIL Staff.

DISCUSSION ON POLICIES THAT ENABLE VALUE-BASED PAYMENT ARRANGEMENTS FOR GENE THERAPIES

JP Wieske of The Campaign for Transformative Therapies (Campaign) thanked the Committee for the opportunity to speak and stated that the Campaign is a piece of the Council for Affordable Health Coverage and it is a big coalition with all sides represented. The intent in this discussion is trying to find some ways to pay for these really significant gene therapies that are coming across the pipeline. In talking a little bit about gene therapy what we are talking about is some transformative treatments that fundamentally change the interaction with a patient in their diseased state and have a durable sort of cure for really serious medical conditions. The expectation is that these are going to be quite expensive as we move through. One of the gene therapies we talked about that is out already is Zolgensma and it deals with spinal muscular atrophy. It's expensive but it is changing the lives of children. We're also talking about the next couple that are definitely coming out that are related to hemophilia. Those are also likely to be very expensive but again, sort of change the way people interact. If we look at

what's coming this is a message from the future that everybody needs to pay attention to. There's a ton of gene therapies that are going to be coming out in the next three years and financing these is going to be a major issue both for private health insurers and through Medicaid as a matter of course. Sixty-three are expected to be approved by 2030 and that means that there are going to be some significant costs that are going to attach.

So when we look at hemophilia specifically, the question is if gene therapy is going to cost $3 million dollars for a patient to get, is there actually a value delivered? That question actually has been answered to some degree. There is a report on this which found that this $3 million dollar gene therapy will not only deliver a much better result for patients, but in the long run may be less expensive. Obviously the issue here is that it's a $3 million dollar gene therapy and being able to afford it. So, one of the things that we do need to talk about is around Medicaid and financing. There are arrangements that are in play and we were just talking about the issues in private insurance around access how both private and public use access to sort of limit the use of expensive drugs in some cases. The costs are significant as we attach. And then inside Medicaid there is a requirement to cover all medications. So how do we sort of look at this in a different way and move forward? Again we're looking at something that's going to transform the way medicine interacts with patients. We're going to be taking people likely off of Medicaid and public assistance into new jobs in some cases. And this explosion is coming. So you need to find some solutions that are balancing access and costs and what we're talking about from our standpoint when we looked at this is something of value based payment arrangements. There are a number of names that have been used such as outcome-based arrangements or value-based purchasing arrangements. The idea is that you have a shared risk model and it holds manufacturers accountable from the standpoint of a requirement that they have to deliver on the outcomes that they're promising and the drug has to do what it's supposed to do.

But that also means that you broaden the patient access. So these contracts both privately and publicly are done on a one-on-one basis. If you have seen one contract you have see one contract and that's part of the issue that this is going to be a costly endeavor for states to get into and this is something that they need to start planning for now as we see the coming approach. The contracts deal with who gets access to the drugs and what the drug actually costs and what the risk structure is and who the eligible patients are and how the rebates are tracked. All these issues are going to be important. There are a variety of these arrangements. There's a pure outcome space determination, a warranty model, some ability for a payment over time installment plans. All these are in addition to having issues surrounding the technicalities we'll also have such as accounting issues. I would also note one of the things that you may want to look at and understand as you're looking at the pricing is what you're doing from a reinsurance standpoint. If you have one plan covering a $3 million-dollar gene therapy whether it's a care management organization or it's in the ACA or something else, that means there's potentially some adverse selection. One of our co-workers worked at a plan that had 24 of the 26 hemophilia patients in the state of Nebraska enrolled in this plan. Needless to say that plan was not in fact profitable and there's some adverse selection that was sort of applied as a result. So those issues are going to be increasingly important. We believe that using the value-based payment arrangements ensures both broad access and controls costs and as a result aligns incentives between the manufacturers and the payers and the patients.

I want to note some challenges that are sort of in play as you look at this issue and as you talk to your Medicaid folks and other folks. The administration of these again is a one in one administration of the specific drug that attaches. You need to negotiate the specific terms. We just had a call with the Center for Medicare and Medicaid Innovation (CMMI) this week to talk with them about what we can do to promote these outcomes and these contracting arrangements from a state by state basis. So hopefully the federal government will make it a little bit easy. How do you actually measure these outcomes and what outcomes do you want? When we talked to individual state Medicaid folks we had some interesting results and I will tell you that Medicaid offices are not necessarily thinking about it in the same way. Some want clear clinical data, others only want to use claims data. Regarding third party evaluation, how do you pay for this third-party evaluation piece of it? Where does the trust start attaching as a matter of course? And again, operationally how do you deal with managed care organizations, medical providers and others? And then you get to ambiguity over best price. But there are opportunities. And again we're looking at an opportunity as we get into these that medicine is changing, it's changing for the better. There's going to be value delivered to patients and there's going to be value delivered to Medicaid overtime. But there is an upfront cost that attaches and we have an opportunity to align these incentives appropriately. Broaden the access, risk share, manage those costs and manage those costs on the basis of outcome and data analytics so you actually know that you're getting what you're paying for. I would note that it's a number of states from a Medicaid standpoint have already been here. They've already done some of this work so those are certainly folks that you can take a look at and they're up there on the screen. What we're asking for here is for you to be aware of this issue from our standpoint and to take a look at your Medicaid and your insurers to have this discussion up front and to start looking at policies that make sure that this is a path forward from that standpoint.

Bert Bruce, U.S. President of Rare Disease at Pfizer thanked the Committee for the opportunity to speak and stated that he is here with his colleague Jesse Lemberger, a Senior Director in Pfizer's Strategic Pricing group. While JP and I have never met before it's going to look like we've known each other for a while beause we're going to primarily be here to educate a little bit and talk about some of the exact challenges that we're going to look to be able to face together and be able to bring these transformative therapies forward. If we think about where medicine has gone, we think about gene therapies in what we're calling this third wave of potentially transformational innovation. If you go back years ago to symptomatic treatment with things like aspirin, then there was the biologics that were modifying the disease. But as JP talked about what we're looking at now are fundamental diseases and changing the outcome. Some might use the word cure. Some are not actually designed to cure but they're designed to be a fundamental change to a disease. And that's a very significant breakthrough in those areas. Now I'll take a little bit of time just to talk a little bit about gene therapy and what it is and what it isn't because the first column here talks about the area we're going to spend some time talking about today, it's called gene therapy. Sometimes it's called gene transfer and what it's doing is taking effectively a gene that is not working properly and replacing that gene with one that is working properly. So it's not changing the underlying biology of who a person is, but it's correcting something that's incorrect, then allowing that function to work the way that it was supposed to design to.

That's different than the middle column. There's exciting science, it's earlier in this space which is actually going in and editing a gene and changing the way that a gene is designed. And then there's a third category called gene regulation. Some of those are a

little bit earlier and they are more designed to change an individual's foregoing biology. But that's not what we're going to be talking about today, it's going to be about the first category I called gene therapy. We're effectively thinking about it that's taking something that is not functioning properly and replacing it with something that is. And this simple schematic shows a little bit about how that works. There is something that's called a capsid and that sounds like capsule, you can think about it that way. It's an empty container and you put a properly functioning gene which is called a transgene inside of that. The two of those together are called the vector and then you're able to infuse or deliver that to target organs in the body, most commonly the liver but there can be other places. And when it arrives then the capsule dissolves and the correct gene is taken up by the body and replaces. And that's effectively the function of how gene therapy a works. There are 7,000 rare diseases and one of the reasons that there's a lot of promise and most of the examples JP was referring to are in rare diseases of which 95% do not have any approved therapy. And for the vast majority of them there's nothing behavioral, they are genetic and they mostly affect children which means they affect parents which means they affect working parents which is why we're here today. And so if we think about that frame with so many diseases that don't have a cure, if 60 come by 2030 that means that they'll still be well over 6,000 that still have no cure and that's one of the promises in the potential is for very small populations and very targeted ways that a very big difference can be made in areas where there's significant unmet need. But rather than show you another slide because I can't envision how many you're going to see over the next couple of days, I'd like to share a short video and this is about a child and his mom and the child has a disease called Duchenne muscular dystrophy (DMD) and we'll see a little bit about how this affects their day.

After the video, Mr. Bruce stated that DMD is diagnosed usually in boys between three and four years of age and they start off like most boys. This is a disease by the by the way that's specifically only for boys. So I'm not just using the word boys. But then they're not able to keep up with certain milestones, not able to walk as fast or they may be a little bit more clumsy in gaining their balance and it's effectively a genetic disorder that eventually removes the body's ability to continue to develop muscle. Now if you think about what the child in the video was not able to do and you think about what he was still able to do, you'll see that there was a lot in that video. As boys progress through they lose the ability eventually to be able to walk by themselves, but the child still had it. He was in what they call the ambulatory phase where they're still able to move around but as the disease progresses they would lose that ability to ambulate. They call that non-ambulatory. So that exercise that he was getting with his mom or with the physical therapist is very important for him to be able to delay the progression of the disease for as long as possible. And there are different costs obviously that are going to be associated with that age. And so the earlier that a boy like the child in the video would be able to have a treatment that could arrest the disease from progressing any further or change the course of that disease is perhaps a significant breakthrough for himself. Now if you look at DMD, every state has boys that are affected but every state doesn't need to have nor do they have a treatment center for the disease.

There are 33 Duchenne centers that are certified in 21 states. And so what does that mean? Just like most children's hospitals 90% of which treat children that come from out-of-state, the same is true for Duchenne. So, whether you're a state that has a certified center and these centers provide phenomenal care, or your state does not, that simply means that boys in your state and their parents would travel to one of these centers. But therein lies some of the challenges and the opportunities we have to talk

about and should and if a product comes to market here then there has to be an opportunity for the states to work together and for us to work with the states to be able to ensure that access is available. If access is not available then that can mean delays in time for the boys to have access to the medicine and you can imagine in a disease like this every day is very valuable. And so that's part of the reason why we're here is to be able to start the conversation around what are pathways we'd be able to pursue together to ensure that when medicines are available for this disease that patients and their parents have access to those medicines as quickly as they possibly can. Right now there are about 28 states that have the capacity to treat these patients. And what we're doing is states have to sometimes apply to get permission to enter these innovative agreements and so that's a very important permission that we want to talk about because it allows us to be able to think about what type of value-based agreement, what type of model is appropriate? Is it the same for a hemophilia patient as it would be for a Duchenne patient as it would be for a different type of patient? And we see here that CMS has already approved these types of special protocol agreements, the ability to sit down and have these conversations with over 13 states. And there are some including Louisiana where that is pending and those asks have been made to allow us to be able to come to the table. Oklahoma is another example. And so sometimes it overlaps where we're looking to get care and sometimes it does not but what all of these are going to require is the ability for us to partner together to be able to understand how we can create new pathways and to find what those pathways are for individual diseases as we look to bring forward these breakthrough medicines to the patients who need them.

Sen. Mary Felzkowski (WI) stated that we talked about these are coming in the future - do we have any of these gene therapies that are being utilized now and what treatments? Mr. Wieske replied yes - Zolgensma is one that's fairly common and I think the hemophilia is expected to get approval both for hemophilia A and hemophilia B I believe this coming year maybe as soon as in the next few months. And so those will be out and that means once those are priced that's going to be a significant cost driver and so getting ready is the key. Sen. Felzkowski stated that for the states that put this in, was there legislation passed or did their health departments just work with CMS on their own to do it? Mr. Lemberger stated that to clarify, the products are covered and Zolgensma has three publicly available innovative agreements in the market. CMS had to approve the waivers before the negotiation could take place. So all the other states actually cover Zolgensma without an innovative agreement. Sen. Felzkowski stated that so with the agreements were they just negotiated with CMS on their own or did the legislature get involved? Mr. Wieske replied yes and I say yes because it varies state-to-state as some states require their Medicaid required to go to the legislature to get formal approval. In other states they're allowed to negotiate the agreement on behalf of the state and can negotiate directly to do the state plan amendment. There are also other drugs outside of the gene therapies that are in the protocol as well on things that are more population based in some cases. So some of those agreements exist and they continue to be worked on but there are options. In our white paper which you can download we discuss the states that have used it. We have some samples to plan amendments available as well in the states that we believe need legislation and in the states where you can negotiate directly.

Rep. Ferguson stated that if a person has a gene therapy for something that is curable are they then still able to pass that gene on it when they have children or does it correct it completely for when they have children? Would they also still be subject to the same disease even though that person's cured? Mr. Bruce stated that with the examples we're

talking about today it wouldn't affect one way or the other what happens between generations. So you're not changing that ability to pass it on for the good or for the detriment. It's only affecting that individual for their lifetime. Now the other side of that is because you were introducing a one-time therapy that is going into the muscle or going into in this case target the muscle but going for a specific disease it's not like if one doesn't work you can flip over to a different one. And so oftentimes the patients and their parents are making decisions even in participating in these clinical trials are making a one-time decision for your life. And so that means that the selection process is going to be important. Some products are intended to be for every individual who has a disease. Others are not. Others are intended for a subset because of the severity of the disease and what the potential benefit could be.

Rep. Ferguson stated that I'm trying to understand this quality payment so say they have gene therapy and then the patient's not cured then the company would pay 80% back if the patient continues to need treatment and really wasn't cured - is that how it works? Mr. Wieske replied yes - they would negotiate those agreements based on specific metrics to specific drugs and what they're promising. So those are going to vary by agreement. If you're looking at something that obviously costs $3 million dollars you're expecting that is on a patient by patient basis. In other cases for therapies that are a little bit lower cost not necessarily gene therapies but those that are in a population basis - for example there's a heart attack drug and they measure the number of people who have a second heart attack over time and there are others looking at whether or not individuals are on ventilators. There are some that are looking quite frankly whether the patient survives after the first year and then there are different measures after the second year. So there are some variations but state plan amendment allows the negotiation broadly and then individually drugs are negotiated between either the insurer or the Medicaid Agency for what they're measuring and who's measuring it and how they're tracking it.

Rep. Jim Dunnigan (UT) stated that as far as the treatment, how quickly is it effective, and how long does it last? I expect it depends by person but just generally. Let's say there's a treatment for this young guy in the video - what would that do for him? Mr. Lemberger stated that we don't have clinical data. Rep. Dunnigan asked what do you realistically think it will do for him? Mr. Lemberger stated that realistically it would slow the progression. The clinical trial is looking at slowing the progression. So we would hope that it would hold his current status steady for the foreseeable future. Obviously that's a reason to try to treat as young as possible. So now there are patients out there who are eight through eleven but eventually we'd be hoping to treat patients right as they're diagnosed or soon after they are diagnosed. Rep. Dunnigan asked if it would reverse the condition. Mr. Lemberger stated that this type of therapy will not reverse the disease entirely but we're hoping it will slow the progression for many years. Rep. Dunnigan asked if the treatment is an injection and how often does it occur. Mr. Lemberger replied that it is a one time injection. Mr. Wieske stated that to use a hemophilia example as I understand it they are going to be measuring how much factor you have to use and reduction comes relatively quickly and the hope is within a certain period of time that it may not be eliminated but the risk levels drop precipitously for the hemophiliac as time moves on.

Rep. Nuccio stated that if I'm hearing this correctly then these treatments are not going to reverse the disease so somebody will still incur healthcare costs going forward just hopefully at a minimal a level. And then from the cost-share perspective of this are you

assuming whether it's Medicaid or private insurance there's going to be a limitation of stop loss or reinsurance or carve out because of a three-plus million-dollar claim on any one individual policy is going to increase rates for every other member significantly and that's also going to max out their lifetime out-of-pocket max which is then going to also incur more costs going forward for the rest of the members of that policy. Mr. Wieske stated that one of the issues you're going to have when any one of these gene therapies come on is depending on the size of the population that's impacted you may have a large number up front. And the hope is that you have lower costs as time goes on and that normalizes the access to that treatment. And so there is an upfront issue but to your point I think that's one of the things that I think may need to be discussed from an access standpoint – how do you pay for a significant gene therapy? And again to pick on Medicaid, if some care management organizations are covering and others are not you're going to have adverse selection and you're going to have issues potentially with individuals who are employed and maybe to get access to it will go through Medicaid in order to get access to the treatment because it's that important. So that's I think a concern. On the flipside I think most of these diseases that we're talking about are rare diseases that are significantly debilitating and so as a result they're probably already on Medicaid and there are real possibilities depending on what it is that they go off Medicaid so that the costs drop not only for their treatment but as well as for other social welfare programs and they will have better lives and in some cases able to work in ways that they couldn't before.

Rep. Nuccio stated that you just said something that always makes me uncomfortable when we start talking about insurance legislation in benefits like this - "we hope." So how long before you think your industry would have something more definitive than hope for a three plus million-dollar product? Mr. Wieske stated that I think it's a therapy by therapy issue that you look at. So I think if you look at the example I cited for the two genes therapies, they clearly found value and they clearly found it was durable. Once those are approved those are going to be changing lives and cutting costs I think overtime significantly with obviously a significant upfront cost. So I think that's one and I think there's going to be varying success and varying issues like what you talked about with delaying the progression of certain diseases so they're not as debilitating over time and others will be closer to curative. So it's going to vary depending on the gene therapy and I think it has to be looked at on a one off basis from a coverage standpoint.

Mr. Bruce stated that I agree completely with Mr. Wieske and I think we'll all agree that hope can be a dangerous word and it can be a powerful word and you're 100% correct in both. Patients and parents are hoping that these medicines will bring the benefit. We will know five and ten years later much more than we will know when we bring the products out to what extent they're able to deliver on that benefit and the alternatives are part of the equation as Mr. Wieske is talking about. Just to use the two that we've talked about if we're talking about hemophilia, hemophilia patients have access to many different types of medicines. They may not be curative but they're expected to live a normal life span. They incur costs over that life span but they live a normal life span. The child in the video is not going to live to 30 under probably any circumstance and the costs are going to become more significant over that period of time and there are no other alternatives. So what we would be looking at is to be able to have those discussions of what would be appropriate to be able to think about how to provide access to a boy like the one in the video. And what about a boy that's five years older than him? It's going to be a difficult discussion to have to understand what is that value for different people at different times given different alternatives but that's why the

encouragement that we want to have is to be able to come to the table to be able to have those specific conversations whether you're going to be the states that would be receiving those boys or the state who will be getting a phone call from other states because you're treating them. So I appreciate your question and they are difficult challenges and that's why we're here to start the conversation.

Sen. Mike McLendon (MS) asked when the price is negotiated, is it negotiated with the manufacturer or is it through a pharmacy benefit manager (PBM)? Mr. Wieske stated that it's the manufacturer typically and in the agreements that are available they're negotiated down on a one-on-one basis and they're looking specifically at what the outcomes are. So again, while you're saying hope the idea is that if the outcomes are not matching what the cost is that there's a rebate attaching. They're obviously expecting that it's going to hit that but they're negotiated with the manufacturer. Mr. Lemberger stated that PBM's are on the pharmacy benefit and these are on the medical benefit. These are delivered through outpatient hospitals so we typically do not go through a PBM for these types of products. Sen. McLendon asked if you look for it to stay that way? Mr. Lemberger replied yes and stated that we would prefer to negotiate directly with the health insurers. Sen. McLendon asked if pricing is on an individual case basis or is it per disease pricing? With the example you gave, is that pricing that family pays the same as another family that has the same symptoms? Mr. Lemberger stated the product is dosed by weight so there are some technical limitations to delivering the exact same price to every patient. We hope to overcome those limitations and provide the same price per patient but some of those things are out of our control. Sen. McLendon asked if where the patient lives plays a part in it? Mr. Lemberger stated that where they live will only matter whether they have to travel out of state to get therapy. It would not play a role in the price.

DISCUSSION ON GOLD CARD LAWS AND PRIOR AUTHORIZATION REFORM EFFORTS

Asw. Hunter stated that in the healthcare context a gold card is something that is issued to health care providers upon meeting certain condition, typically quality metrics, that allows them to bypass turned prior authorization requirements. We did have a general session on gold cards at our annual meeting in Scottsdale last November which focused on the Texas Gold Card law that has recently been signed into law. A gold card bill was introduced here in Louisiana this year, but it was ultimately changed to be a piece of broader prior authorization reform legislation. Both those pieces of legislation can be found in your binder starting on page 36 and they are also on the website and the conference app. Today's session is meant to serve as a follow up to the Scottsdale session so we can learn a little bit more about gold carding and the thought process that led to the Louisiana bill change.

Jeff Drozda, CEO of the Louisiana Association of Health Plans (LAHP) thanked the Committee for the opportunity to speak and stated that I'm sure if you have not seen prior authorization or gold card legislation in your state yet, you will. And I just want to mention a couple things about prior authorization and there are significant benefits to it. However, from the provider side it definitely needs some significant improvement in terms of fraud, waste, and abuse and in terms of inappropriate use of high-cost care. Employers ask us to do what we can to keep the cost of premiums down and prior authorization is one way that we do this. Even CMS uses prior authorization for outpatient services and other sorts of services. So to talk about the Texas legislation, I

know that you've heard a little bit about this beforehand but on October 1st they finally came out with their rules a year after passage in 2021 and there are over 100 pages of comments talking about the complexities and the confusion from both the plans and the providers. So, this brings us to what we saw in Louisiana with regard to gold carding prior authorization and it was sponsored by LA Sen. Robert Mills. I do want to thank him publicly because it's his leadership that turned a bill that was a one-size-fit-all bill, into a bill where both parties came to the table to work together and really force the health plans to come up with a program that we can implement in the next year. Sen. Mills took that Texas bill and got it down to a two-page bill and if you're looking for gold card legislation in your state and if you're looking for model legislation I strongly encourage you to look at Sen. Mills' bill because I think it avoided the pitfalls that happened in Texas and some of the other places around the country. In a nutshell, the bill directs the health plans to come up with a program excluding pharmacy services and says you need to file that plan with the Department of Insurance (DOI) in a form that will be developed by the DOI and then after a certain date the program will be implemented. So it's very simple but it does force both parties to come to the table and ask what can we do that's best for the patient? And that's the number one goal for all parties involved.

Maria Bowen, VP of Government Affairs at the Louisiana State Medical Society, thanked the Committee for the opportunity to speak and stated that I think all of you have a similar society or a medical association in your state so you're probably familiar with who we are and what we do on behalf of physicians. A lot of times I tell people physicians are not good physician advocates. They are very good patient advocates but they do not do a very good job of advocating on behalf of themselves or on behalf of the practice of medicine. That is because they are very frequently in clinic and in hospitals with 24/7 jobs. It's hard for them to rearrange their schedules. So, I'm going to try to do them justice, but I invite you if you are a physician to feel free to chime in. So I think many of you have likely seen a lot of these graphs and charts that are provided by the American Medical Association (AMA). What I would like to reiterate to you is that from a physician perspective it's the patients who are receiving or attempting to receive the medical benefit but they're also the ones who were the victims of delayed care and if you look at every one of these graphs that I've provided for you they clearly show that from a physician outlook patient care is delayed - 93% of those would report some delay. And you can see by the graphs that they are significant in certain circumstances – 34% of physicians reported that delayed care has serious adverse effects on medical care.

So, the impact on the physician office and their practice is equally challenging. If you look at what we're talking about on this slide, two days in a physician's life is spent on prior authorization. Some of the facts that are available or available at the top of the slide are from the Physicians Foundation and that's a great survey that just came out this past week that you may want to look at and I can send all of this to NCOIL staff if anybody would like to receive them. Keep in mind that physicians do work seven days a week. Patients do need medical care seven days a week. Getting prior authorization does not always happen seven days a week. Again, this is a challenge in the physician community that we look to overcome. So back in 2018 a group of national organizations convened and developed a consensus statement to improve prior authorization. Those are the groups that were involved and these are the five reform categories that were addressed. Yet here we are in 2021 and while we've made the consensus statement and seemingly agreed to a number of different things most of my physician providers would tell you that it's not much better. Regarding the Louisiana legislation, just to give you an idea of why Sen. Mills helped us with this, this is from a physician in his district.

The physician was requesting a prior approval to insert a spinal cord stimulator into a patient with spinal cord damage. The request was for imaging of the lower back so that the physician could appropriately place the wire to stimulate the spinal cord. The request for imaging was denied. This is the denial – "your records show that your doctor needs imaging to assess your spinal cord. Your entire spinal cord should be visible on neck and upper back studies. Lumbar spine or your lower back pictures would only be needed if your doctor knows or suspects that your spinal cord extends into your lumbar spine."

Even me with a non-medical background can tell you that's a bit ridiculous but this is what they get every day. These are the types of reports that I hear from physicians. It's ludicrous at best and when they go to overcome some of these denials keep in mind that they are inserting themselves into a contract that they are not a party to. The contract that is being discussed is between the patient and the health insurer. So they're already in a predicament but they will also tell you that it's very easy for someone to deny them where it may be more difficult for someone to look in the face of the patient and say no. And yet on the other side of it, does a patient always understand what is needed or why they are asking for those services? So there are a lot of challenges when we start talking in medical terminology. As Mr. Drozda said, this is what we started with the original bill and some of the outlines are there. The amended bill is really I think kind of clever. It gives the opportunity for the health insurers to be very creative in what they come forward with to help us try to alleviate some of the challenges that we face with prior authorization. We are looking forward to seeing what those look like. And I will say just in conclusion everybody asks me what we're going to do next? I don't know. I work for a board of directors. I have a council that I have to answer to and we have to vote on those things. So, right now we are watching the Texas rulemaking, we're watching what's happening both with Federal legislation and rulemaking. We're waiting to see what happens in July 2023 with plans that are filed with the DOI. And our follow-up discussion on any legislation next year will not occur until January. So, those are kind of our talking points and I've given you the link to the AMA website fixpriorauth.org. It is a great resource if you've not looked at it. It has the opportunity for patients, physicians, consumers and employers to provide stories on prior authorization if they have those to share. And I would just encourage you as legislators to please reach out to your physician community. Obviously, Sen. Mills did discuss what was happening in his community with a number of physicians. Reach out to them and talk to your employers. There are also statistics that show a great deal of employer impact when an employee is awaiting healthcare services and a lot of that is related to denials for prior authorization.

Miranda Motter, Senior VP of State Affairs & Policy at America's health Insurance Plans (AHIP) thanked the Committee for the opportunity to speak and stated that I was here back in November of last year where I did have the opportunity to sit alongside the Texas Hospital Association and the Texas Medical Association to talk about the Texas bill at that time and to talk about the concerns in the challenges that we saw with that law and I also spent a lot of time talking about options and talking about alternatives to things like a one-size-fits-all sort of blank check for providers. But we spent time talking about electronic prior authorization and how that really can be significant for providers to do just what Ms. Bowen stated earlier in terms of reducing administrative burden for them. Our recent statistics even tell us that doctors today continue to manually submit at a 60% rate prior authorization submission and even in the pharmacy space which is largely electronic they're still doing so at around 38%. So when you think about electronic submission those are the types of things that can really give providers faster

time to decision, faster time for patient care, and it can significantly reduce administrative burden and it actually provides them a lot more information we found through that survey in those results that I shared back in November of 2021.

In March of this year I had another opportunity to present before NCOIL to talk about again another kind of opportunity that really sits in front of providers as they think about trying to reduce administrative burden. And the time I spent here was focused on how providers can do so by taking on a financial risk for the medical decisions that they make for coverage issues by entering into value-based relationships. And we heard the prior panel talk about that certainly in the context of drugs and gene therapy but that is a significant way that providers can look to either waive or reduce significantly prior authorization. So here today I have the privilege and opportunity to share really briefly some survey results from a gold carding program survey that we asked our plans to share. And we did so really in further of this consensus statement that Ms. Bowen mentioned earlier that health plans entered into with hospitals, with physicians, and with pharmacists back in 2018. And as you can see in one of the documents I shared it really lists with quite a description the work that health plans have been doing in furtherance of that consensus document by further targeting the types of services that are subjected to prior authorization and by providing the availability of automation for providers and their offices to take advantage of electronic platforms so that they don't have to 60% of the time submit these prior authorizations manually. Regular reviews of our prior authorization, both the systems and the services that we require prior authorization, are important as is using input directly from providers to make sure that those are still consistent with evidence based clinical guidelines that will ensure quality care and then will protect patients. And then lastly, continuing to wave in certain instances those prior authorizations when needed.

So, I wanted to just make sure that the results that I share with you today is in furtherance of that 2018 commitment. We've been really striving to work with providers on the ground to get this work done so that we can again continue to improve the process and improve potentially the administrative burden that we know providers feel but do so in a way that doesn't jeopardize or risk quality of care for patient safety and at the same time make sure that we also are not jeopardizing affordability. I would also just reiterate before I move on the issue that Mr. Drozda did raise. Purchasers of healthcare whether it's employers fully insured, whether it's the self-insured employers, whether it's the federal government through Medicare and certainly through Medicaid, all of the purchasers are looking to and demanding ways to ensure affordability of care and to reduce fraud, waste, and abuse and to ultimately make sure that patient safety and quality of care is preserved and all of these purchasers are using prior authorization and demanding that. So let me get into the survey results. There are six highlights. Gold carding programs have increased since 2020. Gold carding programs are most effective when they are used selectively, so not one-size-fits-all. And they should be continually evaluated so there is regular review of the provider, regular review of the decision that they made and making sure that they are connected to and align with evidence based quality standards. As I said earlier gold carding programs today are being used more frequently. In 2019 around 32% of plans were using those and today around 58% of plans are using those. Another finding in the survey is that gold carding programs work better for some services than they do for others – 73% of plans reported that gold carding programs work better where there is a clear and a consistent clinical standard for that service. So for example things like high-tech imaging, cardio services, elective inpatient medical services, orthopedic services. Those are all places where there are

clear and consistent clinical standards where gold carding programs can be effective. Another finding in the survey is that gold carding programs include those providers where there is a sufficient prior authorization volume so in other words you can actually look and test a measure and that they also have a low denial rate and a high approval rate that's really important.

Asw. Hunter stated that due to time constraints, the Committee's meeting must conclude and before that Sen. Mills is going to make some comments. Asw. Hunter thanked Ms. Motter for her remarks and noted that the documents she referenced can be found on the website and on the app. Sen. Mills thanked Asw. Hunter and thanked everyone for speaking today and stated that it's a work in process in Louisiana but for the other legislators in the room I was surprised at how much pent-up frustration there was with the medical doctors and the physicians and the providers when we did speak with them. And as hard as they work they're not necessarily that good at getting it out in the public and letting you know what their problems are. So Ms. Bowen has a full-time job trying to represent them and get that voice out. They're generally under-represented and we need ten Ms. Bowen's out there to probably properly represent them because Mr. Drozda and others are so good at what they do. But we started five miles apart and we got maybe a mile apart towards the end. We're making some progress and I do appreciate the work on this. It's important for prior authorization. We don't have a good handle on it yet but we're making progress and we've got to keep working.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Hackett and seconded by Sen. Klein, the Committee adjourned at 11:30 a.m.

616 Fifth Avenue, Unit 106
Belmar, NJ 07719
732-201-4133
CHIEF EXECUTIVE OFFICER: Thomas B. Considine

National Council of Insurance Legislators (NCOIL)

Biomarker Testing Insurance Coverage Model Act

Sponsored by Asw. Pam Hunter (NY)

Draft as of October 18, 2022. To be discussed during the Health Insurance & Long Term Care Issues Committee Meeting on March 12, 2023.

Table of Contents

Section 1. Title

This Act shall be known and cited as the "[State] Biomarker Testing Insurance Coverage Act."

Section 2. Definitions

(a) "Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention. Biomarkers include but are not limited to gene mutations or protein expression.

(b) "Biomarker testing" is the analysis of a patient's tissue, blood, or other biospecimen for the presence of a biomarker. Biomarker testing includes but is not limited to single-analyte tests, multi-plex panel tests, and whole genome sequencing.

(c) “Consensus statements” as used here are statements developed by an independent, multidisciplinary panel of experts utilizing a transparent methodology and reporting structure and with a conflict of interest policy. These statements are aimed at specific clinical circumstances and base the statements on the best available evidence for the purpose of optimizing the outcomes of clinical care.

(d) “Nationally recognized clinical practice guidelines” as used here are evidence-based clinical practice guidelines developed by independent organizations or medical professional societies utilizing a transparent methodology and reporting structure and with a conflict of interest policy. Clinical practice guidelines establish standards of care informed by a systematic review of evidence and an assessment of the benefits and costs of alternative care options and include recommendations intended to optimize patient care.

Section 3. Health Insurer Requirements

(a) Health insurers, nonprofit health service plans, and health maintenance organizations issuing, amending, delivering or renewing a health insurance contract on or after [DATE] shall include coverage for biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a covered person’s disease or condition when the test is supported by medical and scientific evidence, including, but not limited to:

1. labeled indications for a test approved or cleared by the Food and Drug Administration (FDA) of the United States government or indicated tests for an FDA approved drug;

2. Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations or Medicare Administrative Contractor (MAC) Local Coverage Determinations; or

3. Nationally recognized clinical practice guidelines and consensus statements.

(b) Such coverage shall be provided in a manner that shall limit disruptions in care including the need for multiple biopsies or biospecimen samples.

(c) The covered person and prescribing practitioner shall have access to a clear, readily accessible, and convenient process to request an exception to a coverage policy provided pursuant to the provisions of this Section. Such process shall be made readily accessible on the health insurer’s, nonprofit health service plan’s, or health maintenance organization’s website.

Section 4. Medicaid Coverage Requirements

(a) The State Medical Assistance Program (Medicaid Program) shall cover biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a recipients disease or condition when the test is supported by medical and scientific evidence, including, but not limited to:

1. labeled indications for a test approved or cleared by the Food and Drug Administration (FDA) of the United States government or indicated tests for an FDA approved drug;

2. Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations or Medicare Administrative Contractor (MAC) Local Coverage Determinations; or

3. Nationally recognized clinical practice guidelines and consensus statements.

(c) Risk-bearing entities contracted to the Medicaid Program to deliver services to recipients shall provide biomarker testing at the same scope, duration and frequency as the Medicaid program otherwise provides to enrollees.

(d) The recipient and participating provider shall have access to a clear, readily accessible, and convenient processes to request an exception to a coverage policy of the Medicaid Program or by risk-bearing entities contracted to the Medicaid Program. Such process shall be made readily accessible to all participating providers and enrollees online.

Section 5. Rules

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

Section 6. Effective Date

This Act shall take effect [xxxxx] and shall apply to al policies and contracts issued, renewed, modified, altered or amended on or after such date.

616 Fifth Avenue, Suite 106
Belmar, NJ 07719
732-201-4133
CHIEF EXECUTIVE OFFICER: Thomas B. Considine

National Council of Insurance Legislators (NCOIL)

Medical Loss Ratios (MLR) for Dental Health Care Services Plans Model Act

Sponsored by Del. Steve Westfall (WV)

Draft as of February 8, 2023. To be discussed during the Health Insurance & Long Term Care Issues Committee Meeting on March 12, 2023.

Table of Contents

Section 1. Title

This Act shall be known and cited as the "[State] Medical Loss Ratios (MLR) for Dental Health Care Services Plans Act."

Section 2. Purpose

The purpose of this Act is to provide for transparency of the expenditure of dental health care plan premiums, and to require annual reports and rebates to patients if the medical loss ratio exceeds a certain percentage.

Section 3. Definitions

(a) "Commissioner" means the Insurance Commissioner of this state.

(b) "Dental carrier" or "carrier" means a dental insurance company, dental service corporation, dental plan organization authorized to provide dental benefits, or a health benefits plan that includes coverage for dental services.

(c) "Dental health care service plan" or "plan" means any plan that provides coverage for dental health care services to enrollees in exchange for premiums, and does not include plans under Medicaid or CHIP.

(d) "Medical loss ratio" or "MLR" means the minimum percentage of all premium funds collected by an insurer for dental insurance plans each year that must be spent on actual patient care rather than overhead costs, administration, and other expenses.

Section 4. Transparency of Patient Premium Expenditures

(a) A carrier that issues, sells, renews, or offers a specialized dental health care service plan contract shall file a Medical Loss Ratio (MLR) annual report with the commissioner that is organized by market and product type and contains the same information required in the 2013 federal Medical Loss Ratio (MLR) Annual Reporting Form (CMS-10418).

(b) The MLR reporting year shall be for the fiscal year during which dental coverage is provided by the plan. All terms used in the MLR annual report shall have the same meaning as used in the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18), Part 158 (commencing with 158.101) of Title 45 of the Code of Federal Regulations, and Section 1367.003.

(c) If data verification of the carrier's representations in the MLR annual report is deemed necessary, the commissioner shall provide the carrier with a notification 30 days before the commencement of the financial examination.

(d) The carrier shall have 30 days from the date of notification to submit to the commissioner all requested data. The commissioner may extend the time for a health care service plan to comply with this subdivision upon a finding of good cause.

(e) The commissioner shall make available to the public all data provided to the commissioner pursuant to this section.

Section 5. Excess Revenue; Patient Rebate

(a) A carrier that issues, sells, renews, or offers a plan shall provide an annual rebate to each enrollee under that coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the carrier on the costs for reimbursement for services provided to enrollees under that coverage and for activities that improve dental care quality to the total amount of premium revenue, excluding federal and state taxes and licensing or regulatory fees, and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance, is less than 85%***.

****Drafting Note: States may wish to consider a different percentage in order to account for varying state economic realities.****

(b) The total amount of an annual rebate required under this section shall be calculated in an amount equal to the product of the amount by which the percentage described in subsection (a) of this section exceeds the insurer's reported ratio described in subsection (a) of this section multiplied by the total amount of premium revenue, excluding federal and state taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance.

(c) A carrier shall provide any rebate owing to an enrollee no later than xxxxx of the fiscal year following the year for which the ratio described in subsection (a) of this section was calculated.

Section 6. Rules

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

Section 7. Effective Date

This Act shall take effect xxxxxxx.

616 Fifth Avenue, Suite 106
Belmar, NJ 07719
732-201-4133
CHIEF EXECUTIVE OFFICER: Thomas B. Considine

National Council of Insurance Legislators (NCOIL)

Hospital Price Transparency Model Act

Sponsored by Rep. Tom Oliverson (TX), M.D. – NCOIL Vice President
Co-sponsored by Rep. Rachel Roberts (KY)

Draft as of February 8, 2023. To be discussed during the Health Insurance & Long Term Care Issues Committee Meeting on March 12, 2023.

Table of Contents

Section 1. Short Title

This Act shall be known and may be cited as the [State] Hospital Price Transparency Act.

Section 2. Purpose

The purpose of this Act is to require healthcare facilities to disclose prices for certain items and services provided by certain medical facilities; provide administrative penalties; prohibit collective action of debt for non-compliant facilities.

Section 3. Definitions

(1) "Ancillary service" means a facility item or service that a facility customarily provides as part of a shoppable service.

(2) "Chargemaster" means the list of all facility items or services maintained by a facility for which the facility has established a charge.

(3) "[insert relevant state health agency acronym, if any]" means the [insert relevant state health agency].

(4) "Collection action" means any of the following actions taken with respect to a debt for items and services that were purchased from or provided to a patient by a hospital on a date during which the hospital was not in material compliance with hospital price transparency laws:

> (a) Attempting to collect a debt from a patient or patient guarantor by referring the debt, directly or indirectly, to a debt collector, a collection agency, or other third party retained by or on behalf of the hospital;
>
> (b) Suing the patient or patient guarantor, or enforcing an arbitration or mediation clause in any hospital documents including contracts, agreements, statements, or bills; or
>
> (c) Directly or indirectly causing a report to be made to a consumer reporting agency.

(5) "Collection agency" means any:

> (a) Person who engages in a business the principal purpose or which is the collection of debts; or
>
> (b) Person who:
>
> > (i) Regularly collects or attempts to collect, directly or indirectly, debts owed or due or asserted to be owed or due to another;
> >
> > (ii) Takes assignment of debts for collection purposes; or

(iii) Directly or indirectly solicits for collection debts owed or due or asserted to be owed or due to another.

(6) “Consumer reporting agency” means any person that, for monetary fees, dues, or on a cooperative nonprofit basis, regularly engages, in whole or in part, in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties. “Consumer reporting agency” includes any person defined in 15 U.S.C. sec. 1681a (f) or [insert citation to appropriate state law]. “Consumer reporting agency” does not include any business entity that provides check verification or check guarantee services only.

(7) “Debt” means any obligation or alleged obligation of a consumer to pay money arising out of a transaction, whether or not the obligation has been reduced to judgment. “Debt” does not include a debt for business, investment, commercial, or agricultural purposes or a debt incurred by a business.

(8) “Debt collector” means any person employed or engaged by a collection agency to perform the collection of debts owed or due or asserted to be owed or due to another.

(9) “De-identified maximum negotiated charge” means the highest charge that a facility has negotiated with all third party payors for a facility item or service.

(10) “De-identified minimum negotiated charge” means the lowest charge that a facility has negotiated with all third party payors for a facility item or service.

(11) “Discounted cash price” means the charge that applies to an individual who pays cash, or a cash equivalent, for a facility item or service.

(12) “Facility” means a hospital licensed under [insert appropriate state law].

(13) “Facility items or services” means all items and services, including individual items and services and service packages, that may be provided by a facility to a patient in connection with an inpatient admission or an outpatient department visit, as applicable, for which the facility has established a standard charge, including:

(a) supplies and procedures;

(b) room and board;

(c) use of the facility and other areas, the charges for which are generally referred to as facility fees;

(d) services of physicians and non-physician practitioners, employed by the facility, the charges for which are generally referred to as professional charges; and

(e) any other item or service for which a facility has established a standard charge.

(14) “Federal Centers for Medicare and Medicaid Services” or “CMS” means the Center for Medicare and Medicaid Services in the United States Department of Health and Human Services.

(15) “Gross charge” means the charge for a facility item or service that is reflected on a facility’s chargemaster, absent any discounts.

(16) “Hospital” means, consistent with 45 CFR 180.20, a hospital:

(a) Licensed or certified by the [Department] pursuant to [insert citation to appropriate state law]; or

(b) Approved by the [Department] as meeting the standards established for licensing a hospital.

(17) “Hospital price transparency laws” means Section 2718(e) of the “Public Health Service (PHS) Act,” Pub.L. 78-410, as amended, and rules adopted by the United States Department of Health and Human Services implementing section 2718(e).

(18) “Items and services” or “items or services” means “items and services” as defined in 45 CFR 180.20.25-3-803.

(19) “Machine-readable format” means a digital representation of information in a file that can be imported or read into a computer system for further processing. The term includes .XML, .JSON, and .CSV formats.

(20) “Payor-specific negotiated charge” means the charge that a facility has negotiated with a third party payor for a facility item or service.

(21) “Service package” means an aggregation of individual facility items or services into a single service with a single charge.

(22) “Shoppable service” means a service that may be scheduled by a health care consumer in advance.

(23) “Standard charge” means the regular rate established by the facility for a facility item or service provided to a specific group of paying patients. The term includes all of the following, as defined under this section:

(a) the gross charge;

(b) the payor-specific negotiated charge;

(c) the de-identified minimum negotiated charge;

(d) the de-identified maximum negotiated charge; and

(e) the discounted cash price.

(24) "Third party payor" means an entity that is, by statute, contract, or agreement, legally responsible for payment of a claim for a facility item or service.

Section 4. Healthcare Facilities Required to Disclose Certain Prices to Patients/Public Availability of Price Information Required

Notwithstanding any other law, a facility must make public:

(1) a digital file in a machine-readable format that contains a list of all standard charges for all facility items or services as described by Section 5 of this Act; and

(2) a consumer-friendly list of standard charges for a limited set of shoppable services as provided in Section 6 of this Act.

Section 5. List of Standard Charges Required

(a) A facility must:

(1) maintain a list of all standard charges for all facility items or services in accordance with this section; and

(2) ensure the list required under Subdivision (1) is available at all times to the public, including by posting the list electronically in the manner provided by this section.

(b) The standard charges contained in the list required to be maintained by a facility under Subsection(a) must reflect the standard charges applicable to that location of the facility, regardless of whether the facility operates in more than one location or operates under the same license as another facility.

(c) The list required under Subsection (a) must include the following items, as applicable:

(1) a description of each facility item or service provided by the facility;

(2) the following charges for each individual facility item or service when provided in either an inpatient setting or an outpatient department setting, as applicable:

(A) the gross charge;

(B) the de-identified minimum negotiated charge;

(C) the de-identified maximum negotiated charge;

(D) the discounted cash price; and

(E) the payor-specific negotiated charge, listed by the name of the third party payor and plan associated with the charge and displayed in a manner that clearly associates the charge with each third party payor and plan; and

(3) any code used by the facility for purposes of accounting or billing for the facility item or service, including the Current Procedural Terminology (CPT) code, the Healthcare Common Procedure Coding System (HCPCS) code, the Diagnosis Related Group (DRG) code, the National Drug Code (NDC), or other common identifier.

(d) The information contained in the list required under Subsection (a) must be published in a single digital file that is in a machine-readable format.

(e) The list required under Subsection (a) must be displayed in a prominent location on the home page of the facility's publicly accessible Internet website or accessible by selecting a dedicated link that is prominently displayed on the home page of the facility's publicly accessible Internet website. If the facility operates multiple locations and maintains a single Internet website, the list required under Subsection (a) must be posted for each location the facility operates in a manner that clearly associates the list with the applicable location of the facility.

(f) The list required under Subsection (a) must:

(1) be available:

(A) free of charge;

(B) without having to establish a user account or password;

(C) without having to submit personal identifying information; and

(D) without having to overcome any other impediment, including entering a code to access the list;

(2) be accessible to a common commercial operator of an Internet search engine to the extent necessary for the search engine to index the list and display the list as a result in response to a search query of a user of the search engine;

(3) be formatted in a manner prescribed by the [insert relevant state health agency];

(4) be digitally searchable; and

(5) use the following naming convention specified by the Centers for Medicare and Medicaid Services, specifically: <ein>_<facility name>_standardcharges.[jsonxmlcsv]

(g) In prescribing the format of the list under Subsection (f)(3), the [insert relevant state health agency] must:

(1) develop a template that each facility must use in formatting the list; and

(2) in developing the template under Subdivision (1):

(A) consider any applicable federal guidelines for formatting similar lists required by federal law or rule and ensure that the design of the template enables health care researchers to compare the charges contained in the lists maintained by each facility; and

(B) design the template to be substantially similar to the template used by the Centers for Medicare and Medicaid Services for purposes similar to those of this chapter, if the [insert relevant state health agency] determines that designing the template in that manner serves the purposes of Paragraph (A) and that the [insert relevant state health agency] benefits from developing and requiring that substantially similar design.

(h) The facility must update the list required under Subsection (a) at least once each year. The facility must clearly indicate the date on which the list was most recently updated, either on the list or in a manner that is clearly associated with the list.

Section 6. Consumer-Friendly List of Shoppable Services

(a) Except as provided by Subsection (c), a facility must maintain and make publicly available a list of the standard charges described by Section 5 of this Act for each of at least 300 shoppable services provided by the facility. The facility may select the shoppable services to be included in the list, except that the list must include:

(1) the 70 services specified as shoppable services by the Centers for Medicare and Medicaid Services; or

(2) if the facility does not provide all of the shoppable services described by Subdivision (1), as many of those shoppable services the facility does provide.

(b) In selecting a shoppable service for purposes of inclusion in the list required under Subsection (a), a facility must:

(1) consider how frequently the facility provides the service and the facility's billing rate for that service; and

(2) prioritize the selection of services that are among the services most frequently provided by the facility.

(c) If a facility does not provide 300 shoppable services, the facility must maintain a list of the total number of shoppable services that the facility provides in a manner that otherwise complies with the requirements of Subsection (a).

(d) The list required under Subsection (a) or (c), as applicable, must:

(1) include:

(A) a plain-language description of each shoppable service included on the list;

(B) the payor-specific negotiated charge that applies to each shoppable service included on the list and any ancillary service, listed by the name of the third party payor and plan associated with the charge and displayed in a manner that clearly associates the charge with the third party payor and plan;

(C) the discounted cash price that applies to each shoppable service included on the list and any ancillary service or, if the facility does not offer a discounted cash price for one or more of the shoppable or ancillary services on the list, the gross charge for the shoppable service or ancillary service, as applicable;

(D) the de-identified minimum negotiated charge that applies to each shoppable service included on the list and any ancillary service;

(E) the de-identified maximum negotiated charge that applies to each shoppable service included on the list and any ancillary service; and

(F) any code used by the facility for purposes of accounting or billing for each shoppable service included on the list and any ancillary service, including the Current Procedural Terminology (CPT) code, the Healthcare Common Procedure Coding System (HCPCS) code, the Diagnosis Related Group (DRG) code, the National Drug Code (NDC), or other common identifier; and

(2) if applicable:

(A) state each location at which the facility provides the shoppable service and whether the standard charges included in the list apply at that location

to the provision of that shoppable service in an inpatient setting, an outpatient department setting, or in both of those settings, as applicable; and

(B) indicate if one or more of the shoppable services specified by the Centers for Medicare and Medicaid Services is not provided by the facility.

(e) The list required under Subsection (a) or (c), as applicable, must be:

(1) displayed in the manner prescribed by Section 5 of this Act for the list required under that section;

(2) available:

(A) free of charge;

(B) without having to register or establish a user account or password;

(C) without having to submit personal identifying information; and

(D) without having to overcome any other impediment, including entering a code to access the list;

(3) searchable by service description, billing code, and payor;

(4) updated in the manner prescribed by Section 5 of this Act for the list required under that section;

(5) accessible to a common commercial operator of an Internet search engine to the extent necessary for the search engine to index the list and display the list as a result in response to a search query of a user of the search engine; and

(6) formatted in a manner that is consistent with the format prescribed by the [insert relevant state health agency] under Section 5 of this Act.

Section 7. Reporting Requirement

Each time a facility updates a list as required under Sections 5 and 6 of this Act, the facility must submit the updated list to the [insert relevant state health agency]. The [insert relevant state health agency] must prescribe the form in which the updated list must be submitted to the [insert relevant state health agency].

Section 8. Monitoring and Enforcement

(a) The [insert relevant state health agency] must monitor each facility's compliance with the requirements of this chapter using any of the following methods:

(1) evaluating complaints made by persons to the [insert relevant state health agency] regarding noncompliance with this chapter;

(2) reviewing any analysis prepared regarding noncompliance with this chapter;

(3) auditing the Internet websites of facilities for compliance with this chapter; and

(4) confirming that each facility submitted the lists required under Section 7 of this Act.

(b) If the [insert relevant state health agency] determines that a facility is not in compliance with a provision of this chapter, the [insert relevant state health agency] must take the following actions:

(1) provide a written notice to the facility that clearly explains the manner in which the facility is not in compliance with this chapter;

(2) request a corrective action plan from the facility if the facility has materially violated a provision of this chapter, as determined under Section 9 of this Act; and

(3) impose an administrative penalty, as determined in Section 10 of this Act on the facility and publicize the penalty on the [insert relevant state health agency] Internet website if the facility fails to:

(A) respond to the [insert relevant state health agency] request to submit a corrective action plan; or

(B) comply with the requirements of a corrective action plan submitted to the [insert relevant state health agency].

(c) Beginning not later than 90 days after the date of the enactment of this Act, the [insert relevant state health agency] must create and maintain a publicly available list on its website of hospitals that have been found to have violated the hospital price transparency rule, that has been issued an administrative penalty or sent a warning notice, a request for a corrective action plan, or any other written communication from the [insert relevant state agency]. Such penalties, notices, and communications must be subject to public disclosure under 5 U.S.C. 552, notwithstanding any exemptions or exclusions to the contrary, in full without redaction. Such list will be updated at least every 30 days thereafter.

(d) Notwithstanding any provision of law to the contrary, in considering an application for renewal of a hospital's license or certification, the Department must consider whether the hospital is or has been in compliance with hospital price transparency laws.

Section 9. Material Violation; Corrective Action Plan

(a) A facility materially violates this chapter if the facility fails to:

(1) comply with the requirements of Section 4 of this Act; or

(2) publicize the facility's standard charges in the form and manner required by Sections 5 and 6 of this Act.

(b) If the [insert relevant state health agency] determines that a facility has materially violated this chapter, the [insert relevant state health agency] must issue a notice of material violation to the facility and request that the facility submit a corrective action plan. The notice must indicate the form and manner in which the corrective action plan must be submitted to the [insert relevant state health agency], and clearly state the date by which the facility must submit the plan.

(c) A facility that receives a notice under Subsection (b) must:

(1) submit a corrective action plan in the form and manner, and by the specified date, prescribed by the notice of violation; and

(2) as soon as practicable after submission of a corrective action plan to the [insert relevant state health agency], act to comply with the plan.

(d) A corrective action plan submitted to the [insert relevant state health agency] must:

(1) describe in detail the corrective action the facility will take to address any violation identified by the [insert relevant state health agency] in the notice provided under Subsection (b); and

(2) provide a date by which the facility will complete the corrective action described by Subdivision (1).

(e) A corrective action plan is subject to review and approval by the [insert relevant state health agency]. After the [insert relevant state health agency] reviews and approves a facility's corrective action plan, the [insert relevant state health agency] must monitor and evaluate the facility's compliance with the plan.

(f) A facility is considered to have failed to respond to the [insert relevant state health agency] request to submit a corrective action plan if the facility fails to submit a corrective action plan:

(1) in the form and manner specified in the notice provided under Subsection (b); or

(2) by the date specified in the notice provided under Subsection (b).

(g) A facility is considered to have failed to comply with a corrective action plan if the facility fails to address a violation within the specified period of time contained in the plan.

Section 10. Administrative Penalty

(a) The [insert relevant state health agency] must impose an administrative penalty on a facility in accordance with [insert relevant state code section] if the facility fails to:

(1) respond to the [insert relevant state health agency] request to submit a corrective action plan; or

(2) comply with the requirements of a corrective action plan submitted to the [insert relevant state health agency].

(b) The [insert relevant state health agency] must impose an administrative penalty on a facility for a violation of each requirement of this chapter. The [insert relevant state health agency] must set the penalty in an amount sufficient to ensure compliance by facilities with the provisions of this chapter subject to the limitations prescribed by Subsection (c).

(c) For a facility with one of the following total gross revenues as reported to the Centers for Medicare and Medicaid Services or to another entity designated by [insert relevant state health agency] rule in the year preceding the year in which a penalty is imposed, the penalty imposed by the [insert relevant state health agency] must not be lower than:

‘‘(i) in the case of a hospital with a six-bed count of 30 or fewer, $600 for each day in which the hospital fails to comply with such requirements;

‘‘(ii) in the case of a hospital with a bed count that is greater than 30 and equal to or fewer than 550, $20 per bed for each day in which the hospital fails to comply with such requirements; or

‘‘(iii) in the case of a hospital with a bed count that is greater than 550, $11,000 for each day in which the hospital fails to comply with such requirements

(d) Each day a violation continues is considered a separate violation.

(e) In determining the amount of the penalty, the [insert relevant state health agency] must consider:

(1) previous violations by the facility's operator;

(2) the seriousness of the violation;

(3) the demonstrated good faith of the facility's operator; and

(4) any other matters as justice may require.

(f) An administrative penalty collected under this chapter must be deposited to the credit of an account in the general revenue fund administered by the [insert relevant state health agency]. Money in the account must be appropriated only to the [insert relevant state health agency].

Section 11. Legislative Recommendations

The [insert relevant state health agency] must propose to the legislature recommendations for amending this chapter, including recommendations in response to amendments by the Centers for Medicare and Medicaid Services to 45 C.F.R. Part 180.

Section 12. Prohibiting Collective Action of Debt Against Patients for Non-Compliant Facilities

(1) (a) Except as provided in Subsection (1)(b) of this section, on and after the effective date of this section, a hospital that is not in material compliance with hospital price transparency laws on the date that items or services are purchased from or provided to a patient by the hospital must not initiate or pursue a collection action against the patient or patient guarantor for a debt owed for the items or services.

(b) This Section applies, on and after [Insert applicable date here], to critical access hospitals licensed and certified by the Department pursuant to 42 CFR 485 Subpart F.

(2) If a patient believes that a hospital was not in material compliance with hospital price transparency laws on a date on or after the effective date of this section that items or services were purchased by or provided to the patient, and the hospital takes a collection action against the patient or patient guarantor, the patient or patient guarantor may file suit to determine if the hospital was materially out of compliance with the hospital price transparency laws and rules and regulations on the date of service, and the noncompliance is related to the items or services. The hospital must not take a collection action against the patient or patient guarantor while the lawsuit is pending.

(3) A hospital that has been found by a judge or jury, considering compliance standards issued by the Federal Centers for Medicare and Medicaid Services, to be materially out of compliance with hospital price transparency laws and rules and regulations:

(a) Must refund the payer any amount of the debt the payer has paid and must pay a penalty to the patient or patient guarantor in an amount equal to the total amount of the debt;

(b) Must dismiss or cause to be dismissed any court action with prejudice and pay any attorney fees and costs incurred by the patient or patient guarantor relating to the action; and

(c) Remove or cause to be removed from the patient's or patient guarantor's credit report any report made to a consumer reporting agency relating to the debt.

(4) Nothing in this Section:

(a) Prohibits a hospital from billing a patient, patient guarantor, or third-party payer, including health insurer, for items or services provided to the patient; or

(b) Requires a hospital to refund any payment made to the hospital for items or services provided to the patient, so long as no collection action is taken in violation of this Section.

Section 13. Rules

The [insert relevant state health agency] shall adopt rules as necessary to effectuate the provisions of this Act.

Section 14. Effective Date

This Act shall take effect xxxxxx.

616 Fifth Avenue, Suite 106
Belmar, NJ 07719
732-201-4133
CHIEF EXECUTIVE OFFICER: Thomas B. Considine

National Council of Insurance Legislators (NCOIL)

Pharmacy Benefits Manager Licensure and Regulation Model Act

Adopted by the Health and Long Term Care Issues Committee and Executive Committee on December 8, 2018
Sponsored by Sen. Jason Rapert (AR)
To be discussed during the interim meeting of the Health Insurance & Long Term Care Issues Committee on February 17, 2023 and considered for re-adoption during the Committee's meeting on March 12, 2023.

Table of Contents

Section 1. Title

This Act shall be known as and may be cited as the "[State] Pharmacy Benefits Manager Licensure and Regulation Act."

Section 2. Purpose

(a) This Act establishes the standards and criteria for the regulation and licensure of pharmacy benefits managers providing claims processing services or other prescription drug or device services for health benefit plans.

(b) The purpose of this Act is to:

(1) Promote, preserve, and protect the public health, safety, and welfare through effective regulation and licensure of pharmacy benefits managers;

(2) Promote the solvency of the commercial health insurance industry, the regulation of which is reserved to the States by the McCarran-Ferguson Act (15 U.S.C. §§ 1011 – 1015), as well as provide for consumer savings, and fairness in prescription benefits.

(3) Provide for powers and duties of the Insurance Commissioner, the State Insurance Department; and

(4) Prescribe penalties and fines for violations of this Act.

Section 3. Definitions

For purposes of this Act:

(a) "Claims processing services" means the administrative services performed in connection with the processing and adjudicating of claims relating to pharmacist services that include:

(1) Receiving payments for pharmacist services;

(2) Making payments to pharmacists or pharmacies for pharmacist services; or

(3) Both subdivisions (a)(1) and (2) of this section.

(b) "Other prescription drug or device services" means services other than claims processing services, provided directly or indirectly, whether in connection with or separate from claims processing services, including without limitation:

(1) Negotiating rebates, discounts, or other financial incentives and arrangements with drug companies;

(2) Disbursing or distributing rebates;

(3) Managing or participating in incentive programs or arrangements for pharmacist services;

(4) Negotiating or entering into contractual arrangements with pharmacists or pharmacies, or both;

(5) Developing formularies;

(6) Designing prescription benefit programs; or

(7) Advertising or promoting services.

(c) "Pharmacist" means an individual licensed as a pharmacist by the State Board of Pharmacy.

(d) "Pharmacist services" means products, goods, and services, or any combination of products, goods, and services, provided as a part of the practice of pharmacy.

(e) "Pharmacy" means the place licensed by the State Board of Pharmacy in which drugs, chemicals, medicines, prescriptions, and poisons are compounded, dispensed, or sold at retail.

(f) (1) "Pharmacy benefits manager" means a person, business, or entity, including a wholly or partially owned or controlled subsidiary of a pharmacy benefits manager, that provides claims processing services or other prescription drug or device services, or both, for health benefit plans.

(2) "Pharmacy benefits manager" does not include any:

(i) Healthcare facility licensed in [this State];

(ii) Healthcare professional licensed in [this State]; or

(iii) Consultant who only provides advice as to the selection or performance of a pharmacy benefits manager.

Section 4. License to do business – Annual statement – Assessment

(a) (1) A person or organization shall not establish or operate as a pharmacy benefits manager in this State for health benefit plans without obtaining a license from the Insurance Commissioner under this Act.

(2) The commissioner shall prescribe the application for a license to operate in this State as a pharmacy benefits manager and may charge application fees and renewal fees as established by rule.

(b) The commissioner shall issue rules establishing the licensing, fees, application, financial standards, and reporting requirements of pharmacy benefits managers under this Act and not inconsistent herewith.

Section 5. Gag clauses prohibited

Drafting Note: *In addition to the Model language set forth below, States seeking to enact "gag clause" legislation may look to Federal law for guidance. Specifically, S.2553 – The Know the Lowest Price Act of 2018" – and S. 2554 – The Patient Right Know Drug Prices Act."*

(a) In any participation contracts between pharmacy benefits managers and pharmacists or pharmacies providing prescription drug coverage for health benefit plans, no pharmacy or pharmacist may be prohibited, restricted, or penalized in any way from disclosing to any covered person any healthcare information that the pharmacy or pharmacist deems appropriate regarding the nature of treatment, risks, or alternatives thereto, the availability of alternate therapies, consultations, or tests, the decision of utilization reviewers or similar persons to authorize or deny services, the process that is used to authorize or deny healthcare services or benefits, or information on financial incentives and structures used by the insurer.

(b) A pharmacy or pharmacist may provide to an insured information regarding the insured's total cost for pharmacist services for a prescription drug.

(c) A pharmacy or pharmacist shall not be proscribed by a pharmacy benefits manager from discussing information regarding the total cost for pharmacist services for a prescription drug or from selling a more affordable alternative to the insured if a more affordable alternative is available.

(d) A pharmacy benefits manager contract with a participating pharmacist or pharmacy shall not prohibit, restrict, or limit disclosure of information to the Insurance Commissioner, law enforcement, or state and federal governmental officials investigating or examining a complaint or conducting a review of a pharmacy benefits manager's compliance with the requirements under this Act.

Section 6. Enforcement

(a) The Insurance Commissioner shall enforce this Act.

(b) (1) The commissioner may examine or audit the books and records of a pharmacy benefits manager providing claims processing services or other prescription drug or device services for a health benefit plan to determine if the pharmacy benefits manager is in compliance with this Act.

(2) The information or data acquired during an examination under subdivision (b)(1) of this section is:

(A) Considered proprietary and confidential; and

(B) Not subject to the [Freedom of Information Act][1] of this State

Section 7. Rules

(a) The Insurance Commissioner may adopt rules regulating pharmacy benefits managers that are not inconsistent with this Act.

(b) Rules adopted under this Act shall set penalties or fines, including without limitation monetary fines, suspension of licensure, and revocation of licensure for violations of this Act and rules adopted under this Act.

Drafting Note: *Although Section 7(a) expressly authorizes rules not inconsistent with this Act, as opposed to those merely implementing it, states may also wish to consider providing the Insurance Commissioner with specific guidance to adopt regulations relating to:*

(1) Pharmacy benefits manager network adequacy;

(2) Prohibited market conduct practices;

(3) Data reporting requirements under State price-gouging laws

(4) Rebates;

(5) Prohibitions and limitations on the corporate practice of medicine (CPOM)[2]

(6) Compensation;

(7) Procedures for pharmacy audits conducted by or on behalf of a pharmacy benefits manager;

(8) Medical loss ratio (MLR) abuses;

(9) Affiliate information sharing;

(10) Lists of health benefit plans administered by a pharmacy benefits manager in this state.

Section 8. Applicability

[1] DRAFTING NOTE: State FOIAs have different names in different states, often called Open Records Acts, Public Records Act, Public Records Law, etc. and thus the specific title used in this subsection needs to be tailored accordingly.

[2] Commissioners may wish to evaluate whether PBMs disregarding of physicians' prescribing practices and substituting their (PBMs') own judgment through the use of mandated step therapy constitutes the practice of medicine

(a) This Act is applicable to a contract or health benefit plan issued, renewed, recredentialed, amended, or extended on and after _____.

(b) A contract existing on the date of licensure of the pharmacy benefits manager shall comply with the requirements of this Act as a condition of licensure for the pharmacy benefits manager.

(c) Nothing in this Act is intended or shall be construed to be in conflict with existing relevant federal law.

Section 9. Severability Clause

If any provision of this act or the application of this act to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of this act which can be given effect without the invalid provision or application, and to this end, the provisions of this act are declared severable.

Section 10. Effective Date

This Act is effective immediately.

EXECUTIVE COMMITTEE MATERIAL

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
EXECUTIVE COMMITTEE
2022 NCOIL ANNUAL MEETING – NEW ORLEANS, LA
NOVEMBER 19, 2022
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Executive Committee met at the Sheraton New Orleans Hotel in New Orleans, LA on Saturday November 19, 2022 at 12:00 PM (EST).

NCOIL President, Assemblyman Ken Cooley (CA), Chair of the Committee, presided.

Other members of the committee present:

Rep. Deborah Ferguson, DDS (AR)
Sen. Jason Rapert (AR)
Rep. Matt Lehman (IN)
Rep. Edmond Jordan (LA)
Rep. Brenda Carter (MI)
Sen. Paul Utke (MN)
Asw. Pam Hunter (NY)
Sen. Bob Hackett (OH)
Rep. Carl Anderson (SC)
Sen. Mary Felzkowski (WI)
Del. Steve Westfall (WV)

Other legislators present were:

Rep. Kerry Wood (CT)
Sen. Robert Mills (LA)
Sen. George Lang (OH)
Rep. Forrest Bennett (OK)

Also in attendance were:

Will Melofchik, NCOIL General Counsel
Pat Gilbert, Manager, Administration & Member Services, NCOIL Support Services, LLC

QUORUM

Upon a motion made by Asw. Pamela Hunter (NY) and seconded by Rep. Carl Anderson (SC), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a motion made by Asw. Hunter and seconded by Del. Steve Westfall (WV) the Committee voted without objection by way of a voice vote to approve the minutes of the Committee's July 16, 2022 meeting in Jersey City.

FUTURE MEETING LOCATIONS

Asm. Cooley stated that we have had a tremendous meeting in New Orleans. As we look ahead, the 2023 Spring Meeting will be in San Diego, CA from March 9th-12th, the 2023 Summer Meeting will be in Minneapolis, MN from July 19th-23rd, and the 2023 Annual Meeting will be in Columbus, OH from November 15th -18th. NCOIL has also recently signed a contract with the Francis Marion Hotel in Charleston, SC for the 2025

Spring Meeting from April 24th-27th. Rep. Anderson stated that he was glad NCOIL will be coming back to South Carolina.

Asm. Cooley continued that the 2026 Summer Meeting will be in Boston, MA at the Westin Copley Place from July 15th-18th. It is likely that the 2025 Summer Meeting will be in Chicago pending confirmation from Illinois on their NCOIL membership status.

ADMINISTRATION

Will Melofchik, NCOIL General Counsel, stated that NCOIL set a record this Meeting for the highest-attended NCOIL National Meeting ever with 393 total attendees including 68 legislators from 28 states which includes 9 first time legislators from 8 states. Additionally, 9 Insurance Commissioners participated with 17 total insurance departments represented.

Mr. Melofchik gave the 2022 unaudited financials through October 31st of this year showing revenue of $1,427,394.14 and expenses of $1,066,530.89 leading to a surplus of $360,863.23 heading into this meeting.

CONSENT CALENDAR

Asm. Cooley noted that the consent calendar includes committee reports including resolutions and model laws adopted and re-adopted therein, as well as ratification of decisions made and actions taken by the NCOIL Officers in the time between Executive Committee Meetings.

The Consent Calendar included:

• The Life Insurance & Financial Planning Committee adopted the NCOIL Paid Family Leave (PFL) Insurance Model Act.
• The Financial Services & Multi-Lines Issues Committee adopted the NCOIL Insurance Regulatory Sandbox Model Act. The Committee also re-adopted: Model Act to Support State Regulation of Insurance by Requiring Competition Among Rating Agencies (with amendments); Model Act Prohibiting Consumer Reporting Agencies from Charging Fees Related to Security Freezes; Credit Report Protection for Minors Model Act; and Credit Default Insurance Model Legislation.
• The Property & Casualty Insurance Committee adopted the NCOIL Delivery Network Company (DNC) Insurance Model Act; and the NCOIL Dog Breed Insurance Underwriting Protection Model Act.
• The Articles of Organization & Bylaws Revision Committee adopted amendments to the NCOIL Articles of Organization & Bylaws.
• The Joint State-Federal Relations & International Insurance Issues Committee readopted the Exhaustion of Administrative Remedies Model Act and the Producer Compensation Disclosure Model Amendment to the Producer Licensing Model Act.
• 2023 NCOIL budget as adopted by the Budget Committee on 11/18/2022.
• Ratification of decisions made and actions taken by the NCOIL Officers and staff in the time between Executive Committee Meetings.

Asm. Cooley asked if any Committee member wanted anything removed from the consent calendar. Hearing no such requests, upon a motion made by Rep. Anderson

and seconded by Asw. Hunter, the Committee voted to adopt the consent calendar without objection by way of a voice vote.

OTHER SESSIONS

Asm. Cooley stated that during the course of this meeting, the Institutes Griffith Foundation held both a Legislator Luncheon and Breakfast. Paul Traynor JD, LLM, Assistant Professor of Law at the University of North Dakota School of Law gave an outstanding presentation on pandemic related business interruption coverage as it relates to the past, present, and future. At the breakfast, Amanda Cook Ph.D., Associate Professor in Economics at the Bowling Green State University Schmidthorst College of Business and Tice Sirmans Ph.D., Assistant Professor of Risk Management and Insurance at the Illinois State University College of Business delivered a primer for public policymakers exploring the structure of the U.S. health insurance system. Asm. Cooley noted it was interesting how when someone mentioned during the breakfast that health insurance could be discussed for hours, he recollected when he first attended an NCOIL Meeting in Washington, DC in 1990, a topic was health insurance, so that can certainly be talked about for hours, indeed decades.

There were also three interesting and timely general sessions including: Have Data Privacy Laws and Regulations Kept Up with 21st Century Technology?; Examining the Impact of Wildfire Risk on the Insurance Market; and What's it Going to Cost Me? – A Discussion on Hospital Price Transparency.

Featured speakers included: Louisiana Lieutenant Governor The Hon. Billy Nungesser who spoke at the Welcome Breakfast on Thursday and gave an outstanding overview of the great state of Louisiana; and John Ashford, Chairman & CEO of the Hawthorn Group, who gave an overview of the recent midterm elections during the Luncheon on Friday which was really terrific.

NOMINATING COMMITTEE REPORT

Rep. Matt Lehman (IN), NCOIL Immediate Past President and Co-Chair of the Nominating Committee, stated that the Nominating Committee met Thursday and voted to recommend the new slate of officers for next year which includes two new officers. The Committee's recommendation is Minnesota Senator Paul Utke for the position of Secretary, New York Assemblywoman Pamela Hunter for the position of Treasurer, Texas Representative Tom Oliverson, M.D. for the position of Vice President, and Arkansas Representative Deborah Ferguson, DDS for the position of President. As you may notice, the slate of officers is slightly out of order due to Assemblyman Kevin Cahill (NY) departing the legislature and not having Rep. Oliverson serve as President. Importantly, this slate of Officers maintains the bipartisan makeup of the NCOIL leadership.

Upon a motion made by Rep. Lehman and seconded by Rep. Anderson, the committee voted without objection by way of a voice vote to adopt the new slate of officers. Rep. Lehman then recognized Asm. Cooley. Rep. Lehman stated he is honored to present Asm. Cooley with the outgoing NCOIL president plaque representing all of the great work he did during his year as NCOIL president. Rep. Lehman noted that it's been an honor to serve together with Asm. Cooley and he will pray that Asm. Cooley comes back

as he provides great stability to the organization. Rep. Lehman concluded by thanking Asm. Cooley for his service at NCOIL and offering his congratulations on a great year.

Asm. Cooley stated that he received a report last night stating that he is now 16 votes down in his race for re-election to the CA Assembly. Asm. Cooley stated that he lives in a very balanced part of California and 123,000 votes have been counted already and he is now just 16 votes down. It actually works out to be a 50/50 race and so all you can do is just sort of watch and wait. There are still probably 30,000 votes left to be counted. Asm. Cooley noted that he represents almost a half million people and has a very well educated older electorate so they vote like clockwork and as much as we are in an era when democracy is under attack, the fundamental idea that people's votes matter is important and is certainly embodied in our constitution.

Asm. Cooley continued that while he is hopeful he will be returning to the legislature, this is American democracy at work and however it sorts itself out every vote matters and there is a system to count them with integrity and the chips will fall where they are. It has been a great privilege to be a part of NCOIL and to serve as president this year and I am hopeful of returning. Again, democracy is fantastic. Asm. Cooley then asked Rep. Ferguson, the newly elected NCOIL President, to provide some remarks.

Rep. Ferguson stated she is grateful to serve as NCOIL President and can't say enough how much she values the organization. Having been involved with a lot of other organizations since becoming a legislator, the limited focus on the insurance market and all of the things accomplished here is what she values most. Rep. Ferguson stated she certainly is following in big footsteps of Asm. Cooley and Rep. Lehman and everyone she's learned from and particularly wants to thank Sen. Jason Rapert (AR), NCOIL Immediate Past President as she certainly would not have been as involved in NCOIL had it not been for his mentorship and encouragement. A lot of people find their friendship interesting because they are in different political parties and disagree on a lot of issues, but they have worked on healthcare and insurance issues collaboratively and that is really representative of what NCOIL is. Rep. Ferguson stated that she wants the organization to remain bi-partisan and have speakers representing both sides of issues because that is the best way to be informed of different points of view. Legislators also must remain respectful to speakers during discussions as we can surely be respectful of other people's opinions even if we don't agree with them.

Rep. Ferguson further stated that she also wanted to thank the corporate sponsors as well as The Hon. Tom Considine, NCOIL CEO and Mr. Melofchik, as well as everyone at NCOIL as they do a great job. With the help of all of the leadership, NCOIL has really turned around in positive ways and is in good fiscal shape. Rep. Ferguson also stated that she really looks forward to serving with her fellow officers as she's gotten to know them during her involvement with NCOIL and they are great people.

Asm. Cooley stated that he appreciated Rep. Ferguson's remarks and talking about the role Sen. Rapert had in being a mentor to her and how he's been very important to the organization. In the nature of his elected life, this is Sen. Rapert's last meeting, so as both a proud mentor and part of this organization, Asm. Cooley invited Sen. Rapert to offer some comments.

Sen. Rapert thanked Asm. Cooley and stated that he attended his first NCOIL Meeting in Santa Fe, NM in 2011 and remembers being immediately drawn in and was asked to be

a part of the organization by Rep. George Keiser (ND), former NCOIL President who passed away last year. For those who knew him, you couldn't think of NCOIL without his presence. Sen. Rapert stated that he appreciated Rep. Ferguson's kind words and he remembers Rep. Brenda Carter's (MI), who is here today, first meeting and is glad she has stayed engaged. Sen. Rapert stated that since this is his last NCOIL meeting as a legislator, he wanted to say he learned we would be a lot better off if we handled our problems nationally as he sees them handled here amongst colleagues and that means a lot.

Sen. Rapert continued by saying NCOIL has been a place where he has made lifelong friends and he was here during a big transition period for the organization and back then he did not know that the best was yet to come for the organization. The leadership that Cmsr. Considine and Mr. Melofchik have provided has been excellent. Sen. Rapert stated that fortunately he will still get to see everyone because he's been asked to continue in a legislative and regulatory affairs position which will include covering NCOIL so that's exciting. Sen. Rapert thanked everyone for their friendship and said it has been an honor to serve as an NCOIL officer.

ANY OTHER BUSINESS

Mr. Melofchik stated that the current auditor utilized for NCOIL is Collins & Co. out of Pennsylvania. There's a limited number of auditing firms that do this work for organizations like NCOIL. He continued that the firm does some guaranty association work and some insurance trade association work. They have been with us for a number of years and continue to put new eyes on the account each year and meet with the NCOIL Audit Committee both with staff in the room and out of the room. It is staff's recommendation that the organization continues to retain that firm.

Hearing no questions or comments, upon a motion made by Sen. Utke and seconded by Rep. Carter, the Committee voted without objection by way of a voice vote to retain Collins & Co. for the 2022 audits.

Asm. Cooley then offered the opportunity for any nominations of legislators to the Executive Committee.

Rep. Lehman stated he would like to nominate Oklahoma Representative Forrest Bennett.

Pursuant to NCOIL bylaws, the chair of the committee responsible for insurance legislation in each legislative house of each Contributing State shall automatically, by nature of his or her office be a member of the Executive Committee. As such, Mr. Melofchik stated that Rep. Kerry Wood (CT), Co-Chair of the CT Joint Insurance & Real Estate Committee should be added to the NCOIL Executive Committee.

Sen. Bob Hackett (OH) stated that Sen. George Lang (OH) is extremely strong on insurance issues and would like to nominate him to the Executive Committee. Additionally, Sen. Hackett noted that Sen. Jay Hottinger (OH) has been involved with NCOIL for 26 years and is now term limited and will be leaving the legislature at the end of this year. Sen. Hottinger has been a great supporter of the organization and successfully got numerous NCOIL Models passed into Ohio State Law.

Upon a motion made by Rep. Lehman and seconded by Sen. Hackett, the Committee voted without objection by way of a voice vote to add Rep. Bennett, Rep. Wood, and Sen. Lang, to the Executive Committee.

Asm. Cooley asked if there was anything else anyone would like to say. Rep. Ferguson stated that one thing she would like everyone to take back to their states is that NCOIL will come to state insurance committees, sometimes with the Institutes Griffith Foundation. Rep. Ferguson stated that when she first became involved in NCOIL, the Griffith Foundation conducted an Insurance 101 session and they will come and do a similar thing in state legislatures. NCOIL will also come to talk about the organization. Everyone should take advantage of that because it would be great to have more legislative colleagues attend NCOIL meetings. Rep. Ferguson also thanked Louisiana for hosting NCOIL.

Rep. Edmond Jordan (LA) stated that he wanted to thank the members of NCOIL and all of the participants for coming to Louisiana and making this the highest attended NCOIL Meeting ever. For a state and city that relies on tourism, he was glad to see so many people attend this meeting and hopes everyone brings back with them that New Orleans and Louisiana are open for business.

Rep. Carter stated that Sen. Rapert changed her life as when she was new at NCOIL and didn't know why she was there, Sen. Rapert reached across the aisle and saw value in her and she thanks him for that.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Carter and seconded by Del. Westfall, the Committee adjourned at 12:30 p.m.