30 DAY MATERIALS AND TENTATIVE GENERAL SCHEDULE
NCOIL SUMMER MEETING
JULY 19 - 22, 2023

As of June 20, 2023, and Subject to Change

The Minneapolis Marriott City Center Hotel
Minneapolis, Minnesota

NCOIL SUMMER MEETING
Minneapolis, Minnesota
July 19 - 22, 2023
TENTATIVE SCHEDULE

WEDNESDAY, JULY 19TH

Budget Committee	9:30 a.m.	-	10:00 a.m.
Audit Committee (Members Only)	10:00 a.m.	-	10:30 a.m.
NCOIL Open Golf Outing to Benefit the Insurance Legislators Foundation (ILF) Scholarship Fund	12:30 p.m.		
Tour of Minnesota State Capitol	3:00 p.m.		
IEC Board Meeting	4:30 p.m.	-	5:15 p.m.
Welcome Reception and Golf Awards Presentation	6:00 p.m.	-	7:30 p.m.

THURSDAY, JULY 20TH

Registration *Exhibits Open: 8:00 a.m. – 5:00 p.m.*	8:00 a.m.	-	5:00 p.m.
Welcome Breakfast	8:15 a.m.	-	9:45 a.m.
Networking Break	9:30 a.m.	-	9:45 a.m.
General Session NCOIL Special Environmental, Social, and Governance (ESG) Series Part 2: Social Aspects	10:00 a.m.	-	11:30 a.m.

Joint State-Federal Relations & International Insurance Issues Committee	11:30 a.m.	-	1:00 p.m.
The Institutes Griffith Foundation Legislator Luncheon Litigation Roundup: The High Court and the Circuits Speak on Insurance ***Open to Public Policymakers and Staff Only***	1:00 p.m.	-	2:00 p.m.
Health Insurance & Long Term Care Issues Committee	2:00 p.m.	-	3:45 p.m.
Networking Break	3:45 p.m.	-	4:00 p.m.
Financial Services & Multi-Lines Issues Committee	4:00 p.m.	-	5:15 p.m.
Adjournment	5:15 p.m.		
CIP Member & Sponsor Reception	6:00 p.m.	-	7:00 p.m.

FRIDAY, JULY 21ST

Registration *Exhibits Open: 8:00 a.m. – 3:00 p.m.*	8:00 a.m.	-	3:00 p.m.
Workers' Compensation Insurance Committee	9:00 a.m.	-	10:30 a.m.
Networking Break	10:30 a.m.	-	10:45 a.m.
NCOIL – NAIC Dialogue	10:45 a.m.	-	12:00 p.m.
Luncheon with Keynote Address	12:00 p.m.	-	1:30 p.m.

Note: There will be a room (Maple Lake on the 4th floor) available throughout the duration of the conference for informal meetings. Attendees should feel free to meet with legislators there throughout the meeting.

General Session Silicon Valley Bank, Signature Bank, and First Republic Failures: Are We in a Banking Crisis?	1:30 p.m.	-	3:00 p.m.
Life Insurance & Financial Planning Committee	3:00 p.m.	-	4:15 p.m.

Articles of Organization & Bylaws Revision Committee	4:15 p.m.	-	4:45 p.m.
Adjournment	4:45 p.m.		

SATURDAY, JULY 22ND

Registration *Exhibits Open: 8:00 a.m. – 11:00 a.m.*	8:00 a.m.	-	11:00 a.m.
Property & Casualty Insurance Committee	9:00 a.m.	-	10:45 a.m.
Networking Break	10:45 a.m.	-	11:00 a.m.
General Session The Ongoing Effort to Achieve Mental Health Parity	11:00 a.m.	-	12:30 p.m.
Executive Committee	12:30 p.m.	-	1:00 p.m.

******Please note all speakers listed are scheduled to speak as of June 20, 2023. There will be modifications between now and the start of the Meeting.******

******Note: There will be a room (Maple Lake on the 4th floor) available throughout the duration of the conference for informal meetings. Attendees should feel free to meet with legislators there throughout the meeting.******

Wednesday, July 19th, 2023

Budget Committee
Wednesday, July 19, 2023
9:30 a.m. – 10:00 a.m.

Chair: Asw. Pam Hunter (NY) – NCOIL Treasurer
Vice Chair: Sen. Travis Holdman (IN) – NCOIL Immediate Past President

1.) Call to Order/Roll Call/Approval of November 18, 2022 Committee Meeting Minutes
2.) 2024 Budget Planning Discussion
3.) Any Other Business
4.) Adjournment

Audit Committee (Members Only)
Wednesday, July 19, 2023
10:00 a.m. – 10:30 a.m.

Chair: Rep. Tom Oliverson, M.D. (TX) – NCOIL Vice President
Vice Chair: Sen. Neil Breslin (NY)

NCOIL Golf Outing to Benefit ILF Scholarship Fund
Wednesday, July 19, 2023
12:30 p.m.

Tour of Minnesota State Capitol
Wednesday, July 19, 2023
3:00 p.m.

IEC Board Meeting
Wednesday, July 19, 2023
4:30 p.m. – 5:15 p.m.

Welcome Reception and Golf Awards Presentation
Wednesday, July 19, 2023
6:00 p.m. – 7:30 p.m.

Thursday, July 20th, 2023

Welcome Breakfast
Thursday, July 20, 2023
8:15 a.m. – 9:45 a.m.

1.) **The Hon. Grace Arnold – Minnesota Insurance Commissioner**
    -Welcome to Minneapolis
2.) **The 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.) Any Other Business
6.) Adjournment

Networking Break
Thursday, July 20, 2023
9:45 a.m. – 10:00 a.m.

General Session
NCOIL Special Environmental, Social, and Governance (ESG) Series
Co-Chairs: Rep. Tom Oliverson, M.D. (TX) – NCOIL Vice President
Asw. Pam Hunter (NY) – NCOIL Treasurer
Part 2: Social Aspects
Thursday, July 20, 2023
10:00 a.m. – 11:30 a.m.

Moderator: Rep. Tom Oliverson, M.D. (TX) – NCOIL Vice President

Professor Joan Schmit
Distinguished Chair, Risk Mgmt. & Insurance
University of Wisconsin-Madison

Stuart Carruthers
Partner
Stikeman Elliott, LLP

Sridhar Manyem
Senior Director – Industry Research
AM Best Rating Services, Inc.

Evelyn Boswell
Director, Diversity Equity & Inclusion
Nat'l Ass'n of Insurance Cmsrs. (NAIC)

Roosevelt Mosley, FCAS, MAAA, CSPA
Principal and Consulting Actuary
Pinnacle Actuarial Resources, Inc.

Joint State-Federal Relations & International Insurance Issues Committee
Thursday, July 20, 2023
11:30 a.m. – 1:00 p.m.

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

1.) Call to Order/Roll Call/Approval of March 10, 2023 Committee Meeting Minutes
2.) Presentation on Tribal Insurers and Their Role Within the State-Based System of Insurance
    Mark Echo-Hawk, Chief Legal Officer – Sovereign Nations Health Consortium (SNHC)
3.) Presentation on Recent Federal Healthcare Reform Proposals
    Joey Mattingly, PharmD, Ph.D., MBA - Associate Professor & Vice Chair for Research, Department of Pharmacotherapy – University of Utah
4.) Overview of Minnesota's "Basic Health Program"
    Julie Marquardt - Acting Assistant Commissioner/State Medicaid Director – Minnesota Department of Human Services
5.) Discussion on Internal Revenue Service (IRS) Proposed Regulation on Captive Insurers
    James Kendrick, First Vice President, Accounting and Capital Policy – Independent Community Bankers of America (ICBA)
6.) Any Other Business
7.) Adjournment

The Institutes Griffith Foundation Legislator Luncheon
Litigation Roundup: The High Court and the Circuits Speak on Insurance
Thursday, July 20, 2023
1:00 p.m. – 2:00 p.m.
*****Open to Public Policymakers and Staff Only*****

Paul E. Traynor, JD, LLM
Assistant Professor of Law
University of North Dakota School of Law

Health Insurance & Long Term Care Issues Committee
Thursday, July 20, 2023
2:00 p.m. – 3:45 p.m.

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

1.) Call to Order/Roll Call/Approval of March 12, 2023 and May 19, 2023 Committee Meeting Minutes
2.) Presentation on New At-Home Addiction Treatment Programs
    Brian Holzer, M.D., President & CEO - Aware Recovery Care
3.) Continued Discussion on NCOIL Medical Loss Ratios for Dental (DLR) Health Care Services Plans Model Act
    Del. Steve Westfall (WV) – Sponsor
    Rep. Rita Mayfield (IL) – Co-sponsor
    Michael Adelberg, Executive Director – Nat'l Ass'n of Dental Plans (NADP)
    Owen Urech, Director of Gov't Relations – NADP
    Chad Olson, Director of State Gov't Affairs – American Dental Ass'n (ADA)
4.) Consideration of NCOIL Hospital Price Transparency Model Act
    Rep. Tom Oliverson, M.D. (TX) - NCOIL Vice President – Sponsor
    Rep. Rachel Roberts (KY) – Co-sponsor
    JP Wieske, VP of State Affairs – Council for Affordable Health Coverage
5.) Consideration of NCOIL Biomarker Testing Insurance Coverage Model Act
    Asw. Pam Hunter (NY) – NCOIL Treasurer – Sponsor
    Sen. Paul Utke (MN) – NCOIL Secretary – Co-sponsor
6.) Introduction of Resolution in Support of Embedded Provision in the State Insurance Code to Protect Health Savings Accounts-Qualified Health Insurance Policies from Certain State Benefit Mandates
    Sen. Jerry Klein (ND)
    Kevin McKechnie, Executive Director, HSA Council - American Bankers Association
7.) Any Other Business
8.) Adjournment

Networking Break
Thursday, July 20, 2023
3:45 p.m. – 4:00 p.m.

Financial Services & Multi-Lines Issues Committee
Thursday, July 20, 2023
4:00 p.m. – 5:15 p.m.

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

1.) Call to Order/Roll Call/Approval of March 11, 2023 Committee Meeting Minutes
2.) Discussion on Proposed Amendments to NCOIL Insurance E-Commerce Model Act
Rep. Edmond Jordan (LA) – Sponsor
3.) Discussion on NCOIL Resolution in Support of Existing Law Exemptions for New Data Privacy Laws
Rep. Forrest Bennett (OK) – Sponsor
4.) Discussion on NCOIL Federal Home Loan Bank (FHLB) Insurer-Member Model Act
Sen. Travis Holdman (IN), NCOIL Immediate Past President – Sponsor
Derek Akin, VP, Ass't General Counsel – FHLB of Dallas
Melissa Dallas, FVP, Corporate Secretary & Counsel – FHLB of Cincinnati
5.) Discussion on Resolution in Support of Establishing National Standards and Procedures for the Reporting and Payment of Premium Taxes Due as a Result of Interstate Insurance Transactions
Bill Bryan, Director – Providence Insurance Partners, LLC
6.) Any Other Business
7.) Adjournment

CIP Member & Sponsor Reception
Thursday, July 20, 2023
6:00 p.m. – 7:00 p.m.

Friday, July 21st, 2023

Workers' Compensation Insurance Committee
Friday, July 21, 2023
9:00 a.m. – 10:30 a.m.

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

1.) Call to Order/Roll Call/Approval of March 10, 2023 Committee Meeting Minutes
2.) "State of the Line" Presentation – An Update on the Status of and Trends in the Workers' Compensation Insurance Marketplace
Jeff Eddinger, Senior Division Executive – National Council on Compensation Insurance (NCCI)
3.) Presentation on Trends in States After Adoption of Drug Formularies
Ramona Tanabe, CEO – Workers Compensation Research Institute (WCRI)
4.) Presentation on Minnesota Workers' Compensation System
Jennifer Wolf, President – Minnesota Workers' Compensation Insurers Association (MWCIA)
5.) Consideration of Re-adoption of Model Laws
a.) Model Act on Workers' Compensation Coverage for Volunteer Firefighters – Originally Adopted 11/24/13; Readopted 7/15/18
b.) Workers' Compensation Pharmaceutical Reimbursement Rates Model Act – Originally Adopted 7/12/13; Readopted 7/15/18; Amended 12/8/18
c.) Construction Industry Workers' Compensation Coverage Act – Originally Adopted 11/22/09; Readopted 7/15/18
d.) Model Act Regarding Workers' Compensation Insurance Coverage in Professional Employer Organization (PEO) Relationships – Originally Adopted 11/15/07; Readopted 11/24/13, 7/15/18
6.) Any Other Business
7.) Adjournment

Networking Break
Friday, July 21, 2023
10:30 a.m. – 10:45 a.m.

NCOIL – NAIC Dialogue
Friday, July 21, 2023
10:45 a.m. – 12:00 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 March 5, 2022 Committee Meeting Minutes
2.) Recap of NAIC D.C. Fly-in and Preview of NCOIL's D.C. Fly-in
3.) Follow-up Discussion on Presentation from Sovereign Nations Health Consortium
4.) Update on Draft NAIC Consumer Privacy Protection Model Law
5.) Discussion on NAIC's Public Adjuster Licensing Model Act and Development of NCOIL's Public Adjuster Professional Standards Reform Model Act
6.) Discussion on NAIC's Development of Model Bulletin on Issues Relating to Artificial Intelligence and the Insurance Industry

7.) Discussion on Recent Federal Trade Commission (FTC) Activities
8.) Any Other Business
9.) Adjournment

Luncheon with Keynote Address
Friday, July 21, 2023
12:00 p.m. – 1:30 p.m.

General Session
Silicon Valley Bank, Signature Bank, and First Republic Failures: Are We in a Banking Crisis?
Friday, July 21, 2023
1:30 p.m. – 3:00 p.m.

Sridhar Manyem
Senior Director – Industry Research
AM Best Rating Services, Inc.

Aaron Klein
Miriam K. Carliner Chair & Senior Fellow
The Brookings Institution

James Kendrick
First Vice President, Accounting and Capital Policy
Independent Community Bankers of America (ICBA)

Max Zappia
Deputy Commissioner, Financial Institutions Division
Minnesota Department of Commerce

Life Insurance & Financial Planning Committee
Friday, July 21, 2023
3:00 p.m. – 4:15 p.m.

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

1.) Call to Order/Roll Call/Approval of March 10, 2023 Committee Meeting Minutes
2.) Continued Discussion on NCOIL Life Insurance is a Promise for Life Model Act
Sen. Travis Holdman (IN) – NCOIL Immediate Past President – Sponsor
3.) Presentation on Minnesota Project to Increase Access to Long-Term Services and Supports
Steve Schoonveld, FSA, MAAA, Managing Director, Global Insurance Services – FTI Consulting

4.) Discussion on NCOIL Resolution Opposing the Return of a U.S. Department of Labor Fiduciary Rule

Rep. Carl Anderson (SC) – Sponsor

Bianca Weiss, State Gov't Relations Manager – National Association of Insurance and Financial Advisors (NAIFA)

5.) Update on Interstate Insurance Product Regulation Compact (IIPRC) Activities

Karen Schutter, Executive Director - IIPRC

6.) Any Other Business

7.) Adjournment

Articles of Organization & Bylaws Revision Committee
Friday, July 21, 2023
4:15 p.m. – 4:45 p.m.

Chair: Sen. Walter Michel (MS)
Vice Chair: Rep. Kevin Coleman (MI)

1.) Call to Order/Roll Call/Approval of November 17, 2022 Committee Meeting Minutes
2.) Discussion and Consideration of Proposed Amendments to NCOIL Articles of Organization & Bylaws
3.) Any Other Business
4.) Adjournment

Saturday, July 22, 2023

Property & Casualty Insurance Committee
Saturday, July 22, 2023
9:00 a.m. – 10:45 a.m.

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

1.) Call to Order/Roll Call/Approval of March 11, 2023 Committee Meeting Minutes
2.) Introduction and Discussion of Proposed Amendments to NCOIL Model State Uniform Building Code

Rep. Jim Dunnigan (UT) – Sponsor

Valerie Brown, Deputy Executive Director - United Policyholders

3.) Introduction and Discussion of NCOIL Catalytic Converter Theft Prevention Model Act

Rep. Tom Oliverson, M.D. (TX) – NCOIL Vice President; Rep. Edmond Jordan (LA) - Joint Sponsors

Pat Martin, Senior Vice President & General Counsel – National Insurance Crime Bureau (NICB)

4.) Introduction and Discussion on NCOIL Public Adjuster Professional Standards Reform Model Act

Rep. Michael Meredith (KY) – Sponsor
Rep. Matt Lehman (IN) – NCOIL Immediate Past President – Co-sponsor
Anne Marie Franklin, Governmental Affairs Manager - Kentucky Farm Bureau
Cole Kline, President - American Association of Public Insurance Adjusters (AAPIA)
Holly Soffer, AAPIA Legal Advisor
Chris Aldrich, President - National Association of Public Insurance Adjusters (NAPIA)
Brian Goodman, General Counsel - NAPIA

5.) Consideration of Re-adoption of Model Laws

a.) Consumer Protection Towing Model Act – Adopted 7/15/18
b.) Model Act Regarding Auto Airbag Fraud – Originally Adopted 11/22/09; Readopted 7/15/18
c.) Model Act Regarding Disclosure of Rental Damage Waivers – Originally Adopted 3/1/08; Readopted 7/15/18
d.) Model Anti-Runners Fraud Bill – Originally Adopted 7/11/03; Readopted 7/8/05, 11/20/10, 7/15/18
e.) Model State Uniform Building Code – Originally Adopted 3/3/07; Readopted 7/15/12, 7/15/18
f.) Property and Casualty Insurance Domestic Violence Model Act – Originally Adopted 3/1/98; Readopted 7/11/03, 7/13/05, 11/20/10, 7/15/18

6.) Any Other Business
7.) Adjournment

Networking Break
Saturday, July 22, 2023
10:45 a.m. – 11:00 a.m.

General Session
The Ongoing Effort to Achieve Mental Health Parity
Saturday, July 22, 2023
11:00 a.m. – 12:30 p.m.

Moderator: Rep. Rachel Roberts (KY)

Daniel Blaney-Koen
Senior Legislative Attorney
American Medical Association

Tim Clement
Director of Legislative Development
American Psychiatric Association

David Lloyd
Chief Policy Officer
The Kennedy Forum

Pamela Greenberg, MPP
President & CEO
Ass'n for Behavioral Health and Wellness (ABHW)

Executive Committee
Saturday, July 22, 2023
12:30 p.m. – 1:00 p.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 March 12, 2023 Committee Meeting Minutes
2.) Update on Future Meeting Locations
3.) Administration
    a.) Meeting Report
    b.) Receipt of Financials and Audit
    c.) Consideration of Audit
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

BUDGET COMMITTEE MATERIAL

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
BUDGET COMMITTEE
NEW ORLEANS, LOUISIANA
NOVEMBER 18, 2022
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Budget Committee met at The Sheraton New Orleans Hotel on Friday, November 18, 2022 at 4:30 p.m.

Senator Jerry Klein of North Dakota, NCOIL Chairman At Large, presided.

Other members of the Committee present were:

Rep. Deborah Ferguson, DDS (AR)
Asm. Ken Cooley (CA)
Rep. Matt Lehman (IN)
Asm. Kevin Cahill (NY)

Other legislators present were:

Sen. Paul Utke (MN)

Also in attendance were:

Will Melofchik, NCOIL General Counsel

MINUTES

Upon a Motion made by Rep. Matt Lehman (IN), NCOIL Immediate Past President, and seconded by Asm. Ken Cooley (CA), NCOIL President, the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 13, 2022 meeting.

CONSIDERATION OF 2023 BUDGET

Sen. Jerry Klein (ND), NCOIL Chairman at Large, thanked everyone for joining and noted that we're here today to consider the adoption of NCOIL's 2023 budget. For those who were at the Committee's last meeting in July, you'll recall that we discussed the proposed budget in detail and all questions and/or comments were resolved. A copy of the proposed budget is before you. Also, there is a separate handout before you which shows the "2022 Actual" financial numbers as of October 31. Those numbers are updated from the June 30 numbers which were the last numbers shown to the Committee at its July meeting. As you can see, NCOIL is having a good year. Some minor changes have been made to the proposed budget since we last met in July. I'll turn things over to Will Melofchik, NCOIL General Counsel, who can explain.

Mr. Melofchik stated that the change made since July relates to reclassifying certain Corporate & Institutional Partner (CIP) revenue. As stated in note 2 of the proposed budget before you, after consultation with the auditor, it was agreed that we should reflect revenue to where it is really attributable. Specifically, while the CIP revenue all

comes in as dues, a portion of it covers the registration costs for CIP member attendance at NCOIL National Meetings. Accordingly, we are now breaking out that portion and moving that revenue portion out of dues and into National Meeting. The end result is that in the proposed budget before you, CIP revenue is reduced by $115,000 and National Meeting revenue is increased by $115,000 in the aggregate. Mr. Melofchik asked if there were any questions on that or anything else.

Asm. Cahill asked for clarification between note 1 in the proposed budget, which states that as of today, 28 states have paid 2022 NCOIL dues, and the current financial numbers which show NCOIL dues revenue at $520,000. Asm. Cahill stated that if NCOIL state dues payments are $20,000, the current revenue number should be $560,000. Mr. Melofchik stated that discrepancy is due to the fact that some states, including NY, split the NCOIL dues payment between Chambers and if one of those states has only paid through one Chamber, that state is still included in the count of states that have paid NCOIL dues. NCOIL is still awaiting some of those state dues payments. Additionally, there are a small amount of states where only one Chamber pays dues at a reduced amount of $10,000. Asm. Cahill asked if NY had submitted its full NCOIL dues payment. Mr. Melofchik replied yes.

Mr. Melofchik asked if there were any other questions or comments on anything. Hearing none, upon a Motion made by Rep. Lehman and seconded by Asm. Cahill, the Committee voted without objection by way of a voice vote to adopt the 2023 proposed budget.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Lehman and seconded by Asm. Cahill, the Committee adjourned at 4:45 p.m.

JOINT STATE-FEDERAL RELATIONS & INTERNATIONAL INSURANCE ISSUES COMMITTEE MATERIAL

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
JOINT STATE-FEDERAL RELATIONS & INTERNATIONAL INSURANCE ISSUES COMMITTEE
SAN DIEGO, CALIFORNIA
MARCH 10, 2023
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Joint State-Federal Relations & International Insurance Issues Committee met at The Westin San Diego Gaslamp Hotel on Friday, March 10, 2023 at 9:45 a.m.

Representative Jim Dunnigan of Utah, Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Deborah Ferguson, DDS (AR)
Sen. Mark Johnson (AR)
Sen. Travis Holdman (IN)
Rep. Rita Mayfield (IL)
Rep. Michael Sarge Pollock (KY)
Rep. Brenda Carter (MI)
Sen. Paul Utke (MN)
Sen. Bob Hackett (OH)

Other legislators present were:

Sen. Jesse Bjorkman (AK)
Sen. Justin Boyd (AR)
Rep. Denise Ennett (AR)
Sen. Ricky Hill (AR)
Asm. Tim Grayson (CA)
Rep. Rod Furniss (ID)
Sen. Win Stoller (IL)
Sen. Robert Mills (LA)
Rep. Kelly Breen (MI)
Rep. Kevin Coleman (MI)
Rep. Kristian Grant (MI)
Sen. Mark Huizenga (MI)
Rep. Mike McFall (MI)
Rep. Julie Rogers (MI)
Rep. Lori Stone (MI)
Rep. Helena Scott (MI)
Sen. Lana Theis (MI)
Sen. Michael Webber (MI)
Rep. Cameron Parker (MO)
Sen. Nellie Pou (NJ)
Asm. Ken Blankenbush (NY)
Sen. Jeremy Cooney (NY)
Asm. Jarett Gandolfo (NY)
Asw. Pam Hunter (NY)
Rep. Tim Barhorst (OH)
Rep. Brian Lampton (OH)
Rep. Mark Tedford (OK)
Rep. Ryan Mackenzie (PA)
Rep. Carl Anderson (SC)
Rep. Kirk White (VT)

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 November 19, 2022 meeting in New Orleans, LA.

PRESENTATION ON FEDERAL AND STATE DATA FROM BALANCE BILLING INDEPENDENT DISPUTE RESOLUTION PROGRAMS

Tom Naughton, Division President, Federal Services at Maximus thanked the Committee for the opportunity to speak and stated that in January, 2022 the federal surprise billing arbitration program was instituted. Cases started to be received and distributed to federal arbitrators in April of 2022 and this morning I'm going to talk to you for a few minutes about preliminary data out of the program and some of the challenges and opportunities within that program and how that existing program has impact on the existing state programs and states that do not have existing programs currently. So, the volume in that program has been more significant than initially expected. I've been involved in dispute resolution programs for 25 years and have a very good understanding of expected volumes when these programs are instituted and we were projecting the federal program to have somewhere probably between 20,000 to 30,000 cases in the first year and it had received over 100,000 cases in the first six months. And although the preliminary data is not out for calendar year Q4 of 2023, we're putting that at probably about 150,000 cases for the first calendar year of the program. So that's a large number and I think what's most important associated with that number is only about 30% of those cases have been accepted for full arbitration. There's a number of reasons why 77% of the cases aren't accepted for arbitration. I'm going to talk about that a little bit and some of the challenges in the states there and I think even more importantly as you break that down to date of that 30% probably only 10% have been fully decided cases wherein an arbitrator says the award goes to the provider or the award goes to the payer. And to underscore what we believe is the primary pain generator or confusion is right now there are 22 states that have their own surprise billing arbitration program and 28 states plus territories that do not. And within the 22 states that have existing programs they are labeled as bifurcated states by the Center for Consumer Information and Insurance Oversight (CCIIO) and the Centers for Medicare & Medicaid Services (CMS). That means a provider depending on a specific claim may go to a state program in the state of Georgia or he or she may need to send that claim to the federal program and I think the outreach and education to provider groups across the states has not been overly effective. So many providers are submitting cases to the federal program that actually should be going to the state program. That creates a significant amount of delay and stakeholder frustration and other hurdles to getting the job done and making sure the program is effective.

One issue that I think states could take on to assist their providers of the 22 states that are bifurcated is that I believe only six of them allow Employee Retirement Income Security Act of 1974 (ERISA) opt-in. So that's the bifurcation. If you're not a state regulated plan you have to go to the federal program. States such as New Jersey and

Virginia allow ERISA plans to opt in to the state arbitration program therefore providers do not have to go the federal pathway. I think states with existing programs would benefit from considering an ERISA opt in into that program because it would give the providers one pathway, one door to deal with and one set of rules. And more importantly existing state programs, how they're managed and the rules of those arbitrations are different than the federal program so the bifurcated states right now have providers sort of being treated differently for the same problem. So a provider could go to the New Jersey state arbitration program and get one answer and then go to the federal program for the exact same claim just an ERISA plan and get a different answer. So you have a similarly situated problem which has strong potential for getting two different answers. That's mostly because there is and I'll put in quotes, "default" arbitrator answer on the federal side to go with the average in network rate of the payor and that is not included in many of the state programs.

So a provider going to the state of New Jersey is going to get a much different arbitration through the state program than they do at the federal level - same with the state of Georgia and all the bifurcated states. For the remaining states that don't have programs, I think considering instituting their own program, which is a zero budget program because the payers pay the cost of the arbitrations and can also pay the cost of setting up the program for the state, would also do a lot to help provide for confusion and give them an easier access to resolve their disputes with the payers. It would also be very helpful to the payors to really have one program to utilize as opposed to two pathways. Another issue that I think is impacting is provider education. CCIIO does not have a formal outreach education program to providers in the specific states and I think if they engaged with any of the national independent dispute resolution entities (IDRE's) to provide outreach and education or if the states, particularly the bifurcated states, asked an arbitrator that knows all the programs to come in and provide education to their hospital associations, to their medical associations, to their specialty groups, and really show them how the nuances of the two different programs and their rights and responsibilities under both sets of programs - I think that would go a long way to ease provider confusion and help them in the process. Those are the two main pain generators that I really wanted to bring up here. As I said the data right now is still very preliminary because so few cases have been decided and I think probably six to nine months from now we will have a better idea of why cases are decided for providers or payers and the reasons for that, etc.

One other thing I wanted to underscore as this is an important nuance between state programs and the federal program - the federal program has recently decided that if an arbitration case includes an encounter and that encounter includes half a dozen claims or codes, each of those codes becomes a separate arbitration. That leads to much more significant expense for providers to engage in the program. It leads for much more significant expense for arbitrators to complete and it in my opinion will only lead to confusion and frustration within the program. Historically, in an arbitration program you get one encounter and you go through the codes and you make determinations based on the rules of the arbitration program and it's one arbitration. To take a seven code or 12 code encounter and turn that into a 12 code arbitration is going to exponentially increase the cost and time to get work done and will only I think further increase frustration and confusion on the part of providers and payers. So that is the update of significance on this program and again, I would just underscore that I think States that have existing programs considering allowing opt-in of ERISA plans into the state

program would be very helpful and I think states that don't have programs should now consider setting up their own program to be helpful to their providers and payers within that state. And again further outreach and education to the provider and payor associations within specific states will only help the program.

Rep. Dunnigan asked if he heard correctly that only 30% of the cases are accepted? Mr. Naughton replied yes. Rep. Dunnigan asked what happens to the other 70%? Is the initial resolution just what ends up happening? Mr. Naughton stated that the other 70% may be rejected because they should have gone through an existing state program. They may be put on hold because CMS is not sure how to handle that specific type of case or there is information that is required to complete the arbitration that has not been submitted. Those are the main reasons for rejecting cases. Rep. Dunnigan stated that I think you said 70% of the cases are going to the feds and should go to the states? Mr. Naughton stated we don't have that data yet but I would say it's at least 40% to 50%. Rep. Dunnigan asked when that happens is it just sent back to the States or just rejected? Mr. Naughton stated that it's rejected and the provider now has to go through the process again of going through the state. Rep. Dunnigan asked if there is an additional fee associated with that. Mr. Naughton stated that there could be depending on the state.

Rep. Dunnigan asked if there is enough data to see by either providers or the insurance plans if the states or the feds are considered to be more friendly to their cause? Mr. Naughton stated that we don't have enough data from the federal program yet to do a good comparison right now. I would say anecdotally the federal program likely leans towards payers at this point but there's a very good example from the state of New Jersey which has had arbitration programs since 2007. And in 2007 the payers were here and the providers were here and we actually did about 5,000 cases that year and providers were winning a significant amount of the time. And so in 2008 we did 10,000 cases. In 2009 we did 12,000 and then we did 15,000 in 2010 which for the state of New Jersey is a significant number of arbitrations. And what happened after that was the payers and providers started coming together so that in 2011 we were down to 8,000 cases and winding down to the point where starting in 2015 and going forward you're really seeing cases where folks just always are going to arbitrate every case no matter what or it's a new code or case of first impression but the volume has gone down significantly in the New Jersey programs and has stayed right around south of 5,000 cases since 2015. So a year from now we should have data and you should actually start to see middle ground starting to be achieved and based on our experience it usually takes about three to five years to get to the middle ground of what we would call success where the arbitrations are again people that always want to arbitrate or it’s cases of first impression. Rep. Dunnigan stated that if you were to look through your crystal ball, if you had 150,000 cases this year in the first year, what will we have the second year? Mr. Naughton stated that our projections for the next year are over 200,000 cases.

Sen. Bob Hackett (OH) state that Ohio got a real good solution but how we got that solution is both the plans and the providers got together with the Department of Insurance almost being a referee. I think we all got involved saying that we did not want too many cases arbitrated and I agree with you there but I don't know if I agree with some of your statements of trying to get everything together because you're going to have certain states that are going to be extremely more liberal than conservative states

and it's a difficult scenario of how to do that. But my question to you though is how is Ohio doing? Is it too early to tell? Because we didn't want too many cases, but we wanted to be fair. The providers and the plans played a major role and you had both sides working towards that solution. Mr. Naughton replied yes, they did, and we were definitely involved in some of those negotiations and discussions. For Ohio, it's too early to tell but I would also say you achieved your goal of not getting too many arbitrations.

WHAT QUALIFIES AS "PREVENTIVE SERVICES?" A POLICY DISCUSSION, AND BRIEFING ON *BRAIDWOOD MANAGEMENT, INC. V. BECERRA*

Justin Giovannelli, Associate Professor, Center on Health Insurance Reforms, Health Policy Institute, McCourt School of Public Policy, Georgetown University, thanked the Committee for the opportunity to speak and stated that much of our work is understanding state and federal regulation of private health insurance. Certainly a significant chunk of that is trying to understand the implementation of the Affordable Care Act (ACA) and how states have responded to that federal law. So what I hoped to talk to you about today is the federal preventive services protection which was enacted with the ACA back in 2010 and give you an overview of that protection from a legal standpoint and talk about a recent lawsuit that is challenging that protection and talk about an option or two that you all as state legislators may have depending on the outcome of this case. I think you're going to hear a bit more about some of the particular services that have been classified as preventive under the statute and perhaps about other aspects of the litigation but I'll try to provide an overview of all of that. So federal preventive services protection requires coverage of many preventive services without cost sharing. And that last part is really important. There's a lot of evidence to suggest that if there is imposition of cost sharing on even these high values services that are covered now by health insurance companies that individuals don't get those services if they have to pay out of pocket often. So this protection provides access to those services without cost sharing. It applies very broadly to almost all private health insurance so all of the fully insured markets that you all regulate as well as ERISA regulated employer benefit group health plans. So it's important to get an understanding of the litigation that I'm going to talk about in a second and to get a sense of what kind of services we're talking about.

So instead of listing all of the preventive services that seemed to be a good idea in 2010, what the statute did instead was identify three different expert bodies, the U.S. Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), and the Health Resources and Services Administration (HRSA), and indicate with respect to each of them that certain types of services recommended by these expert bodies would need to be covered without cost sharing. So for example plans must cover all items and services with an "A" or "B" rating from the USPSTF. There actually is more language there with respect to it needing to be evidence-based items and services but you get the general idea. So this has been the framework that everyone's operated under for the past dozen or so years and I'll talk a little bit about how many folks are covered by plans that have this protection in a little bit. What we have more recently is this litigation challenging aspects of that or really the entire protection that I've described - that's the *Braidwood Management* case. This is a lawsuit in the Northern District of Texas. There are a couple of elements to it. One involves a comparatively more narrow claim under federal law under the Religious Freedom Restoration Act (RFRA). That challenge at this point is primarily about coverage of anti-

human immunodeficiency virus (HIV) medication. I'm not going to really get into that element of the case today. I'm happy to answer questions about it if you'd like. Then I'm going to focus more on the broader constitutional challenges to the provision and this is really important. We have here a challenge based on the U.S. constitution to the power of the U.S. Congress. This is really a federal lawsuit without implications for the authority of all of you to regulate health insurance under state law. It's obviously a very significant piece of litigation but it's really all about Federal power under the U.S. Constitution.

There are two main elements of the constitutional challenge that I'll outline briefly here and I'm happy to talk about them in more detail if you'd like. So, the first is grounded in the Appointments Clause of the Constitution. The second has to do with something called the Nondelegation Doctrine. The plaintiffs in this case are a couple of businesses, a couple of individuals, who objects to this provision of the law, the Appointments Clause. The argument here is that the individuals who sit on these expert bodies are in a legal sense officers of the United States and because they are officers they've got to be appointed in a certain way that complies with the Constitution and the argument is that they have not been. The second argument surrounds the nondelegation doctrine. This is a doctrine that has not gotten much use or attention in recent years. The Supreme Court last used it to strike down a law back in the early New Deal years in the 1930s but there is certainly an indication from the current Supreme Court that there is an interest in perhaps revitalizing this doctrine. And the gist of it is that while Congress can certainly delegate authority in certain circumstances, when they do that they have to provide an intelligible principle for how that authority should be exercised and the argument here from the plaintiffs is that when Congress said that these expert bodies will identify recommendations that have to be covered they were delegating authority to the bodies without any sort of guidance for how that should be done.

So that's the legal challenge. We have an opinion on the merits in the District Court issued back in September of last year. It's a merits decision it's not a decision on the remedy which is really important. So, on the merits what we have is in some fashion a split decision but I will emphasize here this is really round one to use my boxing metaphors here. The decision from the District Court was to agree with the plaintiffs on their Appointments Clause challenge as to the USPSTF recommendations. So, the court concluded that there was a violation there. Really it concluded that all of these experts should count as officers of the United States and were not properly appointed, but for two of the three bodies their decisions are in effect ratified by the U.S. Department of Health and Human Services (HHS) and so that cures any constitutional problem. The USPSTF is different. Its decisions cannot be ratified so the court said we have a violation there. The court also agreed with the plaintiffs on the RFRA challenge. Again, I'm not going to really touch on that at the moment but there's that there as well. The non delegation claim, the court rejected it primarily because of existing precedent on this issue. So, as I indicated this is a type of approach to federal administrative law that we haven't seen much of in many years and there is binding U.S. Fifth Circuit Court of Appeals precedent where the Texas Court sits that easily disposed of that sort of challenge. But the court recognized, which is absolutely correct, that the current Supreme Court might think differently.

And so while the government prevailed on this claim in the District Court we may see more of it as the case goes up on appeal and his case will definitely go up on appeal. It

will definitely go to the Fifth Circuit. It very well may wind up in the Supreme Court in years to come. A word on the remedy - the court decided on the merits but it didn't decide about what should happen because of this appointment's clause violation. That's been briefed by the parties. The court could issue a decision any time. The plaintiffs have asked for a universal remedy. Basically, they want the requirement to cover the USPSTF recommendations to be struck down nationwide so that a requirement that would no longer be in effect in any state. We don't know if the District Court will agree with that approach but there's some reason to believe in the merits opinion that it might. So, what is currently at issue is more than 50 preventive services that are recommended by the USPSTF and they must be covered. Things such as: screenings for a range of cancers, for depression, for high blood pressure, preeclampsia screening, folic acid for pregnant women. These are services that are currently required to be covered. Plaintiffs assert that they should not be required to be covered and have asked the District Court to issue a nationwide ruling. So that's where we stand in the District Court on appeal. Again, everything is really on the table. I think there's certainly reason to believe that the higher courts could actually issue a broader ruling in favor of the plaintiffs and so really at that point you're talking about more than 100 preventive services potentially at issue affecting a lot of Americans. And I tried to provide some state specific estimates of folks who might be impacted by this and if you can't see it on the screen I'm happy to give you that data if you'd like to see it.

But these are the numbers of people in states that would be affected by a ruling making this coverage no longer required. We're talking a lot of people. So, what might states do if they are so inclined? Well, step one is to take a look at current law and see what is required under current law. So of course as you know there are a fair number in virtually all states certain state required benefits. They are certainly not as comprehensive as the coverage framework we've worked with the last dozen or so years under the federal protection. Also some of these state laws do not speak to cost sharing and do not require preventive services to be covered without cost sharing unlike the current federal framework. So depending on what the status of your laws are and your interest one thing that states can do is require the fully insured markets to cover the services that are currently required to be covered under federal law. As I indicated at the outset, the lawsuit's all about federal law, it's not about state law, it's not about state power to regulate. States certainly have authority to enact laws that look just like the federal provision if you're so inclined. There are more than a dozen states that have something like that on the books already for their individual markets and certainly this could be done in other places. As I wrap up here, I would say of course there's a major drawback to this particular solution and that's simply of course that while you all have regulatory authority over fully insured plans you do not over ERISA federally regulated plans and so the large numbers of people affected by a decision here, many are folks you can't actually help if you're inclined. But for fully insured markets there is state authority and certainly you can act in this way if you would like.

Emily Carroll, Senior Legislative Attorney at the American Medical Association (AMA) thanked the Committee for the opportunity to speak and stated that the AMA is the largest professional association of physician residents and medical students in the U.S. We have members practicing in every state in every specialty. We very much appreciate the opportunity to be here to discuss the importance of preventive healthcare and our concerns about an overly broad remedy in the *Braidwood* case that could jeopardize the access of coverage of preventive services to millions of Americans.

Physicians certainly know the value of preventive care when it comes to helping their patients live long healthy lives. Ensuring that patients can receive services without financial barriers is of the utmost importance to our members. Preventive care can mean the difference between kicking a smoking habit or living with a heightened risk of dozens of illnesses. It's the difference between taking a statin or suffering a heart attack. It's the difference between catching a patient's cancer early or catching it after it's too late. Identifying and treating conditions before they worsen or before they present at all yields better outcomes for patients and saves money for the overall healthcare system. Physicians recognize they have an obligation to ensure that their patients and the public as a whole receive medically indicated preventive services. Principle seven of the AMA's principles of medical ethics state a physician recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health. And opinion 8-11 of the code specifies that while a physician's role tends to focus on diagnosing and treating illness once it occurs physicians also have professional commitment to prevent disease and promote health and well-being for the patients and the communities.

This is because preventive care first and foremost saves and improves the quality of lives. There's an extensive body of evidence demonstrating how preventive care can help patients live long healthy lives. Such services aimed at this include prevention, early detection and treatment of potentially fatal medical conditions and chronic diseases, as well as services aimed at encouraging people to live healthy lifestyles. These services can identify or these services can help identify diseases at earlier stages when they are more treatable or may reduce a person's risk for developing a disease. For example according to the American Cancer Society cervical cancer incidence and mortality rates have decreased by almost 50% in the past three decades and this is attributed to screening which can detect both cervical cancers at an early stage and precancerous lesions. Screening can identify people at risk for developing type 1 diabetes before they even become symptomatic and screening in pediatric populations has shown to lower hba1c's and shorten hospital stays at diagnosis. Smoking cessation reduces the risk of 12 different cancers and can help improve health outcomes after a cancer diagnosis. It also reduces risk and improves health outcomes after a diagnosis as to cardiovascular diseases, stroke, aneurysms, respiratory diseases, asthma, pregnancy and reproductive health. And late entry into prenatal care or no prenatal care at all is known to contribute to poorer birth outcomes especially in increases in low birth weight and preterm babies. Ensuring access to preventive care also saves money within the healthcare system. By reducing the amount of undiagnosed or untreated conditions preventive care reduces cost through less invasive or complex treatments. Put simply cancer is easier and cheaper to treat at the outset than after it has metastasized.

HIV is less costly to prevent than treat. Prediabetes screening is cheaper than treating diabetes. A flu shot is cheaper than caring for a patient in the hospital with the flu. But despite all the benefits it's often difficult for physicians to get patients to access preventive services and this can be particularly true for minoritized and marginalized communities. For example, an estimated 1.2 million Americans at risk of HIV infection should be taking pre-exposure prophylaxis (PrEP) according to the Centers for Disease Control and Prevention (CDC) but only 25% are doing so and use among Black and Hispanic patients is especially low. Studies have shown that out-of-pocket payments can be a barrier to use of recommended preventive services and reductions and cost

sharing were found to be associated with an increased use. Congress recognized this when it passed the ACA and it recognized the role of health plans and payers in improving access to preventive care. In enacting the ACA, Congress sought to guarantee access to services like these regardless of financial constraints and I want to stress how important this access is to the AMA and our physician members. Congress was really careful to make sure that insurers would be required to cover only effective high value services through evidence-based recommendation. And just to be clear one more time as to the types of services we are talking about. We're talking about screenings, genetic assessments, risk reducing medications and behavioral counseling for various cancers including breast, colorectal, lung, skin and various forms of cancers of the female reproductive system.

We're talking about preventive services for pregnant people and those who have recently given birth including screening for aspirin use in those with high risk for preeclampsia. Interventions to support breastfeeding. Screenings for sexually transmitted diseases. Folic acid supplements for neural tube defects. Gestational diabetes screening. Preventative medications for newborns and blood testing. We're also talking about services for populations at high risk for certain conditions including aneurysm screenings for older men who have a history of smoking. Cardiovascular disease screening including among at-risk populations. Tuberculosis screening. Screening for osteoporosis in older women. Screening for diabetes and type 2 diabetes in adults who are overweight. And statin use in adults with cardiovascular risk factors. And we're also talking about preventive mental health screenings including anxiety, depression and suicide risk screenings in children and adults. Removal of guaranteed access to these services could have devastating effects. As mentioned, currently 151.6 million people have private health care coverage that covers preventive services with zero cost sharing. A literature review in 2022 found that 35 separate studies determine the majority of findings conclude that cost-sharing elimination led to an increase in utilization for select preventative services. Literature also suggests that this is particularly true for low socioeconomic groups and those who experience the greatest financial barriers to care. Additionally, the availability of no cost preventive care has improved utilization and health outcomes among populations that have been historically subject to discrimination. If the court were to apply a broad remedy in the *Braidwood* case, we fear a return to pre-ACA regulatory regimes where insurers could charge patients for preventive care at their will.

It's likely health plans and employers would impose deductibles and copays for some or all the services recommended by the task force. Imposing a co-pay or high deductible to access preventive care for patients will deter some and in particular those of limited means from scheduling such care. And gutting this requirement will significantly set us back as a society in terms of improving health outcomes in marginalized communities. Moreover we'll all be affected by the confusion that emerges. For the first time in ten years we will have to scrutinize insurance plans to determine what preventive care they cover and at what out-of-pocket costs and we will likely see a race to the bottom in terms of insurance. Insurers and payers will alter their plans in ways to distort the functioning of the system and many insurers will likely design their preventive benefits to attract healthier customers forcing other insurers to follow suit to compete. Ultimately if the court invalidates the task force recommendations nationwide physicians will be left in a really tough situation. They'll struggle to encourage their patients to accept services they know will save their lives but they'll see many other patients, some of their most

vulnerable patients, turn down medically indicated care because of financial barriers. As we wait to see what the court decides in terms of the remedy we are reminded that remedies are about equities and those equities here include the ability of patients to continue receiving no cost preventive care as they have for over a decade. The past ten years have shown the benefits of no cost preventive coverage and that's why the AMA and a number of other medical societies have asked the court to consider this before ordering a remedy that could upset this process.

Greg Baylor, Esq., Senior Counsel, Director of Center for Religious Schools at the Alliance Defending Freedom (ADF) thanked the Committee for the opportunity to speak and stated that ADF is involved in many religious liberty cases including this one. ADF has been and continues to be involved in many disputes involving the application of insurance coverage mandates that violate the religious freedom of our clients, including the *Hobby Lobby* case that made it to the Supreme Court. And the *Zubik* case which subsequently made it to the Supreme Court. Given that involvement and experience it'll be no surprise to you that I wanted to focus on the RFRA aspect of the case and I think it's helpful perhaps to put RFRA into a little bit of context. Religious liberty in general we lawyers like to think that there's two categories of legal rules that violate religious liberty or at least infringe upon religious exercise. There are those rules which are thankfully pretty rare that target religious exercise for particularly adverse treatment. And then there's the other kind that's more complicated, it's a rule that sort of applies to everybody but happens to sort of incidentally impose a burden even a serious substantial burden upon a religious claimant. And that division matters because judges want to know what test they should apply and how much scrutiny should they apply to the government's action in a particular case. And there's been a debate about this, about what do you do with a law that wasn't intended to go after religious exercise but nonetheless imposes a burden as significant as if the law were targeted at religious exercise exclusively.

And for a time the U.S. Supreme Court when it was interpreting the First Amendment's free exercise clause said “look we don't care where the burden comes from the burden is the burden and therefore in order to uphold the spirit and the letter of the First Amendment we need to apply what's called strict scrutiny to this burden.” So under strict scrutiny the Court will ask the claimant “tell us how bad this is for you - how substantial is the burden on the exercise of your religion?” And if the claimant is able to prove to the court that that burden is significant enough the Court will turn to the government and say “look what are you trying to accomplish here - how important is your interest - is it compelling?” And then they'll ask “is there any other way you can do this - is the means that you've chosen to pursue your objective the least restrictive one?” Eventually the Supreme Court changed its mind about this and said “you know what if it's not targeting, if it's a generally applicable facially neutral rule we're going to no longer apply strict scrutiny.” There was great uproar on all sides of the spectrums political, ideological, and religious and that resulted in the passage of RFRA which restored strict scrutiny, this test is hard for the government to win with, to cases not just involving targeting of religious exercise but to incidental burdens on religious exercise of generally applicable and facially neutral laws. So that statute passed in 1993 and resulted in a number of victories for religious claimants. Unfortunately, at least from my perspective, about four years later the Supreme Court said “Congress you had the authority to restrain the federal government with RFRA but you do not have the authority to restrain state and local governments.” So I think this goes to the point about the impact of this case on the state system. A RFRA conclusion in favor of the plaintiffs in this case doesn't

necessarily control the power of state legislatures and state administrative agencies to enforce insurance coverage mandates against religious claimants.

So that's the backdrop - let's move to litigation over mandates in general. I think the debate in this area started when states themselves started adopting contraceptive coverage mandates well in advance of the ACA. And some of the states had robust religious exemptions for those religious entities that didn't want to include that in their employee health plans for religious reasons of conscience. But some states had very narrow exemptions and that necessitated litigation in New York and California by Catholic charities that did not want to cover contraceptives and sterilization and they lost those cases because the tests the courts were using was not strong enough. But then fast forward to when the federal government adopts a contraceptive mandate via the ACA. Again an insufficient religious exemption was there which prompted literally hundreds of lawsuits challenging the contraceptive mandate. Many of the plaintiffs challenged only the abortifacient contraceptives, the ones that can and do sometimes interfere with implantation of the young human being in the uterine wall. Many of the Roman Catholic challengers challenge the whole thing - they didn't want to be sort of complicit in the provision of any contraceptives and their legal claim to challenge this was RFRA which as you will recall requires the claimant to say "this is really bad for my religion, it's making me do something that's against my religion, I'm offending God by engaging in the behavior that this statute or administrative regulation forces me to do."

So the courts in these cases turned to the government and said, "okay what are you trying to accomplish here and is there some other way you can do it?" And Hobby Lobby prevailed in its case because there was some other way to do it. HHS had set up a mechanism by which non religious non profits could comply but they didn't offer that alternative mechanism to Hobby Lobby and other for-profit entities owned by people of faith. So they prevailed. And then the nonprofits prevailed as well on sort of a complicated reasoning and eventually because the rules were changed when President Trump came into office in 2017. So that's the background to *Braidwood*, let's talk a little bit about the case. What is it that they objected to on religious grounds? Well, when the case got to the stage that we're talking about right now the remaining objection was to the PrEP medication and the plaintiffs argued that they believe that homosexual behavior is contrary to their religion and then they said "look if we include that medication in our employee health plans we're going to be facilitating behavior that we think is inappropriate, immoral or sinful." And the court agreed that this requirement imposed the substantial burden on their religious exercise for purposes of RFRA. And this was not hard and not controversial at least as a legal matter because *Hobby Lobby* had already paved the road for this. I mean *Hobby Lobby* if it stands for anything it stands for the proposition that if you make someone include in their health plan an item that violates their conscience that's a substantial burden.

So the court turned to HHS and the other defendants and said "okay what is it that you're trying to achieve here? What's your interest? How compelling is it?" And of course the interest is reducing the incidence of HIV and the spread of HIV and the resultant health problems and deaths that occur when that happens. And the plaintiff said, "hey we don't disagree that that's a compelling interest but you're asking the question at the wrong level of specificity - the question is not whether the interest is compelling sort of in the abstract - the question is whether it's compelling and necessary with respect to this plaintiff." So you don't ask the question "what would it be like if this mandate didn't

exist?" The real question is "what would it be like if this mandate didn't apply to this particular claimant?" And obviously the consequences are much lower when you're talking about one employer as I understand that the employer making this claim had about 80 employees. So the court concluded that this violates RFRA. There's no other way to comply. There's no other mechanism that they've offered to Braidwood to comply with this and there are less restrictive means by which they could accomplish this purpose. Throughout the HHS mandate litigation one of the things that the plaintiffs argued was "you know what there's another way you guys can do this - you can actually pay for it yourself." And interestingly enough the Biden Administration and its proposed rule about the contraceptive mandate in which they're proposing to replace the Trump rules has proposed precisely that. So that women who work for employers who have objected, who have opted out, who'd been given exemption under the law, they have an opportunity to get the coverage cost free to them through the federal government paying for it, not through the mechanism of the objecting employers health plan and at the health plan expense.

So what does this mean in *Braidwood*? Who won? What's the remedy going to look like? Well, they haven't said yet exactly what the remedy for the RFRA violation will be but I have no doubt in my mind that the only entity that will be exempted because of this decision from the PrEP coverage mandate is the company itself. Now certainly other employers can file their own lawsuits and use that decision as a precedent but the *Braidwood* case itself does not confer on anyone else the right to opt out of this requirement. So what are the implications for the states? As mentioned, this means that if this stands up on appeal there will be a certain number of women and others given the scope of the preventive services that are required to be covered that won't have that protection or that mandate of federal law. And presumably the role for the states can be to step in and provide that themselves. One issue about that and that's the last thing that I'm going to say is just because a state level mandate can't be attacked based on RFRA, because it doesn't apply to state and local governments, it doesn't mean that it can't be challenged under comparable statutes and constitutional provisions in state law. So if a state were to adopt a sort of PrEP coverage mandate there's a significant possibility that some employers would turn around and file litigation not under RFRA but under state statutes that provide for strict scrutiny and under state constitutional provisions that provide for strict scrutiny.

Rep. Mike McFall (MI) stated that his question is for Mr. Giovannelli: you had mentioned that there were states that had done this - which states were those? Mr. Giovannelli stated that by our count there are something like 15 or so states that have provisions actually that they had enacted before this litigation frankly in response to other federal challenges to the ACA that take slightly different forms but in some fashion basically mirrors the language of the federal statute and so state lawyers should always take a look at everything you're considering and acting on but to our mind these are provisions that don't in any way rely on the federal protection continuing and do not implicate any of the federal constitutional or statutory issues that are raised in *Braidwood*. Rep. McFall asked for some of those states. Mr. Giovannelli stated that off the top of my head, and I'm happy to provide you this afterwards, I believe New York has such a statute and Oregon is making slight changes to theirs and I believe Washington state and New Mexico.

Rep. Lori Stone (MI) stated that I'm directing this to Mr. Baylor but anyone on the panel is open to it - has anyone approached this issue from the position that they're having an individual's religious beliefs imposed upon them and that their individual rights are being violated because someone is stripping them of access? Mr. Baylor stated that I think that argument has been made kind of in the court of public opinion but it's not been made in the course of a legal case and it's not a case that would succeed because RFRA and the Free Exercise Clause and state analogs to those things don't restrain non-governmental individuals. There are some exceptions but for the most part you can't sue someone else who's a non-governmental entity for violating RFRA with a free exercise clause. But in a kind a conversational sense or in discussions in the media and in other public forums people have said, “Yes, you’re imposing your religion on me.” So you’re right about that but it’s not a valid legal argument.

Rep. Rita Mayfield (IL) directed her questions to Mr. Giovannelli. I also wanted to get that list of states that are already doing this. I know that Illinois has something like this because we do offer the PrEP and other preventive services but I would like a comprehensive list. And then for your recommendation asking that there be parity between group market carriers and individual market carriers you're saying that they need to add the same required benefits without cost sharing? Mr. Giovannelli stated that what I was suggesting is that under the current framework the federal protection applies to all fully insured plans, individual and group market plans and it also applies to ERISA regulated plans over which you all lack authority. But over the fully insured plans that you can regulate you would have authority to pass this requirement in the individual market but then also for coverage that is offered to small and large businesses too. Rep. Mayfield stated that and these states that have already implemented this is that what they've done or did they implement something different? Mr. Giovannelli stated that our investigation looked at the individual market specifically and the 15 or so states that I’m throwing around is with respect to the individual market. I know that some of those states the protection is broader into the group markets. I can’t say for sure how many that’s the case for.

Rep. Mayfield stated that my next question is how does offering preventive maintenance impede somebody's religious rights? Mr. Baylor stated that in most states they have a moral assessment about what's religiously permissible and not permissible and a lot of the times you're talking about an action that the person themselves believes that they may not do but there's another doctrine both in religious and non-religious philosophy about being complicit in somebody else's behavior and I think that is what we're talking about when we're talking about a contraceptive mandate and when we're talking about a PrEP mandate. It's not so much that the person is being compelled to do the thing ultimately that they object to but they're being required to facilitate it and to play an indispensable role in the causal chain and I think it's a kind of a well settled principle of ethical philosophy that's a legitimate kind of thinking about what's morally permissible and what's not. It's not limited to the things that you do but it includes the things that you're sort of complicit in by the things that you add to the process and as a legal matter it's been accepted by courts that you can have a valid religious freedom claim because you're being compelled to be complicit in something that you believe to be against your religion.

Rep. Mayfield asked if this claim is about the health insurance carrier being mandated to offer the preventive maintenance having a religious objection as opposed to an

individual that is receiving the health care? Mr. Baylor stated that the plan sponsors are typically the plaintiffs in cases challenging these so it's the employer or the University that has a student health plan, they are the challenger because at least in the ACA case the mandate applies both to carriers and to third party administrators (TPAs) and to the plan sponsor. Most TPAs don't have a religious objection to providing any of this but there are some. Guidestone which works with the Southern Baptist Convention, they were a plaintiff in the HHS mandate litigation not because they were a plan sponsor and objected because of that but they were actually the plan provider or the TPA so both kinds of plaintiffs can assert these claims. Rep. Mayfield asked if the plan sponsors are corporations? Mr. Baylor replied yes. Rep. Mayfield stated that corporations are not exactly people. They're comprised of people but they're not people. Mr. Baylor stated that of course there's a distinction between corporations and natural persons but this was actually an important part of the *Hobby Lobby* case. RFRA confers religious freedom protection on persons and of course the definition of person in federal statutory law does include non-natural entities like corporations, partnerships and all the rest and the federal government in defending these challenges to the HHS contraceptive mandate, its first argument was Hobby Lobby doesn't have a right to claim the protection of RFRA and some of those arguments were sort of legal and more rooted in the text and some of them were more like how does a company have a religious belief? And companies have positions on questions even if they're not natural people and the conclusion was the owners of the company, the Green family in the case of *Hobby Lobby*, they were the leaders of the organization and could decide for it what the entity's religious views are so it's a question that got asked in the Supreme Court but it's been settled.

Rep. Julie Rogers (MI) stated to Mr. Baylor that you just mentioned the ethical philosophy and the complicit behavior and so my question is what about infants - what about situations where the person being affected potentially by HIV had no decision making in that? So going down the road of the argument saying that the religious institutions don't want to cover HIV medications because of this complicit behavior, what about the infant that had no choice in the matter that contracts HIV from his or her mother in the womb? Mr. Baylor stated that almost every religious liberty claim involves a balancing of competing interests and the strict scrutiny test that I laid out that is applicable under RFRA and many state analogs takes account for all the interests involved in the case. So the first interest they focus on is whether this imposes a burden on the religious exercise of the entity that doesn't want to include something in its health plan and suppose that they satisfy that you move on. And then the government identifies its interest and in the analysis of that interest you do consider the impact on third parties. That's just part of the analysis, how much will giving this at any exemption undermine the goal that the government is trying to pursue and you can certainly raise evidence about what kind of impact it would have on third-parties. That's why we argued in the contraceptive mandate cases not that individuals should never get this coverage but that the company itself or the individual wouldn't be complicit in providing it and we recommended that the government itself pay for that so that the ultimate beneficiaries of the plan would get what they want but just leave us out of it. And again, the Biden Administration has belatedly embraced that view in the current notice of proposed rulemaking on the HHS contraceptive mandate so it's a valid consideration. It's taking into account in the test and the Biden Administration is doing probably at least from their perspective the right thing to make sure that people get the coverage they want.

Rep. Rogers stated that I have a quick follow-up - I just want to thank Ms. Carroll for her comments as covering preventive care is not only the moral and right thing to do but it's oftentimes the fiscally conservative thing to do as pointed out. So for the insurers in the room if this case does go in a different direction I implore you to do the right thing and step up and do preventative coverage.

UPDATE ON PREPARATIONS FOR/IMPLICATIONS OF END OF PUBLIC HEALTH EMERGENY (PHE)

Miranda Motter, Senior VP, State Affairs and Policy at America's Health Insurance Plans (AHIP), thanked the Committee for the opportunity to speak and stated that I want to spend just a couple of minutes revisiting a couple of issues that we have previously spoken about. The first is Medicaid redeterminations and some legislation that was passed at the end of the year which has now decoupled one of the major requirements as part of Medicaid redeterminations from the end of the PHE. And since that time we also now have an announcement from the Administration about when the COVID national emergency and the public health emergency will end so I really just wanted to provide a couple of updates relative to those announcements and some key dates and then certainly a series of resources that you will find hopeful and some links included in this presentation. With that I will start with the Medicaid redeterminations and a piece of legislation that Congress passed at the end of the year called the Consolidation Appropriations Act of 2023. Many of you are very aware of the work that sits in front of the states with the decoupling of the Medicaid redetermination processes from the maintenance of eligibility requirements. The most recent numbers I think I saw this week out of CMS indicate that individuals that are currently receiving health insurance coverage under Medicaid has reached about 93 million individuals all across this country. I know many of your Medicaid directors and staffs and Governor's office health policy staff and many of you and your staff and insurance Commissioners in this room have been very focused on this issue. There is a number of individuals that will now with this decoupling be sitting in a situation where they will need to go through an annual redetermination process that had paused during the PHE.

Originally, the Medicaid redetermination maintenance of eligibility requirement which essentially was in the Family's First Act that Congress passed, Congress provided states an additional Federal Medicaid Assistance Percentages (FMAP) percentage, a 6.2 percentage, if they did not terminate anybody's Medicaid eligibility throughout the PHE. Prior to the passage of this Consolidation Appropriations Act that was all going to be tied to the end of the PHE. This legislation now gives us a date certain. I think the last time we talked there was a lot of uncertainty about when the PHE was going to end and so while a lot of work was being done in the states it wasn't quite clear when all of that needed to start. We now have a date, March 31st. As a result, and is laid out in that statute that additional 6.2% which sits on top of the FMAP that each one of your states have as it relates to your Medicaid agencies will begin to decrease. So that decreasing will be 6.2% through the 31st of March. So beginning on April 1st states may begin to terminate individuals who no longer are eligible for Medicaid and you'll see there the additional leveling down of the FMAP as we get to December 31st of 2023. The other two things that passed as part of that federal legislation are there are state requirements as it relates to how states will conduct their redetermination. They must comply with eligibility requirements. They need to use a national change of address database. That's the one thing I know that many states are very concerned about is having updated

contact information to actually do the outreach to individuals who may need to be redetermined and then certainly for those individuals that are no longer deemed eligible for Medicaid. States must also provide a report to the federal government to provide information about what is happening and how that is going. And then certainly there are enforcement and corrective action provisions included in that legislation.

So with that I just wanted to provide a visual of actually what that looks like relative to the key dates and policies. So you'll see here states could begin their unwinding or their redetermination processes to internally determine who may or may not be eligible beginning as early as February 1st. They cannot terminate coverage until April 1st but they could start on February 1st to do that internal analysis about who is and who is not eligible. If they started on February 1st those states needed to provide a report to CMS on February 1st about what that plan is. If a state started after that their deadline for providing that report is February 15th. So there should be some good visibility in terms of state work as it relates to this. The other dates up there were ones that I just mentioned as it relates to leveling down of the FMAP and then I would also just note a couple of the links there at the bottom that do provide some good resources from CMS that talk about the different dates and what that looks like and what states should be aware of and understanding the impact. One of the things that we have been spending a lot of time focusing on is certainly during this unwinding process there will be a number of individuals that are no longer deemed eligible for Medicaid and so trying to understand where those individuals can find access to health insurance coverage. This is a high level number that came from the Urban Institute that really shows that in most instances most of the individuals that will be transitioning off of Medicaid have the opportunity to transition into employer sponsored coverage. I will tell you at least from my personal perspective this was a little bit of a surprise to me but we knew that individuals would have access to employer sponsor coverage. The numbers then after that you will see that there's still anticipation of a pretty high number of uninsured individuals going to the Children's Health Insurance Program (CHIP) and then individuals being able to purchase in the individual market whether that's in the marketplaces and the subsidized marketplace or just in the individual market.
AHIP released just yesterday and there's a link there at the bottom - we thought it was really important not just to understand this from a national perspective but to understand with some visibility what may be taking place in your individual states, again for a source of support as you are working with your Medicaid agencies and with your Governor's offices and with your insurance Commissioners and quite frankly all of the provider stakeholders on the ground and patient advocacy groups on the ground and employers on the ground to really understand where they may have access to coverage. The modeling that you just saw there once it winds up it indicates that most individuals will be able to transition to employer sponsored insurance coverage and you'll see there it's really slightly under 50% to slightly over 50% depending upon the state. Let's move now to the end of the National Emergency and the PHE. So while we are focusing certainly on the decoupling that's happening and the date of April 1st and Medicaid redeterminations we do now have a date certain for the end of the National Emergency and the PHE. The Administration has announced that will end on May 11th. They have formally made that announcement and has also recorded it in the Federal Register.

So essentially what does that mean as the federal government and as we all across the states are moving back to a return to normal? There will be a number of impacts. I know a number of these impacts we talked about I think at one of the very initial

conversations that we had about Medicaid redeterminations because that was one of many changes that took place during COVID. But you will have things because of waivers that states took advantage of, waivers that the federal government provided across different markets and you'll also have things that took place in individual state Medicaid agencies whether they did that by state plan amendments or other kind of waivers and flexibility that they took advantage of. Again really the purpose is to understand that there are likely changes in front relative to COVID vaccinations and tests and treatments and telehealth services. The emergency use authorization which many of you know gave the federal government and the Food and Drug Administration (FDA) the ability to quickly move through products that were needed during COVID. There are also elements of this that won't change and this emergency use authorization is one of those areas that will remain the same. The Prep Authority which really provided immunity from legal liability was another change that took place and then as many of you know there were many changes and flexibilities given to healthcare professionals during COVID. So again the resources are listed there in my slides if you need them.

Asw. Pam Hunter (NY), NCOIL Treasurer, stated that when we had this conversation last year it was concern about the amount of people who are going to be dropped off the Medicaid rolls because municipalities weren't prepared and there was supposed to be an end date and then they moved the date again so I'm just trying to get some clarity as to the numbers that we expect will be dropped from the Medicaid rolls. And I know some people aren't eligible anymore because maybe they're working now and they're not eligible but a lot of people are transient too especially low income people that have had a lot of movement during COVID. So what has been the expected number of people to drop off? But also what has been the directive from I guess the feds to states as far as getting themselves together in order to make sure that they are identifying all of the people to make sure that if they need insurance that they're getting insurance? Because they can't have back coverage for people if they get dropped off and isn't there a certain waiting period before they get on again? That's concerning.

Ms. Motter stated that as you indicated the number of individuals that will have to go through this process is significant because they haven't done this in over three years. The estimates that we've seen in terms of individuals that will lose Medicaid eligibility is really anywhere between five million to 17 million and those numbers obviously have adjusted and as I said just last week we saw the new 93 million total number so absolutely it's a significant number. States have been planning to your point of how do they get in front of this? How do they make sure that they are reaching out? How do they make sure they've got the right contact information? Because that is really going to be the key - being able to contact the person at the right address and really getting that person to do what they need to do to maintain their eligibility. So there are many different things happening all across the country in a variety of ways using best practices from one state to another in making sure that those plans are very thorough and that they look at making sure that they are moving through the population in a certain number per month so not doing too many too soon. Also, another way that states are looking at this is maybe doing their redeterminations by population so maybe taking the individuals that they think are going to be ineligible first and then moving through to other populations. I will tell you there is a workforce concern present across this country in many different businesses and in state government and it is very true in Medicaid agencies and many states this actually happens at the county level. So. in Ohio for

example there's 88 different counties that may be doing this so it doesn't always wind up to one agency. As a result I would say it is incredibly important to one make sure that you're working across agencies. This I think originally surfaced and there was a lot of thought that this was just a Medicaid issue but when you look at these numbers and when you understand that a number of the individuals actually could move to employer sponsored coverage, this is an insurance issue, this is an employer issue, this is a provider issue to make sure that providers have a reimbursement resource going forward and so there is a lot of work. There's a lot of sharing across levels the best practices that are there. As health plans we are really standing ready and trying to help states to try to fill some of that workforce gap that is existing in state agencies and health plans in many instances know where the members are better than the states. Our data is more up to date and so to the extent that you can work with your health plans in the state it's really helpful but a lot of planning is underway.

Sen. Bob Hackett (OH) stated that remember we all know about the cliff effect where people can come off Medicaid and phenomenal coverage and then have less even though they're getting higher incomes which came through COVID because of the demand for workforce, etc. The question I have though is we see in almost all the states we're having a huge increase in the number of Medicaid state employees. We're really seeing that huge in Ohio. In your mind is that temporary? And why can't our managed care plans handle it? Ms. Motter stated that does not surprise me. The workforce that's going to be needed to help with this volume I think is absolutely true and then to your second question I would say health plans stand ready and are working very aggressively and deeply with the state agencies where they can and where they're given permission to do that direct outreach to enrollees.

Rep. Rogers stated that I think there's some challenges and I spoke with some of my health plans in my state that because of Health Insurance Portability and Accountability Act (HIPAA) laws they're prohibited from trying to reach out proactively. So I do think that the states have a big role in trying to help push this information out and we should have been doing this in my opinion late last year. In our state alone we have 400,000 people that this could affect. The other thing I wanted to note and I did not know this until I started diving into it a couple months ago is that the marketplace is significantly subsidized by the federal Inflation Reduction Act (IRA) so in my opinion the other thing that is needed is navigators to handhold some of these Medicaid patients that are no longer eligible because there are products and they may be very cost effective they may be $10 a month whereas before the products were just so cost prohibitive that they wouldn't look at them. So I think getting the word out with digital tool kits as well as having some hand holding to have a soft landing for these folks to go I think is critically important.

Rep. Deborah Ferguson, DDS (AR), NCOIL President, asked if there is anything in place from the health insurance plans to help smooth this transition? I worry about patients that may have a prior authorization for immunotherapy or medication and all those kind of things. Is there some process to sort of smooth those people from Medicaid to an insured plan where they don't have to immediately change providers or get a new prior authorization and have a gap in their care? Ms. Motter stated that is a great question and as you probably know in many states the Medicaid managed care plans also have a product on the exchange marketplace and so that is a place where if there is an opportunity to move somebody who is ineligible in Medicaid over to the exchange

marketplace where they might have the ability to receive subsidies, where there can be that continuity of coverage to really help with that.

Rep. Brenda Carter (MI), Vice Chair of the Committee, state that you mentioned that 50% of the people will go into some employer base insurance. I'd like to know how would they be able to get that insurance if they are not employed? Many Medicaid people are on Medicaid because they can't get the job. Ms. Motter stated that's a great question, and many of the individuals that I'm speaking to are those that have remained on Medicaid throughout COVID and they may have obtained a job. They may have got a promotion in a job or obtained a different kind of job and as a result of that change in employment that is taking place during COVID it would provide them access to that employer coverage. Rep. Carter then asked what about the recipients who didn't get a job, what is their recourse? Ms. Motter stated that so certainly the individuals that don't hopefully there is an opportunity for them to purchase affordable health insurance coverage through the marketplace and through the additional subsidies that have been extended through the IRA so that certainly is another strong opportunity for them. What we hope is that individuals won't become uninsured. We know that has a significant impact not only on that own person's life to not have access to healthcare but it certainly has an impact across the healthcare market for employers, for providers, where you have a higher percentage of uninsured.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Hackett and seconded by Rep. Carter, the Committee adjourned at 11:15 a.m.

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CHIEF EXECUTIVE OFFICER: Thomas B. Considine

Internal Revenue Service
Room 5203
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

June 8, 2023

Re: IRS Proposed Rule 109309–22

Submitted electronically via: https://www.regulations.gov/commenton/IRS-2023-0017-0001

Dear Sir or Madam:

We write to you today regarding IRS Proposed Rule 109309-22 (the Proposed Rule), which we submit clearly violates the McCarran-Ferguson Doctrine, pursuant to 15 U.S.C.A. § 1011 et seq. For the past 78 years, that Doctrine's directive of "the business of insurance shall be regulated by the States" has led to the strongest, safest and most successful insurance market in the world. The Proposed Rule would abrogate the States' authority in a number of ways related to the captive insurance area. Accordingly, we oppose adoption of the Proposed Rule.

The National Council of Insurance Legislators (NCOIL) is a national legislative organization with the nation's 50 states as members, represented principally by legislators serving on their states' insurance and financial institutions committees. NCOIL writes Model Laws in insurance and financial services, works to preserve

the State jurisdiction over insurance as established by the McCarran-Ferguson Act over seventy-five years ago, and to serve as an educational forum for public policymakers and interested parties. Founded in 1969, NCOIL works to assert the prerogative of legislators in making State policy when it comes to insurance and educate State legislators on current and breaking insurance issues.

A wide range of businesses across America, ranging from small to huge, have established captive insurance companies. A significant subset of these are on the smaller to medium size of the range and are able to make a small insurance company election, known as an 831(b) tax election. These captives mitigate against extremely relevant risks such as business interruption, cyber risk, and other high-severity, low-frequency issues, for their parents and sponsors, which include banks, auto dealers, manufacturers, farmers, and others.

Congress established Section 831(b) of the Internal Revenue Code, (IRC) as is its right. While Congress gave to the States the authority to regulate the "business of insurance" in the McCarran-Ferguson Act of 1945, Congress did reserve for itself the right to pass laws expressly relating to insurance. Section 831(b) of the IRC constitutes such an express Act.

The IRS apparently has some concerns with certain companies' use of Section 831(b). We at NCOIL take no position on those concerns, other than to condemn fraud in all instances.

However, the IRS goes too far in its attempt to deal with its concerns with the Proposed Rule. It seeks to assert itself into captive insurance companies' loss ratios, which it cannot do. Loss ratios constitute the very heart and core of "the business of insurance" and as such shall be "regulated by the States." Congress did not give the IRS the authority to promulgate a rule with the force of law that "specifically relates to the business of insurance," but rather saved such authority for itself via its legislative prerogative.

We at NCOIL urge the IRS to retract the Proposed Rule and return to the drawing board to address its stated concerns with Section 831(b) of the IRC in a way that is narrow, tailored, non-retroactive, and most importantly does not violate the McCarran Ferguson Doctrine by infringing on the Congressionally-delegated rights of the States to regulate the business of insurance. Failing that, we urge the Department of the Treasury to reject the Proposed Rule.

Very truly yours,

Tom Considine
CEO
NCOIL

Will Melofchik
General Counsel
NCOIL

Please see this link for more information on the “Basic Health Program” - https://www.medicaid.gov/basic-health-program/index.html

HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
SAN DIEGO, CALIFORNIA
MARCH 12, 2023
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee met at The Westin San Diego Gaslamp Hotel on Sunday, March 12, 2023 at 9:00 a.m.

Delegate Steve Westfall of West Virginia, Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Deborah Ferguson, DDS (AR)
Rep. Matt Lehman (IN)
Rep. Rachel Roberts (KY)
Sen. Robert Mills (LA)
Rep. Brenda Carter (MI)
Sen. Lana Theis (MI)
Sen. Michael Webber (MI)
Sen. Paul Utke (MN)
Asw. Pam Hunter (NY)
Sen. Bob Hackett (OH)

Other legislators present were:

Sen. Jesse Bjorkman (AK)
Rep. Rita Mayfield (IL)
Rep. David LeBoeuf (MA)
Del. Nic Kipke (MD)
Rep. Kristian Grant (MI)
Rep. Julie Rogers (MI)
Rep. Zach Stephenson (MN)
Sen. Nellie Pou (NJ)
Rep. Mark Tedford (OK)

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. Robert Mills (LA), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Sen. Mills and seconded by Rep. Matt Lehman (IN), NCOIL Immediate Past President, the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's November 17, 2022 meeting in New Orleans, LA, and the Committee's February 17, 2023 interim Zoom meeting.

CONTINUED DISCUSSION ON NCOIL BIOMARKER TESTING INSURANCE COVERAGE MODEL ACT

Del. Westfall stated that we will start today with the continued discussion on the NCOIL Biomarker Testing Insurance Coverage Model Act (Model), sponsored by Asw. Pam Hunter (NY), NCOIL Treasurer, and co-sponsored by Sen. Paul Utke (MN), NCOIL Secretary. You can view the model on the website and on the app and in your binders on page 302. We will not be voting on the model today as we're still in the information gathering and development phase but I think a vote is likely at the summer meeting in July. But before we go any further I'll turn this over to Asw. Hunter for a few remarks. Asw. Hunter stated that I am looking forward to continuing the discussion on this model. As many know, I do have a similar bill introduced in the New York State Legislature currently. As was noted, we are not voting on this model today and hopefully we'll be concluding in July as we've been having several discussions about this model. And thank you Sen. Utke for being a co-sponsor. I think that shows that this bill does have bi-partisans support. This model is consumer oriented and it has struck a chord as it has been enacted in Arizona, Illinois, Louisiana, Rhode Island, and introduced in California, Minnesota, New York, Ohio and Washington. I also want to mention because there may be some confusion that this model is really intended to deal only with post diagnosis to determine the most effective treatment options. So we're not just talking about just having testing at any time. I'm always open to opinions and if there are any options to make language changes please make sure you forward them to myself or send them to NCOIL staff and we'll take a look at them. We want to make sure that this is the strongest model possible that you could bring back to your states.

Adara Citron, MPH, Policy Analyst at the California Health Benefits Review Program (CHBRP) thanked the Committee for the opportunity to speak and stated that last year we analyzed California Senate Bill 912, which is similar to the model, at the request of the California legislature and today I'll just give a quick overview of who CHBRP is, a little bit about the bill we analyzed, key deliverables and findings, what happened to the legislation and then a couple of thoughts wrapping it up. CHBRP is an independent analytic resource at the University of California. We provide multidisciplinary evidence-based and nonpartisan analysis at the request of the California legislature. We do not make recommendations about legislation or the language and we conduct our analyzes within 60 days, usually before the policy committees hear the legislation. Our charge really is to provide a holistic view of potential impacts of legislation. We start with a policy context and also a lay person's interpretation of the bill language. We provide background on the impacted test treatments or services, and a review of the medical effectiveness based on peer-reviewed and published literature. So this is, does the test treatment or service work? We look at benefit coverage, both baseline benefit coverage and how the legislation would result in changing benefit coverage, and then any potential cost impacts so increases in utilization, changes in premiums, and potential cost savings. And then we wrap it up with an overview of public health impacts for the California population for whom this bill would impact. So SB912 was introduced in early 2022 and really it would have required coverage of biomarker testing for the purposes of diagnosis, treatment and appropriate management or ongoing management of an enrollee's disease or condition. The key thing here is that it only would have required coverage for biomarker testing as supported by medical and scientific evidence and the bill language includes several definitions of what medical and scientific evidence is. It includes label indications from the U.S. Food and Drug Administration (FDA) or an

indicated test for an FDA approved medication, a national coverage determination from Medicare as well as nationally recognized clinical practice guidelines and consensus statements.

The definition also includes definitions of biomarker and biomarker testing and the definition of biomarker is really similar to the FDA's definition. The definitions encompass a vast array of biomarkers and biomarker tests and these definitions really encompass traditional biomarker tests such as white blood cell counts and ranging to biomarkers for genetic variations and could potentially use whole genome sequencing. So traditionally with CHBRP's analytic approach and so as I mentioned before we're looking at medical effectiveness, benefit coverage and changes in utilization. And when we started to look into biomarker testing we identified more than 500 biomarker tests that would likely fall under the purview of SB912. We excluded some of the more traditional biomarker tests like white blood cell count so this is really more advanced biomarker testing and within our 60 day timeline it just wasn't feasible to provide analysis on 500 different biomarker tests. So we adopted a modified approach and we examined biomarker testing generally. So I want to acknowledge that there could be gaps in our analysis but because the world of biomarker testing is so broad we really weren't able to drill down more specifically. So to review the clinical practice guidelines that are out there, there are so many clinical practice guidelines that would be included in the definition of SB912 and without doing a side-by-side comparison of every single clinical practice guideline it's really hard to tell are all of these guidelines in agreement? Do they conflict with each other? There are a wide array of diseases and conditions for which biomarker testing is appropriate and also, biomarker tests can be used for multiple purposes. So for example the brackaging for breast and ovarian cancer it's commonly performed for screening purposes, it can also be performed when someone is diagnosed to help guide treatment decisions.

So, as I said before we looked at benefit coverage really broadly and generally what we heard from health insurance carriers in California is that if biomarker testing is supported by medical and scientific evidence, they cover it. Now that's not to say there aren't other barriers to coverage. So prior authorization requirements may be in place for some biomarker tests. Carriers can also vary in which clinical practice guidelines they use. Some develop internal guidelines, some purchase external guidelines and some rely heavily on externally published guidelines. So SB912 could result in some change to benefit coverage but likely it's at the margins and doesn't represent a substantial change in benefit coverage. When we looked at the utilization of biomarker tests among the 24.5 million Californians whose insurance would be subject to SB912, more than 300,000 Californians had received biomarker testing and the cost of the biomarker test really ranges and there's some differences between the cost for commercial enrollees and those enrolled in the Medicaid program. So, one case study we did looked into medications with biomarker indications and the theory is if you use biomarker tests you can impact healthcare utilization and expenditures. So there has been literature that's found biomarker testing can be cost effective if you identify the best treatment from the onset. You could avoid putting someone through unnecessary treatments or less effective treatments. So there are some medications that require or indicate that biomarker testing should be performed prior to use but then there are other medications that say this medication is associated with these biomarker tests but testing is not routinely performed for those medications. So the number of users who use the medications far exceeds the number of users who receive biomarker testing who are

using these medications. So there's clearly a mismatch somewhere. And also just a note about the medications, the cost of the medications really vary depending on whether it's covered under the medical benefit or the pharmacy benefit and this really has to do with the type of medication, the frequency and whether the medication is clinician or self-administered.

And so the cost of these medications range substantially between about $4,000 annually to almost $150,000 annually. So the biomarker testing landscape is really changing rapidly. New biomarkers are being identified, tested and approved for clinical use every year. New medications or therapies with biomarker indications are also being identified and released under FDA approval. And then the reasons for biomarker testing, it really does vary depending on screening purposes and what treatments are available. And also enrollee characteristics, there is literature out there that indicates that there are disparities in biomarker testing by race and ethnicity, age and socioeconomic status and one of the big things that I want to highlight is that there are some substantial clinical barriers to whether patients receive biomarker testing and some of these barriers include clinician familiarity with guidelines and knowledge of best practices and their expertise in genomic testing and then access to multidisciplinary teams. So SB912 was vetoed by Governor Newsom at the end of 2022 and his veto note was that the guidelines may conflict with each other and conflict with existing guidelines put out by the federal Medicaid program. A new bill was just introduced in 2023 in California, SB496. The bill language was very similar to SB912 and this bill will likely be heard by the Senate Committee on Health in April of this year. So just a couple of final thoughts, evidence-based analysis of really broad legislation like this is challenging within a short period of time. We were able to provide some helpful information to the legislature and it did help craft the conversations in California. The reference in the legislation to multiple forms of clinical guidelines can result in conflicting requirements and broad guideline requirements like this are also a challenge for regulators to implement and confirm compliance with the legislation. And then something you all know I'm sure is that some Californians have insurance not subject to state regulation so even if this bill were to pass there's still a subset of Californians for whom these requirements would not apply. Thank you very much - my contact information is on the slides and the analysis we did on behalf of the California legislature is available on our website as well.

Scott Lippman, M.D., Distinguished Professor of Medicine and Associate Vice Chancellor for Cancer Research at UC San Diego thanked the Committee for the opportunity to speak and stated that I will focus the talk on oncology specifically because that's what I do and know best but certainly as you know the same issues of biomarker testing exist in other diseases, rare genetic diseases and certainly other diseases that the biology detected by the biomarker of the disease can be targeted by drugs and the goal in cancers is to make precision medicine relevant for every cancer patient. Dr. Lippman then stated his potential conflicts of interest including being a co-founder of i09 and being on the scientific advisory board of Biological Dynamics but noted that he will not discuss any off label uses. So precision cancer medicine has a profound impact on patient survival. There are two components to precision medicine - genomic testing, biomarker testing, and then matching drugs targeting the actual genomic alterations that the biomarker testing can detect. And I'll show you some recent data but the field's very aware of this so called gap in genomic testing. Genomic testing in cancer is the single most important factor in treating cancer patients and when I mentioned recently there was actually a perspective in the New England Journal of Medicine about three or four

months ago that actually was titled “Closing the Gap in Genomic Testing.” It was the first time we understood the magnitude of the problem. We always knew that biomarker testing and uptake wasn't perfect but this was a very sobering study of 38,000 patients in the U.S. And I'll show you the data as it’s really stunning in terms of genomic testing where the gap was much larger in various underserved communities.

So this shows you the impact on survival I mentioned and this is a fairly recent paper from the University of Colorado Cancer Center, one of the top centers for lung cancer in the world. And they show the results for lung cancer which is the number one cause of cancer mortality worldwide and in the U.S. there are about 2.2 million cases a year. And just to orient you to this is the way we plot outcome often in cancer with the overall survival on the vertical axis the percentage and the time the patients are alive on the X axis. So if you look at the top white curve this is the outcome of again this is real patient data in large numbers that had genomic testing and matching drugs. And the red is patients that do not have genomic testing and therefore no matching during the same time and you can look at this several ways but it's really dramatic patients that get genomic testing and match drugs, 60% of the patients were alive at five years compared to 2% in unmatched patients. The median survival is nine months in unmatched patients and almost seven years in match patients so this shows that dramatic effect. Lung cancer happens to be the poster child for precision therapy and cancer and 40% to 60% of patients have actionable targets and FDA approved drugs. So this is the data from that large New England Journal report that I mentioned and the data is that only 22% of cancer patients in the U.S. ever receive FDA approved companion diagnostics. So we're talking about recommendations in the package insert for the drug. It really allows the drug to be given and yet it’s 20%, one of five patients in the U.S. I can tell you these figures are much worse in some other countries and certain underserved populations in this country. Biomarker legislation will go a long way to changing this. And then I'll just finish with sort of the polar opposite. The lung cancer and that's head and neck cancer this is what I do and this is what we're faced with in the clinic. I'm a medical oncologist and see head, neck and lung cancer patients. So, as opposed to lung cancer, head and neck cancer there are no biomarkers to test for. There are no companion diagnostics. There are no actionable targets in this disease. And the treatment for patients with your current disease is that virtually 100% of patients will be offered immunotherapy, immune checkpoint therapy, which has really revolutionized the treatment of solid tumors the past five years or so.

But as you see here in the same way we got the survival on the vertical axis and months on the horizontal axis, the top curve are the patients that were treated with immunotherapy and the bottom were not treated with chemotherapy and you can see this long-term survival in about 10% to 15% of patients. So you're talking about treating 100% of patients, 15% of whom will have the durable benefit. And so this is the opposite. So what we really need here mostly is markers that help narrow down who to treat so called resistance biomarkers as opposed to the lung cancer situation I just showed. When you have a situation like this we're treating 100 patients and 15 benefit, the consequence is profound. There’s loss of time in many cases. The median survival may be three to six months. There's increasing costs and unnecessary toxicities which can be quite severe and so there's really a need to develop that and there’s recent work in biomarker testing head and neck that illustrate the importance of resistance markers, who not to give a certain therapy and give an alternative therapy. And this is the challenge in the cancer happens to be in human papillomavirus negative head, neck

cancer which is the most frequent. Head, neck cancer worldwide there are about 900,000 cases and 300,000 deaths a year. So I mentioned on the left you can see that the cure rates are about 15%. So on the left identifying the 85% primary immunotherapy resistance, primary meaning before you treat the patient you know ahead of time by these biomarker testing has huge financial and quality of life and toxicity implications. The classic biomarkers on the bottom left that work for some other diseases do not work and are not FDA approved companion diagnostics for head neck cancer.

So in the last slide or two I put up to make a couple points that biomarker testing, again this is that head and neck cancer the one where you know we have no biomarkers and everyone's treated. Looking for biomarkers and feeling confident and valid is if it relates to the biology of the disease and in the bottom middle where it says immune hot and cold, you may have heard of these terms these are very commonly used in immunotherapy of all diseases. Immune hot on the left means those little dots get into the tumor. You can see those dots get into the tumor. But on the right with immune cold this is what it looks like under a microscope. The tumor is invisible to your immune cells so your cytotoxic cells that attack and kill tumors cannot see immune cold tumors. And there's a lot of ways that happens one of which involves a chromosomal alteration loss of a region of the short arm of chromosome 9 so called 9P. And I won't go into detail here other than to make the point that when you look for new biomarkers, there's a very active field you want to be sure it ties to the mechanism of immunotherapy efficacy as immunotherapy virtually never works in tumors that are immune cold. And then in the last slide you can just see on the right and pick the bad color with the red curves but the capital mark curves on the right are just meant to show that the idea that when we talk about biomarker testing in precision therapy we're talking about biomarkers that predict the benefit or resistance of a certain class of drugs. Not all drugs, not all situations, it's very specific to that drug. And that's the difference actually between prognostic and predicted biomarkers. So predicted biomarkers are like this and you can you see in the right that patients that are treated with immunotherapy do very poorly in red if they have this deletion of a region of chromosome 9. Whereas on the left when the patients with the same disease are treated with chemotherapy, not with immunotherapy the curves overlap. So this is a classic example of a predictive biomarker.

Rep. Matt Lehman (IN), NCOIL Immediate Past President, stated that we heard at the very beginning from Asw. Hunter that this is not intended to be a predictor but more of a post for treatment but yet multiple times you talked about predictive. What's the reason for not moving this towards predictive? Dr. Lippman stated that in cancer this bill is virtually entirely focused on predicted markers and what that means is patients who have a tumor and they get a biopsy at diagnosis, before treatment have these biomarker tests on that tissue and in some cases blood. So it's before treatment so they can predict outcome. Now there's roles that biomarkers have on treatment to monitor the effects and so on but the main usage is in precision medicine and the definition of precision medicine really is predicted biomarkers - a biomarker test that will tell you likely whether a patient will likely respond or be resistant to a certain therapy or classic therapies before you treat them.

Rep. Deborah Ferguson, DDS (AR), NCOIL President, stated that I just heard from patients that sometimes if they begin on the wrong therapy and didn't have biomarker testing, that it's very difficult to get a second line of therapy approved. Is that true with most insurance or is that just coincidentally people I've talked to? Dr. Lippman stated

that I don't know whether insurance approves that but I can tell you that if you don't do biomarker testing in the first line and up front before they treat it and try to make it up later, patients do not do as well and there's actually a lot of work Guardant Health did with patient advocacy groups to start a campaign in 2020 called “stop, test, and wait” to have anyone with cancer wait and get the biomarker testing first because if you wait until you start something else and then try to test markers patients don't do as well. Rep. Ferguson stated that I guess are we gradually phasing out chemotherapy - is the standard of care becoming immunotherapy for most cancers? Dr. Lippman stated that I don't know for sure but I strongly believe that chemotherapy will continue to be a backbone of therapy going forward and that immunotherapy and target therapies will add to that but immunotherapy is extremely complicated and we don't really understand the kind of effects. We've done trials where adding chemotherapy to immunotherapy is worse than immunotherapy alone and then we’ve seen where it's better. So I think it will have a key role as well but I think chemotherapy is going to also have a role. And just to mention, we use chemotherapy broadly but certain drugs like platinum salts which have been used for 50 years as a backbone, we now have new genomic tests for ovarian and breast cancer that actually help you personalize platinum therapy. So it's one of my concerns that we sort of lump everything to chemotherapy but there are clearly different types and some of our so-called chemotherapy can actually be targeted to certain genomic events and BRCA one, two is an example. And for homologous recombination deficiency, Myriad has a test. So I think even although platinum has been around we've only realized recently in the past few years that actually there are predictive genomic markers, biomarkers that help us decide whether to give platinum but again that doesn't apply to other types of chemotherapy.

Sen. Robert Mills (LA) stated that it sounds as though biomarker testing should be done immediately after a diagnosis. How available is biomarker testing around the country? I come from Louisiana so sometimes we're the last to know and the last to have. Dr. Lippman stated that you bring up a very key issue. We're focused on reimbursement because we believe that is an important factor on whether biomarker testing is done but there are other issues. This field, as was mentioned, is moving so quickly so there's really an issue of education for patients, families and doctors in the community and also being more efficient with the way we do biomarker testing. In some cases for instance the actual testing of a biomarker can take a number of weeks and certain patients you can't wait that long. A classic example is a study in pancreatic cancer which is sort of again the prototype of the most refractory aggressive human cancer that actually used this genomic marker with platinum combination and it was very effective. But they concluded, this is Sloan Kettering, that it wasn't feasible or ethical clinically because it took three to six weeks to get the test and the survival in pancreatic cancer happens to be three to six months. So you bring up the fact that there are a number of issues that account for these very low uptakes but you try to take one at a time and there are educational programs and different things but we do think that the cost certainly has an effect on whether the test is ordered.

Rep. Julie Rogers (MI) stated that the analogy I would use is using a sledgehammer instead of a screwdriver to fix a problem. Customized medicine is the way of the future and I appreciate the presentation. My question is for the legislation - can you talk a little bit more about the conflict that arose with Medicaid and do you think it might be beneficial in other states looking to adopt this to possibly have two bills and have one Medicaid specific and one that's for commercial insurance? Ms. Citron stated that is a

good question and one of the challenges with Medicaid is it really is a state and federal partnership and the Centers for Medicare & Medicaid Services (CMS) doesn't usually make coverage determinations at the federal level other than broad sweeping brushes. You could break it up but I don't know that it would improve the legislation because you still have the conflict of clinical practice guidelines even within the commercial sphere. As we heard there's really good evidence in cancer but if you move outside of cancer there are less well known sources at the national level. The National Comprehensive Cancer Network (NCCN) is really well known and really well respected but are there other associations that have a really comprehensive set of clinical practice guidelines for biomarker testing - no. That's one of the biggest issues. Dr. Lippman stated that I don't know if doing two bills would have increased the chance of SB912 passing. I was actually asked to testify in the California Senate onSB912 and it was approved unanimously and also through the Assembly I believe so we were very surprised when it was vetoed and I got a ton of calls and emails asking what happened and I had no idea. I can tell you what I heard but it was certainly really surprising to hear that. I don't think it'll solve all the problems as was just mentioned but I do think that it'll make an impact.

Asw. Hunter stated that I appreciate everyone's comments and I think Dr. Lippman's slide was very poignant regarding the folks who did not get this biomarker testing. I do hope that when we get to July that we get some more information from anyone out there who has questions or concerns. But I do think that as we are having conversations about preventative medicine that there's a lot of research and development going on. This is what is going to be helping us in the healthcare industry going forward and we need to make sure as we're bringing these bills in all of the states that all of our constituents have equal access. And I hear Sen. Mills talking about how it shouldn't be only the wealthy, it shouldn't be only a very small percentage and hopefully by introducing and enacting bills like this it will be broader so that more people who are affected by cancer and any other diagnosed issues will be able to get the expansive comprehensive healthcare that they deserve. Thank you and I look forward to this being voted on in our July meeting.

Del. Westfall thanked everyone and stated that as Asw. Hunter noted this will probably be voted on in July so if anybody has any more information on the topic, bring it to Asw. Hunter, myself, or NCOIL staff.

INTRODUCTION AND DISCUSSION ON NCOIL MEDICAL LOSS RATIOS (MLR) FOR DENTAL HEALTH CARE SERVICES PLANS MODEL ACT

Del. Westfall stated that next on the agenda is the introduction and discussion of the NCOIL Medical Loss Ratio (MLR) for Dental Healthcare Services Plans Model Act (Model) which I am sponsoring. You can view the model on the website or on the binder on page 305. As you may know I am sponsoring a near identical piece of legislation in my home state of West Virginia. I've decided to hold that bill to see what NCOIL comes up with. I'm a pretty strong believer in what NCOIL comes up with is a pretty good idea. So, I'm still committed to the issue and I'm looking forward to working with everybody on the model. Similar to Asw. Hunter, I'm certainly open to any remarks and comments about the model. In fact, the bill in West Virginia looks a lot different than when it was first introduced. There will not be a vote on the model today. We'll hear from our list of speakers and determine the best procedure to move forward with on the model.

Chad Olson, Director of State Gov't Affairs at the American Dental Association (ADA) thanked the Committee for the opportunity to speak and stated that I'm joined here today by Dr. Robert Hanlon who will give the patient provider perspective on this issue. We have another doctor here who is a an oral maxillofacial surgeon and he sees both the major med plans that have an MLR and dental plans. I could speak about that maybe after in the lobby. The model's purpose is to ensure commercial dental coverage offers good value to dental patients. An MLR is the percentage of insurance premiums that is spent on actual patient care rather than on overhead costs like executive salaries and administration. The model does three things. First it adds transparency to dental insurance by requiring carriers to report their MLR annually to the state insurance commissioner. Second, it sets a minimum standard for dental insurance MLR at 85%. In other words, dental insurance carriers would have to spend at least 85 cents of every dollar they collect in premium on patient care. And finally if a carrier does not meet the 85% threshold they will be required to refund the difference to covered patients and groups. This is a policy that has been successfully implemented on medical insurance and many dental insurers already report maintaining an MLR at or above the standard. Dentists and patients agree that this standard is important for dental insurance. So if you haven't heard, late last November there was a ballot initiative on this very issue in Massachusetts and it was approved by voters by an overwhelming 72%. And so just to show you once voters were educated on this issue they came that way in a big way and we'll go into that a little bit more later. I expect you to hear from dental insurers that they cannot possibly meet a minimum dental MLR, that it will drive them out of business or out of states that pass this law.

My contention would be that there's nothing further from the truth. First, this policy has been in place for 10 years for major medical insurance and insurers continue to be profitable as we well know. Second, many dental insurers already meet the MLR standards being included in these laws. This policy is something to nudge them in the right direction. You will also hear from the dental insurers that this policy will force them to raise premiums. This model does not require insurers to raise premiums and insurers have other options to choose from including making operations more efficient rather than ask patients for more money. Now you may have heard one of the panelists today speak yesterday about changing more to electronic communication to patients. That's one way to save money. MLR would encourage the plans to engage in that kind of activity. Because most consumers do not have the freedom to switch carriers, this is not an issue that can simply be left to the free market without additional protections for consumers. Most people get their dental insurance through their employers. The only way to protect patients is to ensure that all dental insurance is good value. And finally I want to be very clear that MLR is not a partisan issue. The ballot initiative in Massachusetts had a win margin of eight points higher than the Democrat candidate for Governor. At least 10 states to date in this session have seen bill's filed with Republicans and Democrats, red or blue states if you will: Arizona, New Hampshire, Oklahoma, and Connecticut have all seen bills filed on this. During COVID, dental insurers continued to collect premium without having to pay out for patient care. Major medical plans around the country had to provide rebates for customers. This was not so for dental plans. Having an MLR statute in place would ensure patients with dental plans have true assurance that they are receiving value for their dollars. So let me give you an example of how MLR can have a positive effect on the access to care side. According to the National Association of Dental Plans (NADP) own data, roughly 50% of dental plan subscribers don't go to the dentist for routine care in a calendar year.

Establishment of an MLR will incentivize the plans to encourage their subscribers to get the care they need. More subscribers going to the dentist means the plans are better able to meet, this MLR percentage. And what's the result? Patients end up with better oral health. That's just one outcome.

Dr. Hanlon, member of the Board of Directors of the California Dental Association (CDA), thanked the Committee for the opportunity to speak and stated that I'm a practicing endodontist and I've been providing dental care in Escondido, California for the past 25 years. Prior to that I was a general dentist in the U.S. Navy for 10 years and I've seen first hand for years the negative effects on my patients that a lack of value in dental insurance can have. California has been at the forefront of the MLR discussion for a decade trying to increase the value that dental plans provide to the enrollees and ensure that patients can get the care that they need. In 2014, California passed the first national dental MLR reporting requirement and we have nine years of data on these dental MLRs. There is a wide variation in the MLRs, for some over 85% to many under 50% and some shockingly low with MLR percentages in the teens or twenties. What that means is that for every dollar a patient spends on their premiums 75 cents or more goes to plan profits or overhead and in some cases less than 20 cents of that dollar goes toward patient care. This wide range in dental MLRs raises an important question about what value dental plans are providing to patients especially when you consider that compared to medical insurance dental plans essentially operate in a wild west environment and have much less oversight or regulation than what has been applied to full service health plans. Dental plans have no standardized benefit, no caps on patient out-of-pocket costs and lack many of the patient protections that exist with medical insurance.

Dental plans cap out a patient's maximum benefit of typically $1,500 to $2,000 annually as a total amount a plan will pay toward a consumer's dental needs in a calendar year. Although premiums have gone up the average annual dental maximum has not significantly increased since the 1970s. When adjusted for inflation a $2,000 annual maximum benefit in 1970 would be equivalent to $15,745 in 2023 dollars. There's a reason people think dental care is expensive and it's based on how little dental insurance actually covers for most patients. Because I provide a major restorative service many of my patients are shocked when they realize how little their dental plan will pay towards towards the treatments or that their actual annual maximum comes nowhere near close to covering the cost of their total care. When patients need it the most, dental insurance still leaves them on the hook for the majority of the cost. One of the big lessons for me during and after the pandemic is the number of patients I saw who deferred or delayed dental treatment. Small to moderate lesions that could have been successfully treated with simple restorations were now enlarged to a point where patients needed a root canal and a crown. Many patients could not absorb these out-of-pocket costs and decided to have the tooth extracted. That's no way to improve their oral health and no way to improve their overall health. I want to thank you for the opportunity to come speak with you about the frustrations that both providers and patients are seeing with dental insurance. I urge your consideration of this model as an MLR requirement for dental plans is a key element of a comprehensive reform strategy needed to make dental insurance a really meaningful benefit.

Jeff Album, VP of Public & Gov't Affairs at Delta Dental of California, thanked the Committee for the opportunity to speak and to explain why my good friend Mr. Olson, as

good a person as he is, is just wrong on this issue. I want to begin by thanking Del. Westfall for delaying the legislation in West Virginia so that this conversation could happen and ensure what we go forward with is a very informed and educated understanding of what a loss ratio is or isn't specifically for dental. Because dental is not medical. It is different in every way and we're going to do a little seventh grade fractional math to begin to understand why a loss ratio for a low premium product does not provide the assurance particularly of value that it might for medical at almost 20 times the cost of dental. And the next 10 minutes of my presentation can be summarized this way - I'm holding here a tape measure and a bottle and this tape measure absolutely will define how tall this bottle is. It will tell you how wide it is. It's a very trusty worthwhile metric to measure width and length. What this tape measure does not do, is it does not tell you what's in this bottle. This could be wine, this could be water, this could be booze, it could be anything. It doesn't tell you what the quality of the water is in here. There's nothing about the tape measure that gives you the particular measurements of the purity of the water. And I say all of this because what this tape measure is to this bottle of water is what a dental loss ratio is to a dental plan and I'm going to explain myself and why that is. It certainly does not measure value as my colleague Mr. Olson opened his conversation with. So let's begin with where MLRs came from. They've not been around for very long. They were introduced as part of the Affordable Care Act (ACA) in 2010. They never existed previously and MLRs were a very small element of a very large and radical restructuring of the entire healthcare marketplace and the way health benefits are provided. The ACA overhauled the entire thing. It took millions and millions of taxpayer dollars and gave them to low-income Americans so that they could afford to buy a health product from a health plan. It completely structured and standardized the benefits that health plans offered going forward from 2010.

So apples to apples, every plan is offering either a gold, platinum, silver, bronze product in all of these new public health exchanges. One in every state. Some are administered by the federal government, others by the state itself. But these new places, taxpayer dollars in the millions, were created and millions of Americans who were previously uninsured were now insured thanks to those changes. And what the MLR did was it was a way of providing some accountability for health plans who are all offering the same product across the board to ensure that when you compare their price and you look at their administration it's patients who are getting the majority of those dollars in terms of care, etc. None of this happened for dental as it’s not an essential health benefit (EHB). There's no such thing as essential dental benefits except for children under the ACA. So this really is a solution in search of a problem. Dental carriers are not making excessive profits. I know what my plan makes and I've taught and I know what my colleagues make and if you even just go to Google and ask what is the net average net profit for a dental insurer, it's somewhere between 2.5 and 3 cents for every premium dollar that's charged. I don't know a lot of businesses that can exist or do exist for 2.5 to 3 cents but the very low net profit is predicated on high volume and take up of dental in the dental benefits marketplace. Now we don't have any problem with take up from large companies and when you look at these loss ratio numbers I'm going to show you what you'll see is that the many dental plans offered to large employers come in at 85%, 88%, even 90%. Sure no problem, as others have referred to other dental plans here.

But the people who don't have dental, there's 50 million Americans without dental insurance today. There's another 20 or so million who I would say marginally have dental insurance and I say marginally not because their plan is bad but because it

depends on them spending their own money without the benefit of a group benefit manager, without the benefit of a company sponsoring those benefits. They're paying their own money. And whether they're going to continue to buy that dental plan year after year depends entirely on its cost. And it's the cost of dental benefits that I am worried about if this approach goes forward and I'll explain why. So first of all let's look at the radical difference between medical and dental plans. And this has to do with the denominator that's going to be in that loss ratio. A medical plan at $600 a month per person, some of them are more, has about $120 to spend on both profit and administration because it's premium, its denominator is $600. The average dental plan can run anywhere between $15 and $50 per person per month and let's just take $25 as being a medium average premium for dental plans and you see at 85%, you only have $5 a month and if you had lowered it to 70% because I've heard people say well let's just lower the number would you accept it then? Well you can go all the way down to that and you've only left the dental plan $7.50 a month to administer the plan. And remember the profit's only 2%. So we can give up profit not that that would be very smart and still not come anywhere near as close to having the amount of dollars that are necessary to sell and to administer a dental plan. Now in California where this idea of setting an MLR for dental plans was discussed ad nauseam about five years ago, we agreed to do transparency and by the way we still favor transparency on this issue. We agreed to transparency and to report our numbers by market segment because a loss ratio for a large preferred provider organization (PPO) plan is a lot different than a loss ratio for either an individual or small plan or for a dental health maintenance organization (DHMO) plan in the individual and small group market. And there's a reason for that. The loss ratio does not report the value of small premium to these people who are marginally insured or have to pay for it with their own money, and it has absolutely no measurement of what the savings are to the patient when they purchase this plan and how much money do they save on dental care and how much more often are they prompted to visit the dentist as a result of having a low premium product. You are not going to see that here. So again, these are the actual numbers. There is no reason to believe these numbers would be significantly different in any other place of the country. There are a lot of states that don't have DHMO because they're too rural in nature and there aren't enough dentists able to participate in that model. By the way another aspect of DHMO is a loss ratio doesn't capture the amount of patient care that is paid for in these services because the dentist actually performed services for which the dental plan doesn't pay but the dentist is collecting a monthly capitation amount that allows them to do better in subsequent years as the patient's health gets better. So patients are receiving a lot more than what is shown in this chart but the model simply doesn't lend itself to being reported on similar to what I've showed you about the bottle water and the tape measure.

I want to dissuade the group from this idea that administrative cost is evil in a dental plan. What do we do with what we spend on administration? We make our call centers faster. We pay our dentists faster. We offer more online services so that patients can see what their cost will be beforehand and understand their benefits. We manage the utilization of these benefits to make sure that the services that they are being offered are the services they actually need and are in accordance with professional standards. We have all these compliance issues, the same ones as the medical. This is not the wild west. Dental plans are regulated to the teeth in every state where I am and I've been here 30 years. We have to comply with almost every regulation and bill that's been passed for health plans. We are generally not exempted from most healthcare

legislation and certainly we run an appeal and grievance process so a dentist has somewhere to go if he or she doesn't like the way we adjudicated the claim. We have quality management programs. We have to pay a broker or we won't sell the darn thing in the first place. And that broker commission by the way takes up a greater percentage of premium, because our premium is so low, than it does for medical plans. So medical plans did not face the same fallout of having to put broker premium in the administrative pile when they report on these lost ratios. If I were a broker I would be concerned about this issue because that's going to be one of the first things dental plans cut if they're going to have to try and get their numbers up.

I've already mentioned all state laws but I really wanted to call attention to two things here. The quality management program which ensures and protects the patient and also cuts down on fraud, waste and abuse which happens quite a bit in dentistry. I hate to say it but there is a small minority of dentists who greatly affect the overall cost and price of dentistry because they are not practicing to the standard. And secondly, the negotiated rates. The work we do to maintain networks of dentists at rates below their normal price resulting in patient savings. These all add up to greater access to care. Let's take a look, I'm going to go with a low premium product here to show you why a very good product might come in with a dental loss ratio if you looked at it by itself and not in connection with other higher price products, why it might come in at a low MLR of only 53%. So the cost of acquisition, marketing broker commission would probably would be $1.50 out of this $15 monthly premium. The profit is only 50 cents. So we're making less profit than brokers are actually making on commission on this particular product. The operations and maintaining the networks is going to cost around $5 and that leaves about $8 that will be spent on claims, which will go into the denominator. So we have a ratio here of eight to 15. Now we could go to a higher loss ratio product and take a look at it. It wouldn't be a $15 product, it'd probably be a $50 product and because the denominator is so large, the administration, the cost of operations, networks, could be twice as much in real dollars but it will be a smaller percentage as a numerator. And for that reason you have a more expensive product that spends more on administration that comes in at a higher MLR than this $15 product. Just a quick word about rebating. Because we're dealing with such a low denominator, premiums that can be $12, $15, $20 per person per month, for some plans that are marginally under the loss ratio whether it's 80% or 70%, I don't care what number you pick, we're going to end up with rebates of 32 cents or other very small numbers. And by the way the cost of an envelope, printing, paper and postage, this does not include the cost of time and paying people to calculate all this stuff and execute the rebating. But just the paper and postage is $1.27. That’s self defeating and it just drives up the cost of administration further. So the act of rebating drives your loss ratio lower again because we're dealing with premiums that are so low.

I'm not going to spend a lot of time on these two charts. I’m just going to tell you what the point is when you look these and what they show you is that a PPO plan for an individual at 58%, these are actual plans we offer in Covered California today - this product that costs $155 total for the year actually will yield this enrollee savings of $3,200 over the retail cost of care that he could choose to receive. In fact if they do nothing but see the dentist twice and get their x-rays they are going to more than double what the cost of the premium was. They get their premium back and plenty more afterwards. Here's a much higher, more expensive plan. It's a higher MLR at 65%, it's a PPO also offered to individuals and with the same services acquired this patient is only

going to save $2,300, $1,000 less over the retail cost of the dentistry they received. However, it's still a good plan. If they see the doctor twice they are still going to get back their premium and then if there's anything that the dentist finds that needs to be treated that's going to be savings on top of that. In West Virginia we ran a scenario of meeting an 80% and I know the proposal is 85%, that seems so absurd, I just had to go with 80% but 80% is absurd also. In the West Virginia Public Exchange we would have to double the cost of our current basic product from $11 to $23 to meet that loss ratio and this is with zero profit. We've already eliminated the profit in order to hit this number. So the only conclusion you ought to draw from all of these examples is that dental benefits today are more affordable, offer more benefits without some of them having an annual maximum, and they're more often selected by people who would otherwise be uninsured. Under an MLR we're going to have to increase premium and increase benefits beyond what the market is willing to pay and that's going to result in fewer patients to dentists. Everyone loses: enrollees and patients. We're going to consolidate so there will be less competition. Plans that don't have large group and specialize in small group are going to go away and there will be fewer of us trying to solve the problem of people without dental insurance.

Jill Rickard, Regional VP of State Relations for the American Council of Life Insurers (ACLI), thanked the Committee for the opportunity to speak and stated that ACLI is very much in agreement with Mr. Album's remarks. We would reiterate everything that he has said but there are some points that are specific to our members who are life insurers who do often offer supplemental products like dental. We have 280 life insurance member companies who offer a wide range of products that protect people through all stages of life. This includes not only life insurance and retirement products but also Paid Family and Medical Leave (PFML), long-term care (LTC), disability income insurance, as well as supplemental insurance products like dental benefits and vision care. Our members typically include dental benefits as a small but vitally important part of the portfolio of financial products that they make available to employers and individuals. Imposing a loss ratio on dental plans as Mr. Album presented will not equate with more dental care and will decrease the availability of affordable dental coverage. Families without dental insurance are less likely to visit a dentist for regular cleanings and preventative exams which increases the chance not only for poor oral health but overall health outcomes. First, with respect to life insurance companies, there are complexities to the financial reporting, solvency requirements and administrative and delivery functions of life insurance versus their health and dental insurance counterparts. We would request that these be carefully considered in any loss ratio or financial reporting public policy discussions. Life insurance must build and maintain reserves differently from health and dental only carriers because of the different nature of their risk. As you all know, unlike health and dental claims that tend to be paid closer to the issue date of the policy, life insurance claims are usually larger and also paid many years after a policy is issued. Because of this, life insurers report their financial solvency using a formula and forms that are different from health and dental insurance. We are finding this to be a problem in Massachusetts where the ballot initiative did not recognize the differences so life insurer’s risk is being put at a disadvantage which will increase the cascade of bad outcomes. Importantly, as Mr. Album touched upon there is a huge variation in costs of administration between large groups, small group and individual plans. It is more difficult to administer a loss ratio the smaller a group gets as there obviously are fewer economies of scale and other points that go into the calculation of administration.

My second point is that life insurers rely heavily upon brokers and agents to present a package of financial production products to employers. Dental insurance is a small but important part of this package because of its high demand. Imposing a loss ratio on dental will make it difficult for life insurers and all dental insurers to compensate their brokers for their important services not only in selling the products but in educating employers and individuals about their dental coverage choices and servicing the products they choose. And there aren't insurance exchanges or navigators at least in most states to replace these vital agent and broker services and these brokers and agents are people who make their living in your communities selling insurance and they contribute to local economy so this is an important consideration. And then finally I'll reiterate that we agree with Mr. Album that there are better ways to address this issue. It is premature to oppose a loss ratio and we would respectfully suggest that a better first step toward effective policy development is to require loss ratio reporting over a period of years similar to the approach adopted recently in Maine as well as in California. Allow the regulator to review reporting and identify any outliers and then empower it to conduct remediation if necessary for those outliers. It's important to note that after reviewing the comprehensive reports of the myriad of dental benefit carriers offering plans in one of the nation's largest marketplaces over a long period of time, the California Department of Insurance determined not to recommend a dental loss ratio. Thank you and we look forward to working on alternatives in West Virginia and here at NCOIL.

Rep. Ferguson stated that in full disclosure I'm a retired dentist but to Mr. Album's point, they are very different than medical plans. Medical plans have unlimited lifetime and annual maximums. Dental plans actually cover very little in terms of services. To your point the value of a dental plan for a patient is the negotiated rate that instead of paying what I charge, you're paying a reduced allowable amount so I don't think it's unreasonable to have an MLR when a dental plan is actually not covering much dental care. I have dental insurance and it has an annual maximum of $5,000 or $6,000. Mr. Album stated that dental plans cover exactly what the people who purchase us ask us to cover. I would love nothing more than to sell you a dental plan that covers 100% of all the services that your patient needs over the course of the year and the price of that dental plan is unacceptable to corporate America. and it's not what they're willing to purchase, it’s not what they are willing to do. And again it's not the dental plan that is determining this. What they are willing to do is to buy a product that makes the patient more than twice as likely to visit the dentist to receive diagnostic and preventive care at 100% of coverage and to cover most of their basic services and then to greatly cut down on the cost of those major services that they need and they might not otherwise get. Rep. Ferguson stated that some of these small plans pretty much just cover having your teeth cleaned and having X-rays and maybe simple fillings. They really don't cover any restorative services. Mr. Album stated that there are a lot of dental plans that only cover diagnostic and preventive, California doesn't allow it. Many regulators don't and that brings up an excellent point that in states all over this country we're required to file and approve the products that we're selling, what we cover and what we don't and at what price we’re paying it and we're required to send all of our financial data to the regulator. In Nevada for instance we have to file and approve products and from time to time a proposed rate increase is rejected because they look at our loss ratio and they say, “no you didn't buy enough patient care last year we're not going to approve” so in effect there's actually loss ratio thresholds happening in regulatory departments all across the country today.

Mr. Olson stated that there are two things to say, one is the quirk of dental insurance and how it's constructed currently, it's a quirk of historical inertia. And as Dr. Hanlon pointed out the annual maximums have not gone up and that's kind of I think what you're getting at as well Rep. Ferguson. So in real dollar terms these plans have got increasingly less value since the 1970s. Giving less and less to patients in terms of actually paying for care and instead really just selling a network discount. I think what a dental loss ratio would do is nudge them in the right direction toward incentivizing them to pay for more patient care and rethinking their plan designs. The so-called 180/50 plan where a major service is only covered at 50% and then the patient is responsible for the rest, does not provide a lot of value to a patient that has real severe needs.

Rep. Rita Mayfield (IL) stated that she agrees with Mr. Olson and asked if anybody introduced any legislation that would require that the out-of-pocket expense be either removed or dramatically reduced. Mr. Olson stated that plan designs currently are with a lot of patient cost sharing certainly. What an MLR would do is sort of nudge in their very direction reconsideration of major services. As Mr. Album said, preventive services are usually covered 100% by these plans but then it reduces pretty significantly after that.

Rep. Lehman stated that the one big concern here is what the MLR has done to the healthcare world and to use Indiana as an example, we have I would call it a duopoly in Indiana between Anthem and United Healthcare and part of it is I can't be a million dollar company and be forced to push 85% of my revenue out the door. I can't be a billion dollar company. I have to be $180 billion. In United's case I have to be $286 billion and now 4% profit or 2% profit looks really good to my investors. I understand the MLR issue. My concern is do we only create an alternate problem which is now we push the little guys out because I can't survive with having to push money out the door. I like the idea of the disclosure so I can see as a consumer what percentage is being used. But if we go to the 85/15 I'm afraid some of those who want to be disruptors in the marketplace won't be able to compete. Mr. Olson stated that I and the ADA would be happy to talk with the plans about solutions to that very concern and in some cases I've actually talked with Del. Westfall about them. Some of them could involve perhaps only a certain number of covered lives for the insurer in the state in the implementation of an MLR for dental plans. I think there could be a graduated approach to or maybe something akin to the ACA where there's a tier between small group and large. I think that there are several solutions that could still get to this good reform that would still apply an MLR. I will tell you that when it comes to the size of plans and profitability, transparency is excellent but we haven't seen a lot of change in California in terms of behavior of the plans since the reporting has taken place and that's why a rebate incentivizes a change of behavior which again is about nudging in the right direction.

Del. Westfall thanked everyone and stated that we will move forward on this in some fashion. Anybody that has any suggestions or information please reach out to me or NCOIL staff.

INTRODUCTION AND DISCUSSION ON NCOIL HOSPITAL PRICE TRANSPARENCY MODEL ACT

Del. Westfall stated that next on our agenda is the introduction and discussion of the NCOIL Hospital Price Transparency Model Act (Model) sponsored by Rep. Tom Oliverson, M.D. (TX), NCOIL Vice President, and co-sponsored by Rep. Rachel Roberts (KY), Vice Chair of the Committee. You can view the Model on the website and the app and in your binders on page 308. We will not be voting on the Model today. I'll turn it over to Rep. Roberts for remarks.

Rep. Roberts stated that I'm very proud to co-sponsor this model alongside Rep. Oliverson. For those of you that were at our meeting in New Orleans this past November you may have sat in on the session focused on hospital price transparency. We all price compare when we shop for things for our family and we use that information and the reviews associated to make the best decisions and that's really what we're driving at here. People want and deserve to know how much a hospital procedure is going to cost them and it shouldn't be so complex and so vague to find those answers for patients. The model you see before you represents a combination of the laws passed in Texas and Colorado and as you'll hear from our speakers today a lot of the state action in this area stems from a federal hospital price transparency regulation that hospitals unfortunately have been very slow to comply with. So states and NCOIL are stepping up to say to the hospitals that if you don't comply with the federal rule you'll also be violating state laws. That may have more teeth and more ability to help incentivize these businesses to comply and while hospital compliance has increased slightly over the past several months we still have a long way to go to get to a number that is close to full compliance.

Jonathan Wolfson, Chief Legal Officer and Policy Director at the Cicero Institute, thanked the Committee for the opportunity to speak and stated that the Cicero Institute is a state focused policy think tank. We're headquartered in Austin, Texas and our objective is to design entrepreneurial solutions to the toughest public policy problems. And we've been talking a lot at Cicero about how to take price transparency that members like Rep. Roberts and others have been talking about and really making it useful for patients. So I'm going to take kind of the next step and just talk about why price transparency really matters to our patients and the communities that we live in. And so the promise of price transparency as Rep. Roberts already mentioned is that patients will know how much care is going to cost before they show up. They'll be able to shop for the treatment they want and compare prices. And that doctors can compete on price and quality just like every other professional. Lawyers do this, dentists even are doing this. There's lots of people who do this. Lots of complicated marketplaces where these things exist. And this has been the promise of price transparency. I've been writing about this since the early 2000s when I was in the Bush Administration. This has been a conversation people have been having for a long time but time after time after time we don't really see the outcome that patients are using these data. And so this is the promise and we all want to get there but the problem is that patients often have little incentive to use price transparency information to make health care decisions. Now sometimes there are barriers to price transparency problems. That is the information is not available. You know there are some interesting studies talking about even though there are federal rules and regulations that require hospitals to post their prices and all this information they haven't necessarily done so. There's obviously a fight over how much of that has happened but it does appear that there's a lot of data that are not available that when I was at the Trump Administration writing some of those price transparency rules the expectation was it would be currently produced.

Some of that information is hard to use. Sometimes it exists but it comes in a really complicated, really large file format. It's not easy for patients to access that information. Sometimes patients just don't know that they have the ability to ask. We haven't built this culture in our country where you can ask. You know, if you go into a law firm it's not uncommon to say how much is this going to cost me? Or if you go to the mechanic shop you're going to ask how much is it going to cost? But people have been trained over the years to walk into their doctor's office, present their insurance card, and be told we'll let you know how much this is going to cost and what you owe some time in the future. Go get your care and it's all going to work out okay. Only to have those people find out months, even years later that they've actually got really large expenses and unfortunately patients actually their actual individual out of pocket costs for a treatment can vary very little because of insurance. Now insurance is a wonderful tool and it really does help patients but it does hinder price transparency promise because if a patient knows that the difference between finding a lower cost option is going to save them $5, even though the insurance company is going to save $5,000, the patient doesn't necessarily have a big incentive to use that information. Often doctors don't have the information of how to use this price transparency information. They've got a really complicated electronic health record in front of them and they don't necessarily have the ability to say, “hey did you know that if you don't go to CVS for this drug but if you go to Walgreens you can actually save on this prescription?” A lot of that information is not yet available for doctors and ultimately insurance will punish patients who save money if they don't stay inside of networks because it doesn't get covered. And so even if you know that there is a doctor's office that'll do a knee replacement down the street for $25,000 less than the more expensive facility where you're currently sitting, if you go outside of the network your insurance company says congratulations you owe the full $10,000 for that treatment whereas if you'd gone in network to a significantly more expensive location you would be paying less out of your own pocket.

So these are all barriers that exist to price transparency promise in our market and so the Cicero Institute we think about how do we evaluate these problems and then try to build model policies and then we have an arm that has lobbyists on the ground in various states. We’ve said what could be done to try to incentivize patients and especially the highest cost patients because these are the folks who know at the very beginning of the year that they're going to exceed they're out of pocket max. I had a secretary when I was in private law practice who was on a couple of injection treatments. She knew no matter what happened, no matter what decision she made in the year that the only thing that mattered to her were two numbers. The number of her total premium for the year and her out-of-pocket max because she was going to pay the full amount of both of those things no matter what happened that year. If her kid broke her arm that's what she was going to pay. If everybody in her family was totally healthy other than the injection regimen she was on she was going to have to pay that amount and so she had no incentive to look for lower cost options. If her kid broke her arm she can go to the most expensive place in town regardless of whether the quality was any better or whether the treatments were any better for her kid. She could go there because her total cost for the year wasn't going to change. Now sure there's a possibility that if she found lower cost options and lots of people in our network in our group made smart decisions, she might see a premium reduction over time but that was the only possibility of a savings that she could see in the future if she was making wise decisions that we would all talk about.

Now unfortunately one other piece of information we should all remember is that almost every study that's been done says that higher cost and higher spending health care does not usually correlate with better quality care. In almost every study that's been done it is either been the reverse or it has been found to have absolutely no bearing on the quality. And so if the story was our healthcare expenses are going way up but we're getting way better care then maybe none of this matters. Maybe we don't want to incentivize people to shop because maybe they'll shop for lower cost options that save them money but ultimately make them less healthy. But none of the evidence indicates that. And whether you look at the Surgery Center of Oklahoma or other organizations that have gone into business and have said we're going to be a cash option and they've provided high quality care, we see that there are opportunities for people including high cost patients to find lower cost options. So our patient's right to save proposal has three specific prongs. The first is to require cash rate disclosures for all shoppable services, so this is not going to be emergency heart attack treatments but cash rate disclosures from all providers. This would not just be as the federal rules with hospitals but this would be all providers. So if you have a doctor's office you would need to provide the cash rate disclosures for the treatments that you offer at your facility. Secondly, we say that any patient who finds a lower cost direct pay price than the lowest negotiated rate from their insurance company can go to any provider pay the cash price for that treatment whether that doctor is in or out of network and the insurance company would then be required to provide deductible credit for that treatment. And then finally, for those patients who exceed their deductible they not only get those expenses if they find that lower cost out of network option or in network option at a cash direct pay price, if they find that lower cost option they not only get it counted toward their out-of-pocket maximum but they also get a cost share savings with the insurance company. So go back to that knee replacement if somebody finds a knee replacement for $10,000 less at a direct pay price, again in or out of network, then the insurance company would get $5,000 of extra profit and the patient would get to take that extra $5,000.

So if we go back to my secretary now she would have an incentive to go and find a lower cost injection facility that's going to offer her a cash option because she pays cash she gets reimbursed by your insurance company not just for the cost she expended if it's an excess of pocket maximum but she's also going to have the opportunity to have a saving sharing with the insurance company. So what are the benefits of this policy if it were to go into effect? First of all, providers would save time and money on paperwork as we've already discussed a little bit and as we all know from talking to doctors a huge chunk of doctor’s time and resources are spent not on providing care but on having interactions with insurance companies, seeing whether things are in network, having a fight over that. All of those things move outside of the doctor's office because the patient can get pre-authorization and then you move straight ahead. You don't have to go back and forth for the doctors and the insurance companies. Second, patients are free to visit the best providers at the best price. If they have a next door neighbor who got a great treatment but that doctor happens to be outside of their network, if that doctor offers a direct pay price, they have that option. Patients have the opportunity to save money and it's not going to cost the insurance companies any extra money either. The highest cost patients will indeed as I already mentioned have the highest incentive to shop for care because they under the current system have zero incentive to do it. If you give them some sort of cash savings option of sharing that savings with the insurance company they'll have incentive to shop. And insurers have an incentive to encourage shopping

because especially for those patients at the higher echelon where there's that cost savings, if this is worded correctly, it would not and I'm going to go to the MLR because that's what we were just talking about it would not have to count against the MLR as far as administration. It could count toward care costs. And so this is a way for insurance companies to actually make additional money counted toward care but in encouraging the market to move toward a functioning marketplace just like we see in so many other areas of the market. So the bottom line is that patients right to save incentivizes patients to make price transparency work by rewarding patients who shop for lower cost high quality care will reduce healthcare spending, reduce premiums and empower the patients to build a marketplace like we all say that we really want in healthcare.

Aaron Wesolowski, VP of Policy Research, Analytics and Strategy at the American Hospital Association (AHA) thanked the Committee for the opportunity to speak and stated that today I'd like to cover a couple things. I want to just provide some background on exactly what the federal requirements are around transparency and also level set to where hospitals actually are and complying with those rules. And I think that's important in terms of entertaining state level requirements as well. First the AHA's position on transparency, our number one priority is pursuing price transparency efforts that actually help patients access clear and accurate cost estimates when they're preparing for hospital care. We also support streamlining price transparency requirements as you'll see in my slides. Even at the federal level there's a fairly complex web of federal transparency requirements so it's important to understand that when contemplating state requirements on top of those federal requirements. We're going to continue to work with hospitals and with CMS on improving compliance and as you'll see compliance is actually come quite a long way in the two years that the requirements have been in place at the federal level. And I do want to just sort of address there has been a lot of coverage of hospital compliance and CMS has actually helped clear the record recently in terms of saying where hospitals are at in terms of compliance. Hospitals are generally much further along than some organizations have claimed. So first at the federal level, again on January 1, 2021 hospitals were required to comply with the new hospital transparency rule. The key component of that is that they're required to post machine readable files of five standard charges, gross charges, payer specific negotiated rates, de-identified minimum and maximum negotiated rates and discount of cash rates. They're also required to provide patients with either an out-of-pocket cost estimator tool or payer specific negotiated rates for at least 300 shoppable services. So obviously the rates that payers pay hospitals are highly complex as these various requirements outline there isn't typically a single standard rate for a single standard service. It can be driven by a number of factors. Some services are bundled. Some rates are affected by the overall volume of care and obviously the number of services in the acuity of care can play a role in those rates as well. So it's highly complex.

In addition to those federal requirements the federal No Surprises Act (NSA) requires hospitals and providers to share good faith estimates with uninsured self-pay patients for most scheduled services. And the NSA also includes a provision for advanced explanations of benefits that insurers will be required to provide to enrollees and implementation of that is still pending. There's additional rule making coming on that. But hospitals are going to have to provide good faith estimates to health insurers for them to operationalize that policy as well. So again this sort of highlights the fact that patients face a range of sources when pursuing pricing information. Some of this information as I noted with all the standard charges and the good faith estimate and

eventually the advanced explanation of benefits have a number of different rates and they really depend on the circumstances. So consumers are potentially faced with complex and even conflicting information. Information that doesn't necessarily apply to their specific care scenario. Again they have access to the machine readable files which by design are not consumer friendly. They will have access to either the hospital's online patient cost estimator or the list of shoppable services and again those eventual advanced explanation of benefits and good faith estimate. And that is in addition to whatever state level policies may exist that direct patients to a variety of other price estimating tools. So it's a fairly complicated matrix of pricing information so it's important to keep that in mind especially if the end goal is to actually provide patients with clear information about pricing. So in terms of implementation considerations, hospitals have been working towards providing more accurate estimates. I'll just note that that implementation date of January 1, 2021 came at the height of the pandemic in the middle of a surge so not optimal timing in terms of when to implement an entirely new administrative requirement.

So admittedly hospitals got off to a slow start. They were managing surges, managing vaccine administration in 2021. A lot was happening at that period in time and these requirements require administrative effort and cost to implement. These are fairly complex technology solutions that are pulling from a variety of different sources and putting them on the website is not as easy as flipping a switch. So important to acknowledge that and again, I noted that it's not as simple as just putting a single standalone rate. These rates are highly complex. They are subject to negotiations with health insurers and they can be applied in a number of different ways depending on the care scenario. I noted the large investments in staff time and resources and during this period the last two years CMS has been working with hospitals closely on compliance. They've done a couple of assessments which we'll talk about in a moment. They've increased their enforcement. They've increased penalties. So CMS has been pretty engaged while also acknowledging that implementation didn't happen at the most ideal time for this requirement. They have been working with hospitals and with the AHA on increasing compliance. So in terms of the actual implementation status, hospitals have come a long way. Just in the last month CMS issued the results of their second compliance assessment and what they found was that in the key categories of compliance hospitals have made really tremendous progress. On the machine readable file requirement, the first assessment they did for 2021 they found that 30% of hospitals were in compliance. In 2022 that number was 82%. The consumer friendly display website assessment criteria in 2021, 66% of hospitals were in compliance and that number is also at 82%. And across both requirements the consumer friendly and the machine readable requirements CMS found that in 2022 70% of hospitals were in compliance compared to 27%. So that demonstrates real progress over just two years of implementation so there’s no reason to suspect that won't continue into the future. CMS noted when they released those assessment requirements that they're going to continue their enforcement efforts, ramp them up as I noted they've already increased the penalties for non-compliance. They're also going to look at streamlining reporting and improving enforcement.

So again it’s important to note that CMS is in addition to hospitals working through implementation of a new requirement. So it’s important to acknowledge that especially as states are contemplating adding additional enforcement mechanisms on top of what CMS is doing. CMS has been engaging in that and ramping that up over time and it's

showing real results. CMS isn't the only organization that's found increased compliance. Turquoise Health is a health tech company that's been seen as a central resource for information about transparency. They mine these transparency files and produce analysis for consumers and for employers to use that information. What they found is that compliance has increased by about 150% or so since the first year. They're seeing 63% of hospitals with posted cash prices, 65% of hospitals with negotiated rates and 76% of hospitals have posted machine readable files. They produce a transparency scorecard and determine whether individual hospitals and systems are compliant, mostly compliant, etc. What they found is that about 80% of hospitals have mostly complete or complete information. So again the picture is tremendous improvement in terms of compliance so our recommendations to all policymakers whether at the federal or the state level is to first of all understand what requirements exist and have a focus on reviewing and streamlining those existing transparency policies so as not to increase patient confusion and also to minimize unnecessary regulatory burden on providers. We would like to see folks continue to take an eye towards taking a patient center approach. And we'd also like to see folks look at other ways of streamlining the billing and patient financial experience process in ways that look at things like prior authorization denials, delays in care and that sort of thing. So there are a lot of opportunities for streamlining here.

Rep. Roberts stated that as a provider myself, I just want to also say as people are crafting legislation in this space we absolutely need transparency. I appreciate you outlining the federal requirements that we already have but we want to also make sure that we're looking at quality. So when you for example look at a really complex thing like spine surgery you don't want to just go with the lowest price. And there's a lot of things to consider including outcomes, including safety, including infection control rates. So it's a really tricky thing when you're looking at price, what does price mean?

Sen. Mills stated that this is obviously important. We've talked about it for several years and we are making progress and as a legislator I'm trying to be patient but we're a long ways from where we need to be where a common person could actually use a tool and understand what they're potentially looking at in terms of exposure. But I guess my biggest concern is, is it realistic for us to expect that we're going to have an effect long term on pricing and in the equality of those pricings. If a procedure’s the same one hospital to another but the list price is $60,000 at one and $25,000 at another, are we going to be able to with public pressure or with disclosure to bring those numbers down to ultimately affect the cost of healthcare in America or are we just dreaming? Mr. Wesolowski stated that I'll be honest I think we are skeptical as to whether or not these transparency efforts are really going to drive down cost. I think transparency can have the biggest impact in terms of arming patients with understanding what their actual out of pocket costs are going to be. Whether or not they actually drive down costs I don't think that there's a tremendous amount of research to show that's going to happen in healthcare because of how complex pricing and services are. Sen. Mills stated that I was afraid that was the answer.

Mr. Wolfson stated that I'll take a slightly contradictory view. We've seen Lasik quality go way up, prices go way down. Things that people are allowed to be part of the market instead of the insurance kind of being the main driver of the market has worked. And we've seen those costs go down and we're seeing kind of the opposite in veterinary because now people are getting veterinary insurance and the cost of veterinary’s going

up. I mean in some ways the MLR, I'm not taking a position on the, on the federal level for health insurance has just caused everybody to say well it's cheaper for me as the insurance company, I can make more money as an insurance company if I let the prices go up because my MLR allows me to do it. I mean there's some interesting arguments. I absolutely agree with Rep. Rogers that quality needs to be part of these conversations but if patients are given that information and they're incentivized financially to make these decisions we can bend those cost curves. Sen. Mills stated that I think we've got to stay the course and I'm certainly not giving up but it's going to be a long term process and I want CMS and I want the AHA to stay on top of this and report to us on an annual basis.

Rep. Roberts thanked everyone and stated that I'll go back to the comment about quality. So a really good example if you haven't had a chance, I'd invite you to look at the Center for Improving Value in Health Care (CIVHC) in Colorado at civhc.org. They have a really great marketplace in Colorado that lets you shop for instance a knee MRI and it will show you, I just did it while we were sitting here, so if I live in Aspen, Colorado and I need an MRI I can go to Aspen Valley Hospital it's $2,600. If I'm willing to drive three hours to Denver, that MRI is $220. There's still going to be additional costs for the radiologist who reads it and all of those things but that's a pretty big amount of information and power for me as a consumer to have in that way. So I think this is a great conversation. We all want to make sure that our consumers, our clients, the customers have as much information as possible to make the best decisions for themselves but also to keep our overall healthcare costs down. So thank you again for keeping this conversation going. I look forward to our next conversation around this hopefully very soon.

Del. Westfall thanked everyone and stated that we will continue to discuss this model and if there are any questions on the topic or if anyone would like to provide any information please contact myself, Rep. Oliverson, Rep. Roberts, or NCOIL staff.

CONSIDERATION OF RE-ADOPTION OF NCOIL PHARMACY BENEFITS MANAGER (PBM) LICENSURE AND REGULATION MODEL ACT

Del. Westfall stated that last on our agenda is consideration of the readoption of the NCOIL PBM model act (model). A copy of the model is in your binder on page 329. Per NCOIL bylaws all models must be readopted every five years or they sunset. As a reminder, we discussed this model at this Committee's interim meeting last month for the purpose of soliciting any feedback before we voted on readoption today. We didn't hear any comments opposing readoption during the interim meeting and neither me or the NCOIL staff received any comments since then. Accordingly, I'll entertain a motion to readopt the model. Hearing no questions or comments, upon a Motion made by Rep. Lehman and seconded by Sen. Mills the Committee voted without objection by way of a voice vote to readopt the Model.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Hackett and seconded by Asw. Hunter, the Committee adjourned at 10:45 a.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
INTERIM COMMITTEE MEETING – MAY 19, 2023
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee held an interim meeting via Zoom on Friday, May 19, 2023 at 12:00 P.M. (EST)

Delegate Steve Westfall of West Virginia, Chair of the Committee, presided.

Other members of the Committee present were:

Asm. Tim Grayson (CA)
Rep. Rod Furniss (ID)
Rep. Matt Lehman (IN)
Rep. Deanna Gordon (KY)
Sen. Robert Mills (LA)
Asw. Pam Hunter (PA)
Sen. George Lang (OH)

Other legislators present were:

Rep. Dafna Michaelson Jenet (CO)
Rep. Rita Mayfield (IL)
Sen. Jeff Barta (ND)
Asm. David Weprin (NY)
Rep. My-Linh Thai (WA)
Del. Walter Hall (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 Asw. Pam Hunter (NY), NCOIL Treasurer, the Committee voted without objection by way of a voice vote to waive the quorum requirement.

INTRODUCTORY REMARKS: CHAIR WESTFALL

Del. Westfall thanked everyone for joining the meeting and stated that the purpose of the meeting is for the Committee to continue discussion on the NCOIL Biomarker Testing Insurance Coverage Model Act (Model), sponsored by Asw. Hunter and co-sponsored by Sen. Paul Utke (MN), NCOIL Secretary. The Committee will be voting on the Model during the NCOIL Summer Meeting in July, so this meeting is primarily an opportunity to discuss the specific comments and suggested revisions to the Model that have been submitted thus far. The Committee's meeting in July will be reserved only for brief comments and then a vote, so I really do urge everyone to speak up today and not wait until July as the Committee will have other business to work on at that meeting. Since the time of announcing this interim meeting, we have received two letters with specific

comments on the Model, as well as a letter in general support of the Model. The letters with specific comments were submitted by the Blue Cross Blue Shield Association (BCBSA), and America's Health Insurance Plans (AHIP). The general letter in support was submitted by a large coalition of organizations. All of that information, as well as prior committee minutes and prior letters are on the NCOIL website page for this meeting.

CONTINUED DISCUSSION ON NCOIL BIOMARKER TESTING INSURANCE COVERAGE MODEL ACT

Asw. Hunter thanked Del. Westfall for calling this meeting today in order to further discuss this important Model. I'm looking forward to hearing comments from everyone today, and voting on the Model in July. I think this Model is a great opportunity for NCOIL to be involved in what can be truly described as a groundswell of support for this very important issue. Legislation very similar to the Model has been enacted in 9 states, and it has been introduced in 12 other states, including my home state of New York. And just as a point of reference, just this past week we had our insurance committee meeting in NY and this Model passed through with bipartisan support, unanimously. This is not a blue state-red state issue, this is a consumer issue. When something reaches this many states, it can't be dismissed as something only a few or a handful of states are entertaining. Rather, this needs to be recognized and described as truly an emerging trend in healthcare public policy.

One thing I would like to mention again is that the Model is really focused and intended to deal only with biomarker testing post-diagnosis – you have been diagnosed with cancer and then the option for biomarker testing is then introduced and it's used to determine the most effective treatment options. We're not talking about just having testing, and having that testing covered by insurance, at any time. I want to make that very clear – this is after someone has been diagnosed with cancer. So if biomarker testing should be and can be required based on the type of cancer that's been diagnosed, this should be an option. Accordingly, enactment of this legislation in states should theoretically save money because remember we had conversations on this before with breast cancer screening and colonoscopy and prostate screenings about how it's going to cost so much money and we can't do it and then now everyone is doing it across the country and it's saving lives and saving money as a preventive measure. This is again post diagnosis but we want to make sure we are saving lives using the best treatment options that we have available based on the specific targeted type of cancer that you have.

I am certainly open to making changes to the Model, and we've been having this conversation for a year and the only opposition received is from health plans which is not surprising. We have received limited comments from my colleagues the past year but we wanted to have this meeting well in advance of the 30 day materials for the Summer Meeting to provide everyone with another opportunity to provide additional information or questions or concerns so you can bring them forward and close this chapter on this Model so everyone can bring it back to your states and I don't know if Rep. Tom Oliverson, M.D. (TX), NCOIL Vice President, is here today but I believe this passed in Texas last week.

Del. Westfall stated that we'll now move to discussing the Model. In terms of format, we'll hear from interested persons first and then hear from legislators. If you have already submitted a letter, please do not repeat what is in the letter. Please either supplement the letter or address something in a letter submitted by someone else. Any interested persons that would like to make any comments, please feel free to jump in and say your name and who you are representing. We also have the "raise your hand" function available on Zoom that staff is monitoring.

Hilary Gee Goeckner, Director of State & Local Campaigns, Access to Care, at the American Cancer Society, thanked the Committee for the opportunity to speak and thanked Asw. Hunter for her leadership on this important issue and urged the Committee's support on the Model. I'll make some comments in response to the opposition letters that were submitted. As a reminder, biomarker testing is all about connecting patients with the most effective treatment for their conditions. As Asw. Hunter noted, there is broad bipartisan support across the country for this. Some breaking news this morning - in addition to the states mentioned by Asw. Hunter, Oklahoma's bill just passed within the past hour and is on the way to the Governor's desk so this is now law in AR, AZ, IL, KY, LA, MD, NM and RI. So there is really broad bipartisan support and it is an exciting issue that states are getting legislation on the books on so that more patients can benefit. There are very real coverage gaps currently in both public and private insurance plans. Although most plans are covering some biomarker testing for some patients, many patients that can benefit are missing out on the testing needed to make sure they have the right treatment plan. So what this legislation does is level the playing field so that more plans are playing by the same rules because they are not all routinely covering necessary and appropriate and really standard of care tests. One example is a paper I referenced in my letter that analyzed plans in every single state and compared those written policies for coverage of biomarker testing only looking for testing in advanced non-small cell lung cancer, breast cancer, melanoma, and prostate so these are really proven tests with many targeted treatments available, these aren't particularly new or unproven or unjustified tests and 71% of policies reviewed are more restrictive than those gold standard guidelines that every oncologist consults in determining whether to order biomarker testing.

As Asw. Hunter noted, this legislation has very clear guardrails – this isn't any test under the sun that calls itself a biomarker test that has to be covered. There are clear circumstances under which testing should be covered and also sources of evidence that must be met in order for a test to qualify. The circumstances are diagnosis, treatment, ongoing monitoring of a disease or condition, and also those sources of evidence must be met – rigorous scientific and medical evidence - to ensure tests are covered only when effective and providing useful information to inform the treatment of patients and really shape their treatment decisions. Timely access to guideline indicated biomarker testing can help achieve the triple A that everyone's always after – better health outcomes, improved quality of life, and reduced healthcare costs by avoiding unnecessary or ineffective treatments. For example, some breast cancer patients might not get any benefit from years of hormone therapy but would also have a lot of side effects and an impact on quality of life. Some prostate cancer patients might actually choose to forgo surgery that can often cause really devasting impacts on quality of life for a really non-aggressive slow growing cancer that wont actually cause them to die any sooner so having that information is really valuable to patients and their doctors to determine what the best most personalized treatment plan is for a particular patient.

This language has been thoroughly vetted and received bipartisan support in 11 states and counting as of this morning and endorsed by more than 50 patient and provider groups some of which have signed the letter that you have in your packet for today. We urge your support for this state driven evidence based policy.

Patrick Plues, Vice President of State Government Affairs for Biotechnology Innovation Organization (BIO) thanked the Committee for the opportunity to speak and thanked Asw. Hunter for bringing this before NCOIL, and thanked NCOIL for taking up this legislation. Many of BIO's member companies research, manufacture and develop biopharmaceuticals that are more efficiently and more effectively used in combination with biomarker testing. BIO fully supports the biomarker testing legislation under consideration and we applaud the efforts by the American Cancer Society to pass this state legislation requiring health plans and Medicaid programs to cover biomarker testing. Continued advances in science and genomics are driving increased understanding of the human physiology and how diseases in the human body might work. As more biomarkers are identified they have the power to greatly improve how we treat patients by providing researchers with new ways to measure disease activity, shortening the amount of time that is required to demonstrate therapy is providing benefit to the patient, allowing researchers to better understand how effective a treatment is against a disease. Biomarker testing also allows for more efficient care delivery which often means cost savings.

By spending a little bit more upfront on testing, we can often find out if certain treatments will or will not work so the payers don't foot the bill for the treatment and it's not a waste of time for the physician or patient. Biomarker testing also allows doctors to identify patients at low risk of disease progression who don't need additional treatment or won't benefit from expensive therapies and allowing them to avoid this care altogether. This Model as mentioned levels the playing field so that various plans follow the same rules. And I'd also like to add that BIO also represents a number of manufacturers in the rare disease space that are outside of cancer and there are applications of biomarker testing in the rare disease space. On average it takes between five and seven years to accurately diagnose but also treat a patient and in the rare disease space which are often degenerative diseases the longer you wait to find a treatment the more irreversible damage you give to a rare disease patient.

Randi Chapman, Managing Director of State Relations for BCBSA, stated that I really appreciate the opportunity to speak before you all today and certainly understand the importance of this issue both to NCOIL and as well as to our members, those 115 million people that BCBS companies serve. We always want to ensure that our members are able to access the care that they need in the most affordable way that they can. In listening to the testimony over the past couple of meetings and certainly the words of Asw. Hunter, I wanted to respectfully suggest that in the language in the Model that refers to coverage to biomarker testing for the purposes of "diagnosis, treatment, appropriate management, or ongoing monitoring of a covered person's diseases or condition" - I would suggest perhaps removing "diagnosis" and even perhaps put in "post-cancer diagnosis" as it seems to me that would be clearer in terms of getting to the goal that Asw. Hunter states for the Model in terms of coverage parameters. I know we put in our letter and don't want to repeat anything but I just wanted to add that for the committee's consideration.

Miranda Motter, Senior VP of State Affairs at AHIP thanked the Committee for the opportunity to speak and for the opportunity to engage with this Committee and members of NCOIL over the past year and a half on this issue. We specifically appreciate the opportunity to present on this topic and we recently submitted a letter on May 11 in advance of this call and I know you all have that. In our letter I'll just quickly point out two things – we thought it was important to highlight the testimony that the committee received from purchasers of healthcare. During the past year and a half the committee did hear from employers that are purchasing biomarker testing today and the committee also heard from California and their employee benefit plan and Medicaid plan relative to the biomarker testing that they are purchasing today. We wanted to highlight those two points as it relates to those purchasers of healthcare, not just health plans but those who are actually purchasing biomarker testing today. And again the two points I would make is that you've heard testimony that health insurance plans already do offer and purchasers of health insurance coverage including employers and states are already purchasing biomarker testing coverage when that testing is clinically valid and it provides clinical utility. The second thing I'd emphasize is that you've heard employers and purchasers of healthcare including your own state Medicaid programs that they are concerned about the rising cost of healthcare and health insurance and we really do believe that with some of the more expansive definitions in the Model that it could lead to expensive and unnecessary cost and additional cost for those employers and employees and you did hear testimony to that effect from the ERISA Industry Committee (ERIC) just a few months ago. In addition, BCBSA in their letter noted a fiscal note relative to the pending biomarker testing mandate in Ohio that does talk about the additional testing cost that the state legislature will have to allocate funds for and taxpayers will have to pay for. As a result of the testimony that you've all heard we really just believe that action at this time by NCOIL isn't needed so we respectfully request a no vote during the upcoming meeting in July.

Ms. Goeckner stated that she would just like to offer a few additional comments about the purposes of "diagnosis" in the Model. Biomarker testing is largely referred to as diagnostic testing and this is separate and distinct from a screening test for a general population. So you might have genetic testing if someone in your family is diagnosed with cancer, or a mammogram is a screening test that generally everyone goes for. But a diagnostic test is really helping to subtype a diagnosis and narrow down so Mr. Plues was talking about rare disease diagnosis – this isn't something where everybody walking down the street is going to go get a diagnostic test to see if they might have something. This is something that is under a doctor's care for a treatment or condition and accurately diagnosing that in order to determine the best course of treatment so I would say diagnosis is an extremely important situation for when this testing is appropriate and then also as Mr. Plues touched on there are applications outside of cancer. Naturally, I work for the American Cancer Society so that's our focus but there is lots of exciting work going on in other disease areas and as you'll see the coalition that is supporting this legislation represents many different disease groups like rare disease and autoimmune diseases like arthritis and rheumatoid arthritis. Just today the U.S. Food and Drug Administration (FDA) approved a biomarker test for preeclampsia. Among women who have preeclampsia, about one third respond to a particular treatment and so knowing head of time before you give a pregnant women a presumably very expensive treatment that could cure her preeclampsia you want to know if she is one of the 1 in 3 women who will have an effective response to that or is it not going to do any good to

her or her baby to give that particular treatment. I would encourage you all to keep diagnosis in as all of the 11 states have done so to date.

Sen. George Lang (OH) stated that I appreciate Asw. Hunter's intent in brining this legislation forward and I was diagnosed with stage four colon cancer and it ended up being an advanced form of stage three so I am a survivor and I appreciate the intent of this but I am strongly opposed to this bill and what this bill does. This essentially to me comes down to government interfering with the private sector and with private markets. We should not be telling health plans what they should or should not do. I think it's a good idea to offer this and will ultimately drive down costs but the health plans that want to offer it can price it into their plan and compete against those plans that do not want to offer this. Another big concern I have is that this only affects the little guys – those companies that are the heart and soul of every one of our communities. If you are a large self-funded plan you come under the Employee Retirement Income and Security Act of 1974 (ERISA) and what we pass at the state level will have no impact on them so this will only potentially increase costs to the small guys and they are struggling right now to survive with supply chain issues and inflation issues and workforce development issues and for most businesses, not all, but for most, employee benefits are their second highest cost. I don't want to put this burden on small businesses and I've heard some testimony today that this will help level the playing field against various plans by making sure that everybody is playing by the same rules - that's not the government's job. That is the free market's job. They will have winners and loser as a result of what they put forward. Health plans will enjoy the results of good decisions or suffer the consequences of bad decisions and if there is an advantage for this in the market which I believe there is, employers can use this to their advantage as well when it comes to recruiting employees. I believe over time the private sector is going to handle this and it doesn't require government intervention and if it really will lower costs and I think long term it will then the private sector is going to naturally do this on their own because they want to lower costs as well. Thank you for bringing this forward and I stand in opposition.

Rep. Dafna Michaelson Jenet (CO) stated that I carried this bill in CO and it made it through committee but didn't make the final steps but it was fully bipartisan and it was almost unanimous out of committee and I believe very strongly in the concepts behind this bill regarding a focus on saving people money on healthcare. I am a two time cancer survivor and I will tell you that being able to find the right treatment as opposed to trying this and trying that and seeing what sticks is very much an efficiency and an efficiency model that I would like to see adopted in our insurance plans. I understand that it's not going to be the ERISA funded plans that are covering this but we can start somewhere and the quality of life for the Coloradoans that will benefit from this biomarker bill when it does pass and get to the Governor is very much worth the effort of going forward with this bill.

Rep. My-Linh Thai (WA) thanked the Committee and stated that I am a trained pharmacist so I am going to speak in support of this proposed legislation. Washington, similar to Colorado, has been working on this legislation and we have heard testimony similar to what this committee has heard. At the same time, as a healthcare provider I am sharing with you that perspective. As a healthcare provider when we see incredible advances coming to medicine and technology that could not only save lives but interfere with the decision making between the physicians, providers and patients sooner it saves

the government money but also patients money so we look at multiple different directions for why a piece of policy being introduced is not only about efficiency but about safety and efficacy and when we look at safety and efficiency just imagine medication is currently available for treatment for any type of cancer or any type or rare disease. As a pharmacist I will tell you that not every single medication is completely safe and so if we only sort of experiment in medications for treatment for people who are trying to take care of their loved ones, biomarker testing is a game changer. It is making sure that the medication that is available for that particular condition is a match so we're not playing games with people's lives. We are actually treating people using data and information that is now available to us. In the past it wasn't available for providers or patients and so why aren't we using what is available to provide the best healthcare options possible for our patients. I not only endorse this proposal but really call big and small and government and private insurers to really be looking at this potential life changing testing so that we all share the same underlying mission to providing the best outcomes and services for our patients and our clients.

Rep. Lehman thanked the committee and Asw. Hunter and stated that I kind of echo a little but of what Sen. Lang said. I'm very concerned on the front half of this regarding the model applying only to post diagnosis. The industry people I've talked to have said if I can take someone who has been diagnosed and put them on the right path for treatment, long term it might actually be cheaper. I've been an insurance agent for 30 years and I don't do health insurance anymore but when I did years ago carriers were not big on paying for preventive care and now they do because they see the benefit of getting people healthy and the utilization goes down. If we can get people on the right process and get utilization down post diagnosis that's a positive. I have concerns pre diagnosis and I don't think health plans should be in the position to do that. The other thing I'll agree with Sen. Lang on is with the bigger picture here and I know NCOIL has been pushing it and it's that we've got to start cracking the nut that is ERISA. These are state run plans and we can't touch these plans because of ERISA but what drives people to ERISA is the cost of care. I just talked to a large group the other day of about 100 people who said we've been fully insured for awhile but we just went self insured. They immediately switched from being regulated and taken care of by things we do at the state level to now going to the federal level and ERISA is doing nothing. I really think there are two things at play here - we've got to make sure we narrow it to post diagnosis and then continue discussion of health plans being brought back to the states for control. Those are my thoughts and I'd like to see this keep moving forward but I do think that if it's not clear we need to make it very clear that it is post diagnosis.

Sen. Lang stated that I do believe that this will lower costs and I do believe that the private sector has a stronger interest in lower costs than the public sector especially in this scenario because they are the ones ultimately responsible for paying for it and I appreciate everyone's comments today but my position is still the same. I think it's a noble effort and as a survivor I get it and just to furtherer illustrate my position on this I am totally deaf and rely on two cochlear bone attached hearing aides in order to hear as well as my ability to read lips and when a hearing aid association came to me to force private insurers to supply hearing aids for kids it's a great idea and I'd like to see every private insurance company do that and since I'm the only deaf legislator in OH the thought I'd be their guy and I had to tell them not only will I not move it forward but if it moves forward I will strongly oppose because I think in general government should not be interfering with private markets.

Asm. David Weprin (NY) thanked the Committee for the opportunity to participate and stated that I'm the new Chair of the NY Assembly insurance committee and we just passed Asw. Hunter's bill out of committee a couple of days ago so we're looking to close down session and this is something we'd like to see happen in NY.

Asw. Hunter thanked everyone for their comments and stated that she'd just like to mention again that this model is meant to deal only with biomarker testing post diagnosis. I want to reiterate that and I feel it's important to say, and I absolutely understand the free market and allowing private businesses to grow and thrive but when they fail to meet the needs of our constituency then it is incumbent upon government to step in to make sure that all of its people are taken care of and that is what we're trying to do with this model. There are big healthcare disparities and we've talked about them for as long as I've been at NCOIL whether it be in states that don't opt in fully to Medicaid to where people live and their zip codes. This is leveling the playing field for people to be able to get the treatment based on the cancer that they have been diagnosed with. My mother has died from cancer and my husband has had cancer and both my sisters have had cancer and maybe you don't have a unique form of breast cancer or maybe radiation and chemotherapy is for you but you're talking about filling peoples bodies with deadly chemicals when maybe they are not necessary when simply using a biomarker test after you have been diagnosed with cancer could save your life and give you meaningful quality of life going forward. To me this is a no brainer and to me it's incumbent upon us to make sure we're taking care of all of our constituency and not just businesses and making sure we push back sometimes. Sometimes we agree with the plans and sometimes we don't and sometimes it's incumbent upon us to push that forward if we feel that the needs of our constituents are definitely not being met. I look forward to having this conversation in July in Minnesota and look forward to the model being passed and you can take it back to your states.

Del. Westfall thanked everyone for their comments and stated that any comments or thoughts or suggestions should be submitted to him, Asw. Hunter, Sen. Utke, or NCOIL staff.

ANY OTHER BUSINESS

Del. Westfall stated that there is one last piece of business before we adjourn. As you likely know, registration for the NCOIL Summer Meeting in Minneapolis is open. If you haven't registered, please do so. Also, as a reminder, on the first day of the meeting, we'll be holding another golf outing to benefit the Insurance Legislators Foundation Scholarship Fund. If you haven't yet registered, please do so before it sells out. You can find all meeting and golf registration information on the NCOIL website or by reaching out to NCOIL staff.

ADJOURNMENT

Heating no further business, upon a Motion made by Rep. Lehman and seconded by Asw. Hunter, the Committee adjourned at 12:45 p.m.

616 Fifth Avenue, Suite 106
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CHIEF EXECUTIVE OFFICER: Thomas B. Considine

National Council of Insurance Legislators (NCOIL)

Biomarker Testing Insurance Coverage Model Act

***Sponsored by Asw. Pam Hunter (NY) – NCOIL Treasurer**
***Co-sponsored by Sen. Paul Utke (MN) – NCOIL Secretary**

***Draft as of June 20 2023. To be discussed and considered during the Health Insurance & Long Term Care Issues Committee Meeting on July 20, 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 defined characteristic that is ~~objectively~~ measured ~~and evaluated~~ as an indicator of normal biological processes, pathogenic processes, or ~~pharmacologic~~ responses to an exposure or ~~specific therapeutic~~ intervention, including therapeutic interventions. Molecular, histologic, radiographic, or physiologic characteristics are types of biomarkers. A ~~B~~biomarker~~s~~ is not an assessment of how a patient feels, functions, or survives~~include but are not limited to gene mutations or protein expression~~.

(b) “Biomarker testing” means~~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~~,~~and multi-plex panel tests performed at a participating in-network laboratory facility that is either CLIA certified or CLIA waived by the federal food and drug administration~~, and whole genome sequencing~~.

(c) "Clinical utility" means the test result provides information that is used in the formulation of a treatment or monitoring strategy that informs a patient's outcome and impacts the clinical decision.

~~(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 to guide treatment decisions when the test provides clinical utility to the patient a~~s~~ demonstrated~~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.

(d) Nothing in this Section shall be construed to require coverage of biomarker testing for screening purposes.

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 to guide treatment decisions when the test provides clinical utility to the patient ais demonstratedsupported 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) 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.

(c) 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.

(d) Nothing in this Section shall be construed to require coverage of biomarker testing for screening purposes.

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 all policies and contracts issued, renewed, modified, altered or amended on or after such date.

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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)**

***Co-sponsored by Rep. Rita Mayfield (IL)**

Draft as of February 8, 2023. To be discussed during the Health Insurance & Long Term Care Issues Committee Meeting on July 20, 2023.

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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.

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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 considered during the Health Insurance & Long Term Care Issues Committee Meeting on July 20, 2023.

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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.

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CHIEF EXECUTIVE OFFICER: Thomas B. Considine

National Council of Insurance Legislators (NCOIL)

Resolution in Support of Embedded Provisions in the State Insurance Code to Protect Health Savings Accounts-Qualified Health Insurance Policies from Certain State Benefit Mandates

Sponsored by Sen. Jerry Klein (ND)

Draft as of June 20, 2023.

To be introduced during the Health Insurance & Long Term Care Issues Committee Meeting on July 20, 2023.

WHEREAS, the National Council of Insurance Legislators fully supports the state-based system of regulation for health insurance, consistent with federal statutes, rules, regulations and guidance; and NCOIL supports states continuing serving their role as sources of healthcare innovation in the most meaningful way; and

WHEREAS, individual insureds and/or enrollees and those in the group market require all the resources they need, to effectively manage the ever-increasing cost of health insurance; and

WHEREAS, qualified Health Savings Accounts, coupled with high deductible health plans, are one such tool that helps individuals or those in the employer group market manage those costs; and

WHEREAS, A Health Savings Account ("HSA") is a trust or custodial account offered with a high-deductible health insurance plan that meets specific requirements in the U.S. Internal Revenue Code, as interpreted and administered by the federal Internal Revenue Service. An eligible individual can deduct contributions from income taxes and use contributed funds tax-free for qualified medical expenses; however, consumers cannot benefit from an HSA unless they are enrolled in an "HSA-qualified" plan; and

WHEREAS, many states have recently introduced or enacted sweeping benefit mandate bills and co-pay accumulator bills, to help insureds and enrollees with the cost of health insurance and medical services, by providing for so-called "first dollar or zero dollar coverage" or coverage that otherwise restricts the amount of the applicable deductible, co pay or coinsurance; and

WHEREAS, NCOIL recognizes that certain of these state benefit mandate bills, while well-intended, may have the effect of disqualifying an HSA in a given state because the federal HSA statute requires that HSA-qualified plans apply a minimum deductible (single and family) to all covered benefits that are not defined as "preventive care"; and that a plan will fail to so qualify if a state law requires coverage without (or with limited) cost-sharing for benefits that are not "preventive care"; and that such disqualification may prevent account owners from continuing to make tax-deductible contributions to their HSAs and also cause an insured or enrollee to have to possibly re-file their federal taxes and pay penalties; and these consequences were unseen and cause unintended harm to the individual; and

WHEREAS, it would serve and further legislative economy, to have each state adopt a provision embedded in its insurance code, as eight states have done, to protect the efficacy of HSAs, via a legislative "carve-out", as opposed to the necessity of amending each and every state benefit mandate bill, such as those involving diabetes, breast cancer, prostate cancer and other diseases; that this would ensure that a health insurance plan that is an HSA-qualified plan is exempt from any state law that would cause the plan to be disqualified because the state law requires coverage of and/or cost-sharing for, benefits that would cause the plan to fail to meet the definition of a "high deductible health plan", as that term is set forth in Section 223(c.)(2) of Title 26 of the United States Code.; and

WHEREAS, a number of states have enacted to date such a "carveout " provision[1] and the following provision would serve as a model:

"A health savings account-qualified health insurance policy is exempt from a prohibition on cost-sharing requirements for a covered benefit that is required under state law to the extent the exemption is necessary to meet the criteria for a health savings account-qualified health insurance policy.

This section does not apply to any coverage required by state law that pertains to preventive care as defined by regulation or guidance issued by the United States Department of the Treasury under 26 U.S.C. § 223, as it existed on January 1, 2021, with respect to any health savings account qualified health insurance policy issued, delivered,

[1] Arkansas (2021-Act 939) , Kentucky (KRS Chapter 304, Subtitle 17A. (via Chapter 133/2021), North Dakota (Century Code §26.1-36-01.1), Oregon (ORS §742.008), Pennsylvania **(**P.S. Title 72, § 3402b.5), Rhode Island (Title 27, Chapter 69), Texas (Insurance Code § 1653) and Utah (Title 31A, Chapter 22, Part 6, §657 (via Chapter 198/2022);

amended, or renewed while the regulation or guidance issued by the United States Department of the Treasury is effective."

WHEREAS, NOW, THEREFORE, BE IT RESOLVED, that NCOIL urges states to take action and pass legislation that would protect HSAs and HSA account owners, by providing a 'carveout' or exemption, embedded in their insurance code or insurance law, from relevant state benefits mandate and co pay accumulator bills, to ensure consistency with federal law, rules and guidance.

FINANCIAL SERVICES & MULTI-LINES ISSUES COMMITTEE MATERIAL

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
FINANCIAL SERVICES & MULTI-LINES ISSUES COMMITTEE
SAN DIEGO, CALIFORNIA
MARCH 11, 2023
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Financial Services & Multi-Lines Issues Committee met at The Westin San Diego Gaslamp Hotel on Saturday, March 11, 2023 at 1:30 p.m.

Representative Forrest Bennett of Oklahoma, Chair of the Committee, presided.

Other members of the Committee present were:

Sen. Mark Johnson (AR)
Rep. Rod Furniss (ID)
Rep. Matt Lehman (IN)
Asm. Ken Blankenbush (NY)
Sen. Bob Hackett (OH)
Rep. Jim Dunnigan (UT)
Del. Steve Westfall (WV)

Other legislators present were:

Sen. Jesse Bjorkman (AK)
Sen. Justin Boyd (AR)
Rep. Denise Ennett (AR)
Rep. Deborah Ferguson, DDS (AR)
Sen. Ricky Hill (AR)
Rep. Reginald Murdock (AR)
Sen. Robert Mills (LA)
Del. Nic Kipke (MD)
Sen. Mark Huizenga (MI)
Rep. Julie Rogers (MI)
Sen. Nellie Pou (NJ)
Rep. Zach Stephenson (MN)
Sen. Paul Utke (MN)
Rep. Tim Barhorst (OH)
Rep. Mark Tedford (OK)
Rep. Kirk White (VT)

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 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. Dunnigan and seconded by Rep. Matt Lehman (IN), NCOIL Immediate Past President, the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's November 18, 2022 meeting in New Orleans, LA.

PRESENTATION ON INSURANCE ISSUES SURROUNDING NAME, IMAGE & LIKENESS (NIL) INDUSTRY

Pat Brown, Director of Risk Management and Insurance at Edmonds Duncan, thanked the Committee for the opportunity to speak and stated that I played football for the University of Kansas many years ago and became very passionate about the sport as I played and along the way I became very passionate about financial literacy for student athletes. And for those of you that have played sports in college you have a five year scholarship and in football if you go and you play you can actually stay in the summer and go to class and so forth. So I did that year after year and ended up graduating in four years. The reason I bring that up is not that it was the first time that happened but in order to be eligible to play my last year I had to take courses in order to play and I thought I would work on my MBA but it turns out the MBA was really kicking my butt when I was trying to take courses and play football. So I'm starting to get some stereotypical classes like basketweaving 101 and softball throwing and one class in particular I took was transition from college to the workplace which essentially exposed me to things like everything from stocks to bonds and I became very passionate at that point and really wanted to work with student athletes. So fast forward, year after year I would talk with the university and see if there was an opportunity for me to speak with the athletes about financial matters and each year they told me no don't worry about it and it wasn't until two years ago that Wayne Simien who was an All-American at Kansas reached out to me and said “hey would you like to come talk to the guys about financial empowerment and financial literacy?” So I was able to talk to the guys about financial empowerment. I say that because the whole point of them getting me in front of their players was because of NIL as it was coming down the line and so they were trying to get these guys exposed to these financial matters sooner rather than later.

And so I put this PowerPoint together to try to go through the history of NIL and then kind of where we are and what I think as far as insurance and how these kids are essentially a target moving forward. I want them to realize that I was in their seat at one point in time as well and that I know what it's like to try to manage school and sports at the same time. I mentioned my platform financial literacy for student athletes. Basically I've been doing this talk to former student athletes trying to get them to tell me basically some of the pitfalls and some successes that they've had while they play sports with the hopes that current student athletes will be able to learn from some the successes and failures. So what is NIL? This allows student athletes to now get compensated off their name, image, and likeness whereas before we weren't able to get compensated all. So if there was a camp or something back when I played and they all called it a Pat Brown Camp, I wouldn't be able to get compensated back when I played. So now these kids are able to get compensated which is a good thing depending on who you talk to. Before 2021 we weren't able to be compensated and you have examples like Reggie Bush who was forced to basically give back his Heisman trophy because his family was getting paid from the University boosters and actually had a house out here in San Diego. But Ed O'Bannon was the one that really kind of brought forth things back in 2015. The sports video games that you guys may be aware of, he saw the fact that we weren't able to get compensation, that student athletes weren’t able to get compensated off the name, image and likeness and so he was kind of the one that really brought this forward and the case did settle. I still haven't received the check but the case has settled for about $40 million.

July 1st was when the rules changed in 2021 and so moving forward student athletes are allowed to obviously get compensated. So who is eligible for NIL deals? Basically, anyone that plays college sports is now eligible, men and women and regardless of division 1, 2, or 3. Even high school athletes are now able to get compensated. Here are the ways of finding NIL deals. So anything from social media, to autographs, to advertisement campaigns, student athletes are able to start their own business whether that's t-shirts, whether it's seeing some guys in the state of Ohio have real estate companies. They're able to get compensated because of their name. And I mentioned there at the bottom about the quarterback Bryce Young is in the National Football League (NFL) draft next month and he was getting deals for roughly $1 million when he played and again that's off of Subway, Cash App and some other companies. I put one of your marketplaces, so again not knowing how much or how familiar you guys are but Opendorse and OpenSponsorship are our companies that are basically marketplaces where an athlete can go and put his or her name on and companies can actually contact this website and look for the athlete and they can agree on compensation and then moving forward whatever contract they may sign, they can get compensated that way. And then there's collectives which are basically a collection of fans and boosters who pool together money that it can pay athletes to play for a given school as long as they're not officially paying them to play for a given school. So let that kind of sink in. It's a group of boosters who basically pool money together. Now they can't entice an athlete to come to that particular University but when that athlete gets to said University who's to say that they can't say "hey if you advertise this cup well give you $500,000." Now you can't pay a player to play, but you can pay a player to advertise.

So where there's money involved there's risk and there's an article that I did some time ago where I basically poked holes and discussed what I see kind of coming down the pipeline with regards to these student athletes and how they essentially are going to be treated kind of like celebrities. And a lot of celebrities from time to time may get sued for frivolous stuff regardless of if they did something or not and that's what I see with a lot of these student athletes. Because a lot of the information that's put out there on the internet it talks about the money that these student athletes potentially make. There are some making upwards to $1 or $2 million for an NIL deal and who's to say that there's someone that looks at them a certain way and tries to arrange some type of situation whereby they get hit by a car by and then sue them for something frivolous moving forward. So I just see a lot of casualties with NIL that I think are unfortunately coming down the road. These are some of the things with regards to insurance that student athletes looked at prior to NIL and I have on here total disability. This was something that it only affected a certain portion of student athletes and those were athletes that potentially were going to go in the draft either in the first round or top ten and typically a university can maybe pay the premium but if the kids have financial resources they'll be able to pay the premium. But this is essentially saying if you got hurt you cannot play the game that you're playing then this potential policy would pay out. So again this is before NIL really came into focus. Who can buy this type of policy? Typically people in the first round up to three years prior to their draft eligibility. But the devil is in the details with these types of policies. Another type which is actually an endorsement or a rider of a permanent disability policy is loss of value insurance. So essentially if the value of their draft went down a little bit if they got hurt during the season and instead of going first round they go second or third then this could potentially pay for the difference so they can still get some type of money if their value suffers. Then critical injury,

essentially it's kind of like an Aflac policy. If they were to hurt themselves they would essentially pay a certain amount.

So, what do student athletes need to be concerned about after NIL? Some of the things I think that warrant attention relate to financial fraud. So the thing that I think about this is if you remember FTX, the cryptocurrency that went bankrupt. And guess who they're coming after for that? Shaq, Steph Curry, Tom Brady. These guys are all listed as far as the lawsuit was concerned. They were just a spokesperson and an influencer essentially but yet they still got roped into this as well. So I see something similar maybe not to that extreme but I can certainly see something like that with regards to student athletes. If you have student athletes who have a huge following whether it's social media or whatever platform that these kids are on and they're either saying you should buy a particular product and/or service and that service is faulty will these kids get roped into something like this later on? I have down here libel and slander against a person or brand. You know a lot of times these kids are young and they may have a tendency to kind of go off at their mouth if for whatever reason they don't like a particular person. If they're an "influencer" can someone in fact come back at these kids and say hey I'm offended about what you said about me on your social media platform? So I see things kind of coming down the pipeline with regards to that.

There are also issues relating to Non-performance of a contract. These kids are signing contracts now so if they don't get representation by a qualified attorney they may sign a contract that they don't really read and so what happens when they don't do what they're required to do? Whether that's post something on a media site or post a number of things that you're supposed to do within a given time? What happens if that company or that organization comes back at them and says you didn't do what you're supposed to do so you owe us a certain amount of money. I have down here professional liability, that might be a stretch but all professions have some type of errors and omissions insurance. So again from a liability standpoint, if these athletes aren't doing what they're supposed to do with respect to whatever agreement that they get with a particular organization, that's a concern. Same thing with commercial general liability, I look at all these student athletes as very similar to social media influencers and I think that these policies or something like that should be something that these kids get or maybe at least exposed to when they get to school and they start doing these deals. And then again, I just have some examples of potential things such as a kid going to a meeting and knocking over something whether it's a computer or coffee on a computer, is that kid going to be able to pay for that? If he has an NIL deal that's paying X amount of dollars then he certainly could but if not then would a policy be a prudent thing for that particular student athlete?

Sen. Hackett stated that in Ohio and we're in charge of the workers comp budget and it's going to be coming over from the House in the next two to three weeks and one of the things we see is there's an amendment in there that in pro-sports people qualify for permanent partial disability and they get paid for the contract. And I don't know if any of the other people here deal with it in other states but there's a law firm in Cleveland that will jump in and it has a national reputation and the Browns and the Bengals and now the Blue Jackets are they're facing this thing and they would like us to do legislation that outlaws it. But the person does qualify for both under that scenario but I understand they signed a contract. Do you know anything about that? Have you ever run across that where they do permanent partial and then they get paid and they even go back and

play and they still get permanent partial from workers comp. Mr. Brown stated that I'm not really familiar with work comp but there is the temporary policy that is floating around out there for a disability and I know the devil is in the details with those policies as far as who can actually benefit from those and file a claim.

Sen. Hackett stated that well I think with permanent partial, they can play with it but it's still a bit with disability. Mr. Brown stated that so they're able to file for both sides of that is what you're saying? Sen. Hackett stated, yes it sounds like it and sounds like double dipping. Mr. Brown replied, yes it does. Sen. Hackett stated I've been in the business for a long time and you can't really double dip. Mr. Brown stated that that you can't double dip. There's actually a kid from Kansas State who was playing basketball at the University of Miami and some of you guys may know the story but he passed out on the court and he actually had a total disability policy and so he either could file that claim or if he fought back and continued to play, which he did and he transferred to Kansas State, he was basically able to continue playing and not file the claim. The policy was for about $5 million so he basically turned down that money to go play for Kansas State. Sen. Hackett stated in this case it's a professional. JP Wieske, VP of State Affairs at Horizon Gov't Affairs, stated that we dealt with a little bit of that in a couple of cases. If you look inside the contracts of some of the major sports figures actually most of their salary is not actually attributable to their athletic performance. They have a separate executive sort of piece which would be outside that but obviously the total disability and personal disability rules are sort of separate and I think you would have to figure that out because those same rules apply I think to people in general who have partial disabilities that may be able to continue work but just not working in exactly the same way or in the same field necessarily but maybe similar. They may have similar income. But I think that you'd need to be careful to sort of take a look as to whether or not it applies to other people as well outside the athletes since it's major dollars. Sen. Hackett stated that workers' comp says we have so little we don't even want to mess with it. The Bengals have showed me just this week, it's over 30 people in one year under that scenario and then you add on the Browns and others and it's interesting and I'm curious if anyone else has dealt with it.

DISCUSSION ON POTENTIAL NCOIL CONSUMER DATA PROTECTION MODEL ACT

Rep. Bennett stated that next on our agenda is a discussion on the potential development of an NCOIL consumer data protection model act. We had an interesting general session on different types of data privacy laws at our last conference in New Orleans and now we're going to start discussion surrounding whether or not NCOIL should develop its own consumer data protection model act. We discussed this a little bit yesterday in our NCOIL-National Association of Insurance Commissioners (NAIC) Dialogue. Guiding this discussion today will be the Virginia consumer data protection act which is on the website and the app and in your binders on page 249. The NAIC's development of their consumer protection privacy model act will also be referenced. The cover page to that model appears in your binders on page 90 and you can view the model on the website and the app. Today we'll hear from our list of speakers and then determine how best to proceed in terms of developing an NCOIL model act.

Andrew Barnhill, Head of Public Policy at IQVIA, stated that I appreciate the invitation to kickstart the discussion about data privacy as we start to think about potential models for the future. To really start this off the perspective that I'm going to bring is one that helps

us to balance the importance of consumer protections along with a framework that works particularly for healthcare companies and health insurers and that's the direction that I'm going to take my comments today. So a little bit of background for those who might not have been in New Orleans when I gave a little bit of an intro into this, I lead public policy for IQVIA which is the world's largest clinical research and health technology company. We conduct clinical trials in all 50 states and all around the world and we have had a close eye on data privacy particularly in regard to healthcare data for as long we've been in existence as an organization. And one of the things that we have found is that this discussion, this topic area is coming to even greater focus at the states right now. Just a little bit more background on our company on the screen I won't go through all of that but it gives you a sense of what we work with which is a variety of types of healthcare data, both data that may be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other forms of clinical data that helps us in the delivery of care for patients all around the world. You might know us from some of our work during the pandemic. We conducted the clinical trials on two of the four approved vaccines. We also did a variety of surveillance work both here in the U.S. and in other countries to make sense of what was happening on the ground particularly in partnership with state public health departments including some of your states are here represented today.

One of the other recent examples of how healthcare data can really make a difference is an example that goes back to 2017 during Hurricane Maria that was hitting Puerto Rico as a really strong category four hurricane. Some of you might remember we were contacted by the U.S. Department of Health and Human Services (HHS) and the Centers for Disease Control and Prevention (CDC) to help try to come up with a list of the prescription medication usage by residents of Puerto Rico and assisting with some of the relief efforts. In using our data capabilities and extracts that we have we were able to provide the list of all the top 200 prescription drugs in Puerto Rico and their utilization rates within 45 minutes of the request from the federal government. So that's just one example from one company but I use that as we start thinking about the importance of healthcare data surrounding this conversation of data privacy and how it can be of service to the companies, to patients, but also to our governments at the federal and state level as well. So how did we get here to discussing data privacy so much. You're seeing in the news a lot now that you might not have seen even just a couple of years ago. We have seen a failure to act by Congress as technology grows and advances and as consumers become even more interested in who is sharing their data, who is selling their data, and what sort of rights that they have to protect that data both in the healthcare space and in the consumer space as well. As a result, we've seen a number of states begin to act. Actually California was among the earliest actors in privacy legislation and was first to hit the mark on it and also inspired a number of states in the future. At present we have five states that are pursuing comprehensive data bills this session but there are others that are at various phases of process. We saw some that were introduced last year that didn't pass and you've seen other states that are beginning to consider legislation to date.

There are also a number of bills out there that address particular types of data privacy. So you have some states that are interested in regulating data brokers for instance and have data broker registrations in places such as what you find in California and Vermont and now a proposal in Massachusetts. You have others that are focused on specific types of data itself such as biometric data and healthcare data more broadly. And then you have the select group which I've identified some on the map here that want to

pursue a comprehensive data privacy standard for their states. Now what we're beginning of course to see is that this creates a patchwork of policies out there and other states have an incentive to act with the absence of federal legislation. Today the model that I think is helpful for us to use as a launching point for discussion is Virginia's. Virginia passed the consumer data protection act in 2021 and this particular data privacy bill actually just went into effect January 1 of this year. This model is actually one that's being used by a number of states as they begin to draft their own bills. Florida for instance has borrowed a lot from Virginia. Colorado shared ideas with Virginia in their early stages and there are several others who are recognizing the Virginia model as one that is workable for other states. This bill clearly defines who's personal data is covered. It clearly defines consumers as residents of the state who are acting in individual or household contexts. It also imposes no significant record-keeping requirements on insurers, healthcare entities and other companies aside from documenting data protection assessment. So one of the things that we found with some of the proposals that have been bubbling up is the compliance and record-keeping requirements are difficult particularly for smaller businesses. Well Virginia makes sure that is not particularly a challenge. It also clarifies that consumers are not those acting in commercial or employment context and it separates the language between those two. There's some states that sort of merge the boundaries between when consumers are acting in their individual capacity or in a commercial or employment context.

So what specifically does this bill protect? I've identified some of the key areas of protection here. One is the right to know, access and confirm your personal data. Another is to correct inaccuracies in personal data. That was something that many consumers identified as something that they would like to see in their state privacy legislation. Another important provision is the right to opt out of the sale of personal data which has certainly driven a lot of discussions in states and at the federal level on data privacy legislation. And then in addition to that there are a number of other provisions that we see Virginia does really well. So why is this particular model good in the healthcare space and why might it matter to health insurers? It has a clear carve out for protected health information under HIPAA. But in addition to that it also identifies private information that occurs in the scope of clinical research or other forms of academic research as carved out of this particular bill. And so information that may have been de-identified in accordance with HIPAA or in accordance with requirements of clinical trials is given an exception for the purposes of this law itself. In addition to that it's worth noting that it's helpful for some of the smaller healthcare businesses that we mentioned earlier by including what's considered a 30 day cure period which allows companies to address some non-compliance so if there is an identified issue with how their company is operating in the state relative to data privacy, they have the opportunity to correct it within a fixed window of time. So our argument is that we recognize the growth of interest surrounding data privacy legislation at the state level particularly with the absence of a federal standard and if we are going to pursue a model across a variety of states, the Virginia model that just passed a couple years ago and went into effect two months ago is one that really carefully balances the interests of the consumers and the interests of companies including healthcare insurers.

Mr. Wieske thanked the Committee for the opportunity to speak and stated that I think when you look at this issue from our standpoint I think you are seeing a number of things come together from a data standpoint. Yesterday Oklahoma Insurance Commissioner Glen Mulready talked about the NAIC and the fact that if the NAIC doesn't take action

then in the absence of that you're going to see some significant issues that sort of attach in the states and we've already started to see some crazy stuff in a number of states. Not to pick on Oregon but Oregon I believe had a bill that would have required collection of dollars for anonymized data and to try to figure out how you would get money back to the consumer for anonymized services that were commercial in nature is obviously problematic. I don't even know how you do that. I would also note that Congress is unlikely as we talked about to take action given the split and given the issues there and it's unlikely that there's going to be a consensus on movement and how you look at this. And I would also note that NCOIL uniquely positioned with this issue. As we heard earlier today and in discussion of Rep. Lehman's underwriting transparency model act, this is an organization where we can come to consensus and have a discussion and we can push both sides of this discussion to come up with a middle ground that makes sense both for consumers as well as the industry. And to circle back to former California Assemblyman and NCOIL President Ken Cooley he always said in his time as president of NCOIL that this is the place where you have the discussion and you go back to your states and you're the giants in your state in your caucus about discussing these issues. And I think that's an important aspect of this as well. While we're wedded to a lot of the language in the Virginia model we understand that there are pieces here that may have to be adjusted. There may be expansions that may have to happen in some protections and coverage of other areas. But I think this is going to be an important conversation for NCOIL going forward.

Jon Schnautz, Ass't VP of State Affairs at the National Association of Mutual Insurance Companies (NAMIC, thanked the Committee for the opportunity to speak and stated that I'm not a data privacy expert by any stretch of the imagination but the main reason I'm participating in this panel is to kind of lend some level setting and perspective from the property & casualty (p&c) side of things as NAMIC is a p&c trade association. So as to the Virginia law, it is a data privacy statute of general applicability that I think it's important to note includes a lot of exceptions. One of those exceptions that's most significant for our purposes is the Gramm- Leach-Bliley act exception which for p&c insurers at least mostly takes them out of the act recognizing that they have a parallel set of federal data privacy requirements that they comply with. So that's kind of just some initial level setting about what Virginia does and doesn't do in its act. I will say there are some aspects of the Virginia act that we think are good in terms of data privacy laws. We tend to try to stay engaged on those anyway even if they don't apply to the industry because an exemption can always be lifted and you don't want to hang everything on just that. I can talk about some of those particular things in a little more detail if the committee would like to ask. The other thing that I want to make clear just to connect this and I think everyone remembers from the discussion yesterday if you were present in the NCOIL-NAIC dialogue, there is currently proposed a very hot issue at the NAIC around revising its model law on data privacy. There's a draft exposed on that right now and the comment deadline is April 3rd. If it were April 4th I could tell you exactly what our comments were going to be. Spoiler alert they're going to be a lot of them. We have a lot of concerns with the NAIC model. So the idea that there might be something for NCOIL to do here is not one that we are not open to but I guess to be clear we do have a parallel proposal there that very much does apply to the industry because that's what NAIC does. To that point I would say that one of our sort of bedrock principles on any regulation here would be things that could be reflective of what the NAIC is doing and what I mean by that is having one single set of standards. To go back to a point I made earlier today, not having duplicative requirements do the same

thing is important. We want to avoid the questions of which do you follow and how do you follow both and that sort of thing. And also having the enforcement of whatever is passed be in the hands of the state insurance regulator is important. We may or may not like parts of the NAIC's proposal but we do agree that however it's going to be enforced they are the proper party to be enforcing it and we think that's the right mechanism.

And then finally, one of the other speakers alluded to the federal activity on this. There is some serious activity going on compared to what there's been a lot of previous years. Will that actually get anywhere in terms of amending Gramm-Leach-Bliley or something like that is probably a slim hope given the state of federal affairs right now. But it's at least a possibility and so we try to keep our eye on that as well because again we're trying to have one clear set of guidelines to comply with. I guess the final point I would make and I think I can only speak to p&c but I think this applies to a lot of insurers. As I said the Virginia law is general applicability. People who are just in the business of selling data that's literally all they do, department stores and all kinds of entities across the spectrum commercially. I know this is not a new concept but information is critical to what insurers do. I mean at some level the purpose of insurance is to help people understand risk and then help them protect against it and we need good and in some cases private information from people to do that. That's part of providing the service and whatever model might come out we think that would be important to preserve. The final point I guess I would make just to loop back given what the Virginia law is and isn't, if NCOIL is determined to do something here maybe it's not a model act. Maybe it is some sort of a resolution that would support a certain set of exceptions to a law of general applicability. I don't know but I think we could very easily get comfortable with something like that because we have in other states.

Robert Herrell, Executive Director of the Consumer Federation of California (CFC), thanked the Committee for the opportunity to speak and stated that I had worked for about half a dozen years for the California Department of Insurance as a deputy insurance commissioner and prior to that as a staffer in the California legislature. So I think my role here in part is two-fold. One is to try to give you a little bit of the local or regional flavor of California, one of the states that in Mr. Barnhill's presentation was one of the first out of the box if you will. I can go over that very briefly. I'm going to focus more on non-health partly because I have less expertise in the health area but I will touch on that. And then just kind of pivoting over to pick up on what Mr. Schnautz was saying about big picture considerations as you decide to go down this road or not go down this road. I would also note I'm on the Board of the Consumer Federation of America (CFA) and obviously they have a significant interest in data privacy. At the federal level the one thing I would just note for all of you is to be aware of is for a state like California or Virginia or some other states that in certain areas have taken important steps forward, the big concern that we always tend to have is if the feds act is it going to override? Is it going to be a floor or a ceiling? We prefer the floor so that states can go beyond that if they want to. I know that there is a lot of pushback historically from industry and they want a uniform standard. You hear it all the time especially in the insurance area, the crazy patchwork quilt argument I call it. I'm not unsympathetic to it but I do think that as state legislators you want to think about potentially in some areas going beyond and that would depend on local issues.

Also, it was mentioned what's brewing at the NAIC. I think it was called hotly contested. I think that's perhaps an understatement. While I'm not in the middle of the day to day on that I do think that's very important to the extent that NCOIL has significantly strengthened your relationship with NAIC. I saw evidence of that yesterday. I think this is an area where it's very important that you continue to coordinate and collaborate with them on that. I say this candidly as someone who has been historically a bit critical of the NAIC because in California we would look at NAIC models in various areas and just feel like they were too weak in terms of consumer protection. And usually the argument in California has been how far above the NAIC model to go but that's again part of what you deal with in your respective state legislatures. Some brief history, 20 years ago I was fortunate enough to be the lead staffer on a bill that got signed by then Governor Gray Davis in California in 2003 on consumer financial privacy. I can tell you that was a multi-year battle. There was an initiative threat that forced folks to the table to negotiate in I wouldn't say good faith but in better faith. That resulted in that compromise legislation that was California SP1 of 2003 sponsored by then state senator Jackie Speier who then went out to Congress and just retired from Congress after a number of years. California was the first state to do something on data breach notification and the like. The history in California has been that it's been initiative threats that have tended to force more meaningful conversations. That happened again in 2018 with an initiative threat by a gentleman named Alastair Mactaggart for stronger privacy laws and in California there's a kind of a version of an indirect initiative where it didn't used to be the case but now if something's about to qualify for the ballot there's a sort of deadline given and either the legislature will come up with an agreement such that the sponsors of the initiative agree to withdraw it or not or you go forward and kind of fight the fight on the ballot. That was reached at the last minute in 2018. It led to AB375 of that year. Then, as stated, there was what I call the rush to get whole industries carved out of that law and insurance was in fairness part of that for the reasons that have been stated such as Gramm-Leach-Bliley and other considerations.

I will touch briefly on health - you may or may not remember when Governor Schwarzenegger was Governor of California there was a massive scandal and it dealt with the UCLA Medical Center and essentially long story short what was happening was high profile, particularly celebrity patients, personal private information was being leaked. We now know hindsight being 20/20 that some of that was happening by staff at the UCLA Medical Center who were interacting with so-called pay to play outlets like TMZ and others to get paid to leak information about a story. That spurred, I think, Governor Schwarzenegger to take action and then there's been additional moves in health privacy beyond that at the state level that I won't go into the detail of for lack of time. So most recently in 2020 California supported an initiative Prop24 by about 56%, the California privacy rights act. That is just now being implemented in California as sort of privacy agency if you will with a minimum funding threshold was created. They've just been promulgating some rules and they should become final within the next month or two. So there's been a lot of action in California. I would urge you whatever you do in this area take a good look at the panoply of things that we've done in California. It is a state that has taken privacy rights very seriously and has been I think moving the ball forward. All information is important and I say this to someone who’s focus is less on health than on other areas but I think one could make the argument that health information is almost first among equals. It is so personal, it is so private, it is so important. And we live in a world where portability of that information is actually important at some level for the

future effectiveness of our healthcare system. That is no easy balancing act but it is an important one as you consider it.
Broadly, a couple of thoughts on this if you go down this road, the CFC and many of our other consumer organizations generally believe that whenever possible, allow for opt in. Making the individual consumer have that power to decide is preferred to opt out. What we know historically about opt-out regimes is at one level you create an incentive with an opt-out regime to make a decision complex and you essentially create an option where the more legalistic and confusing an opt out decision is for the consumer, the less likely they are to exercise that. So do as much opt-in as you can or if you can't do opt-in do a clear, easy to effectuate opt out. Again our bias is opt in but we literally had readability experts take a look at some of these opt out notices and they literally told us you had to be basically at a doctorate or PhD level to sufficiently understand the language and those opt out notices. That does not serve consumers at all. You want to have something that's readable, understandable and actionable. I'm mirroring my own comments from this morning. That is the goal and it really cuts across a number of lines. I'm not going to go into too much detail about the Virginia model. I do think there are some very beneficial provisions in it. I think you always want to be very careful about exemptions that's almost always where the fight and the debate is whenever you want to go down the road to privacy at the state level so keep them as narrow as possible. There is always going to be that push-pull where various industries will come in and they will tell you an amazingly unique story that causes them to need a carve out. Resist that temptation as much as is humanly possible.

I'll touch on two more things. One is about definitions, they're very important obviously. With "sale", 20 years ago when I was working on this issue as a staffer, sale literally meant sale. The industry has changed and evolved some would argue devolved into you don't have the kind of direct sale that you may be used to two decades ago. It's all about kind of leasing, sharing that information. You can go online right now and essentially buy access to very specific populations of people, de-identified that would trouble you and amaze you. That is a thing. So be very careful on your definitions about "sale." Make sure you capture broadly all the ways in which value is exchanged not just traditional sale, or renting, or leasing. Finally, a quick note on enforcement. The point was made about insurance commissioners enforcing this. I want to make a broader point that goes beyond just the insurance area. Whenever you have enforcement our view is you want whoever the regulator is to have enforcement capability. You should have your attorney general have enforcement capability. You should have depending on what you call it your county district attorneys have enforcement capability. In some states you have large cities where city attorneys have a big enough shop where they might be able to enforce. And finally there is in some situations a role for a private right of action. Now you can put a box around that and you can limit the amount that could be collected or damages or things like that. But I think it's important to have as broad an array of enforcement possibilities as possible. I say that not because I want the privacy cops chasing after everything but I do think that it makes sure that industries are as attentive as they need to be to following these reasonable rules and giving consumers as much control as is humanly possible over their information and what's done with it.

Rep. Bennett stated that I am curious as a person who grew up sort of giving my data to the internet at an early age, I've looked around the world and seen what data privacy laws exist elsewhere and in Europe it's pretty clear cut - the consumer owns their data. And this conversation's been very complex but they seem to have figured it out and I

wonder what is the difference between Europe and the U.S. on this issue? Are they doing it wrong? Do you see an avenue for us to do that? Do you even want that? Mr. Herrell stated that I'll give you a real short answer and then I'll expand just a tiny bit on it. In two words the difference is political will. Now there's a more nuanced version of that answer which deals with historically, and those of you who've been in the insurance space have seen this, and I don't want to paint with too broad a brush but I want to make the point that Europe and a lot of areas have tended to come out with fantastic rules in various industries and sectors. Then where things have gotten really challenging is in the enforcement of those rules. Again I don't want to be painting with too broad a brush. That's my sense of the challenge here. So I think that it remains to be seen. I agree with you Rep. Bennett that they have laid down a very clear marker. Your information is yours. And I think that's the bias walking in that we ought to have to protect consumers. Then it gets trickier when you're dealing with enforcement and you're also dealing with the European Union (EU) which is over 20 nations. That can get a little funky too. So there are various multinational groups within Europe that are meant to handle some of this but the marker is clear and the more that you can get that sort of clear statement of purpose, I think generally speaking the easier it is to then flush that out.

Rep. Bennett stated that in Oklahoma we've had this conversation. Just roughly off the top of my head I can think of several more technology companies that are based in California than there are in the state of Oklahoma and the thought is that a place like California where these places are domiciled can more aggressively control or set standards. So I guess my question is, is a state by state solution the best from that standpoint because different states have different levels of authority over these companies? Mr. Herrell stated that it's a fair question and I'm more than a little sympathetic to the challenges that are entailed when you're dealing with different levels of standards in different states. I really am. It's one of the reasons why Europe has kind of gone down this road. Now granted those aren't states, those are countries that through the EU and the different mechanisms have done that. Let me use an anecdote to kind of make that point. When we were in very intensive negotiations nearly 20 years ago about the Consumer Financial Privacy Data Law, we were well aware that it was a California conversation that was very quickly going to turn into a de facto national standard conversation literally right after the bill got signed by the Governor. I think within a week or two then State Senator Speier and I traveled to Washington DC and met with just now retired U.S. Senator Richard Shelby and others who had been part of that broader privacy coalition because we knew that the opponents of the bill in California immediately raced to DC to try to take the legs out from under it. So, in a perfect world you have a national solution. But the concern that I have is historically that national solution has been too weak on consumer protection so therefore that's why we go into the national solution is preferred but having it be a minimum level of standard that states can go beyond if they wish. That's not perfect by any means but I think it's the way that we try to protect consumers to the maximum extent possible.

Mr. Wieske stated that I agree in general you want a nationalized standard. Having said that insurance is state regulated and it's subject to specific state regulation and your ability to sort of enforce it. I think you can take a look at the cyber security issue that the NAIC worked on and the fact that they want to have control differently than the national standard. Also note that if you're looking at Europe you're looking at a whole different world for negotiation standpoint. I happen to have a boss who was the chief negotiator as the President of the NAIC in dealing with a lot of these issues and trying to figure out

how to actually have American companies operate in Europe and have European countries operate in the U.S. and I'm not so sure that environment and the way they look at it is right and I appreciate the idea and the consumer protection that's attaching to it but I'm not so sure that works in a place like the U.S. in the same way. And I'm not so sure people would be happy with the lack of access to certain types of products and the ability to sort of move data through in the same way that it works now. That would be a concern. Mr. Schnautz stated that I think what this conversation has revealed at least in part is that this is a complicated issue both in terms of who ought to be doing it and what ought to be done and I guess I would say the question probably ought to be how does NCOIL fit into that? I would at least encourage maybe waiting another month or so as you're going to know sort of what comes out of the NAIC. We can give you some more concrete feedback on that and then again if the idea is to do a model based on Virginia's law, it would be odd to have an NCOIL model that generally doesn't apply to insurance. So I think the concept of what the best way to approach this regarding whether it's a resolution or an actual model, focusing in on what sliver of that belongs here might be the easiest path forward. Mr. Wieske stated that I would just agree and add on that, to use Plato's analogy it's the shadow and the cave wall that you're looking at here as you're moving forward and we need to get closer to that ideal. We may not get there but I think even having the conversation here given that the NAIC is having it and given that it's happening in state legislatures is going to be hugely important on a go forward basis.

Rep. Bennett thanked everyone for their comments stated that I suspect we'll continue discussing this topic in some fashion so if you have questions or feedback please let me or NCOIL staff know.

DISCUSSION ON E-DELIVERY OF INSURANCE DOCUMENTS AND POTENTIAL AMENDMENTS TO NCOIL INSURANCE E-COMMERCE MODEL ACT

Rep. Bennett stated that next on our agenda is the discussion on the electronic delivery of insurance documents and potential amendments to the NCOIL Insurance E-commerce model act and on page 265 there are some examples of state laws dealing with this issue along with the NCOIL model I just mentioned. For this topic we're going to hear from our speakers today and then determine whether or not to make any amendments to the model either at our summer or fall meeting.

Mollie Zito, Associate General Counsel at UnitedHealthcare thanked the committee for the opportunity to speak and stated that as part of UnitedHealthcare's sustainability strategy we are working to reduce paper usage not only in UnitedHealthcare but also in the healthcare system as a whole. And so what we would be interested in doing is working with members of NCOIL as well as stakeholders on an amendment to the NCOIL insurance e-commerce model act that would allow employers who have fully insured health plans to attest that their employees are wired, which means that they have access to smartphones or computers and internet, and that if they're part of the health benefit plan that they would receive their health benefit plan documents electronically. They would have the option of opting out and getting their documents through paper. And I want to emphasize that this would be an optional thing for employers. We wouldn't mandate it. I also want to emphasize that this is in the group market. So just a little bit about the e-delivery landscape right now. We have state and federal laws that have been in place for a long time, much before employees had access to smartphones and computers and laptops that they carried with them and a lot of times

these laws hamper that. And the Employee Retirement Income Security Act of 1974 (ERISA) in 2002 actually did a safe harbor for plan sponsors or employers that allowed them to say that their employees were wired at work which means that they had access to their health benefit plans electronically and if they were wired at work then the employer could send their documents electronically. This is different as fully insured plans are regulated at the state level. And we don't have that same opportunity on the state level and so that's why we're looking for this amendment to give those employers the same option to say, “okay my employees are wired at work and I can give them their health plan documents electronically.”

So there's many benefits to e-delivery, this slide outline several of them. There's ease of administration for employers. I'm sure it’s the same for a lot of you where I know my employer tells me if I want to see my paycheck I need to go look on the internet. If I want my tax documents I need to go look at the internet. If I want my W-2 I go to the internet. And so there's a lot of administrative ease for the employer if we do allow them to send the health benefit plan documents electronically. But there's also the consumer experience. And I really wanted to focus there for a minute because we’re seeing that if you have access to your health benefit plans ready on your phone or your computer, you have the option to “control F” - what are my benefits for colonoscopy? What are my benefits per person for prescription drugs? And this improves health literacy and engagement in personal health and we think that's going to lead to better health outcomes. Last October, Morning Consult did a poll regarding this very issue asking employees would you care if your employer sent you your health plan documents electronically? There's several statements on this slide but the last one is the most important that 94% of the respondents said that a proposal to allow your employer to send you health plan documents electronically that they would approve of that. In addition to the benefits that employers and employees see we also have environmental benefits of e-delivery. And then lastly, this is I think the most important slide as this law has started to be implemented in a few states around the U.S. As was mentioned to this Committee last year, it was implemented in Texas. It's also implemented in Georgia and Iowa. The law is sitting on the Governor's desk in Mississippi and it's passed the Tennessee Senate and we expect it to be introduced in several other states as well this session. UnitedHealthcare hasn't put forth any model language for the committee today but NCOIL staff did include in your binders the Georgia law that was enacted and we have drafted some legislative language along those lines and we have sent it around to several health insurers and other associations that work with NCOIL. It is our hope today that we can work with you and stakeholders on this between this meeting and the summer meeting in Minneapolis to come to some consensus on some legislative language that we could put forth as an amendment to the NCOIL’s Insurance e-commerce model.

Jeff Album, VP of Public and Gov’t Affairs at Delta Dental of California, thanked the Committee for the opportunity to speak and stated that Delta California actually is the Delta Dental plan of record in 15 states with about half of all Americans who have dental insurance are in one of our plans across the country. I'm going to work really hard not to duplicate everything Ms. Zito said because I agree with everything she said and she's already said it. But I can give a slightly different view on it that all of the issues around paper-based transactions are more acute for dental even than for medical. So obviously this is just a visual of how things work today. An employer buys a dental plan. They send a note either by email or paper to every enrollee and says, “hey do you want to opt

in to electronic communications?" And that leads you to a website where you start an account and all of your health documents will flow there. The problem is in dental particularly, fewer than 1% of dental enrollees actually end up taking the opt in to electronics while many medical enrollees also skip their chance to opt in. Although I promise you they have a much better track record than 1% in getting their members to do it because let's face facts as much as my dental industry people colleagues who are here don't want to hear it, dental is not the most important thing to most employees and not even to all state legislators but the fact remains medical of course is fundamental. And of course in banking transactions everyone opts-in. Almost everyone opts-in to banking because that's your money and you use it every day. So where an industry is in your mind in terms of a priority very much has an impact on how readily you read your option to opt-in or opt-out and in dental we see a real opportunity here to take advantage of how culture has changed in the three years of the pandemic. We have watched society move electronically and I mean people at all economic sections have learned how to order food on DoorDash and do everything electronically because it was a need and we haven't dropped those things just because we're not wearing masks anymore. People are more likely to opt-in to electronic communications with their banks and brokerages like I said because that's where their money is.

So what's the solution? How do we increase the number of people who electronic opt-in? Why don't we give employers a little bit of credit. As Ms. Zito said, when they sign up for work in many industries and certainly not all of them but in many industries it is an electronic connection that they are signing up for that's their job. They receive their instructions electronically. They receive their initiatives electronically. They receive their appraisals electronically. They receive their paychecks via bank wire and they receive that electronically. That is the direction we are going in. Let group benefit managers attest to who has access and allow them to opt-in. Like I said this is not all businesses - a trucking company might not have the same electronic connection to truck drivers as they do to other white collar executives who might work on other aspects of that particular business. So we're not saying opt-in all truck drivers to electronics. We're saying let the group benefit manager make a very educated review and then let's give every employee the absolute simple easy right. And in this matter, I totally agree with Mr. Herrell's comments earlier that the opt-out must be simple. It must be easy, not what a college educated person has to be able to read - something that a junior high school person would understand. Make it easy for them to opt-out and make it a legal requirement that they receive that option to opt-out. My colleagues already mentioned this, this is a trend legislatively beginning in 2018 with Kansas and then Louisiana in 2019 and Wyoming in 2020 and Georgia, Texas and Mississippi recently. And the last three states that have done this have all followed the same sort of legislative implementing language and conditions for allowing a group opt-in to electronics. A group benefits manager has the right to do it, but they're not mandated. They must attest and confirm that the people they are opting in have electronic literacy and electronic means to receive those communications. Opt-out must be made available at all times, anytime. They can go back and forth. That's their business. And there are exceptions to the type of health and dental plans where this should be allowed. Medicaid, Medicare, individual health and dental including public health exchange plans - these are all forms of healthcare and dental care where there isn't a group benefit manager able to attest to electronic connection. Even if they've signed up for a health plan over the internet that doesn't convey complete comfort and computer literacy and so we are saying no we're not talking about any of those plans in this proposal.

So, in summary it's a change from the current enrollee opt-in to paperless to an optional default group level opt-in with enrollee opt-out. It's needed because most health and dental enrollees never bother to read the fine print and the proposal does not include individuals for whom there can be no attestation as to whether they are connected or not. And the advantages of e-delivery have already been covered by Ms. Zito. And here I show you the typical paper transactional cost of a dental plan enrollee in a given year. There's all the documents that we have to send them every single time a date of service has occurred and some of them are once a year. An evidence of coverage (EOC) is once a year. An explanation of benefits (EOB) is after every routine cleaning, and you're at $9.75. We sell dental plans at $15 per person per month so for $150 annual premium it's about 6%. So we could be lowering the cost of dental care. For dental there are twice as many people who don't have dental insurance as medical insurance and 6% could be the difference between buying a plan or not. People who have a plan are more than twice as likely to get care as people who don't. So this last slide shows some language that gets it done. This mirrors language that was passed in all of those states where we have championed this particular initiative and we are optimistic that you'll consider this here at NCOIL as a model act. I'm sure we would get more and more states to get the ball rolling on this.

Mr. Herrell thanked the Committee for the opportunity to speak again and stated that very briefly in terms of California context when I was at the department of insurance I spent the better part of 2013 and 2014 perhaps going into 2015 negotiating with the insurance industry about this very issue and those were long, tortured, painful negotiations. But we were not opposed to electronic delivery of things. We just wanted to make sure there were certain protections for consumers and guard posts if you will. So that's the context. I probably would have to turn in my consumer advocate card for life if I didn't point out the deep irony of when it is something that the insurance industry or segments within the insurance industry is interested in, they can magically make it work. When it's in the consumer's interest and it forces the consumer to take an action then all of a sudden it's too costly and difficult. Let's just be aware of that irony. Our point has always been consistent, give people the maximum amount of control. Having said that, what gives me a little bit of pause in this group benefit manager situation is, does that person really know the situation of all the employees that they're attesting for? Let's think about vulnerable populations. That could be lower socioeconomic status, lower education. We're having a debate in this country about broadband access in rural communities where largely it doesn't exist. We've also had a major shift in population coming out of COVID where more people are kind of working in all kinds of places. Let's just not be in such a rush here. And I understand the business argument, I really do. The savings, etc. But let's not be in such a rush that we kind of forget some of those protections. In terms of cognitive impairment, how likely is an employee going to be to acknowledge and admit and then pass that information along that there may be an issue of cognitive impairment?

So these are signposts that I think are important we don't forget. The redundancy is important in some circumstances. I appreciate that some of that has been built into the approach here but you want to be very careful because the argument is well pieces of mail get misplaced or you know they have the old address or something like that. My personal email account is a Yahoo account. That's quickly becoming a dinosaur where most email accounts are Gmail or others. There's been stuff that I was supposed to get

in my email account that I didn't get. So one of the debates we had in 2013 and 2014 in California was how do you verify? How do you certify that it was actually received? And while that technology has advanced some I don't think it's there quite yet where you have that level of confidence that you absolutely could bank on it. So these are just some bigger picture thoughts that I think are very important to the extent that NCOIL is going to go down this road. The irony is that we started this afternoon and one of the panelists talked about this sort of preposterous proposal in Oregon where people might be able to get a dividend, my word not theirs, about what it is. Well here Delta Dental to their credit has just said it saves us $9.75 per year. Should the consumer get a little part of that? If you want me to opt-in, make your case. And maybe that case is part of the financial case and maybe if you throw a few bucks my way or give me a reduction in my rate or something maybe then I am more likely to opt-in. That is the idea that then leads to those kinds of proposals in other states and municipalities.

Rep. Bennett thanked everyone for their comments and stated that we will likely be discussing this topic in some fashion going forward so if you have any questions please let me or NCOIL staff know.

PRESENTATION ON DEVELOPMENTS IN DIRECT PROCUREMENT OF INSURANCE

Bill Bryan, Director of Providence Insurance Partners, LLC, thanked the Committee for the opportunity to speak and stated that I'll be brief and say I'm here to try to give you all money - money to which you and your taxpayers are legally entitled to and are in many cases not receiving because of the lack of understanding of the way that we place insurance works. So without further ado, with independent procurement here are the things we're going to cover. What is it? Why do we need it? Why should this body be supporting it? What can states do to support it? And then what can carriers such as ours due to make it work better? Independent procurement actually goes by several names. You may also refer to it as direct procurement, self procurement, foreign procurement, and all those terms mean the same thing. The history goes back to the late 1890s there were two U.S. Supreme Court cases then which established a constitutional right for individuals to obtain insurance outside of their jurisdiction. There's been a number of developments since then. The McCarran-Ferguson Act in 1945 specifically recognized procurement as a valid means and something that was not precluded by McCarran-Ferguson. There was an important case in the 1960s, *Todd Shipyards*, which again validated the use of procurement and established some rules around taxation between the states. And then there was the Nonadmitted and Reinsurance Reform Act of 2010 (NRAA) which was passed in 2010 which again addressed this issue of how to address taxation where insurance crosses state lines. The current status is it remains a fairly little-known thing. They're probably some people in this room who know a good amount about it and there are some who may not know anything about it. I find that to be true even in groups of experienced insurance people.

So it's again one of the three main methods of obtaining insurance and it is the least known and least used and therefore sometimes one that creates confusion when it is used. Why do we need it? I'm just going to go really quickly through this because I'm not here to talk about health policy. By the way my company exclusively provides stop loss and reinsurance coverage behind self-insured group health plans so we're talking about all this today anyway in the context of stop loss for group health. We have some

real gaps in health insurance coverage in this country. We have about 70 million lower income Americans who are functionally uninsured because they're deductibles and their out-of-pocket annual maximums are as much as ten times their annual savings. That means that you essentially have catastrophic insurance only. It's also more than 20 million people completely uninsured. Those ranks are going to be added to considerably when we get Medicaid redeterminations about to happen over the next year. So we have some gaps and there are people innovating around those problems and coming up with interesting solutions. We work with several companies that do. Some of those things include policies that have no deductibles or low deductibles. The use of reference-based pricing which is a great tool for controlling cost is very unpopular with providers and therefore with insurance companies that have network relationships with providers. Pharmacy Benefits Manager (PBM) transparency is a big cost saving tool and it is often the case that these self-insured group plans are designed in such a way that they just don't line up with stop loss policies that are available for the many carriers in various states. I expect that to fully change over time. The market has a way of adapting to support what's out there and we adapt as well including where we seek admission and whatnot.

But generally speaking it is very difficult to find on a timely basis for a lot of these companies stop loss coverage that matches up with the innovations that people are putting in place to control costs in group health plans. Of course there's no requirement under ERISA that you have any stop loss at all. People could decide to be uninsured which would be unwise and in fact we don't work with companies that allow that. So everybody needs to find stop loss. Small businesses have it for various reasons, some for state rules, some for carrier rules who they will and won't cover and under what terms. And this puts them in a particular disadvantage when it comes to a tight labor market where they really can't compete. So why am I here asking for your help? There are really valuable products. Some of you may have encountered at some other NCOIL events or NAIC events companies that have had tremendous success going out with these low deductible or no deductible plans. They're very popular with employers and employees. The bad joke I started out with about giving you all money when procurement is used centers on the fact that this generates a lot of money in premium taxes. There is no method currently in procurement for the reporting and reliable collection of premium tax so hundreds of millions of dollars a year are going untaxed. If you look around online you'll see a lot of companies that are identifying themselves as "captives." I think of a captive as being something that is captive and is owned by a company that is insuring itself. There's a lot of companies that call themselves that when in fact they insure many companies through protected cells or what have you.

And in very few cases are the premium taxes ever reported or paid by those companies. The NRAA which I mentioned called for the establishment of national compacts amongst the states. Unfortunately although there were two very well intentioned and strenuous efforts made to create those compacts, they failed. So there aren't any currently. It's the wild west. We had an experience a year ago or so an we said you know what we're going to require our insures to report and pay and demonstrate to us that they've paid other taxes. And it happened to be that this program was being piloted in a state I'm not going to name the state for reasons you'll see in a second. And we're going to require you to report and pay that. And they did. Everybody paid. And you know we thought maybe thank you notes would be coming. Instead what came was a lot of confusion, calls, questions, investigations and to this day now those are continuing. I heard a story

last week, an investigator called up one of these people who paid their premium tax and wanted to ask them a bunch of questions about how he found out about the insurance company and how it worked and all that. And he said, “listen first I don't know, I don't remember. Secondly this is the best insurance that I've had in my company in 30 years. And three I got better things to do.” And he hung up the phone. So we found that the lack of understanding is an unhelpful situation. Finally, typically what we've seen when you have this sort of situation where you have a lack of clarity and a need for some sort of standardization that’s not coming, the feds arrive shortly thereafter. So we think that is a definite possibility in this area and one that we would assume that NCOIL as well as the NAIC would disfavor.

What can we do? We would very much like to see and I've discussed this with some leadership here at NCOIL, the possibility of model acts and whatnot. We haven't come forth with one because the truth is more than 40 states already have legislation about direct procurement, about how it's supposed to work and what the taxes are and all that. So we're a little unsure as to what a model act would actually say when all these laws already exist. However, there certainly could be guidance established to say here is a standardized procedure for the reporting and remittance of tax and we would very much like to see that. We also think there's value to establishing online directories by state where even for foreign or out of state insurers where information can be posted like key financial information and warnings by people who've had bad experiences and things like that. So we think there's a lot that states could do but the biggest thing is really standardizing this reporting process. I can say our company and I'm sure many others would really welcome the opportunity if we had clarity as to how this was going to work to demand the insureds give us the authority to report premium taxes due to the states and in fact pay them on their behalf and it would result in a much cleaner system and a lot more taxes collected. What else can we do? As I just mentioned we can demand that authority to report the taxes and perhaps pay them. We already do encourage and facilitate timely reporting and payment of taxes. We can also educate and listen. I spent the last eight months flying around the country talking to many of you and others about this issue. It's pretty esoteric and frankly I've made a lot of eyes glaze over but I keep going. And finally we really welcome input as to any thoughts anyone might have as to a better way to do this in terms of just again providing clarity and a better method and if you have any of those thoughts please reach out to me.

ANY OTHER BUSINESS

Rep. Bennett stated that at our last meeting in New Orleans we heard from Eric Haar, Director of Gov’t and Industry Relations at the Federal Home Loan Bank (FHLB) of Dallas and he gave a presentation on the FHLB system and a couple of insurance specific issues within that system and Mr. Haar is here today to provide a quick update.

Mr. Haar thanked the Committee for the opportunity to speak again about FHLB lending to insurance companies. The FHLB system is a government-sponsored enterprise, a GSE, created by Congress back in the 1930s. We lend money to insurance companies. We also lend money to banks and credit unions but when we lend money to an insurance company they will typically use the dollars they borrow from their regional FHLB to buy mortgage-backed securities or treasuries for the benefit of the organization. They can also borrow money from us to pay shareholder claims and policyholder claims. The issue that we encounter and this is a potential model law for later this year is when

an FHLB lends a dollar to an insurance company we take a little more than a dollar in collateral from them as a backstop to what we lend to them. If an insurer gets into financial trouble or goes into receivership a receiver can place a hold or a stay on all the assets of that failed or failing insurance company thus prohibiting a FHLB from accessing its collateral. That creates delays, it creates legal problems and we are forced to charge insurance companies less favorable lending rates when we lend to them in states where we don't have a fix. So, in 23 states the FHLBs have worked to pass legislation successfully making it clear that a FHLB shall not be delayed from accessing the collateral and only the collateral that it is due. And we work in partnership with insurance commissioners and the receiver and the insurance company so that we have a positive resolution for everyone involved. And so we will be approaching this committee later this year again with this issue.

Rep. Bennett thanked Mr. Haar and stated that it is likely we'll continue discussing this topic in some fashion going forward.

ADJOURNMENT

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

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National Council of Insurance Legislators (NCOIL)

Insurance E-Commerce Model Act

Sponsored by Rep. Edmond Jordan (LA)

Adopted by the Financial Services & Multi-Lines Issues Committee and Executive Committee on March 8, 2020

Proposed Amendments sponsored by Rep. Edmond Jordan (LA) and are to be discussed during the meeting of the Financial Services & Multi-Lines Issues Committee on July 20, 2023.

Table of Contents

Section 1. Title

This Act shall be known as the "[State] Insurance E-Commerce Model Act."

Section 2. Purpose

The purpose of this Act is to provide consumers more choice, convenience and flexibility in managing their insurance.

Section 3. Definitions

As used in this Chapter, the following definitions apply:

(1) "Delivered by electronic means" means either of the following:

(a) Delivery to an electronic mail address at which a party has consented to receive notices or documents.

(b) Posting on an electronic network or site accessible via the internet, mobile application, computer, mobile device, tablet, or any other electronic device, together with separate notice of the posting provided by electronic mail to the address at which the party has consented to receive notice or by any other delivery method that has been consented to by the party. The separate notice of the posting shall contain the internet address at which the documents are posted. For purposes of this subsection, delivery shall be effective upon the latter of the posting or the actual delivery of the separate notice of the posting.

(2) "Party" means any recipient of any notice or document required as part of an insurance transaction, including but not limited to an applicant, an insured, a policyholder, or an annuity contract holder.

Section 4. Electronic delivery of insurance documents and notices

A. As used in this section, the term:

(1) 'Health benefit plan' means a policy, contract, certificate, or agreement entered into, offered by, or issued by an insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services, including a vision or dental benefit plan.

(2) 'Plan sponsor' means a person, other than a regulated entity, who establishes, adopts, or maintains a health benefit plan that covers residents of this state, including a plan established, adopted, or maintained by an employer or jointly by an employer and one or more employee organizations, an association, a committee, a joint board of trustees, or any similar group of representatives who establish, adopt, or maintain a plan.

B~~A~~. Subject to the requirements of this Section, any notice to a party or any other document required by law in an insurance transaction or that is to serve as evidence of

insurance coverage may be delivered, stored, and presented by electronic means if the electronic means meet the requirements of the [Uniform Electronic Transactions Act/state technology law].

CB. Delivery of a notice or document in accordance with this Section shall be considered equivalent to and have the same effect as any delivery method required by law, including delivery by first class mail, first class mail with postage prepaid, certified mail, certificate of mail, or certificate of mailing.

DC. A notice or document may be delivered by electronic means by an insurer to a party pursuant to this Section if all of the following apply:

(1) The party has affirmatively consented electronically, or confirmed consent electronically, in a manner that reasonably demonstrates that the party can access information in the electronic form that will be used for notices or documents delivered by electronic means to which the party has given consent, and the party has not withdrawn the consent.

(2) The party, before giving consent, is provided with a clear and conspicuous statement informing the party of all of the following:

(a) The hardware and software requirements for access to and retention of a notice or document delivered by electronic means.

(b) The types of notices and documents to which the party's consent would apply.

(c) The right of the party to withdraw consent to have a notice or document delivered by electronic means, at any time, and any conditions or consequences imposed in the event consent is withdrawn.

(d) The procedures a party must follow to withdraw consent, which can be no more burdensome than providing consent, to have a notice or document delivered by electronic means and to update the party's electronic mail address.

(e) The right of a party to have any notice or document delivered, upon request, in paper form.

E. The plan sponsor of a health benefit plan may, on behalf of covered persons enrolled in the plan, provide the consent to the mailing of all communications related to the plan by electronic means otherwise required by paragraph (1) and (2) of subsection (D). Before consenting on behalf of a covered person, a plan sponsor must confirm that the covered person routinely uses electronic communications during the normal course of employment. Before providing delivery by electronic means, the insurer for the health benefit plan must:

(1) Provide the covered person an opportunity to opt out of delivery by electronic means; and

(2) Document that the applicable provisions of the conditions under [insert citation from state UETA or similar law] are satisfied.

E~~D~~. An insurer shall take all measures reasonably calculated to ensure that delivery by electronic means pursuant to this Section results in receipt of the notice or document by the party.

Section 5. Change in hardware or software requirements

After the consent of a party is given, in the event a change in the hardware or software requirements needed to access or retain a notice or document to be delivered by electronic means creates a material risk that the party will not be able to access or retain the notice or document to which the consent applies, the insurer shall not deliver a notice or document to the party by electronic means unless the insurer complies with Section 4 of this Act and provides the party with a statement that describes all of the following:

(1) The revised hardware and software requirements for access to and retention of a notice or document delivered by electronic means.

(2) The right of the party to withdraw consent without the imposition of any condition or consequence that was not disclosed at the time of initial consent.

Section 6. Applicability

A. The provisions of this Section shall not be construed to affect requirements related to content or timing of any notice or document required by any other provision of law.

B. If a provision of this Title or other applicable law requiring a notice or document to be provided to a party expressly requires confirmation of receipt of the notice or document, the notice or document may be delivered by electronic means only if the method used provides for active confirmation of receipt by the recipient.

C. This Chapter shall not apply to a notice or document delivered by an insurer in an electronic form before the effective date of this Chapter to a party who, before that date, has consented to receive the notice or document in an electronic form otherwise allowed by law.

Section 7. Contracts and policies not affected

The legal effectiveness, validity, or enforceability of any contract or policy of insurance executed by a party shall not be denied solely because of the failure of the insurer to

obtain electronic consent or confirmation of consent of the party in accordance with the provisions of this Chapter if the notice or document is delivered in paper form.

Section 8. Withdrawal of consent

A. A withdrawal of consent by a party shall not affect the legal effectiveness, validity, or enforceability of a notice or document delivered by electronic means to the party before the withdrawal of consent is effective.

B. A withdrawal of consent by a party shall be effective within a reasonable period of time after receipt of the withdrawal by the insurer.

C. Failure by an insurer to comply with any provision of Section 4 or 5 of this Act may be treated, at the election of the party, as a withdrawal of consent for purposes of this Chapter.

Section 9. Prior consent to receive notices or documents in an electronic form

If the consent of a party to receive certain notices or documents in an electronic form is on file with an insurer before the effective date of this Chapter, and an insurer intends to deliver additional notices or documents to the party in an electronic form pursuant to this Chapter, then prior to delivering the additional notices or documents electronically, the insurer shall comply with the provisions of Section 4 of this Act and shall provide the party with a statement that describes both of the following:

(1) The notices or documents that shall be delivered by electronic means that were not previously delivered electronically.

(2) The party's right to withdraw consent to have notices or documents delivered by electronic means, without the imposition of any condition or consequence that was not disclosed at the time of initial consent.

Section 10. Alternative method of delivery required

An insurer shall deliver a notice or document by any other delivery method permitted by law other than electronic means if either of the following occurs:

(1) The insurer attempts to deliver the notice or document by electronic means and has a reasonable basis for believing that the notice or document has not been received by the party.

(2) The insurer becomes aware that the electronic mail address provided by the party is no longer valid.

The insured’s consent to electronic delivery shall not preclude the insurer from delivering a notice or document by any other delivery method permitted by law.

Section 11. Limitation of liability

An insurance producer shall not be subject to civil liability for any harm or injury that occurs because of a party's election to receive any notice or document by electronic means or by an insurer's failure to deliver or a party's failure to receive a notice or document by electronic means.

Section 12. Posting Policy on Internet

A. An insurance policy and an endorsement that does not contain personally identifiable information may be mailed, delivered, or, if the insurer obtains separate, specific consent, posted on the insurer's website. If the insurer elects to post an insurance policy and an endorsement on the insurer's website in lieu of mailing or delivering the policy and endorsement to the insured, the insurer shall comply with the following conditions:

(1). The policy and an endorsement must be accessible to the insured and producer of record and remain that way while the policy is in force;

(2). After the expiration of the policy, the insurer shall either

(a). Make the expired policy and endorsement available upon request, for a period of five years; or

(b). If the insurer continues to make the expired policy or endorsement available on its website, keep the insured's user ID active for a period of five years;

(3). The policy and endorsement must be posted in a manner that enables the insured and producer of record to print and save the policy and endorsement using a program or application that is widely available on the internet and free to use;

(4). The insurer shall provide the following information in, or simultaneous with, each declaration page provided at the time of issuance of the initial policy and any renewals of the policy:

(a). A description of the exact policy and endorsement form purchased by the insured;

(b) A description of the insured's right to receive, upon request and without charge, an electronic and/or a paper copy of the policy and endorsement; and

(c) The internet address at which the policy and endorsement are posted;

(5) The insurer, upon an insured's request and once without charge following receipt of the initial copy, shall mail a paper copy of the policy and endorsement to the insured; and

(6). The insurer shall provide notice, either electronically or in writing at the insured's option, of any change to the forms or endorsement; the insured's right to obtain, upon request and once without charge following receipt of the initial copy, a paper copy of the forms or endorsement; and the internet address at which the forms or endorsement are posted.

B. This section does not affect the timing or content of any disclosure or document required to be provided or made available to any insured under applicable law

Section 13. Receipt of Claim Payments by Electronic Transfer

All claims brought by insureds, workers' compensation claimants, or third parties against an insurer shall be paid by check or draft of the insurer or, if offered by the insurer and the claimant consents, electronic transfer of funds to the order of the claimant to whom payment of the claim is due pursuant to the policy provisions, or her/his attorney, or upon direction of the claimant to one specified. However, when the employer has advanced the claims payment to the claimant, the check or draft shall be paid jointly to the claimant and the employer; or, if consented by all parties, the electronic payment shall be paid to the trust account. The check or draft shall be paid jointly until the amount of the advanced claims payment has been recovered by the employer. The electronic payment shall be held in trust until the amount of the advanced claims payment has been recovered by the employer.

Section 14. Rules

The Insurance Commissioner may adopt rules to implement the provisions of this Act.

Section 15. Effective Date

Section 14 of this Act shall take effect immediately. The remaining sections of the Act shall take effect 180 days following enactment.

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CHIEF EXECUTIVE OFFICER: Thomas B. Considine

National Council of Insurance Legislators (NCOIL)

Resolution in Support of Existing Law Exemptions for New Data Privacy Laws

Sponsored by Rep. Forrest Bennett (OK)

Draft as of June 20, 2023.

To be introduced during the Financial Services & Multi-Lines Issues Committee Meeting on July 20, 2023.

WHEREAS, consumer information from millions of Americans is being collected, organized, and utilized to better understand consumer behavior, perform research, develop new products and services, and create "big data"; and

WHEREAS, the use of big data has accelerated innovation and produced positive outcomes in the insurance and health care sectors and in a myriad of other industries; and

WHEREAS, big data is being used to revolutionize health care, especially in the acceleration of drug development to treat rare diseases; and

WHEREAS, increased data collection in connection with clinical trials and the use of data to study the impact of drug utilization on patient health are helping to ensure that health care treatments, including drugs, are safer; and

WHEREAS, the protection of consumer data is an important public policy issue; and

WHEREAS, some industries, including the health care and insurance fields and those performing clinical research, are subject to longstanding, comprehensive, and robust data privacy requirements; and

WHEREAS, state legislatures are increasingly considering and enacting legislation that would establish data privacy regimes for data brokers and others not already subject to such a framework; and

WHEREAS, it is imperative to safeguard the confidentiality of a consumer's health records without sacrificing or undermining advances and innovation in health care; and

WHEREAS, the states that have established data privacy regimes for data brokers and others not already subject to such a framework (e.g. Texas and Virginia) have included narrow exemptions in those laws that recognize the requirements clinical researchers must already comply with and avoid the adoption of duplicative and conflicting data privacy mandates; and

BE IT NOW THEREFORE RESOLVED, that the National Council of Insurance Legislators (NCOIL) supports innovation in health care in an environment that protects a consumer's right to privacy; and

BE IT NOW FURTHER RESOLVED, that NCOIL urges states that are considering legislation that would establish data privacy regimes for data brokers and others not already subject to such a framework to incorporate exemptions for:

- Identifiable private information that is subject to the federal regulations established for the protection of human subjects in research (i.e. 45 C.F.R. Part 46 and 21 C.F.R. Parts 6, 50, and 56);

- Identifiable private information that is collected as part of human subjects research pursuant to the good clinical practice guidelines issued by The International Council for Harmonisation of Technical Requirements for Pharmaceuticals for Human Use;

- Information that is deidentified in accordance with the requirements for deidentification pursuant to Health Insurance Portability and Accountability Act (HIPAA); and

- Information originating from, and intermingled to be indistinguishable with, or information treated in the same manner as information maintained by a covered entity or business associate as defined by HIPAA or a program or a qualified service organization as defined by 42 U.S.C. § 290dd-2; and

BE IT NOW FURTHER RESOLVED, that the exemptions encouraged in this Resolution are not intended and should not be interpreted to be exclusive of other exemptions to comprehensive data privacy regimes that states may consider; and

BE IT FINALLY RESOLVED, that a copy of this Resolution shall be sent to the Members of each State's committee with jurisdiction over data privacy laws.

Resolution in Support of Establishing National Standards and Procedures for the Reporting and Payment of Premium Taxes Due as a Result of Interstate Insurance Transactions

Sponsor TBD - To be introduced for discussion the Financial Services & Multi-Lines Issues Committee on July 20, 2023.

WHEREAS, the Nonadmitted and Reinsurance Reform Act ("NRRA"), which came into effect July 21, 2011, establishes that only an insured's home state is permitted to collect premium taxes due as a result of payments made to an insurance carrier for a policy issued outside of said insured's home state, unless 100% of the risk covered by the said policy is also located outside of the insured's home state;

WHEREAS, despite provisions of NRRA which called upon the states to create national standards and procedures for reporting and collection of premium taxes due as a result of interstate insurance transactions, and two major efforts, the Nonadmitted Insurance Multi-State Agreement ("NIMA") and the Surplus Lines Insurance Multi-State Compliance Compact ("SLIMPACT"), by groups of states to achieve such a result, no national standards or procedures, other than the general guidelines set forth in NRRA have yet been established;

WHEREAS, the lack of national standards and reporting and enforcement mechanisms has resulted in an ongoing loss of tax revenue to the states, the size of which is currently unknown but is at minimum in the hundreds of millions of dollars[2];

WHEREAS, continued shortfalls by the states in the identification and collection of premium taxes due as a consequence of interstate insurance transactions may result in further federal intervention, a result that would be counter to NCOIL's charter and purpose;

WHEREAS, while the preservation and reinforcement of the primacy of each state in overseeing insurance activities within its borders is a cornerstone of NCOIL's mission, NCOIL's members recognize that certain market conditions and critical needs of their citizens may be met in a timely fashion only through the acquisition by its residents and corporate entities of insurance products from carriers in other jurisdictions;

WHEREAS, as evidence of the demand for additional insurance capacity and flexibility, a bill known as the "Self-Insurance Protection Act" was introduced in the U.S. House of Representatives on April 23, 2023[3];

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[2] As an example, one state recently conducted an investigation and found that its five largest corporations all owed unreported premium taxes for policies obtained from carriers in other jurisdictions.

[3] 118th Congress, 1st Session, H. R. 2813

WHEREAS, if enacted, the effect of the Self-Insurance Protection Act as presently drafted would be to broaden ERISA pre-emption to include stop-loss insurance coverage for self-insured group health plans, and thus remove all state jurisdiction over said coverage, and also to eliminate taxation on premiums for such coverage, both of which outcomes would be highly detrimental to state insurance regulation and antithetical to NCOIL's core mission;

WHEREAS, inasmuch as the discouragement of lawful and compliant interstate insurance transactions, whether through active opposition or through lack of clarity in compliance, reporting, and tax remittance procedures, may be used by proponents of initiatives such as the Self-Insurance Protection Act as evidence in support of the need for such radical and unwanted changes;

WHEREAS, companies – whether they are true carriers or "captives" behaving as *de facto* carriers – which fill such unmet insurance needs should in all cases be required to report and remit (or cause to be remitted) all premium taxes due to each state in which an insured is domiciled, as required under NRRA;

WHEREAS, such tax reporting and remittance obligations should apply uniformly, whether a policy is obtained from a registered Excess and Surplus Lines carrier; from a Non-admitted carrier through the compliant use of Independent (also known as Direct) Procurement; or from a "captive" insuring individuals or companies domiciled in other jurisdictions;

WHEREAS, in *State Board of Ins. v. Todd Shipyards Corp*. (370 U.S. 451) (1962), the U. S. Supreme Court upheld the Constitutional right of individuals and companies to obtain insurance from carriers outside of their states of domicile;

WHEREAS, NOW, THEREFORE, BE IT RESOLVED that NCOIL urges each of the states and U. S. territories, as well as the District of Columbia, to work cooperatively to accomplish the following:

- Establish and publish clear guidelines for the reporting and remittance of premium taxes in each state;

- Make clear distinctions between the various types of interstate insurance transactions, including Excess and Surplus Lines; Independent Procurement, and captive insurers, establishing and publishing procedures for the reporting and remitting of premium taxes for each type;

- Formally recognize the rights and responsibilities established in the various codes and judicial decisions referenced above, and specify state expectations for demonstration of compliance with same;

- Require each insurance company or other risk bearer licensed in any jurisdiction to report annually (or more frequently) to its licensing agency any premium taxes

that are due to other states, irrespective of whether or not the insurer must report and pay said taxes directly ;

• Take measures to permit insureds who are directly responsible for reporting and remittance of premium taxes for policies acquired through Independent Procurement to assign said functions to issuing carriers, and/or to third parties such as third party administrators or accounting firms;

• Encourage each state and territory to enact laws and/or regulations which give insurance carriers the right to report premium tax obligations to the states in which they are due, and shield carriers against any claims and/or legal action taken against them by insureds as a consequence of such reporting;

• Take all steps necessary to ensure compliance.

BE IT FINALLY RESOLVED, that a copy of this resolution shall be sent to legislative leaders in each of the states and territories; the chairpersons of the Insurance and Revenue Committees (or equivalent) of each state legislative body; the Treasurer (or equivalent) of each state and state and territory; the Department of Insurance (or equivalent) in each state and territory; the National Association of Insurance Commissioners (NAIC); and all other parties who may have an interest in the lawful reporting and collection of premium taxes.

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National Council of Insurance Legislators (NCOIL)

Federal Home Loan Bank Insurer-Member Model Act

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

Draft as of June 20, 2023. To be discussed during the Financial Services & Multi-Lines Issues Committee Meeting on July 20, 2023.

Table of Contents

Section 1. Short Title

This Act shall be known as the [State] Federal Home Loan Bank Insurer-Member Act.

Section 2. Definitions

A. "Federal Home Loan Bank" means an institution chartered under the Federal Home Loan Bank Act of 1932. 12 U.S.C. 1421, et seq. (the "Federal Home Loan Bank Act").

B. "Insurer-member" means an Insurer that is a member of a Federal Home Loan Bank.

C. "FHLB Security Agreement" means a security agreement or any pledge, collateral or guarantee agreement, or other similar arrangement or credit enhancement relating to a security agreement to which a Federal Home Loan Bank is a party.

Section 3. Membership in a Federal Home Loan Bank

A. Insurers duly organized under the laws of any State, eligible for membership under the Federal Home Loan Bank Act, may become a member of a Federal Home Loan Bank and upon becoming a member, may:

(1) purchase stock in; obtain advances from; sell loans to; pledge collateral to; and perform such acts which are necessary and required to make available to it all the advantages and privileges offered by such Federal Home Loan Bank to the extent provided by and in accordance with the Federal Home Loan Bank Act; and

(2) invest in the debt obligations of the Federal Home Loan Banks or of any Federal Home Loan Bank or their legal successor.

[Drafting Note: For purposes of this section, the term "State", in addition to the States of the United States, includes the District of Columbia, Guam, Puerto Rico, the Virgin Islands, American Samoa, and the Commonwealth of the Northern Mariana Islands.]

Section 4. Receivership/Rehabilitation of a Federal Home Loan Bank Insurer-Member

A. Notwithstanding *[INSERT Relevant Receivership Section]*, any secured claim that a Federal Home Loan Bank has on an Insurer-member who is subject to a delinquency proceeding under *[INSERT Relevant Receivership Section]* is governed exclusively by this section.

B. Notwithstanding *[INSERT Relevant Receivership Section]*, a receiver shall not void a redemption or repurchase of any stock or equity securities made by a Federal Home Loan Bank within four (4) months of the commencement of the delinquency proceedings or that received prior approval of the receiver. However, a transfer is voidable if the transfer is made with the actual intent to hinder, delay, or defraud the Insurer-member, the receiver for the Insurer-member, existing creditors, or future creditors.

C. If a Federal Home Loan Bank exercises its rights regarding collateral pledged by an Insurer-member who is subject to a delinquency proceeding, then the Federal Home Loan Bank shall repurchase any capital stock that is in excess of the amount of Federal Home Loan Bank stock that the Insurer-member is required to hold as a minimum investment, to the extent the Federal Home Loan Bank in good faith determines the repurchase to be permissible under applicable laws, regulations, regulatory obligations, and the Federal Home Loan Bank's capital plan, and consistent with the Federal Home Loan Bank's current capital stock practices applicable to its entire membership.

D. Following the appointment of a receiver for an Insurer-member, the Federal Home Loan Bank, within ten (10) business days after a request made by the receiver, shall provide a process and establish timelines for the:

(1) Release of collateral that exceeds the lendable collateral value, as determined pursuant to the FHLB Security Agreement, required to support secured obligations remaining after any repayment of advances;

(2) Release of any of the Insurer-member's collateral remaining in the Federal Home Loan Bank's possession following repayment in full of all outstanding secured obligations of the Insurer-member;

(3) Payment of fees owed by the Insurer-member and the operation of deposits and other accounts of the Insurer-member with the Federal Home Loan Bank; and

(4) Possible redemption or repurchase of Federal Home Loan Bank stock or excess stock of any class that an Insurer-member is required to own.

(E) Upon request from the receiver for an Insurer-member, the Federal Home Loan Bank shall provide any available options that an Insurer-member may exercise to renew or restructure an advance to defer associated prepayment fees, subject to the following:

(1) Market conditions;

(2) The terms of the advances outstanding to the Insurer-member;

(3) The applicable policies of the Federal Home Loan Bank; and

(4) Compliance with the Federal Home Loan Bank Act (12 U.S.C. § 1421, et seq.) and related regulations.

(F) Notwithstanding *[INSERT Relevant Injunction/Stay/Automatic Stay Section]* and any other provision of this title to the contrary, a Federal Home Loan Bank shall not be stayed, enjoined, or prohibited from exercising or enforcing any right or cause of action regarding collateral pledged under an FHLB Security Agreement.

(G) Notwithstanding *[Insert Relevant Powers/Obligations of Liquidator Section]* and any other provisions of this title to the contrary, no liquidator shall have the power to disavow, reject or repudiate an FHLB Security Agreement.

(H) Notwithstanding *[Insert Relevant Prior/Fraudulent Transfer Section]* and any other provisions of this title to the contrary, a receiver shall not avoid any transfer of, or any obligation to transfer, money or any other property arising under or in connection with an FHLB Security Agreement. However, a transfer may be avoided under *[Insert Relevant Prior/Fraudulent Transfer Section]* if it was made with the actual intent to hinder, delay, or defraud either existing or future creditors.

(I) Notwithstanding *[Insert Relevant Preference Transfer Section]* and any other provisions of this title to the contrary, a liquidator or rehabilitator shall not avoid any preference arising under or in connection with an FHLB Security Agreement.

Section 5. Rules

The Commissioner is authorized to promulgate rules necessary to effectuate the purposes of this Act.

Section 6. Effective Date

This Act shall take effect xxxxxx.

WORKERS' COMPENSATION INSURANCE COMMITTEE MATERIAL

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
WORKERS' COMPENSATION INSURANCE COMMITTEE
SAN DIEGO, CALIFORNIA
MARCH 10, 2023
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Workers' Compensation Insurance Committee met at The Westin San Diego Gaslamp Hotel on Friday, March 10, 2023 at 11:15 a.m.

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

Other members of the Committee present were:

Rep. Brenda Carter (MI)
Sen. Pauk Utke (MN)
Rep. Brian Lampton (OH)
Rep. Ryan Mackenzie (PA)

Other legislators present were:

Sen. Jesse Bjorkman (AK)
Sen. Justin Boyd (AR)
Rep. Denise Ennett (AR)
Sen. Ricky Hill (AR)
Asm. Tim Grayson (CA)
Rep. Rod Furniss (ID)
Rep. Rita Mayfield (IL)
Sen. Win Stoller (IL)
Sen. Robert Mills (LA)
Rep. David LeBoeuf (MA)
Rep. Kelly Breen (MI)
Rep. Kevin Coleman (MI)
Rep. Kristian Grant (MI)
Sen. Mark Huizenga (MI)
Rep. Mike McFall (MI)
Rep. Helena Scott (MI)
Rep. Lori Stone (MI)
Sen. Lana Theis (MI)
Sen. Michael Webber (MI)
Sen. Nellie Pou (NJ)
Rep. Tim Barhorst (OH)
Rep. Forrest Bennett (OK)
Rep. Mark Tedford (OK)
Rep. Cameron Parker (MO)
Rep. Carl Anderson (SC)
Rep. Kirk White (VT)

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. Paul Utke (MN), NCOIL Secretary, and seconded by Rep. Brian Lampton (OH), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Sen. Utke 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 November 18, 2022 meeting in New Orleans, LA.

PRESENTATION ON DEVELOPMENTS IN CALIFORNIA WORKERS' COMPENSATION INSURANCE MARKETPLACE

Mitch Steiger, Legislative Advocate for the California Labor Federation (CLF), thanked the Committee for the opportunity to speak and stated that for those who are not familiar with CLF we are essentially a private nonprofit that represents affiliated union locals in California. We represent about 1,400 affiliated union locals as well as over 2 million workers that are members of those locals and through that structure we do our best to provide a unified voice for both union and non-union workers across the state. And so obviously with that being our perspective, workers compensation is definitely an issue that's near and dear to our hearts and arguably this broader issue of how we keep workers safe at work and what we do after injuries happen is maybe more than anything else the reason why there is a labor movement and why it is something that is so important to so many workers. You don't have to go very far back in the history of the state in this country to find a time when workers were openly seen as expendable, when workers died frequently, when workers suffered horrific crippling injuries and the response was basically step aside and make room for more workers. And through years of organizing and some very bloody struggle we now have things like a strong labor movement and a strong workers compensation system here in California and that's why we focus so much on trying to keep it as strong as possible to make sure that we don't slide back into the way things used to be. Very broadly speaking, I think it's safe to say that for the majority of workers the California workers comp system works very well. The vast majority of workers who do file claims in the system do get the medical and indemnity benefits to which they are entitled and we want to make sure that we protect the aspects of the system that work but there is a very significant minority of workers for whom the system does not work and for whom the system can pretty quickly become, no exaggeration to say, a nightmarish experience where it can take the worst pain they've ever suffered in their life and turn it into something that runs their entire life into the ground. That can end with homelessness or a crippling injury that follows them around for the rest of their lives or losing their families or death. We see this sort of thing happen all the time.

And so most of the time when we work on the workers comp system those are the cases that we're focused on. We're focused on those thousands and thousands of workers across the state that are struggling with the system that do have a really tough time getting the benefits that they're entitled to. And so we're very committed to doing what we can to make sure that the system works better for them. And so I'll group my comments into three main areas. I'll start with kind of a general state of the system with apologies to the Workers' Compensation Insurance Rating Bureau of California (WCIRB) for stealing the phrase that they use for their annual report but we'll very quickly go over how the system looks to us as workers. I'll briefly touch on some recent legislation in California that's affected the workers comp system and then conclude by going through what we see as the need for reform and some of the key areas within that. So for workers though we are doing what we can to manage the pandemic and transition out of it and as much as we can get back to normal, COVID really does continue to dominate. We hear this from a lot of workers - it's not uncommon for workers in some industries

such as grocery to have been infected with COVID three, four, or five times and the evidence at this point is pretty clear that subsequent infections increase the risk of long COVID and the outcomes get worse and worse for workers and so we are still very worried about COVID and where it's going to go in the future it doesn't appear to be going anywhere. So we want to do what we can to make sure that our workers comp system accounts for that.

There are still very significant difficulties in securing medical care for a lot of workers. I'll get more into this a little bit later but this is independent of COVID by far the biggest complaint that we hear from workers about the system that whatever the issues are with benefits, whatever the issues are with other areas of the system, it's those workers who need medical care in a timely fashion and struggle to get it that are the ones having the worst outcomes and the ones that we think we should focus on the most. And there's also a rising fear of retaliation. Again, most workers probably don't need to deal with this but where it does exist it is very real and it is not at all uncommon for workers to be fired or have their schedules changed or otherwise face some sort of very significant retaliation simply for the crime of having been injured at work and so that's another one that we really like to focus on. Cost, generally speaking, does continue to decline and AB863 is probably pretty familiar to the California workers comp people in the room. It was a very significant overhaul of the system, probably the biggest piece of it was an entirely new way of dealing with disputed treatment requests and it made a lot of other changes to the system that arrested some of the very out of control cost increases that we were seeing across our system and turned them back generally speaking in the right direction. And while far from perfect it has, we think, overall been a great success and has turned the system into one that overall works better for workers and employers and insurers and everyone else given that the costs do continue to decrease. But a little bit later we'll get more into what's generating the savings and whether or not that's a victory for workers or is a little bit more of a mixed bag.

So for recent legislation probably the most significant one of the last few years was SB1159 that was a joint bill between the Senate Labor Committee and the Assembly Insurance Committee that created a COVID presumption. Early in the days of the pandemic when we saw just waves of workers getting sick with this and really having a hard time convincing their employers that they got it at work, no one really knew how this thing operated, everyone was kind of stabbing in the dark. But there were massive denials even more so than there are now and we fought very hard to implement a COVID presumption across the board for workers. We weren't able to get what we were trying for and covering everyone but it did have a few different pieces that made an extremely significant difference for affected workers. It created a first responder presumption that covered police, fire, and healthcare. That we think has worked pretty well. Basically if you are a worker and one of those injuries and you get COVID the system presumes that you got it at work unless the employer can demonstrate, I think the evidentiary standard is clear and convincing evidence. But the employer can still if they have some compelling evidence that it was not the result of work related exposure they can escape the presumption. But by doing that it makes it much easier for the worker to win the benefits that we believe that they're entitled to. So that the good news. The bad news is that also created an outbreak presumption that we don't think has worked very well at all. It was the result of some I guess I'll call it intense negotiations between all stakeholders and everyone walked away pretty unhappy. But basically what it does is for everyone who isn't covered by the first responder presumption they're only

covered by the outbreak presumption and the first thing that it does is exempt all workers who are employed by businesses with fewer than five employees, which is most businesses in California. So out of the gate most employers are exempted and then everyone else the presumption only applies if there is an outbreak in the workers workplace and that's defined as if there are fewer than 100 workers, 4 workers have to test positive within a 14 day span. If there are more than 100 workers, 4% of all the workers have to test positive in a 14 day period. And the test has to be a PCR test which is extremely difficult to find in some places across the state.

And there is no disclosure to the workers. So they don't know if their employer's in outbreak status or not. They don't even have a clear right to ask their employer or claims administrator if there is an outbreak happening. So it's all kind of on the honor system and hoping that this information is volunteered by those who know it and our experience has been that basically doesn't happen. The only time we've ever heard of anyone benefiting from this presumption was a union that kept very close track of the COVID disclosures from the employer independent of SB1159 and they were able to apply that presumption in some cases. But other than that, we haven't heard of any group of workers that have benefited from that presumption and the bill was set to sunset on 1/1/2023 which brings us to AB1751 which was an extension of the COVID presumption last year. And for the first responder presumption, the original plan was two years but that had to get negotiated down to one year so that absent any other future action will expire at the end of this year. And we also made a pretty serious effort at fixing what was wrong with the outbreak presumption proposed and we had a few different versions of that. Those were all rejected. So the outbreak presumption continues for the rest of this year. I haven't seen any legislation this year that would extend it any further than that but the deadlines are approaching and passing as we speak. So it's not outside the realm of possibility but I think it's looking less and less likely that gets extended beyond the end of this year. There was also legislation last year that created a system whereby workers can receive their indemnity benefits on prepaid debit cards. This is an issue that primarily affects unbanked workers. So those who, there are still a very large number of workers who either won't or can't access traditional bank accounts and so they have to take advantage of a variety of other forms of banking products that are out there to get the money and get the benefits that they're entitled to. And so this bill created a system where they could get prepaid debit cards. We always watch this issue pretty closely because some of these cards can come with some pretty predatory fees and we've seen some workers lose even double digit percentages of their income or benefits to these fees depending on how bad the fee schedules were. But we went neutral on this bill given that the cards themselves actually came with a pretty good fee schedule outline and statute that we would actually like to see applied to all of the prepaid debit cards, maybe even the ones that are used to pay wages. This one sunsets on 1/1/2024. There's also an effort underway to extend this one either a certain number of years or indefinitely. We're waiting for a report from the Commission on Health and Safety and Workers Compensation in California that will basically let us know how well this program is working. We don't really know yet. So we at CLF at least are kind of reserving our judgment on an extension until we learn more about whether or not the system is working that well from this report.

Probably the biggest bill last year was SB 1127 by CA Senate pro Tempore Toni Atkins from lovely San Diego and this bill dealt primarily with presumptions that affect first responders. It was a huge priority for the California professional firefighters, the main

union of firefighters here in California, where they had seen a pretty common problem. Employers who have this 90 day span of time that they can use to accept or deny a claim, the employers would wait until day 88 or 89 and then deny the claim and then start doing everything that they could to fight it and we heard quietly from some employers and employer groups that it really didn't take that long that this was kind of a negotiating tactic and that definitely lines up with how we think the system works. And so the effort was to lower that from 90 to 60 days. It ended up going down to 75 days which is still a step in the right direction but we believe it should still be less time that workers shouldn't have to wait that long for an answer from employers regarding causality. For certain cancer claims the amount of time by which workers can receive those temporary benefits increased from two years to 240 weeks. This is a big deal because with a lot of these cancer claims it takes longer than that to basically figure out what's going on to deal with all the disputes around causality and treatment requests and reach that stationary level. And so that's an important reform to make sure that workers can continue getting the benefits that they're entitled to. And then also increased penalties for unreasonable delays in the system. This is another problem that we see not just obviously with firefighter claims but all across the system there are a wide variety of tactics that some employers or insurers or third party administrators (TPAs) can use to delay things for workers that in the long run cause a lot of harm throughout the system.

CA AB 5, this is one that is very well known to most of us here in California. This does not have to do with first responder presumptions. This one has only to do with employment status, whether someone is an employee versus an independent contractor and this codified a state supreme court decision called the *Dynamex* decision that clarified the test that's used to determine whether or not someone's an employee or an independent contractor. We were very strong supporters of this bill. We think it was one of the biggest victories for workers in California in generations. The explosion of misclassification touches virtually every industry out there and workers who are misclassified lose access to just about every single protection under the labor code and this bill was a major step in the right direction in cutting off the access that some employers believe they had to cut costs by misclassifying workers. Proposition 22 has a workers component to it where it's not really legislation but it was a ballot measure to the people that's essentially throughout the existing workers comp system for gig economy workers and created another one with all sorts of different problems and all sorts of different concerns. And given the constitutional nature of our workers comp system that has largely been the basis for the struggles that Prop 22 has had in the court system as it stands right now it has been thrown out. We'll see where it goes from here but we are obviously major opponents of this proposition and did not support in any way what it did for those workers in terms of throwing out their workers comp system and we hope that it stays thrown out by the different levels of courts.

And I'll just try to briefly touch on the need for reform. As far as indemnity benefits the temporary disability process here we think tends to work pretty well. The benefits are indexed. They replace a fairly significant portion of lost wages. The permanent disability benefits are a totally different matter as they are capped at $290 a week which doesn't really even cover rent in most of the state and we strongly believe that there should be a major increase in that soon. The biggest issue for us and I'll really focus on this one is the need for better medical care for workers. We see delays and denials and problems all across the system, not just for workers but for employers and insurers it makes it hard for everyone to know how much to reserve and how much the system's going to cost in

the future. But obviously we think the biggest issue here is that when workers are getting their care delayed their care gets worse, their injuries get worse, it makes it harder for them to get back to work and in many different ways raises cost throughout the system and generates the need for massive reform in the future that I'm sure we're all hoping to avoid. My email is up there on the screen if anyone would like to reach out and I'm happy to talk more about these issues with anyone who'd like to discuss them.

Kristen Marsh, Senior Vice President and Chief Legal Officer for the WCIRB thanked the Committee for the opportunity to speak and stated that WCIRB is the California Department of Insurance designated statistical agent with respect to workers compensation insurance. When I'm speaking with groups I like to put into context where we kind of fit in. You're familiar with the National Council on Compensation Insurance (NCCI) who collects data with respect to 35 states. This is the share of workers comp direct earned premiums based on National Association of Insurance Commissioners (NAIC) data from 2021. So you can see down at the bottom, California we are actually 19% of the overall 51% covered by what is considered the independent bureau with NCCI having the 35 states and the 43%. Mr. Steiger actually did go through a lot of the legislation pieces. The one thing I was going to mention is with respect to the COVID presumptions that is something that we have been closely watching obviously for impact on cost. As mentioned, that is extended to January 1, 2024 and as of right now there's no legislation to extend it. Another bill to mention was SB216. In California roofing contractors are required to have workers compensation insurance even if they do not have any employees. The idea being that you can't really do roofing work as a solo endeavor. This was expanded to include some other types of licensed contractors and then in January, 2026 it will expand to all licensed contractors will be required to have workers comp in the state of California.

As mentioned, SB 1127, that was an interesting bill and it did have quite a bit of back and forth and one of the things that they are hoping to do is to be able to collect some additional data. So the division of workers compensation is going to be amending their data collection process in order to collect the date when claims are being denied or accepted so that we can look into the issue that Mr. Steiger discussed. And then the last two bills are actually bills that were vetoed. And so in California we have the first responder presumptions that are in place and every year we have additional bills that extend it to additional different peace officers or firefighters in the state and you can see here this particular one got vetoed. It has actually been introduced already again for next year. And then with respect to the post-traumatic stress presumptions, this was put into place in 2020 and it sunsets in 2025. Last year there were some bills hoping to expand it to additional firefighter and peace officers. That was vetoed. It didn't extend out the sunset date, it just expanded it to some additional people. Bills have been introduced this year already to try to expand it to some additional people and also move it into private employers with respect to nurses in particular. Nurses have been introducing bills for quite a few years working to introduce a presumption for all different types of injuries but as of now they have not been successful. If they were that would be the first permanent presumption that goes into place that does impact private employers. So some of the things that we are watching and some different areas that we're focused on, Mr. Steiger did mention SB863 which was a large reform that happened back in 2012. California has kind of this cycle of reforms every so often. We have a downturn and then as costs start to rise we have a new reform package come into place. So what would kind of caused that reform to come to fruition? As you can see for the last 30

years we've had a real steep decline in the number of indemnity claims in the state but you can see for the last 10 to 15 years that decline has plateaued. Same for SB863, those reforms did impact frictional costs. It did reduce costs quite a bit in the system but those also have plateaued. So we're starting to see hitting that bottom and moving into more of a hard market for workers comp in California and what balanced out and kept that from happening is the increase in wages.

We had something like an 11% wage inflation rate and because workers comp is based on how much you pay in payroll, that additional wage level was able to offset some of those costs without needing to raise the rates in California. But next year I don't think we're going to see an 11% inflation rate for wages. So at some point that will start to not cover those additional costs and I do think we will start to see costs increasing in the system. I would also like mention cumulative trauma claims. This is another area that we watch. It's specific to California and a California phenomenon but the percent of cumulative trauma claims of indemnity claims has slowly been increasing and why this matters is cumulative trauma claims are reported much later in the life cycle. They have a lot of medical care. They are expensive claims. We do keep an eye on this factor when we're looking at the market in general. Also on our watch list is medical inflation. Medical deflation actually drove a lot of our reductions the past 10 years. The elimination of a lot of opioids and different things out of the system kept medical costs low but the past five years those also too along with frequency have been starting to creep back up. You'll also see the inflation in the economy and when will that hit workers comp and when will that hit medical care in the state? So far because of the drug formularies and different things that we have in place, costs have been relatively stable but at some point that inflation will find its way into the medical care system. And then long COVID is just something we don't know enough about yet. It is an area that we're starting to study. You can see we do have a significant number of claims, this is based on California Department of Public Health Data in the state with respect to workers comp claims for COVID. And they are continuing to be a significant amount and when you look at the shares of treatment for long COVID, this is based on our 2020 preliminary data but even with mild cases you're seeing 11% of those cases requiring care four months after. That goes up to 40% when you have someone in the Intensive Care Unit (ICU) or someone who had a critical care situation with respect to COVID.

So at this point we just don't know really what we're going to see with long COVID in the future and the impacts that is going to have. The WCIRB does a lot of research, it's one of our main focuses and these are some of our highlights that we're going to be researching in 2023. We are going to be looking at long COVID and we're partnering with the California Department of Public Health to take a look at the claims and see what we can tease out of the data. We're also partnering with John Hopkins on workplace violence and how that will impact workers compensation. And then the other one I would mention is the employee tenure and claims frequency study. That's a real interesting one especially as we start to come out of this kind of COVID recession. We're back to the point now where job losses have been recovered but when you have such a significant increase in jobs in such a short amount of time you do see an uptick in claims because we believe and we're going to study to see if it's true that employee tenure, an employee who's been in a job for a shorter amount of time is likely to have more injuries and be injured just because they don't know the job as well. So those are some of the things that we are going to be looking at. We're always happy to answer

any questions. All of our research is publicly available on our website wcirb.com and please let us know if you would like to hear anything further on any of our research.

Sen. Hackett stated to Mr. Steiger that he was a commissioner about almost 20 years ago and I would ask the question how many providers in my county, which is next to Columbus, did workers comp? And people would guess and the answer was zero and when I talk to their people, and Ohio has improved their systems and it's a state run system and it's working really well, there were three main reasons and one was paperwork was intense and two was they couldn't get a decision made and three was just actually getting paid took a long time. We worked really hard on that and I think Ohio now has a really got a good system with good costs. But that's the thing, I always thought the private insurance companies would work a little quicker than that but it seems that's the problem you have is getting decisions made by the company. Is that it in a nutshell? Mr. Steiger replied yes, you took the words right out of my mouth in pointing out those as the main issues. One of the first things that I do before I give a presentation like this is I go to the division of workers compensation website and I look at the independent medical review (IMR) reports, the second level appeal system here and usually within the first one or within the first one two or three you will see one that to me just exemplifies exactly what's wrong with our workers comp system. The most recent one I looked at was someone who needed six physical therapy visits and it was denied as not medically necessary because he still had two left from his initial six and they said "well let's wait and see how these two go and see if you need more." We probably spent $1,000 denying those claims and six physical therapy visits probably cost more than $1,000 but now that worker's going to go have to go back through that again, deal with that whole process if those two don't work, and it probably won't, and there is just example after example after example. The one I brought up last time I did one of these presentations was someone who needed a heating pad that cost $200 and it was denied and probably $1,000 was spend denying that $200 heating pad.

And we hear from doctors over and over again that they just don't have to deal with this in group health and they have enough of these experiences and they eventually just throw up their hands and they're like "you know what I've got enough patience I'm just not going to deal with the workers comp system anymore." And that creates all sorts of other problems throughout the system. But it's the hassle, it's the paperwork, it's the second guessing. Even when they're in the employer's medical provider network it still happens and it's a major problem that we really need to take a serious look at and we'll see how Ohio does it because we certainly got plenty of room for improvement and are looking for any great ideas that are out there. Sen. Hackett stated that Ohio realizes getting people back to work as quick as possible is still the best thing.

Sen. Mark Huizenga (MI) asked Ms. Marsh, you mentioned opioids and I'm just curious if you have noticed claims for opioids, since the injunctive relief with the federal courts, have started to interfere with state medical and pharmacy practice? Have you noticed that recipients are struggling to find acute opioid therapy? Ms. Marsh stated that we do not necessarily look at whether they're able to get the care. We're simply tracking what care is already provided so I wouldn't be able to directly respond to your question if there is a difficulty with access to opioid care. If you do look at the data though the amount of opioids just being prescribed in the system has dramatically decreased and you are seeing that replaced with anti-inflammatories and other types of treatment in its place and really that came about as part of the SB 863 reforms. We did put in a drug

formulary and I think also at the same time just the general practice of moving away from the significant amount of opioids that were being prescribed.

Rep. Tim Barhorst (OH) asked if someone could tell him the process you use in California for getting your doctors and access and how they're reimbursed? In Ohio it's based off of a Medicare plus 14% rate. And then you talked about your formulary and your preferred drug list do you coordinate that through any other agencies or do you see any opportunity to benefit if you would or could do that? Ms. Marsh stated that we don't - we're not in charge of the formulary, that is the division of workers compensation. We're just collecting the data associated with it so I can't really speak to that portion of your question but yes, it is tied to Medicare in California. Mr. Steiger might know better than me on that but yes it is tied to that rate which is what keeps it relatively low and why we have seen that medical deflation.

DISCUSSION ON PROPOSED U.S. DEPARTMENT OF LABOR (DOL) WORKER CLASSIFICATION RULE

Sen. Hackett stated that next on our agenda is a presentation on the proposed U.S. Department of Labor worker classification rule which has some really important implications for us as policymakers and our constituents as it deals with whether a worker is an employee or an independent contractor. In your binders on page 67 is a news release from the U.S. Department of Labor that provides a little more background on the rule. It is also on the website and an app along with the text of the proposed rule.

Michael Lotito, Co-Chair of the Littler Workplace Policy Institute and Shareholder at Littler Mendelson P.C. thanked the Committee for the opportunity to speak and stated that the rule's origin really started during the Trump Administration where a rule was promulgated and I think most people would say it was favorable from the standpoint of management in being able to support their position that an individual was an independent contractor based on the different control and entrepreneurial aspects of the test. That rule was certainly opposed, for example, by organized labor and others as not being correct. When President Biden was elected and Secretary Walsh took over, there was an effort to withdraw the Trump Rule and while it's complicated and I'd be happy to put you all to sleep to explain it all, a lawsuit was filed by us saying that it was improper to withdraw the rule for different reasons under the Administrative Procedure Act and a federal district judge agreed with us and as a result said that the Trump rule was the appropriate rule which is still in effect despite the fact that this Department of Labor has tried to withdraw it. So this Department of Labor then issued proposed rules that would reverse the Trump Rule and provide a new rule that would make it much easier to find that a worker was an employee. The fact that they did that stayed the appeal of the decision from the district judge until the new rule was finalized. There were 54,400 filed to this proposed rule. Having read them all since I have no life I can assure you that our comments were absolutely the best. We are waiting for the final rule to be issued which we thought according to the regulatory agenda would be the April time frame. Rumors are starting to emerge that that's going to be delayed based upon the complexity of Mr. Walsh leaving as Secretary of Labor and Ms. Su being the Acting Secretary having been nominated to become the secretary.

So, the bottom line is the Trump rule is in effect but there is a lot of uncertainty because we know that this Administration wants to reverse that rule but that's only part of the

story because the National Labor Relations Board also has a rule and under the National Labor Relations Act (NLRA) if an individual is an independent contractor that person cannot be unionized because that individual is not an "employee." Organized labor obviously does not like that because it diminishes the total number of people that they may get as members so there has been protracted efforts before the board dealing with this same issue. There's a case called *Atlantic Opera* where the board asked for *amicus* briefs where tons were filed about a year ago and when we're still waiting for a decision that will set the issue up for the board to define in their view how an independent contractor should be determined for purposes of the NLRA. That decision could come down anytime now and it's a foregone conclusion that this board will issue a decision that's going to be very favorable to finding the individual to be an employee but that's only part of the story because then you have to get to the states. So Prop 22 was already mentioned today and as noted it has been highly contested and based upon technical constitutional issues and the process that we have in California with respect to initiatives. Oral argument was held some time ago for the intermediate court. They have 90 days to issue a decision. The 90th day is Monday. I was scared to death that they would issue a decision this morning so I'd have to read the decision in order to be able to tell you what it meant but that didn't happen. That would be an extraordinarily important decision and whatever the decision is, to either reform or reverse, that would be appealed to the California Supreme Court and sometime either later this year probably early next year the California Supreme Court will issue a decision.

But that's only part of the story, because Illinois is about to drop an AB5 piece of legislation. Colorado has legislation that doesn't deal with the ABC test but is going to force the transportation network companies (TNCs) and the delivery network companies (DNCs) to reveal a lot of information and there will be a challenge if that passes with respect to compulsory First Amendment speech. There's an issue in Massachusetts where they attempted to have a Prop 22 type of referendum that was contested as to whether or not the process was correct and the Massachusetts Judicial Court found that it was not so we're waiting for decisions on different cases that are filed in Massachusetts with the likelihood of another initiative process beginning in 2024, an election year. New York has a situation involving a compromise with the Black Car Fund. There's another one like that in the state of Washington between the state and Teamsters Local 117 where the individuals are still classified as independent contractors but through various mechanisms unions receive money usually as a result of those individuals that are paying the fare for you to the delivery of the TNC for the transportation. There are other states that are considering legislation along these lines. So what do we have? We have a bloody mess because nobody knows under the state rules which vary depending upon wage and hour versus workers comp and you don't know the rules with respect to the feds and you don't know the rule from the Department of Labor and you don't know the level of enforcement which will intensify if Ms. Su becomes Secretary of Labor and you don't know for sure what the board is going to do and whether that case can even be appealed.

Which gets us to I think my main point. Yesterday the Financial Times had an interesting insert called "why employment is a work in progress." COVID dismantled outdated practices but what replaces them remains contested. And that's true. And it's worth reading. We're in a workforce transformation right now like we have never seen in the U.S. including when we went from agricultural to industrial. We have approximately 5.9 million people looking for work and we have approximately 10.9 million open jobs.

We have an enormously serious problem with a skill gap. We have companies that are starting, for example, to build some of the factories that were authorized under the federal legislation and they can't find workers to do the work. I've spoken to the last three secretaries of labor about putting together a nationwide plan so that we can create a 21st century workforce because if you don't have a 21st century workforce then the 21st is not going to be the next American Century. Which is why I founded the Emma Coalition named after my granddaughter because I have no intentions of taking a long dirt nap with my last thought being that my granddaughters are living in China-century. So we tend to get very distracted by all of this weedy stuff as opposed to taking a look in my view of the broader picture and that is how do we recognize that people want to work independently? Because maybe working for the "boss" didn't work out so well because maybe the "boss" wasn't great. Maybe we need to find common ground with a compromise so we can have portable benefits that workers can utilize and make contributions to. Maybe we need to standardize some of these tests so that there's certainty for everybody involved and recognize the possibility of even preemption so that we do have national standards. But most of all we have to have a national plan and the person that comes up with the national plan that deals with the number of people that have been disenfranchised as laid out in the great book Deaths of Despair which was published a few years ago by two notable economists from Princeton. There are too many people that have felt left out. There are too many people that don't have the skills that are necessary and there are too many people that don't have hope. And that's a shame. So we can talk about independent contractors for as long as you want and a lot of people will like 54,400 that filed a comment on the rule but let's not lose sight of the broader issue. There's a lot at stake here for individuals, for the country, for the companies.

Sen. Hackett stated that I agree with you and Ohio is really at a crossroads right now. We have more jobs than we've ever had and they're going to grow tremendously but I say we can't blow this. And in the second issue is a lot of these companies that are coming and we've got a lot of companies from California that have come in the last year, one of the things that we really worry about is these companies say well if we can't find employees in Ohio we'll bring other employees. But then we have housing issues and it's hard to change that overnight. We have to find places for these people to live in a lot of areas of Ohio. So I agree with what you said that these next three years are not only key for this country, they are especially key for Ohio.

Mr. Lotito stated to Sen. Hackett that former Congressman Steve Stivers and I along with the CEOs of eight other state chambers will be meeting in a couple of weeks. They issued a report last year that we helped support that talked about what the states are doing in order to develop these plans and with those states we're forming a task force that Congressman Stivers is part of in order to address these issues in a holistic way.

Rep. Kelly Breen (MI) stated that one of the first things they teach you in law school is never ask a question you don't already know the answer to. Nevertheless, Rep. Breen asked Mr. Lotito if he could explain the difference between the Trump Rule and what is being proposed under the FLA and the IRS 20 factor test from a practical application so we can understand how this is going to be applied? Mr. Lotito stated that on the IRS 20 factor test it would be a lot easier if that was the test that everybody followed. Essentially it comes down to the way you determine control and the way you determine entrepreneurial opportunity. And the rules give you examples of how they will interpret

those two standards and essentially if it's very easy to make out the fact that there's control by the company over the way the manner of work is being done and if there is a limited opportunity for that worker to not only make money from that company but from other companies doing the same or substantially similar work that will make the determination. The IRS test doesn't look at those factors in the same way. So I appreciate the fact that you've asked a question that you didn't know the answer to but I spent a lot of time on this stuff and I don't think I know the answer either. Rep. Breen stated that makes her feel better. Mr. Lotito stated that I'd be more than happy to talk to you offline but in the interest of time it's so weedy and it's just a function of how do you want to interpret it? And I think that in all fairness we want to say that everybody's paying attention to the law but that's not true as people have a preordained vision as to whether or not the individual law is A or B and they're going to come to that conclusion. That's the way it works.

PRESENTATION ON EMERGING ISSUES IN WORKERS' COMPENSATION

Susan Donegon, Chief Regulatory Officer at NCCI, and former Vermont Insurance Commissioner thanked the Committee for the opportunity to speak and stated that 2023 is NCCI's 100th anniversary and for a century we have been a licensed rating advisory and statistical organization for all things workers comp. We work with 38 state insurance and labor and work comp commissions and departments as well as state legislatures. We provide research, education, thought leadership supported by the data that we collect from carriers. We also work with various federal counterparts, Congress, Congressional committees, federal agencies, national trade groups, the insurance trade groups as well as national organizations like NCOIL, NAIC, Southern Association of Workers' Compensation Administrators (SAWCA), International Association of Industrial Accident Boards and Commissioners (IAIABC). And we also cooperate with the other independent bureaus, California is obviously one of them and Ms. Marsh is a colleague. Our research and basically education supports what we understand about workplace trends and we deliver insights so that stakeholders like you are able to make informed decisions. Often folks only have contact with our local NCCI state relation folks so people are often surprised to know that we have over 900 employees including 100 actuaries and 200 data professionals located in our Boca Raton headquarters. We also have folks scattered around the country, more now since remote working is more prevalent. One of the things my regulatory division does is that we track all the work comp legislation that you folks introduce every year depending on how energetic you all are and we consider legislative sessions to start in January and they run through June for the most part although we recognize that many states have different time and duration of sessions and actually some states don't even meet every year.

So, it's not unusual for us to track about 1,000 workers' comp bills over the course of a year and obviously the vast majority of those bills don't pass but we watch to see what the topics and activities are for the most prominent ones and we look at the trends. And we're interested in what might be the most impactful topics to either a specific jurisdiction or to the work comp system as a whole and when I say that we're watching the whole landscape, what I'm saying is we're trying to see what an impact would be on the system. Financial consequences. Good or bad. Changes to the structure of work comp itself. Is the grand bargain still relevant? And what's the possibility of even the elimination of workers compensation? NCCI doesn't take a position on any legislation or regulatory matter. We do not lobby but we do provide data and information to help

policymakers understand their nuances of their proposals that are pending in state houses. That usually involves some kind of a cost impact analysis if we're able to do it. And also we help policymakers understand consequences intended or otherwise. So let me point out a few of what I consider to be the hot topics at this point and some of this will be a little familiar to you as some issues have been tagged today but that's a California point of view and I'm going to bring it up about 40,000 feet because I do more than California and I want to give you a taste of what we're seeing nationally.

Single-payer health is one. Independent contractors, gig economy, marijuana legislation, hallucinogens and psychedelics are others. There can also be issues about PTSD, firefighter and first responder presumptive benefit bills. So there are 10 states that have legislation right now about single-payer healthcare or some states call it universal healthcare. It's the counterpart to “Medicare for all” at the federal level and what's important about that for workers compensation is - is it going to be included or excluded from a particular possible single-payer program? Some legislatures have put in studies for cost benefit analysis of what's going on with the ability to pay for such a program. As a former commissioner in a state that attempted this a while ago in Vermont, we understand the question of how are you going to pay for it? It didn’t pass then but we've got 10 states that are still trying to chew on that issue. Minnesota for example is saying that the medical expense portion is going to be included of workers comp but not the liability portion in what they're considering. In New Hampshire workers comp is not mentioned in their pending bill. Texas has committee conversations going on about what's going to relate to workers comp and group accident and health.

So one of the things I want to remind you through my comments is that when you hear of one state’s approach to workers compensation, keep in mind it's one state's approach. The nuances and differences among the states can be dramatic depending on many factors. Socioeconomic, geopolitical, the types of clusters of states around, and the jobs around the state. And so when you hear about California many of the issues are the same but the details often vary. I’m not going to talk too much more about independent contractors and the gig economy because as just noted we're in a bloody mess so we'll sort of leave it at that and just let me remind you that it's an important issue in workers comp because job classification is at stake. And risk is identified in workers compensation in jobs which then drives premiums so that's a very important thing to remember is that a job classification properly done then identifies the risk so that the carrier and the employer and the employee are all in sync with the correct coverage and the premium. Now let's turn to the fun part. So marijuana legalization, and that's both recreational and medical, but let's leave the recreational aside. That's a little bit too much fun today. And I just want to warn everybody that I still understand that marijuana is a class A schedule 1 drug that still is illegal at the federal level. That has not changed under the Controlled Substances Act but our states, you all got us out ahead of the federal government. So we have 22 states where medical and recreational marijuana is legal, 15 where it's med only, 10 where CBD or non psychoactive are legal. And then we have three states where it's all forbidden. So what's the issue for workers compensation right now? The issue is whether or not on the medical side medical marijuana is covered by workers compensation insurance. Should there be reimbursement for the use of medical marijuana? And if you think that the independent contractor and gig economy situation is a hot mess, just take a look at the legislation for marijuana. We've got many different versions of this around the country now. Kentucky has a bill pending where they're saying medical marijuana is not required to be covered.

Same with North Carolina. Massachusetts has a bill that says it does because in 2020 the state Supreme Court said in a case that neither the plain language of Massachusetts language or the regulatory environment required a carrier to reimburse for that expense.

Now you know why it's being debated in the legislature. And same with Maine. They're saying, no, not right now. But we've got a Connecticut review board that says wait a minute, perhaps a reasonable and necessary treatment would require that it be covered. So we've got situation at the federal level, situations at the state level, legislative issues, legal case issues. Somebody's got to start making some decisions here. So while we're on drugs let's stay on drugs. So hallucinogens and psychedelic legalization, that's a new one for us this year. We had not been following that very closely because it hadn't really been on the radar. So we now have 11 states that have legislation pending in some form about the legalization of psychoactives and it ranges everything from simple lawful possession and use of such things like LSD and mescaline. Natural medicine is what it's also called in Colorado. We also have simply legalization in states. Then we have a middle ground where we're seeing states allowing there to be supervised usage for medicinal and therapeutic purposes, physical and mental. And then we're seeing some states saying, well wait a minute I think we're going to put in some pilot programs so that we can evaluate the use and the results of those types of programs. Utah's the only state I've seen where the word workers compensation has been put into a bill and it's not what you think. It mentions that workers compensation may be a coverage that carriers can issue to a psilocybin production company. So it's to cover the employees that are working in the production and that happens similarly in Utah in a bill about covering workers who are in marijuana production plants and so that's the only place I've seen the workers compensation word.

But what's interesting about psychoactives is that in many ways this is one of the first breakthroughs in some research for things like severe depression and PTSD. And I said there was overlap, so talking about PTSD what we've seen is we've seen research coming from veterans who have been in supervised use of LSD for things like PTSD and severe depression with some very good results. And I think that this is people are saying this may be a new way for us to think about those very serious conditions and to help people who are in need. So stay tuned for that. Turning to firefighter and first responder presumptive bills, there's a lot of activity going on around the country right now for that and we've had firefighter presumptions since 1970 in some shape or form in many states but now it's not only firefighters but first responders as you heard about in California and the expansion of the types of conditions covered. We're knowing more about medicine and about health and about the causes and so we're seeing that is becoming something that the states are really taking on quite aggressively. I'm going to point you to our website. We've got a great deal of information there. We have an interactive map of all legislation around the country. All you have to do is hit your state or your next door neighbor's state and you'll see what's pending. We also have a white paper on firefighter and first responder presumption that you can take down that goes into great detail about that topic too.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Utke and seconded by Rep. Ryan Mackenzie (PA), the Committee adjourned at 12:30 p.m.

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NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)
Model Act on Workers' Compensation Coverage for Volunteer Firefighters
(with Drafting Note)

Adopted by the NCOIL Executive Committee on November 24, 2013, and by the Workers' Compensation Insurance Committee on November 21, 2013. Sponsored for discussion by Rep. Bill Botzow (VT)
Re-adopted by the NCOIL Workers' Compensation Insurance Committee on July 13, 2018 and the NCOIL Executive Committee on July 15, 2018

To be considered for re-adoption during the Workers' Compensation Insurance Committee on July 21, 2023.

Section 1. Purpose

The purpose of this Act is to establish a state definition of "public employment" that affords eligibility for workers' compensation insurance benefits when a volunteer firefighter performs firefighter-related duties that are not directly emergency response; mandates reporting of rosters and hours; and requires use of updated minimums for annual payroll.

Section 2. Short Title
This Act shall be known as the "Model Act on Workers' Compensation Coverage for Volunteer Firefighters."

Section 3. Definition of Public Employment*

"Public employment" includes the following:

A. municipal workers, including volunteer firefighters while acting in any capacity under the direction and control of the fire department

B. members of any regularly organized private volunteer fire department while acting in any capacity under the direction and control of the fire department

Drafting Note: The placement of the definition of "volunteer firefighter" will differ depending on the state law.

Section 4. Reporting of Rosters/Hours

A. The State Fire Marshal shall create a process to receive a roster of volunteer firefighter personnel on an annual basis. The roster must be submitted by the designated time, from each volunteer fire district in the state.

B. The roster shall include individual names and corresponding individual "total hours worked" for each volunteer firefighter.

C. "Total hours worked" means the total number of hours of each volunteer firefighter while acting in any capacity under the direction and control of the fire department.

D. Rosters collected by the State Fire Marshal shall be certified upon receipt and shall be made available to insurance carriers licensed to write workers compensation programs in this state or their designees upon request.

Section 5. Review of Minimum Payroll Basis

Notwithstanding any other provision of law, after review of losses and premium for volunteer firefighters in the state, every five years the Commissioner of Insurance shall prepare a regulation that will establish the minimum annual payroll per volunteer firefighter for the purpose of setting workers' compensation rates for the departments.

Section 6. Enforcement

The [insert applicable state agency] shall have enforcement authority as provided under [insert applicable statute].

Section 7. Effective Date

This Act shall take effect [insert months] after enactment.

* Based on Vermont S. 106, signed by Governor Peter Shumlin on May 16, 2012.

DRAFTING NOTE & APPENDICES

DRAFTING NOTE:

A state may wish to identify a funding source for volunteer firefighter workers' compensation insurance. Approaches that states have employed or considered include:

A. Private market mechanisms

1. Private insurers participate in an assigned risk pool that provides volunteer firefighter workers' compensation coverage. (Vermont)

B. State-based mechanisms

1. Volunteer fire departments may obtain workers' compensation insurance for volunteer firefighters through a group insurance pool administered by a state's non-profit workers' compensation insurance provider, and the state contributes $55 per firefighter per year to help defray premium costs, up to an annual state maximum for such expenditures. (Oklahoma: see Appendix 1, pages 1 to 2)

C. Subsidies

1. A $5 million premium subsidy fund, housed within a state auditor‘s office, helps to defray expected increases in premium costs for volunteer fire departments. (West Virginia: see Appendix 2, pages 3 to 4)

D. Surcharges

1. Coverage is purchased with a fee that each political subdivision pays based on a fixed-dollar value per ____ number of people served in a district. (North Dakota)

2. A state imposes a two percent tax on fire insurance premiums, which the state fire marshal uses to buy a single policy that covers all volunteer firefighters in the state, among other purposes. (Louisiana: see Appendix 3, pages 5 to 7)

E. Tax levies

1. Each county governing body would establish a special revenue fund, financed with a new county tax levy, to reimburse volunteer firefighter departments for their workers' compensation insurance premium costs. (Montana SB 54: see Appendix 4, pages 8 to 9)

APPENDIX 1 – STATE-BASED MECHANISM

Oklahoma

§85-132a. Workers' compensation insurance – Volunteer firefighters.

A. 1. Volunteer fire departments organized pursuant to state law may obtain workers' compensation insurance for volunteer firefighters through the Volunteer Firefighter Group Insurance Pool pursuant to requirements established by CompSource Oklahoma which shall administer the Pool. For the premium set by CompSource Oklahoma, the state shall provide Fifty-five Dollars ($55.00) per firefighter per year. Except as otherwise provided by subsection D of this section, the total amount paid by the state shall not exceed Three Hundred Twenty Thousand Three Hundred Thirty-eight Dollars ($320,338.00) per year or so much thereof as may be necessary to fund the Volunteer Firefighter Group Insurance Pool.

2. CompSource Oklahoma shall collect the premium from state agencies, public trusts and other instrumentalities of the state. Any funds received by CompSource Oklahoma from any state agency, public trust, or other instrumentality for purposes of workers‘ compensation insurance pursuant to this section shall be deposited to the credit of the Volunteer Firefighter Group Insurance Pool. CompSource Oklahoma shall collect premiums, pay claims, and provide for excess insurance as needed.

B. CompSource Oklahoma shall report, annually, to the Governor, the Speaker of the Oklahoma House of Representatives, and the President Pro Tempore of the State Senate the number of enrollees in the Volunteer Firefighter Group Insurance Pool, and the amount of any anticipated surplus or deficiency of the Pool; and shall also provide to the Governor, the Speaker of the Oklahoma House of Representatives and the President Pro Tempore of the State Senate sixty (60) days advance notice of any proposed change in rates for the Volunteer Firefighter Group Insurance Pool.

C. The amount of claims paid, claim expenses, underwriting losses, loss ratio, or any other financial aspect of the Volunteer Firefighter Group Insurance Pool shall not be considered when determining or considering bids for the amount of any premiums, rates, or expenses owed by, or any discounts, rebates, dividends, or other financial benefits owed to any other policyholder of CompSource Oklahoma.

D. Except as otherwise provided by law, any increase in the state payment rate for volunteer firefighters under the Volunteer Firefighter Group Insurance Pool shall not exceed five percent (5%) per annum. Any proposed change in rates for the Volunteer Firefighter Group Insurance Pool must be approved by the Board of Managers of CompSource Oklahoma with notice provided pursuant to subsection B of this section. CompSource Oklahoma shall not increase premiums for the Volunteer Firefighter Group Insurance Pool more than once per annum.

E. For purposes of this section, the term —volunteer fire departments includes those volunteer fire departments which have authorized voluntary or uncompensated workers rendering services as firefighters and are created by statute pursuant to Section 592 of Title 18 of the Oklahoma Statutes, Sections 29-201 through 29-205 of Title 11 of the Oklahoma Statutes, and those defined by Section 351 of Title 19 of the Oklahoma Statutes.

APPENDIX 2 – SUBSIDIES

West Virginia
§12-4-14a. Workers' Compensation Subsidy for Volunteer Fire Departments; creation of program;
Auditor to administer.

(a) For the purposes of this section:

(1) "Fiscal year" means the fiscal year of the state.

(2) "Individual base year premium" means the workers' compensation insurance premium that became due and payable by a volunteer fire department after June 30, 2010 but before July 1, 2011.

(3) "Individual premium" means the workers' compensation premium due and payable by a volunteer fire department in each twelve month period beginning on or after July 1, 2011.

(4) "Total base year premium" means the aggregate workers' compensation insurance premium due and payable by all volunteer fire departments as determined by the Insurance Commissioner after June 30, 2010 but before July 1, 2011.

(5) "Total premium" means the aggregate workers' compensation insurance premium due and payable by all volunteer fire departments in each twelve month period beginning on or after July 1, 2011.

(b) In recognition of the burden of increasing workers' compensation insurance premiums on volunteer fire departments, the Legislature has determined that additional funding assistance should be made available to eligible departments to pay a portion of those premium increases beginning with invoices due and payable on or after July 1, 2011.

(c) There is hereby established a special program which shall be known as the "Volunteer Fire Department Workers' Compensation Subsidy Program." The program shall be administered by the State Auditor from moneys that may be appropriated and designated for the program by the Legislature.

(d) The State Auditor shall administer the distribution of moneys appropriated for Volunteer Fire Department Workers' Compensation Subsidy Program to volunteer fire departments to help defray workers' compensation insurance premium increases.

(1) Volunteer fire departments shall request supplemental funds by submitting to the Auditor the following information:

(A) The previous fiscal year's workers' compensation premium invoices with paid receipts;

(B) The current fiscal year's workers' compensation premium invoices showing the amount due and due date and any applicable paid receipts; and

(C) Any other information the Auditor deems necessary for administering the subsidy on forms and schedules as the Auditor directs. The Auditor is authorized to set up an electronic filing system at his or her discretion for filing of the aforementioned information.

(2) After determining that there is a premium increase and the amount of the premium increase for the volunteer fire department requesting the subsidy, the Auditor shall make disbursements in the manner set forth in subsection (e) of this section subject to the following requirements:

(A) The volunteer fire department must be in good standing with the State Fire Marshal;

(B) The volunteer fire department must be registered with the Auditor's Office in a form and manner prescribed by the Auditor prior to being eligible for consideration of any subsidy, which registration must be completed no fewer than thirty days prior to the due date of the workers' compensation premium;

(C) The volunteer fire department must agree that the subsidy for its workers' compensation insurance premium increase will be paid directly to its insurance carrier by the Auditor and that it will timely pay the balance of the premium due; and

(D) Should a volunteer fire department fail to pay the balance of its workers' compensation insurance premium after a disbursement by the auditor and that insurance policy is subsequently cancelled, the premium paid by the Auditor shall be returned directly to him or her. If the Auditor does not receive a reimbursement for a cancelled policy, he or she shall seek reimbursement for the subsidy portion of the insurance premium from the State Treasurer when the treasurer makes the next quarterly payment to the volunteer fire department pursuant to sections thirty-three and fourteen-d, article three, chapter thirty-three of this code.

(e) Beginning with the fiscal year that starts July 1, 2011, and continuing in each fiscal year thereafter, after the Auditor has verified that a volunteer fire department is eligible for a subsidy pursuant to this section, he or she shall pay on behalf of a volunteer fire department its subsidy, which is calculated by:

(1) Dividing the total amount of premium subsidy allocated by the Legislature to the Volunteer Fire Department Workers' Compensation Subsidy Program by the total premium minus the total base year premium, which calculation produces the "total shortfall multiplier"; and

(2) Multiplying the total shortfall multiplier determined in subdivision (1) of this subsection by the individual premium less the individual base year premium.

(3) In no event shall a volunteer fire department receive a workers' compensation premium subsidy greater than one hundred percent of its premium increase.

(f) For fiscal years after July 1, 2011, the Auditor shall consult with the Insurance Commissioner to determine the total amount of workers' compensation premium due by volunteer fire departments for any subsequent fiscal year. The Auditor may determine payment dates based upon information reasonably available for such a determination.

(g) The Auditor may promulgate emergency rules and may propose for promulgation legislative rules, in accordance with the provisions of article three, chapter twenty-nine-a of this code, as are necessary to provide for implementation and enforcement of the provisions of this section.

(h) The volunteer fire departments' workers' compensation premium subsidy program shall undergo a review to assess its effectiveness after three years of operation. The Auditor shall submit a report to the Joint Committee on Government and Finance not later than February 1, 2015, and provide details of the program operation including funds distributed and departments taking advantage of the subsidy.

APPENDIX 3 – SURCHARGES

Louisiana
§347. Disposition of tax money

A. Monies collected under R.S. 22:342 through 349, after being first credited to the Bond Security and Redemption Fund in accordance with Article VII, Section 9(B) of the Constitution of Louisiana, shall be credited to a special fund hereby established in the

state treasury and known as the "Two Percent Fire Insurance Fund" hereinafter the "fund". Monies in the fund shall be available in amounts appropriated annually by the legislature for the following purposes in the following order of priority:

(1) (a) For the state fire marshal, an amount necessary to satisfy the requirements of R.S. 40:1593, relative to the purchase of group insurance for volunteer firefighters.

(b) For the state fire marshal, an amount necessary to satisfy the requirements of R.S. 23:1036, relative to the purchase of workers' compensation insurance for volunteer firefighters.

(2) (a) For the Fire and Emergency Training Institute at Louisiana State University at Baton Rouge for allocation to the Pine Country Education Center in the parish of Webster, the sum of seventy thousand dollars per year, which shall be transferred without imposition of administrative fee or cost, to be used to develop and operate a firefighter training center operated in accordance with the standards and requirements of the Fire and Emergency Training Institute at Louisiana State University at Baton Rouge.

(b) For the Fire and Emergency Training Institute at Louisiana State University at Baton Rouge for allocation to Delgado Community College, the sum of seventy thousand dollars per year, which shall be transferred without imposition of administrative fee or cost, to be used to develop and operate a firefighter training center operated in accordance with the standards and requirements of the Fire and Emergency Training Institute at Louisiana State University at Baton Rouge.

(3) For the Fire and Emergency Training Institute at Louisiana State University at Baton Rouge, the sum of seventy thousand dollars per year for support of the firefighter training program.

(4) For distribution to each parish governing authority in accordance with rules and regulations established by the state treasurer based upon the formula provided for herein:

(a) Except in Orleans Parish, the state treasurer shall pay over to the treasurer of each governing authority of the parish described in R.S. 22:343 the full amount of money due as determined by the state treasurer. These funds shall be allocated, distributed, and paid to each parish on the basis of a determination of the established population category of each parish as shown by the latest federal census or as determined by the Louisiana State University and Agricultural and Mechanical College Agriculture Center, Department of Agricultural Economics and Agribusiness, under the latest federal-state cooperative program for local population estimates. Such determination shall be submitted by the Louisiana State University and Agricultural and Mechanical College Agriculture Center, Department of Agricultural Economics and Agribusiness, to the state treasurer annually not later than January fifteenth of each calendar year. Any parish governing

authority which is aggrieved by such determination may file a petition for administrative review with the state treasurer not later than March fifteenth of each calendar year. The determination so submitted shall have no effect on the distribution for the fiscal year in which it is made, but shall be utilized for purposes of this Subpart for distribution during the next ensuing fiscal year as follows:

(i) Those regularly paid fire departments of an incorporated municipality or fire and waterworks district in any unincorporated municipality or active volunteer fire departments having a population within its geographical area of one to two thousand five hundred shall receive seven hundred fifty dollars per annum.

(ii) Those regularly paid fire departments of an incorporated municipality or fire and waterworks district in any unincorporated municipality or active volunteer fire departments having a population of two thousand five hundred one to five thousand shall receive one thousand dollars per annum.

(iii) Those regularly paid fire departments of an incorporated municipality or fire and waterworks district in any unincorporated municipality or active volunteer fire departments having a population of five thousand one or more shall receive one thousand two hundred fifty dollars per annum.

(b) Additional funds shall be distributed to each parish based on the following population formula:

(i) Where the population is twenty-four thousand or less, the parish shall receive thirty-four cents for each inhabitant.

(ii) Where the population is twenty-four thousand one to fifty-five thousand inclusive, the parish shall receive thirty-seven cents per inhabitant.

(iii) Where the population is fifty-five thousand one to one hundred thousand inclusive, the parish shall receive forty cents per inhabitant.

(iv) Where the population is one hundred thousand one to two hundred fifty thousand inclusive, the parish shall receive forty-four cents per inhabitant.

(v) Where the population is two hundred fifty thousand one to four hundred twenty-five thousand inclusive, the parish shall receive forty-seven cents per inhabitant.

(vi) Where the population is over four hundred twenty-five thousand, the parish shall receive fifty cents per inhabitant.

(c) Any balance which remains after making the distributions required in Subparagraph (b) of this Paragraph shall be allocated on an equal per capita basis until all of the available funds are utilized.

(d) If the total amount of monies available for distribution pursuant to Subparagraph (b) of this Paragraph is less than the one hundred percent required to fully implement such formula, the amount distributed shall be prorated equally among the formula categories by the state treasurer prior to distribution to each parish governing authority.

B. These funds shall be allocated, distributed, and paid by each parish governing authority to each regularly constituted fire department of the municipality or district, or active volunteer fire department certified by the parish governing authority, based on the population within the area serviced by said regularly constituted fire department of the municipality or district, or active volunteer fire department. In order to determine the amount of the funds which shall be paid to each fire department, district, or municipality, from the parish governing authority, the following formula shall be applied:

(1) Total population serviced by all certified fire units in the parish divided into the total monies received by the parish from this tax equals the per capita available for distribution to certified local fire units.

(2) Total population serviced by each certified local fire unit in the parish multiplied by the per capita available as determined by Paragraph (1) of this Subsection equals the funds due each certified local fire unit in the parish.

C. The distribution of the proceeds from the premium tax shall in no way be considered as a basis for reduction of any additional parish funds currently remitted to local fire units for the purpose of fire protection.

D. (1) All money received under the provisions of R.S. 22:342 through 349 by the treasurer of the governing authority of the parish shall, within thirty days from the time it is received, be paid over by the treasurer to the fiscal representative of the regularly constituted fire department of the municipality or district or active volunteer fire department, as the case may be. If any of these funds are not so distributed either by mutual consent or without consent of the regularly paid fire department of the municipality or district or active volunteer fire department certified by the parish governing authority, such funds shall be invested in an interest-bearing account and any accrued interest on the investment of funds shall be credited and distributed per capita to the regularly paid fire department of the municipality or district or active volunteer fire department, as provided by this Section.

(2) Such money shall be used only for the purpose of rendering more efficient and efficacious the regularly paid fire department of the municipality or district or active volunteer fire department, as the case may be, in such manner as the governing body shall direct.

E. In Orleans Parish the state treasurer shall pay over to the secretary-treasurer of the board of trustees of the Firefighter's Pension and Relief Fund of the city of New Orleans

all monies due shall be used only for the purpose of rendering more efficient and efficacious the pension system of the fire department of the city of New Orleans in such manner as the governing body of said pension fund shall direct as provided by law.

APPENDIX 4 – TAX LEVIES

Montana
SENATE BILL NO. 54 (as introduced 12-12-2012)

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. **Section 1. Workers' compensation for volunteer firefighters -- definitions.**
(1) As of July 1, 2014, an employer shall provide workers' compensation coverage as provided in Title 39, chapter 71, to any volunteer firefighter who is listed on a roster of service.

(2) An employer may purchase workers' compensation coverage from any entity authorized to provide workers' compensation coverage under plan No. 1, 2, or 3 as provided in Title 39, chapter 71.

(3) (a) Except as provided in subsections (3)(b) and (3)(c), an employer shall by the first Tuesday in September of each year certify to the county governing body the dollar amount of workers' compensation premiums paid or expected to be paid for the employer's volunteer firefighters' annual policy period.

(b) (i) By September 3, 2013, an employer not exempted under [section 3(6)] shall provide the county governing body with an estimate of the dollar amount anticipated as necessary to provide annual workers' compensation coverage, starting no later than July 1, 2014, for volunteer firefighters as provided in this section.

(ii) An employer that has provided volunteer firefighters with workers' compensation coverage with funding subject to the limitations in 15-10-420 may choose to provide coverage through the permissive levy allowed in [section 3] and, if that choice is made, shall base the estimated dollar amount under subsection (3)(b)(i) on actual coverage costs.

(c) An employer exempted under [section 3(6)] is not subject to the reporting requirements in this subsection (3) unless the employer requests funding under the permissive levy provided for in [section 3].

(4) The county governing body shall reimburse employers the actual costs as certified in subsection (3) for the workers' compensation coverage for volunteer firefighters from the fund established in [section 2].

(5) An employer shall file a roster of service with the clerk and recorder in the county in which the employer is located and update the roster of service monthly if necessary to report changes in the number of volunteers on the roster of service. The clerk and recorder shall file the original and replace it with updates whenever necessary.

NEW SECTION. **Section 2. Fund for volunteer firefighters' workers' compensation.** (1) Each county governing body shall establish a special revenue fund known as the volunteer firefighters' workers' compensation fund.

(2) Levies imposed pursuant to [section 3] must be placed in the fund.

(3) Expenditures from the fund may be made only to provide reimbursements to employers, as defined in [section 1], for workers' compensation premiums required by [section 1].

(4) Money in the fund must be invested as provided in 7-6-202. Interest and income from the investment of money in the fund must be credited to the fund.

NEW SECTION. **Section 3. County tax levy to pay volunteer firefighters' workers' compensation coverage.**
(1) Subject to subsection (6), the county governing body shall levy an annual property tax in the amount necessary to:

(a) fund premiums for workers' compensation for volunteer firefighters as provided in [section 1]; and

(b) establish a reserve in accordance with 7-6-4034(2)(a). ……

(6) Property located within the boundaries of any incorporated city or town that on or after July 1, 2014, provides workers' compensation coverage to employees as defined in 39-71-118 is not subject to the levy provided for in this section.

NEW SECTION. **Section 4. Public hearing requirement.** Each year prior to implementing a levy as provided in [section 3] and after giving notice of a hearing as provided in 7-1-2121, the county governing body shall hold a public hearing regarding implementation of the levy.

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NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

Model Act on Workers' Compensation Repackaged Pharmaceutical Reimbursement Rates

Model expanded and adopted by the NCOIL Executive Committee on July 14, 2013, and by the Workers' Compensation Insurance Committee on July 12, 2013.
Originally adopted by the committees on March 10, 2013, and March 9, 2013, respectively. Co-sponsored for discussion by Rep. Bill Botzow (VT) and Rep. Charles Curtiss (TN)
Re-adopted by the NCOIL Workers' Compensation Insurance Committee on July 13, 2018 and the NCOIL Executive Committee on July 15, 2018.

To be considered for re-adoption during the Workers' Compensation Insurance Committee on July 21, 2023.

Drafting Note: This model language is intended for inclusion in state insurance code or regulation related to workers' compensation medical fee schedules.

Section 1. Purpose

The purpose of this Act is to establish clear guidelines for reimbursement of repackaged pharmaceutical products in order to help reduce workers' compensation insurance costs.

Section 2. Short Title

This Act shall be known as the *"Model Act on Workers' Compensation Repackaged Pharmaceutical Reimbursement Rates."*

Section 3. Definitions

Drafting Note: Definitions for language in this Act would track definitions in [insert relevant workers' compensation statute].

Section 4. Reimbursement for Repackaged Pharmaceutical Products*

A. All pharmaceutical bills submitted for repackaged products must include the National Drug Code (NDC) Number of the original manufacturer registered with the U.S. Food &

Drug Administration (FDA) or its authorized distributor's stock package used in the repackaging process.

B. The reimbursement allowed shall be based on the current published manufacturer's Average Wholesale Price (AWP) of the product, calculated on a per unit basis, as of the date of dispensing.

Drafting Note: A state where a workers' compensation pharmacy fee schedule is already in place should use the following subsection B, in place of subsection B above:

B. The maximum reimbursement allowed shall be based on the current pharmacy fee schedule reimbursement methodology, utilizing the original manufacturer's NDC and corresponding Average Wholesale Price (AWP) of the drug product, calculated on a per unit basis, as of the date of dispensing.

C. A repackaged NDC Number shall not be used and shall not be considered the original manufacturer's NDC Number. If the original manufacturer's NDC Number is not provided on the bill, then the reimbursement shall be based on the AWP of the lowest priced therapeutically equivalent drug, calculated on a per unit basis.

D. The maximum period during which a provider may dispense a repackaged drug or over-the-counter (OTC) drug is seven days from the date of the employee's initial treatment.

E. The dispense fees otherwise provided in [insert relevant workers' compensation statute] shall be payable when applicable.

Drafting Note: Calculation of the AWP should be based on one or both of the universally accepted reporting databases, Medispan or Redbook, as selected by the payer.

Section 5. Enforcement

The [insert applicable state agency] shall have enforcement authority as provided under [insert workers' compensation statute].

Section 6. Effective Date

This Act shall take effect [insert months] after enactment.

* Based on provisions in TN Dept. of Labor & Workforce Development, Division of Workers' Compensation Rule 0800-02-18-.12

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National Council of Insurance Legislators (NCOIL)

Construction Industry Workers' Compensation Coverage Act

Approved by the NCOIL Executive Committee on November 22, 2009.
Re-adopted by the NCOIL Workers' Compensation Insurance Committee on July 13, 2018 and the NCOIL Executive Committee on July 15, 2018

To be considered for re-adoption during the Workers' Compensation Insurance Committee on July 21, 2023.

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Section 1. Summary

This Act mandates workers' compensation coverage in the construction industry, with certain exemptions; establishes auditing procedures; specifies liability; provides penalties for insurance fraud; and addresses enforcement powers.

Section 2. Definitions

A. "Employee" means any entity as defined by [Insert Applicable Reference to State Definition].

B. "Employer" means any entity as defined by [Insert Applicable Reference to State Definition].

C. "Partner" means any person as defined by [Insert Applicable Reference to State Definition].

D. "Principal Contractor" and "subcontractor" mean any entity as defined under [Insert Applicable State Agency].

E. "Sole proprietor" means any entity as defined under [Insert Applicable Reference to State Definition].

Section 3. Coverage Requirements

A. Every person engaged in the construction industry, including principal contractors, intermediate contractors and subcontractors shall be required to carry workers' compensation insurance, regardless of the number of employees, unless exempted as indicated in subsections (C) and (D).

Drafting Note: States may want to consider the cost impact of this subsection on sole proprietors and self-employed small contractors. Options to consider include exemptions for individuals with high-quality health insurance plans, the use of deductibles to bring down insurance costs, and monthly premium payment plans.

B. For purposes of this Section, "a person engaged in the construction industry" means any person or entity assigned to the Contracting Group as those classifications are designated by the rate service organization designated by the [Insert State Department of Insurance].

Drafting Note: For the purposes of this Act, the [Insert State Department of Insurance] could use standard industrial classification codes and the definitions thereof developed by the National Council on Compensation Insurance (NCCI) and the U.S. Department of Labor Bureau of Labor Statistics (BLS) North American Industry Classification System (NAICs) codes to meet the criteria of the term "construction industry" as set forth in this Act.

C. A sole proprietor or partner engaged in the construction industry shall not be required to carry workers' compensation on themselves if they are doing work directly for the owner of the property pursuant to Section 3(D), but shall be required to carry workers' compensation insurance on any subcontractor, employee or worker not otherwise covered by a policy of workers' compensation; however, if a sole proprietor or partner is working as an intermediate contractor or subcontractor then workers' compensation insurance shall be required on themselves.

D. The provisions of this Section shall not apply to individuals performing work on their own property. As used in this subsection (D), an individual is a natural person.

Drafting Note: States may want to look to state definitions of employer, employee, and existing treatment of homeowners on residential projects to avoid duplicating and conflicting language.

Section 4. Liability

A. Every principal contractor shall be responsible to ensure that any subcontractor with which it directly contracts is either self-insured or maintains workers' compensation

coverage throughout the periods during which the services of a subcontractor are used and, further, if the subcontractor is neither self-insured nor covered, then the principal contractor rather than the [Insert State Uninsured Employer Fund], if applicable, should be responsible for the payment of statutory benefits.

B. If an employee of a subcontractor suffers an injury or disease and, on the date of injury or last exposure, his or her employer did not have workers' compensation coverage or was not an approved self-insured employer, and the principal contractor did not obtain certification of coverage from the subcontractor, then that employee may file a claim against the principal contractor for which the subcontractor performed services on the date of injury or last exposure, and such claim shall be administered in the same manner as claims filed by injured employees of the principal contractor, provided that an intermediate subcontractor that subcontracts with another subcontractor shall, with respect to such subcontract, become the principal contractor for the purposes of this section.

C. 1. The contractor and subcontractor shall provide proof of continuing coverage to the principal contractor throughout the term of the contract between the contractor and subcontractor by providing a certificate showing current as well as renewal or replacement coverage during the term of the contract between the principal contractor and the subcontractor.

2. A subcontractor who allows coverage to lapse because of non-payment during a contract but fails to notify a contractor under Subsection (C) becomes liable to the injured employee and subject to all recovery of payments, plus administrative costs and attorneys' fees.

D. 1. If a claim of an injured employee of a subcontractor is accepted or conditionally accepted into the [Insert State Uninsured Employer Fund], if applicable, both the principal contractor and subcontractor are jointly and severally liable for any payments made by the [Insert State Uninsured Employer Fund], and the [Insert State Insurance Commissioner] may seek recovery of the payments, plus administrative costs and attorneys' fees, from the principal contractor, the subcontractor, or both.

2. A principal contractor who is held liable pursuant to this subsection for the payment of benefits to an injured employee of a subcontractor may recover the amount of such payments from the subcontractor, plus reasonable attorneys' fee and costs.

Section 5. Employer/Contractor Disclosure Requirements

A. Employers shall make available to their workers’ compensation insurance carrier all records necessary for the payroll verification audit and permit the auditor to make a physical inspection of the employer's operation.

B. A principal contractor may require a subcontractor to provide evidence of workers' compensation insurance.

C. An insurance carrier may require each employer to submit a copy of the quarterly earning report at the end of each quarter to the insurance carrier and submit self-audits supported by the quarterly earnings reports and the rules adopted by the state agency providing unemployment tax collection services. The reports must include an attestation by an officer or principal of the employer attesting to the accuracy of the information contained in the report.

D. A principal contractor may require a subcontractor to be able to produce on demand at their principal place of business information required by Section 5(B).

Section 6. Payroll Audit Procedures

A. In no event shall employers in the construction class, generating more than the amount of premium required to be experience rated, be audited less than annually. A minimum of ten percent of employers in the construction class that do not generate more than the amount of premium required to be experience rated will be inspected annually and audited, if necessary. The annual audits required for construction classes shall consist of physical onsite audits.

B. Payroll verification audit rules must include, but need not be limited to, the use of state and federal reports of employee income, payroll and other accounting records, certificates of insurance maintained by subcontractors, and duties of employees.

C. Upon conclusion of an employer audit, the insurance carrier shall report to the [Insert State Workers' Compensation Department or Appropriate Agency] any unresolved employee or independent contractor misclassification, any uncovered or unreported employees, and any other violation of this Act.

Section 7. Penalties

A. For the purposes of this section, "securing the payment of workers' compensation" means obtaining coverage that meets the requirements of Section 3. However, if at any time an employer materially understates or conceals payroll, materially misrepresents or conceals employee duties so as to avoid proper classification for premium calculations, or materially misrepresents or conceals information pertinent to the computation and application of an experience rating modification factor, such employer shall be deemed to have failed to secure payment of workers' compensation and shall be subject to the sanctions set forth in this section.

B. In addition to any other penalty prescribed by this section, the department shall assess against any employer who has failed to secure the payment of compensation as required by Section 3 a penalty equal to 2 times the amount the employer would have paid in premium when applying approved manual rates to the employer's payroll during periods for which it failed to secure the payment of workers' compensation required by this section within the preceding 3-year period or $750, whichever is greater.

C. 1. Any person that knowingly submits an initial application, renewal application, or certificate of insurance as proof of coverage, that is false, forged, misleading, or incomplete information for the purpose of avoiding or reducing the amount of

premiums for workers' compensation coverage is subject to a civil penalty, per violation, not less than [Insert Applicable Amount].

2. In determining intent, the [Insert Appropriate State Agency] shall consider whether a person or organization in a similar size and type of business could reasonably be expected to understand that information being submitted was false or likely to mislead. In assessing the amount of the civil penalty, the [Insert Appropriate State Agency] shall consider any one or more of the relevant circumstances presented by any of the parties to the case, including, but not limited to, the following:

a. the nature and seriousness of the misconduct;
b. the number of violations;
c. the persistence of the misconduct;
d. the length of time over which the misconduct occurred;
e. the willfulness of the defendant's misconduct; and
f. the defendant's assets, liabilities, and net worth.

3. The [Insert Appropriate State Agency] may also require, as civil penalty, that the entity repay any compensation received through such violation, with interest at the rate of [Insert Applicable Percentage].

Drafting Note: States can insert references to existing criminal penalties in their workers' compensation or insurance fraud codes.

D. 1. Whenever the [Insert State Workers' Compensation Department or Appropriate Agency] determines that an employer who is required to secure the payment to his or her employees of the compensation provided for by this Act has failed to secure the payment of workers' compensation required by this Act or to produce the required business records under Section 5 within five (5) business days after receipt of the written request of the [Insert State Workers' Compensation Department or Appropriate State Agency], such failure shall be deemed an immediate serious danger to public health, safety, or welfare sufficient to justify service by the [Insert State Workers' Compensation Department or Appropriate State Agency] of a stop-work order on the employer, requiring the cessation of all business operations. If the [Insert State Workers' Compensation Department or Appropriate State Agency] makes such a determination, the [Insert State Workers' Compensation Department or Appropriate State Agency] shall issue a stop-work order within 72 hours.

2. In addition to serving a stop-work order at a particular worksite which shall be effective immediately, the department shall immediately proceed with service upon the employer which shall be effective upon all employer worksites in the state for which the employer is not in compliance; provided that, if the employer cannot be found and served under due diligence the department may execute service by publishing the stop work order for one week in a news publication having general circulation in the [names of cities] metropolitan areas.

3. A stop-work order may be served with regard to an employer's worksite by posting a copy of the stop-work order in a conspicuous location at the worksite.

The order shall remain in effect until the [Insert State Workers' Compensation Department or Appropriate State Agency] issues an order releasing the stop-work order upon a finding that the employer has come into compliance with the coverage requirements of this Act and has paid any penalty assessed under this section.

4. The [Insert State Workers' Compensation Department or Appropriate State Agency] may issue an order of conditional release from a stop-work order to an employer upon a finding that the employer has complied with coverage requirements of this section and has agreed to remit periodic payments of the penalty pursuant to a payment agreement schedule with the [Insert State Workers' Compensation Department or Appropriate State Agency]. If an order of conditional release is issued, failure by the employer to meet any term or condition of such penalty payment agreement shall result in the immediate reinstatement of the stop-work order and the entire unpaid balance of the penalty shall become immediately due.

5. The [Insert State Workers' Compensation Department or Appropriate State Agency] may require an employer who is found to have failed to comply with the coverage requirements of Section 3 to file with the [Insert State Workers' Compensation Department or Appropriate State Agency], as a condition of release from a stop-work order, periodic reports for a probationary period that shall not exceed 2 years that demonstrate the employer's continued compliance with this section. The [Insert State Workers' Compensation Department or Appropriate State Agency] shall by rule specify the reports required and the time for filing under this subsection.

E. Stop-work orders and penalty assessment orders issued under this section against a corporation, partnership, or sole proprietorship shall be in effect against any successor corporation or business entity, including spouses, that has one or more of the same principals or officers as the corporation or partnership against which the stop-work order was issued and are engaged in the same or equivalent trade or activity.

F. It shall be unlawful for any person to knowingly violate a stop-work order issued by the [Insert State Workers' Compensation Department or Appropriate State Agency] and it is punishable as a felony of the third degree.

G. The [Insert State Workers' Compensation Department or Appropriate State Agency] shall assess a penalty of not less than $1,000 per day against an employer for each day that the employer conducts business operations that are in violation of a stop-work order.

H. Any agency action by the department under this section, if contested, must be contested as provided in [Insert State Chapter Relating to Judicial or Administrative Review].

Section 8. Enforcement

The [Insert State Workers' Compensation Department or Appropriate State Agency] shall have the authority to enforce the requirements of this Act.

Drafting Note: States may wish to consider the following enforcement provisions:

A. The [Insert State Workers' Compensation Department or Appropriate State Agency] shall enforce workers' compensation coverage requirements, including the requirement that the employer secure the payment of workers' compensation, and the requirement that the employer provide the carrier with information to accurately determine payroll and correctly assign classification codes. In addition to any other powers under [Insert State Statute], the [Insert State Workers' Compensation Department or Appropriate State Agency] shall have the power to:

1. Conduct investigations for the purpose of ensuring employer compliance.

2. Enter and inspect any place of business at any reasonable time for the purpose of investigating employer compliance.

3. Examine and copy business records.

4. Administer oaths and affirmations.

5. Certify to official acts.

6. Issue and serve subpoenas for attendance of witnesses or production of business records, books, papers, correspondence, memoranda, and other records.

7. Issue stop-work orders, penalty assessment orders, and any other orders necessary for the administration of this section.

8. Enforce the terms of a stop-work order.

9. Levy and pursue actions to recover penalties.

10. Seek injunctions and other appropriate relief.

B. The [Insert State Workers' Compensation Department or Appropriate State Agency] shall designate representatives who may serve subpoenas and other process of the [Insert State Workers' Compensation Department or Appropriate State Agency] issued under this Act.

C. The [Insert State Workers' Compensation Department or Appropriate State Agency] shall specify by rule the business records that employers must maintain and produce to comply with this Act.

D. Any law enforcement agency in the state may, at the request of the [Insert State Workers' Compensation Department or Appropriate State Agency], render any assistance necessary to carry out the provisions of this section, including, but not limited to, preventing any employee or other person from remaining at a place of employment or job site after a stop-work order or injunction has taken effect.

E. The [Insert State Workers' Compensation Department or Appropriate State Agency] shall adopt rules to administer this section.

Drafting Note: States could use part or all of penalties in Section 7 to offset enforcement and other expenses incurred by the implementation of this Act.

Section 9. Severability

If any section, paragraph, sentence, clause, phrase, or any part of this Act passed is declared invalid, the remaining sections, paragraphs, sentences, clauses, phrases, or parts thereof shall be in no manner affected and shall remain in full force and effect.

Section 10. Effective Date

This Act shall take effect immediately.
Drafting Note: States would benefit by comparing data from different state agencies, e.g. Unemployment and Workers' Comp Departments, to help identify problem employers.

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NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

Model Act Regarding Workers' Compensation Insurance Coverage in Professional Employer Organization (PEO) Relationships

Readopted by the Executive Committee on November 24, 2013 and by the Workers' Compensation Insurance Committee on November 21, 2013.
Originally adopted by the Executive Committee on November 17, 2007, and by the Workers' Compensation Committee on November 15, 2007. Sponsored by Sen. Carroll Leavell (NM)
Re-adopted by the NCOIL Workers' Compensation Insurance Committee on July 13, 2018 and the NCOIL Executive Committee on July 15, 2018

To be considered for re-adoption during the Workers' Compensation Insurance Committee on July 21, 2023.

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Section 1. Short Title

This Act may be called the Model Act Regarding Workers' Compensation Insurance Coverage in Professional Employer Organization (PEO) Relationships.

Section 2. Purpose

The purpose of this Act is to require the registration of professional employer organizations (PEOs) and to regulate the use of experience ratings for workers' compensation insurance in PEO relationships.

[Drafting Note: This model is specifically designed to address the registration and use of experience ratings by PEOs in workers' compensation insurance. Some states may wish to address additional PEO rights and responsibilities, or require PEOs to be licensed.]

Section 3. Definitions

A. “Client” means any employer that enters into a Professional Employer Agreement with a PEO.

B. “Covered Employee” means an employee of the Client whose employment responsibilities are shared between the Client and a PEO.

[Drafting Note: Workers’ compensation law governs whether or not the PEO is considered to be an employer of an individual for workers’ compensation purposes. States must determine if a PEO agreement is consistent with the law.]

C. “Direct hire employee” means an individual who is an employee of the Client and who is not a Covered Employee.

D. “Professional Employer Organization” or “PEO” means an entity or group of entities that offers professional employer services in this State under a PEO agreement.

1. An entity engaged in the business of entering into professional employer agreements, as defined herein, is acting as a PEO regardless of its use of other terms such as “staff leasing company,” “registered staff leasing company,” “employee leasing company,” “administrative employer,” or any other name.

2. A PEO does not include:

a. temporary help services (an entity that recruits and hires its own employees; assigns them to clients on a temporary basis to support or supplement the Client’s work force in special work situations such as employee absences, temporary skill shortages, and seasonal workloads; and customarily attempts to reassign the employees to other clients when they finish each assignment) or

b. independent contractor arrangements

[Drafting Note: This definition establishes a single regulatory category and terminology for these entities, regardless of the terminology used by the parties. In particular, this category of “PEOs” is intended to encompass what was once commonly referred to as “employee leasing firms.” Therefore, states with existing laws governing employee leasing should repeal those laws to the extent that they are superseded by this Model Act or otherwise obsolete, and should update the terminology and substance of any remaining provisions as necessary.]

E. “Professional employer agreement” or “PEO agreement” means an agreement between a PEO and a Client under which the PEO agrees to assume specified employment responsibilities for all or part of the Client’s work force.

F. “Insurer” means an insurance company authorized to do business in this State.

G. “Designated advisory organization” means the entity designated by the [insurance

authority in the state] for the reporting of claims and experience data and for the administration of the workers' compensation experience rating system.

Section 4. Registration Requirements

A. A PEO shall be registered as a Professional Employer Organization with the [insert appropriate state agency]. An insurer may not issue a workers' compensation insurance policy to a PEO that is not registered, nor enter into an agreement with an unregistered PEO to issue policies to Clients of the PEO.

B. An applicant shall file an application for registration with the [insert appropriate state agency] on a form approved by the [insert appropriate state agency] accompanied by a [insert application and fee amounts].

[Drafting Note: Requirements including PEO registration information, timeframe of the initial registration, and renewal procedures should be consistent with existing state law, if any. States that do not currently have statutory PEO registration requirements may wish to review requirements codified by other states.]

Section 5. General Rules

A. The responsibility to obtain workers' compensation coverage for Covered Employees in compliance with all applicable law shall be specifically allocated in the Professional Employer Agreement to either the Client or the PEO. If such responsibility is allocated to the PEO under any such agreement, the agreement shall require that the PEO maintain and provide workers' compensation coverage for the Covered Employee from an insurer authorized to do business in this State, for as long as the agreement is in effect.

B. The Client is responsible for maintaining workers' compensation insurance for the Client's Direct Hire and Covered Employees, either through a PEO agreement for covered employees or through an authorized insurer doing business in this state. The PEO agreement shall not relieve the Client of its responsibility for demonstrating compliance with this State's workers' compensation statute. A policy that excludes coverage for the Client's Direct Hire Employees shall not be accepted as proof of coverage pursuant to Section [insert appropriate reference to proof-of-coverage statute] of the Workers' Compensation Act.

C. A PEO may only provide workers' compensation benefits through a policy written by a licensed insurer. The licensed insurer shall be responsible for the payment and administration of all workers' compensation claims.

Section 6. Experience Rating

A. Workers' compensation insurance premiums with respect to any Client for which a PEO performs services shall be determined based on the experience modification factor of the Client, provided that the Client has sufficient workers' compensation premium volume to be experience rated. The Client's experience modification factor shall be based on exposures and claims for both Covered and Direct Hire employees of the Client. Otherwise the premiums shall be at the rate approved by [insert

appropriate state agency] for an employer that cannot be experience rated.

[Drafting Note: A state may consider that alternative rating mechanisms could be permitted as long as the PEO and insurer are in agreement and both the clients and the integrity of the experience rating system are protected.]

B. The PEO shall maintain separate payroll records and separate records of work-related injuries and illnesses for each Client company and shall report these in a timely and ongoing manner to its insurer.

C. The insurer shall report all loss and payroll information to the designated advisory organization in a manner approved by the commissioner [or other state official if appropriate] that identifies the Client and allows the calculation of an accurate experience rating for the Client on an ongoing basis.

D. Within 60 days after the termination of a PEO agreement, the PEO shall provide the Client with records regarding the payroll and loss experience related to workers' compensation insurance provided to Covered Employees.

Section 7. Severability

If any section, paragraph, sentence, clause, phrase, or any part of this Act passed is declared invalid, the remaining sections, paragraphs, sentences, clauses, phrases, or parts thereof shall be in no manner affected and shall remain in full force and effect.

[Drafting Note: States should consider whether to include rulemaking authority for the appropriate state agencies as part of this Act.]

Section 8. Effective Date

This Act shall take effect on [insert date].

NCOIL – NAIC DIALOGUE MATERIAL

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
NCOIL – NAIC DIALOGUE COMMITTEE
SAN DIEGO, CALIFORNIA
MARCH 10, 2023
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) NCOIL – NAIC Dialogue Committee met at The Westin San Diego Gaslamp Hotel on Friday, March 10, 2023 at 1:30 p.m.

Representative Deborah Ferguson, DDS, of Arkansas, NCOIL President, Co-Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Rod Furniss (ID)
Sen. Travis Holdman (IN)
Rep. Matt Lehman (IN)
Rep. Brenda Carter (MI)
Sen. Lana Theis (MI)
Sen. Michael Webber (MI)
Sen. Paul Utke (MN)
Asw. Pam Hunter (NY)
Sen. Bob Hackett (OH)

Other legislators present were:

Sen. Jesse Bjorkman (AK)
Sen. Justin Boyd (AR)
Rep. Denise Ennett (AR)
Sen. Ricky Hill (AR)
Rep. Reginald Murdock (AR)
Asm. Tim Grayson (CA)
Sen. Win Stoller (IL)
Sen. Robert Mills (LA)
Rep. David LeBoeuf (MA)
Del. Nic Kipke (MD)
Rep. Kristian Grant (MI)
Sen. Mark Huizenga (MI)
Rep. Mike McFall (MI)
Rep. Helena Scott (MI)
Rep. Cameron Parker (MO)
Sen. Nellie Pou (NJ)
Sen. Jeremy Cooney (NY)
Asm. Jarett Gandolfo (NY)
Rep. Tim Barhorst (OH)
Rep. Forrest Bennett (OK)
Rep. Mark Tedford (OK)
Rep. Ryan Mackenzie (PA)
Rep. Jim Dunnigan (UT)

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), NCOIL Secretary, the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Matt Lehman (IN), NCOIL Immediate Past President, and seconded by Sen. Hackett the Committee's November 18, 2022 meeting in New Orleans, LA.

INTRODUCTORY REMARKS

Rep. Ferguson stated that before we get started I just want to note how great it is to again see such a large number of Commissioners attending our conference. We're now reaching the point where this type of large group of Commissioners in attendance is becoming the norm and I think that's great for each of our respective organizations. The high turnout of Commissioners recently is an observable manifestation of our improved relationship throughout the years. We may not always agree on every issue but we can disagree agreeably. Rep. Ferguson then asked all of the participating Commissioners to introduce themselves: Missouri Director and National Association of Insurance Commissioners (NAIC) President Chlora Lindley-Myers; Idaho Director and NAIC Immediate Past President Dean Cameron; Alaska Director Lori Wing-Heier; Arkansas Commissioner Alan McClain; Kansas Commissioner Vickie Schmidt; Louisiana Commissioner Jim Donelon; Montana Commissioner Troy Downing; Oklahoma Commissioner Glen Mulready; and Utah Commissioner Jon Pike

THE RETURN OF THE SYSTEMICALLY IMPORTANT FINANCIAL INSTITUTION (SIFI) DESIGNATION?

Rep. Ferguson stated that the first item we want to discuss is the return of the SIFI designation. As part of the overall effort to avoid a repeat of the 2008 financial crisis the Dodd-Frank Act created the Financial Stability Oversight Council (FSOC) and gave it the ability to designate certain financial institutions including insurers as systemically important. From the beginning serious concerns were raised surrounding the designation process as it relates to insurers since the designation subjected certain insurers to capital and regulatory requirements that were bank-centric and not rooted in an understanding of how the U.S. state-based system of insurance regulation functions pursuant to the McCarran Ferguson Act. Additionally the designation process was flawed because neither state insurance regulators or legislators had voting authority. After the financial crisis AIG, MetLife and Prudential were the designated insurance company entities but they have all since been de-designated. Recently there have been some FSOC meetings, some held behind closed doors, during which a topic of conversation was whether or not to bring back the designation. Does the NAIC know whether or not this revival will move forward and what is the NAIC's position?

Dir. Lindley-Myers stated that at this point the NAIC does not know if that will move forward but we recognize as FSOC members our participation over the years through our representative who is currently Rhode Island Superintendent Beth Dwyer has enabled us to further cultivate relationships with our federal counterparts regarding the financial regulatory community and when we're looking at that and looking at the issues that are there the NAIC continues to believe that traditional insurance activities do not pose a systemic threat to the financial system. We consistently underscore the efficacy of state insurance regulation and its strong record of protecting generations of policyholders. Us and our individual states working with our legislative colleagues is paramount to making sure that we are holding prudential financial issues and regulations

at the core of our individual state of regulation in hand. We don't need any assistance from the federal government. We continue to always work with our banking and financial counterparts. Going forward, it's important that you understand that the movement to go away from SIFI's as far as the designation, in December of 2022 the financial stability board or FSB announced the discontinuation of annual identification of globally systemic important insurers or GSI's recognizing that the activities based in each individual state is at the approach of the International Association of Insurance Supervisors (IAIS) holistic framework committee and it provides more than an effective basis for addressing any systemic risk. We will continue to advocate in Congress for federal regulations to provide the state insurance regulatory representative with a vote on FSOC. Presently we don't have a vote. As I had mentioned earlier Supt. Dwyer is a non-voting member and as the primary regulators of the insurance sector we have the necessary expertise that is needed and we've informed FSOC of that and that we are monitoring their work and that we don't believe that this is something that should come back. But we will through the NAIC and our individual states continue to actively engage with FSOC on this issue as well as broader issues from a regulatory perspective and make sure that they understand that we have this matter well in hand.

Dir. Cameron stated that it's important to stress something that Dir. Lindley-Myers said - we are the state's seat on FSOC, the insurance commissioners, but we are a non-voting member. We've asked Congress multiple times to be a voting member and said that the states should have a voting seat on FSOC. We would certainly invite NCOIL to endorse that idea or support that idea because I think it benefits both you as legislators in your states as well as us in the regulatory community.

UPDATE ON ENHANCED CASH SURRENDER VALUE (ECSV) DEVELOPMENTS

Rep. Ferguson stated that the next issue is an update on ECSV developments. We've been discussing this issue for over a year now and it culminated with NCOIL adopting a resolution last summer identifying certain ECSV products as violating the Standard Nonforfeiture law. That resolution is on the website and it's also in your legislative binders on page 87 if you wanted to refer to that. Since that time the sponsor of that resolution, Sen. Travis Holman (IN), NCOIL Immediate Past President, introduced a bill in Indiana essentially codifying in statute what he was calling for in his resolution. That bill serves as the basis for the NCOIL Life Insurance is a Promise for Life Model Act (Model), also sponsored by Sen. Holman, which will be discussed later today during the Life Insurance and Financial Planning Committee. The Model can be viewed in your binder on page 138. We're aware that NAIC's A committee has been dealing with this issue and a survey has been sent to state insurance departments for reply with information on each respective department's interaction with certain ECSV products. Can you share with us the results of the survey? And what plans does the NAIC have going forward with this issue?

Cmsr. Mulready stated we took the NCOIL resolution and with my urging along with Ohio Insurance Director Judi French who's the Chair of the A committee, we put this survey out there. There are some basic questions such as have you had applications received in your office for that form? If so, who are the companies? If so, who were those offerings to? If so, how many offers were accepted or received there? We don't have that report completed yet. It's being put into a more user-friendly readable version as we speak but that was put out in October. We are in the midst of doing that. There's been

some action taken. Part of the problem is that no state has specific action on that issue as it stands today. Illinois did come out with a bulletin basically stating that their position was it did not violate the smoothness factor for universal life. I took action in Oklahoma where we basically notified the industry we would not be approving any going forward and then asked those four companies who did have filings in our state to stand down and not make any additional offerings. They were very well received. I heard from a number of them and they totally understood and they are doing exactly that, standing down. I know Louisiana has some action taken and Indiana as well took some action. Those are the four individual states that I'm aware of. I will tell you in the big scope of all that and with the results of that survey, it's a really small issue. I think at most and from what I have seen we've received survey responses from about 35 folks that have responded to that. There have been maybe 20 offerings accepted nationwide amongst all the states for those that have been offered. And there's been offerings of 600 from one company and maybe four or five accepted there. And as far as I know only in two states have offers been accepted at this point. In Illinois, the bulletin there basically just said that the smoothness factor did not impact flexible premium universal life. Part of the problem I think is that some of these standards that were put out with the NAIC and the actuarial task force, we're talking about 1980 and universal life was really just coming into play and so I'm not sure how much of that was contemplated. But I'll flip it over to Cmsr. Donelon to talk about what Louisiana has done.

Cmsr. Donelon stated that as noted by Cmsr. Mulready, we have taken action on this by rescinding company form approvals for that activity, three of which voluntarily said they would discontinue marketing those products and using those policy forms that had been approved back in 2019. A fourth, Lincoln National, has filed an appeal to our Division of Administrative Law and that is ongoing in appeal as we speak. I spoke to my Deputy Commissioner this morning about the recently raised issue of retroactivity which frankly we had not considered. We rescind policy forms not all the time but it's not unusual to find that one of our policy form people made a mistake and approved the policy form ten years ago or five years ago that's out there and being utilized. I don't think this was a mistake as such but it certainly was or is a difference of opinion by me as a regulator versus whoever the commissioner was back when those forms were approved. I very much agree that this is a prohibited discriminatory practice and based on that as well as some activity at the NAIC level looking into the issues surrounding this I withdrew my approval. And as I said the three companies that agreed have stood down in that activity but it's not in my judgment an issue of looking back. We did tell the companies we have no intention of taking action to penalize them for having done this in the past and certainly the consumers who accessed it are happy they have their check and are at home. So with that said from my perspective it's a go forward issue only.

Cmsr. Mulready stated that for those new to the issue, basically this is about life insurance companies making offers for a substantially increased cash surrender value that could be 400% of what the actual cash surrender value is at that time. And the folks that have really pushed back against it is the life settlement folks because basically what they're stating is they're doing life settlements and just calling it something different. And in the life settlement world there are consumer protections in place. You've got to have a physician involved, you've got rescission rights, that sort of thing, and that isn't happening in this place so those consumer protections are missing which is what we in the regular world are most concerned about. And I might add through that survey and

nationally we have received no complaints about any of these that have been accepted or offered.

Sen. Hackett stated that I totally agree with what you're doing but one thing to remember and I'm surprised you're not dealing with relates to universal life and the product is only universal life. When I owned a company I had all these policies that were going to blow up 10 to 15 years and because of Tax Equity and Fiscal Responsibility Act (TEFA) guidelines and the IRS guidelines they can't just drop the policy in half and double the premium. I can show you case after case where all they can do maybe is drop it 10-15% and that's not going to really change that much. And some of these people even if they wanted to pay more they've gone over the guidelines of what they could pay in the policy so could they literally say “hey it's probably better for the consumer to cash the policy in now if we incentivize them to do it then to wait when the policy blows up?” I didn't realize it's only on universal life. We have major problems based on that law. We used to sell universal life and I had a case where they put $100,000 in it and the death benefit was only $150,000. We gave the individual his money back in two years and there was enough cash in the policy he ended paying a little more later to run the policy without paying anything. And the IRS said that’s not a life insurance product, it’s a tax deferred product. I agree. They changed the law and I agreed with that but now we’ve got a lot of middle class people that want to have one policy in place there between 75 and 85 years old and their universal life is blowing up and I agree you should reduce it below the minimum issue of the policy but they can't reduce it to say 50% or 60% of the value because it's TEFRA or IRS guidelines of what they're allowed to put in that policy. So I don't disagree with what you're doing, but maybe they're trying to protect the consumer to cash that policy in before it blows up in 10 years. It isn't two or three, I've probably got 50 policies of a group that I took over and they were replacement artists I agree there. They replaced all this whole life on the concept we can double your insurance, same out of pocket. That’s all they did. And of course it was based on 9% and 10% interest rates. I was in the business at that time and I made the client sign a form that if it averaged under 6% it would blow up, it wouldn't make it, even though we were paying 10% and 11%. So I just want to see the reaction from you all on what about all these policies that are blowing up and the people aren't real happy to lose their life insurance.

Cmsr. Mulready thanked Sen. Hackett and stated that is really good feedback and something else for us to consider. It's similarly related to this. And I don't have a great response for you except thank you for bringing that to the forefront. I was with John Hancock at that same time, licensed in 1983, so we're both showing our age, but thank you that feedback. Cmsr. Donelon stated that my only comment would be that I've been dealing with that issue for 15 years and some more aggressive investors as you describe felt the pain in the impossible situation they found themselves in a decade ago. Has anyone done anything that's been effective to address or to solve the problem? I don't think regulation can fix it, I really don't. Sen. Hackett stated that we need the fed’s to fix it - we can’t fix it. All they have to do is say you can drop the policy in the situations I described and they have to change those guidelines based on the people's age and the shape of the policy but they want one set of rules for everybody. And I understand why they did what they did. They were not life insurance policies. But if you’ve been in the business, you know how many of those we have on the books and they’re going to keep blowing up over the next 15 years. Cmsr. Donelon stated that I was not in the business but you're right and I've seen it happening already but it is only going to get worse.

Perhaps our organizations should work together to advocate for a resolution to Congress asking them to fix the problem.

Rep. Ferguson asked Sen. Holman if he would like to comment on his Model on this issue. Sen. Holdman thanked Rep. Ferguson for raising the issue which is a good one and one that I plan on addressing during the Life Insurance Committee's meeting later today. I think there's a misunderstanding by some who view the Model as asking for the Commissioners to rescind existing agreements that have been entered into between the consumer and the insurer. That's not the case and frankly couldn't be the case as we couldn't be pushing ourselves in between the insurance company and the client for fear of a contractual interference. The Model is only asking for the commissioner to rescind the regulatory approval of the form on a go forward basis so that doesn't impact any existing contracts. If the language needs to be tweaked in the Model to make that more clear I'm happy to work on that. When I filed the legislation in Indiana, I quickly got a response from one of the companies that was in the practice of doing the enhanced surrender value offer and we came to an agreement that I would not advance the bill there as long as we continue our discussion and so hopefully the NAIC and we as an organization ourselves can come forward with recommendations and some resolution to the problem.

DISCUSSION ON ISSUES RELATING TO TRIBAL INSURERS

Rep. Ferguson stated that we'll move on to the next topic which is issues relating to tribal insurers. The NAIC American Indian and Alaska Native Liaison Committee has been doing a lot of interesting work regarding insurance issues specific to tribal nations. We're also aware of a survey that was conducted by that committee relating to the growing insurance markets and business models of certain tribal insurers. Can you share with us the results of the survey and what plans if any the NAIC has going forward with regard to these issues?

Cmsr. Downing stated that first a little bit of background about the Committee you mentioned. Fundamentally that's there for consumer protection and access to markets and that's why that committee exists and I think we did a lot of good work on that last year. I'm personally very proud of the work that committee achieved in creating documents on cultural awareness and on communicating between non-tribal and tribal members. We did a document on access to Affordable Care Act (ACA) plans. We did another one on lessons learned during the pandemic. So we produced some interesting information back then and one of the things that came up while I was chairing that committee is we received a complaint actually that was in Maine about Sovereign Nations Insurance and when we first heard about that I'd reached out to Sovereign Nations to see if they were willing to present to the committee, which they did and we were happy to see that happen. And so just a little bit of background for people to understand what Sovereign Nations Insurance is. It's a consortium of three tribes in Utah and they've created an insurance company that right now is doing health insurance but they've made it clear that they plan on looking at other lines as well and so they've also created a regulatory body that's the Sovereign Nations Health Consortium (SNHC). And then finally they have a non-profit association called the Native American Restoration Association and the premise of what they're doing is they made it very clear that they plan on selling policies on reservation and off reservation to enrolled members of tribes and non-enrolled members. Their general counsel came in and presented to us

and he made very clear that they consider non-tribal members as part of their community and intended to sell them policies as well. And one the interesting things about the way they're doing this is they have this I mentioned Native American Restoration Association which is a non-profit that they say does a lot of work in supporting Native American and Indigenous population issues.

But you need to join that association and thereby agree to be bound by the tribal law rather than the state law and on its surface this seems to fly in the face of McCarran-Ferguson and so we've got a lot of issues on how to deal with that and I think that's going to be something bigger than the individual states. So we did do a survey on getting responses from states and we're still getting information about that and trying to put that together. Some of the interesting cases is the State of Washington has put a cease and desist in place to stop them from selling these products in Washington. I know there's some other states that are looking closely at that to try to figure out what it is but I'm going to go back to my main theme that I started with which is there's a consumer protection issue. These plans are being marketed as ACA plans and they're not. They don't have the same protections, they don't have the same coverages and we're particularly concerned about the consumer protection issue there. And I'm going to hand this off to Cmsr. Mulready because I understand he just had a recent meeting related to this.

Cmsr. Mulready stated that I dug into this issue as well when that came about in Oklahoma as our state has a lot of Tribal Nations within our borders – 39 federally recognized tribes. And I met Wednesday of this week with their executive team. They flew out to Oklahoma and we sat down and Cmsr. Downing has covered most of it. The thing that I think wasn't stated that needs to be clearly stated is they believe they operate fully outside of the state regulatory environment- that as a Sovereign Nation they do not have to abide by state law or our state insurance departments and so that's concerning. They did mention to me specifically that when I asked about other insurance coverage that they were very much moving next into burial insurance and small life insurance policies to cover burial items. As they described how they were structured, which I already knew because I was in that meeting in Portland and I knew how they had this SNHC which is their regulator and then they had a wholly owned subsidiary that was an insurance company. And I asked them if they thought that was odd that the regulator would own an insurance company and that didn't strike them as odd as it did me. But at any rate, we did ask them about that and they are moving forward. They were very, very pleasant and we're trying to figure out a way that they could work with us. We didn't really have a lot of common ground to offer them. We said “if you want to do business in Oklahoma this is the path” and I think they were being educated a bit on the path working within the NAIC. But we did finally talk about McCarran-Ferguson which is pretty direct that it's left to the states when it comes to insurance. It was interesting their response, it was that since McCarran-Ferguson was silent on tribes they felt like Federal Native American law overruled that or superseded that on that point so it was an interesting take on that.

Cmsr. Downing stated that one of the things that they've been doing is reaching out to certain states trying to work on memorandums of understanding to operate in those states and I think Utah was one of those states. Cmsr. Pike stated that's what they've been touting. They're basically saying that they would consider doing an agreement or a compact with any state that would like to do that. On the other hand it doesn't mean that

they would be subject to state law is what they're saying. And in the absence of that kind of agreement, they're basically saying we're prepared to go it alone. And they acknowledge, and my colleagues all remember them saying this, that this may well end up at the U.S. Supreme Court or in Congress because of as Cmsr. Mulready said, the absence maybe of specifics in McCarran- Ferguson or other federal law. So it's going to be interesting. I don't know how many of you have watched the Netflix series Stranger Things but it's kind of a parallel universe of insurance that's started, albeit small, about 9,000 members. And because these folks are literally my neighbors, quite literally as their counsel lives about ten miles from my house. I think good intentions are there but it's unique.

Cmsr. Mulready stated that we've focused on this one group but I think this issue as a whole is a big issue for us. I just became aware this week that there was an op-ed in our Oklahoma City newspaper by someone who is the head of a tribe in Oklahoma who has been licensing captives and he wrote an op-ed about it so that's how we became aware of it so we will be investigating that but I just think this is a growing issue across the board. Cmsr. Downing stated that to put a bow on that, obviously we have a number of concerns but the first one is just the consumer protection issue as we have folks selling unlicensed products in our states with what we've seen as somewhat misleading and we just want to make sure that we deal with that appropriately because consumer protection is obviously very high on our list of concerns.

Rep. Ferguson asked if there are any examples of maybe where it was inappropriate insurance like lifetime limits or monthly limits where people thought they had coverage and they didn't? And my second question, is are they in any way tied into the Indian Health Service (IHS)? Cmsr. Downing stated that they're not tied into HIS and we actually had a Commissioners meeting not too long ago where we just looked at some of their marketing videos and the one that stood out to me was they had a program for mental health where you went onto a waiting list until you got a meeting with a chatbot so that's some of the stuff that's in there. There was also and I don't remember the exact details but there was some mentioning of pre-existing conditions being covered a certain percentage of the first year and a higher percentage of the third year and a higher percentage of the fourth year so it was like phasing in coverage of pre-existing conditions. There were a lot of deficits like that. Rep. Ferguson stated that I think I heard you say they are not just covering Native Americans but other individuals as well with sort of unregulated insurance. Cmsr. Downing replied that's correct.

Dir. Wing-Heier stated that when we were at the same meeting our counterpart in Colorado has a claim that he's working on with regards to a consumer complaint and an individual with one of these plans went into the emergency room and was told this was an ACA compliant plan only to be not admitted when he went to the emergency room. And because this person was not admitted they denied the whole claim and he now has a bill for several thousand dollars. It's that type of thing that we're trying to protect consumers from. It's a fine line of what we're trying to do in working with consumers in our states on these plans that we don't have authority over. Cmsr. Mulready stated that I do know too that in Massachusetts, my old home state, they've had a number of complaints on this group and there's one in particular there's an article in the Boston Globe about a similar incident that you just heard about here. A woman presented it to the emergency room I want to say a $20,000 claim and had no coverage for that too.

DISCUSSION ON DEVELOPMENT OF NAIC'S NEW CONSUMER PRIVACY PROTECTION MODEL LAW

Rep. Ferguson stated that next we're going to discuss the development of the NAIC data privacy model law. The NAIC is working to amend its Insurance Information and Privacy Protection Model Act and its Privacy of Consumer Financial and Health Information Regulation with the end result being a new NAIC Consumer Privacy Protection Model Law. The proposed amendments you can find on page 90 of your binders. We understand that the NAIC Privacy Protection Working Group recently exposed for comment the first draft of the model law. Can you provide us with an update as to what led to the NAIC opening up these models as well as a summary of the proposed amendments and what the timeline is for possible adoption by NAIC?

Dir. Lindley-Myers stated that what led to it is the fact that the models hadn't been updated since the late 1980s/early 1990s and everything has changed since then so that's why we were trying to sort of tidy up both models you mentioned and perhaps combine the two because there were things that were in the model that were basically outdated that you'd have to put things in newspapers or things like that and it didn't take into account that you can send it electronically and how you can do that sort of thing. So the intent of the draft model is to promote uniformity amongst all the states to get the state consumer data protection laws sort of united so that on a state by state basis it makes it easier for the insurers and the industry to operate across state lines if our legislators would put that into action. With our draft we've attempted to modernize and streamline consumer data privacy notifications and disclosures. With respect to the third party service providers, that was not a big deal back necessarily back when the models were developed so we're trying to make sure that is out there. It also includes providing consumers with clear information about their rights regarding consent to use their data and the sale of their personal information and transparency and the details of adverse underwriting decisions. We wanted to make sure that most of the language in this new model was drawn from the NAIC's existing privacy models through new concepts which were incorporated in legislation that have been passed recently in all of the various states. The deadline for this exposed draft model is coming up for April 3rd. We're hoping to have all of that information into us by that timeline. The working group is working diligently and looking forward to hearing from stakeholders and others who are engaged in further discussions on how we can develop it to something that could be utilized not only by regulators but also by the industry and consumers. So we want to make sure that everyone's voice is heard and that people understand what's going on especially in light of the fact that there have been data breaches and people's information has been exposed.

Rep. Ferguson asked if Sen. Paul Utke (MN), NCOIL Secretary, had any comments on this issue. Sen. Utke stated that tomorrow during the Financial Services and Multi-Lines Issues Committee, there will be a discussion on the Virginia privacy law in contemplation of using that as a starting point for the development of an NCOIL data privacy model act. We're still in the early stages of that process as a decision hasn't been made yet as to whether to proceed or not but either way the overall topic of data privacy and in the insurance context what insurers can and cannot do with consumers data is so important that we at NCOIL feel we need to be discussing it in some manner. After the discussion tomorrow we will evaluate whether to move forward or not with a model act on that issue. I do have a question for the Commissioners - since we'll be discussing Virginia's

law tomorrow, do the NAIC's proposed amendments to its models have any similarity with Virginia's law or do they conflict in any way with Virginia's law? Dir. Lindley-Myers stated that since the chair of the working group is from Virginia it's in line with the Virginia law but there may be some conflicts with other state laws and that's why we want to flesh this out and make sure that everybody has a stake in it and note that maybe we need to soften this or build this up. So that's the purpose of having this ongoing conversation.

Rep. Lehman stated that in Indiana we just passed the Virginia model out of the Senate and I am the House sponsor of that bill, SB 5. So in going through that, what was interesting to me is seeing the pieces of that puzzle that allow someone to ask if they are using my data and that allow them to be able to correct adverse data. But one thing it allows for is I can ask to be exempt. So are we on some form of a collision course here? If I want my data to not to be used by an insurance carrier how does that play now into their models of underwriting using much more artificial intelligence? That's the thing is I see in that Virginia model is there's a lot of protections for the consumer which I fully support but I think it might run counter to what the industry is doing as a whole and we'll ask the industry this question tomorrow. Do you as the regulators see pieces within that Virginia model that would actually be in conflict now with what some carriers are doing? Dir. Lindley-Myers stated that I would have to answer yes that I see that it would be in conflict but the hope is that we could try to smooth it out and I'm not sure how we can do that such that it would allow people because it's your personal information, if you choose to exclude it then I don't know how the companies can utilize it especially if it's a whole bunch of us that's one side of the other, I don't know how they could actually utilize that data in order to create rates using artificial intelligence. And so that is a bone of contention that we'd have to look at and try to exercise in or out how we were going to do that and how we're going to display that. So I do think that there are issues that are going to collide and I think our jobs as regulators is try to figure out how to minimize that or eradicate it if we can.

Rep. Forrest Bennett (OK) stated that I'm excited about this conversation that we're going to have tomorrow on this issue and in Oklahoma where I am from we've had conversations the last couple of years over data privacy and sort of the overarching concern of the opponents of it at the state level is we understand that there is an issue ultimately of a patchwork of laws across the country is not the solution and you all have spoken to that already. The other alternative to adopting a model law across the country is a federal solution and I know none of us are holding our breath for that but I wonder if any of you have had conversations with anyone at the federal level about whether there is any inkling of an idea of doing that at the federal level? Dir. Lindley-Myers stated that I would say the answer to that is yes so that's why it's important for us to get together legislators as well as the regulators to come up with something that works because we know our states the best. So we've got to come in and get to a point where we can all get together on that to say "hey we know what's going and you're sitting in D.C. and you don't know what's happening in our individual states so let us come together and try to come up with something that will be amenable to all of our constituents and all of our states so that you don't need to get involved." Cmsr. Mulready stated to Rep. Bennett that I think the answer is if we don't, they will.

Rep. Lehman stated that my last comment on this is on this side of the table we hear a lot about the things you're working on - are these models available for us to look at as

well? Dir. Lindley-Myers stated that yes, the proposed amendments have been exposed and they are on our website.

PREVIEW OF ENVIRONMENTAL, SOCIAL, AND GOVERNANCE (ESG) GENERAL SESSION

Rep. Ferguson stated that as you likely know NCOIL announced last month the special series of general sessions to be held throughout NCOIL's 2023 National meetings focusing on ESG policy. The series will be co-facilitated by Asw. Pam Hunter (NY), NCOIL Treasurer, and Rep. Tom Oliverson, M.D. (TX), NCOIL Vice President. The goal of the series is strictly educational and will bring together a wide range of experts to address the challenges and opportunities presented by all different types of ESG public policy. The first session of the series will be held immediately following this Dialogue and will serve as an introduction to ESG with a substantive focus on environmental policy. We plan to address environment, then social, then governance at three different sessions. We know the NAIC doesn't have a formal ESG position and neither does NCOIL but we are interested in hearing about the work of your Climate and Resiliency Task Force and the opt-in insurer climate risk disclosure reporting requirement. That survey can be found on page 93 in your binders. Can you share with us the plans for the task force for this year and beyond?

Dir. Cameron stated that if I might first just take a matter of personal privilege. First of all, thank you this morning for the recognition. I've enjoyed being with this group of Commissioners who have seen how important it is to work with NCOIL and I have been at a lot of meetings. I want to thank you for the relationship and give a special thanks to Cmsr. Tom Considine, NCOIL CEO, and to Rep. Ferguson and to Rep. Lehman who have worked really well with the NAIC over the last year. And I can remember the first NCOIL meeting I attended as a state senator was in Boston and the insurance commissioner sat at that table by herself and it was not a nice meeting as this one is and so we've come a long way and we recognize that we want to work with you. We need to work together. And as you said at the beginning, there are going to be times where from a legislative perspective something that we're doing doesn't make sense and there are going to be times where it's the other way but the more we can communicate and talk about those issues and work through them at least you know where we're coming from and you can then make those decisions.

And we have to handle difficult decisions such as the one that I'm going to talk about now. So let me just say that climate natural disasters, access to coverage, and resiliency have been NAIC priorities and remains such under Dir. Lindley-Myer's leadership. We are working very diligently to work to close gaps in coverage. It is interesting to me as we work in the international market where we're seeing lots of gaps of coverage and yet some of the regulatory decisions help create those gaps. We continue to advocate for a long-term National Flood Insurance Program (NFIP) and allowing us to have a more robust private flood insurance program. We stood up this last year the Catastrophe Modeling Center of Excellence which allows the NAIC and our commissioners to gather a lot of data and information that will help us make appropriate decisions. We are doing much work through the task force that you asked about and one of our leaders in that task force is Dir. Wing-Heier so I'm going to turn it over to her to address that and after she's through we'll ask Cmsr. McClain to talk about solvency work stream.

Dir. Wing-Heier stated that as Dir. Cameron noted, I am co-chairing the task force this year along with California Insurance Commissioner Ricardo Lara. I'm also the NAIC representative to the Sustainable Insurance Form (SIF) at the United Nations (UN). There's many things we are working on and we're finding more and more that we're walking a fine line in dealing with some of these topics. Certainly as you can see on our website that is now live with a page dedicated to resources, we're looking at building codes and land use and we're working with consumers on mitigation efforts. We're also dealing with local state and federal regulators and legislators on consumer incentives and resiliency funding and we continue to work with almost anybody that'll talk to us on looking at other solutions to deal with the catastrophic losses that have been felt if it's wildfires, if it's the storms, if it's the droughts. Even my own state had a typhoon north of the Arctic Circle last year so we all recognize the change to the climate and our need to help the insurers stay solvent to help reduce these losses. It's the thing to do. But we also recognize when we talk about gaps in insurance not only is it hard to find property coverage in many states right now we are also finding it very hard for some of our contractors to find insurance. And why is this important? Well it's important because the heat that comes to your home be it gas or home heating fuel, the same companies that are also looking at risks and their own ESG programs are stepping away from insuring those entities and it is creating a hardship for many contractors. Our thoughts and our goals are to work on a transition that insurance will still be available so that we have fuel in our cars and that we have home heating fuel so when you turn on the on button on your oven if you have natural gas there will be something at the other end. As we go forward we have found that we cannot shut it off all at once. So we're working very hard to work with reinsurers and insurers to admit that we have to have a transition off of carbon base. We don't want to leave the planet worse than we found it. So our emphasis is in recognizing these storms that have happened and the wildfires and the devastation that they have caused, but also saying that we have to have a plan to walk away. And we're not there yet. And the gap is not just the property market which several of my colleagues here can tell you what has happened in their home states and many of you know, but it's also the products that we get from oil, gas, coal and other natural resources that we still need until we have an alternative source.

Cmsr. McClain stated that I'll move to giving a brief report on the solvency work stream and a point of personal privilege, it's a great honor to have Rep. Ferguson from Arkansas as President NCOIL. I also chair the Property and Casually (C) Committee at NAIC where some of the issues regarding access to different lines of insurance come up and some of these matters will often be a topic at the C committee. But with regard to the solvency work stream I want to give a quick report. Our solvency work stream has been exploring and receiving stakeholder input on potential enhancements to the existing regulatory solvency tools that we all use in our departments and to the tools that address climate risk in particular. So last year the workstream recommended that modifications to the NAIC's Financial Analysis handbook, the Financial Condition Examiner's handbook and Own Risk and Solvency Assessment (ORSA) Guidance Manual be considered by the appropriate NAIC groups. So specific to wildfires, the work stream recommended that a wildfire peril be added to the risk-based capital framework for catastrophe risk exposures. That recommendation was adopted and beginning this year the property casualty risk-based capital E working group will require companies for informational purposes only to annually report their modeled wildfire risk. So that'll be good data to collect. This will help to ensure that companies are adequately reserving

the capital necessary to maintain their financial condition when wildfires do occur. After collecting the data for a couple years and measuring against benchmarks then the NAIC will consider an appropriate capital charge to be applied. Based on recommendation from the solvency work stream the risk-based capital E working group is now looking into collecting modeled losses on severe convective storms for informational purposes only. So since the summer national meeting the solvency work stream has hosted several panel discussions to understand the various approaches to the scenario analysis including panelists from several financial organizations as we look at different models.

Dir. Lindley-Myers stated that I do want to make sure that you understand that the NAIC's EX Committee on Race and Insurance is still working. The special committee and its work streams are focused on closing the protection gaps for underrepresented and minority communities by addressing any barriers to access and expanding any opportunities in the insurance sector. At the NAIC's fall meeting in Tampa in December, the special committee unanimously adopted the recommendations that regulators and industry representatives can follow to improve upon their diversity and inclusion efforts. One of the issues is it's not a number counting, it's not I had three yesterday and tomorrow I have four. It is more what are they doing on a systemic level of trying to increase diversity in their ranks which is women, people of color, people with disabilities and the like. In the committee we're looking at all underrepresented areas. We've adopted various recommendations which you can find on the special committee website. This some of the committee's work streams will renew their focus on looking at each individual area and what can be done to enhance the process of trying to get more people into the insurance industry as well as what barriers might exist that we might be able to look at and overcome.

Dir. Cameron stated that first I want to recognize Dir. Lindley-Myers who was just recognized and awarded for her efforts on race and insurance. She's been a dynamic leader there for years and was just recognized. One of the things that the NAIC did at the start of last year is we started to stand up the NAIC foundation which stands for New Avenues in Insurance Careers and it's desire is to help people get into the insurance career model. Not into the agent model which I love but it's into being actuaries and examiners and all of those highly technical areas. We have a shortage in the regulatory regime of those people of those talents and we know the industry has a shortage. We also know that there are lots of folks of different races, different ethnicities, and different genders who have not been able to access that pathway and our goal is to do that. We have a board that has been set up and is established and has completed the bylaws. We've filed to the IRS for approval. We will be putting forth our communications and we'll certainly keep you informed on that and we are also in the process of a survey in the states to see how many would accept different internships because it's not only scholarships but internships and apprenticeships that we will push forward to get people into that pathway.

Lastly, I just want to thank NCOIL and your efforts in engaging in a thoughtful process. You always as an organization put forth the thoughtful process whether we're talking about private equity or in this case at this meeting ESG. We recognize and I know that you recognize we're in a hardening market. In the last two years our market has become more and more difficult and it's becoming more difficult particularly in some rural states but really everywhere. It's also becoming difficult because of the items Dir. Wing-Heier talked about but also because of the reinsurance industry and some of the

pressures that's on the reinsurance industry with regard to ESG. So the only thing that I would respectfully ask is that because we know almost every state is dealing with some ESG legislation, we'd love to know about it and would ask you to work with the insurance commissioners because the last thing we want to do although you will set the public policy, is get down the stream and have less carriers offering coverages to our businesses and our families because of some policy that was passed. So we stand ready to work with you and to make sure that doesn't that doesn't occur.

Rep. Ferguson stated that right after this Dialogue Asw. Hunter is going to facilitate a whole session on ESG so I don't want to steal her thunder but this is obviously a very contentious topic and it's very difficult among states to reach a consensus on this issue. We're not going to have model legislation at NCOIL on ESG, we just want to present an open discussion of ideas and make people aware of both sides of the issue. And there is already ESG legislation going on in most states. I know Arkansas already passed some form of ESG legislation around investment banking and here we want to have a polite discussion around it. The next topic we were supposed to discuss is the NAIC's model bulletin on issues relating to artificial intelligence but we've run out of time so we'll hold that over until the summer meeting.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Hackett and seconded by Sen. Holdman, the Committee adjourned at 2:45 p.m.

LIFE INSURANCE & FINANCIAL PLANNING COMMITTEE MATERIAL

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
LIFE INSURANCE & FINANCIAL PLANNING COMMITTEE
SAN DIEGO, CALIFORNIA
MARCH 10, 2023
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Life Insurance & Financial Planning Committee met at The Westin San Diego Gaslamp Hotel on Friday, March 10, 2023 at 5:00 p.m.

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

Other members of the Committee present were:

Rep. Deborah Ferguson, DDS (AR)
Sen. Mark Johnson (AR)
Rep. Matt Lehman (IN)
Sen. Travis Holdman (IN)
Sen. Michael Webber (MI)
Asm. Ken Blankenbush (NY)
Sen. Bob Hackett (OH)

Other legislators present were:

Sen. Jesse Bjorkman (AK)
Sen. Justin Boyd (AR)
Rep. Denise Ennett (AR)
Sen. Ricky Hill (AR)
Asm. Tim Grayson (CA)
Rep. Rita Mayfield (IL)
Sen. Robert Mills (LA)
Sen. Mark Huizenga (MI)
Sen. Lana Theis (MI)
Sen. Paul Utke (MN)
Rep. Cameron Parker (MO)
Sen. Nellie Pou (NJ)
Sen. Jeremy Cooney (NY)
Rep. Ryan Mackenzie (PA)

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. Michael Webber (MI), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Matt Lehman (IN), NCOIL Immediate Past President, and seconded by Sen. Hackett the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's November 17, 2022 meeting in New Orleans, LA.

INTRODUCTION AND DISCUSSION OF NCOIL LIFE INSURANCE IS A PROMISE FOR LIFE MODEL ACT

Rep. Anderson stated that we'll start by discussing the Life Insurance is a Promise for Life Model Act (Model), sponsored by Sen. Travis Holdman (IN), NCOIL Immediate Past President. A copy of that model is on the website and the app and is in your binders on page 138. Also, in your binders immediately following the Model on page 141 is a Resolution that was sponsored by Sen. Holman and adopted by NCOIL last summer which served as one of the driving forces behind the Model. We will not be voting on this Model today as it's being introduced and discussed for the first time. Before hearing from our speakers today I'll turn things over to Sen. Holman for some introductory remarks.

Sen. Holdman stated that this Model deals with two issues that may at first glance appear to be wholly unrelated but when offered in the right context you'll see the connection. Both issues are contained in the one Model because they each deal with a long-term often lifetime commitment of life insurance underwriting. The first issue deals with recent enhanced cash surrender value (ECSV) endorsements. Generally speaking, these type of products change the term of well-seasoned policies by incentivizing certain consumers to terminate policies in their death benefit protection in exchange for limited time enormous increases in cash surrender value in plain violation of the Standard Nonforfeiture law. These products also carry substantial risk of the same sort as a regulated product they mimic, life settlements, but the carriers who offer them do not follow the consumer protection statutes created by legislators to protect policyholders such as rescission rights, intermediary fiduciary duty, physician certification of consumer competence, and disclosure of competing alternatives. Before turning to the second part of the Model let me say that the Model does not impact enhanced cash surrender provisions offered at the time of initial contracting. Why the industry called two totally different items by the same name is beyond me.

The second issue deals with the relationship between insurers and genetic testing information. The Model permits an insurer to require disclosure of any information known to the applicant that is pertinent to the longevity risk posed by the insured including genetic information resulting for any screening or testing. The insurer should be able to know what the applicant knows and that seems fair. However, the Model makes clear that the policy can't be underwritten on the basis of a requirement that the applicant or insured individual undergo genetic testing or screening and the issuance of a life insurance policy can't be conditioned on the requirement that the applicant or insured individual undergo genetic testing or screening. Taken together these two issues relate to the life insurance principle that similar risks must be treated similarly and that only after following certain laws can changes be made to an existing policy. I've introduced a bill in my home state of Indiana that essentially mirrors this Model. While I have paused my Indiana bill from moving forward with the goal of reaching a compromise with some of the carriers offering these new cash surrender products, I want to keep the conversation going here at NCOIL in order to stay engaged with the issues and ensure that it doesn't drop off the radar. After this meeting I look forward to discussing with staff as to what the next steps will be.

One final note, I mentioned it during the NCOIL-NAIC Dialogue a few hours ago and I want to repeat it here for anyone that was not present at the Dialogue and to ensure it's part of this Committee's record. With regard to section four of the Model, I think there's a misunderstanding by some who view the language as asking for the Commissioner to

rescind existing agreements that have been entered into between the consumer and the insurer. This is not the case and frankly couldn't be the case as that would get us into some constitutional issues surrounding interference of contracts. The Model is only directing the Commissioner to rescind the regulatory approval of the forms on the going forward basis so that doesn't impact any existing contracts. If the language needs to be tweaked in the Model to make this more clear I'm happy to work to do that.

Karen Melchert, Regional VP, State Relations at the American Council of Life Insurers (ACLI) thanked the Committee for the opportunity to speak and thanked Sen. Holdman for his comments that he recognizes that there may be some confusion with the way this Model was drafted with respect to retroactive application and we appreciate his willingness to work with us on that language. I will say we do have some other issues with the language as drafted and that has been communicated with Sen. Holman based on his proposal in Indiana and we would look forward to the opportunity to work with him to address the consumer protection concerns that you have. We do think that the use of these types of endorsements following consumer protection requirements are helpful for the consumer and offers them choices and we would like to preserve the ability to offer enhancements to the policies in ways that are protected for the consumer and are transparent and according to the laws that are on the books today. So we look forward to working with you as we move forward both on your proposal in Indiana and here at NCOIL. We do not have any problems with the second half of your proposal here.

The Hon. Nat Shapo, former Illinois Insurance Director and speaking now on behalf of the Life Insurance Settlement Association (LISA), thanked the Committee for the opportunity to speak and stated that LISA has advocated for review of these enhanced cash surrender offers which we believe implicate the Standard Nonforfeiture law as has been discussed. And also I'd like to point out that one of the reasons NCOIL was most interested in the standard nonforfeiture law was it's an example of kind of a systemic NCOIL concern about the National Association of Insurance Commissioners (NAIC) amending a model law and coming to the legislators and insisting that it be changed and the legislators say, "okay, we're going to take this at face value and do this for you" and then the concern being having made a big deal about passing the laws and then finding out that they're not being enforced or if other models are being pursued while this is being implemented. And so that was the issue here with the Standard Nonforfeiture law that it was something that was changed in the Model, it was asked to be changed by the NAIC and then the question was asked of whether it's being implemented. But I think it's important to realize there's also an unfair discrimination law issue which is a fundamental consumer protection law that goes back long before that's also in play here. The basics are if you and I are identical risks and we get the same we buy the same policy on the same day and pay the same premiums for 15 years, and then yesterday you surrender for $50,000, or an example we've used and it was a real life example - you surrender for $19,000 and I didn't surrender yesterday because I was busy making my case at the NCOIL meeting to everybody I could find and then I get an offer in the mail tomorrow for $360,000 and I accept it. Then you and I have paid the same, we're identical risks, we pay the same premiums for 15 years and you've gotten $19,000 and I've gotten $360,000. It's a rhetorical question - how would you feel about that?

I got paid 18 times as much as you did for the same price – it's a basic unfair discrimination issue. And the same thing on the back end, if we both got offers and I took mine at $360,000 but then you had an issue that you weren't sure you could accept

it, the offer period expires and then you want to surrender and you can't get the $360,000 anymore, it's the same thing of I've got 18 times the benefits for the same premiums. So, that's the Unfair Discrimination law and the Standard Nonforfeiture law and some of this requirement is attempting to get to the same thing but they're both independent bases for concern. Regarding the Model, the ACLI I think correctly likes the second part of the Model but to me the two parts of the Model both spring from the same issue and as ACLI has testified they said insurers underwrite or assess the risk only once, that is at the time of the application. Once underwritten the price and the terms cannot be changed. That was in testimony here a few years ago. If life insurance is different, and there's multiple other instances where the life companies have said we're different from property & casualty (P&C), we're different from health insurance. We get one chance to set the terms of the contract and we live with those terms for 50 years which is why I agree that they should have access to all the information that the insured has which is the second part of the Model. But the flip side of that is if you're going to argue we deserve these protections because we can't change the terms of the contract and we underwrite once and we have to live with our underwriting, well if that's the case then you can't 15 or 20 years into a policy parachute in and radically change the method of calculating cash surrender value. Both of those ideas spring from the same idea - life insurance terms are set at application and issuance and they're set for 50 years and they don't change. Therefore, the second part of the Model states life insurers need full information but the first part of the Model when it becomes convenient they can't change the terms. And there's a consumer protection issue there because if they change the terms 15 years in then everybody who's surrendered the first 15 years had no opportunity for that big enhancement. So that's our basic position and we greatly appreciate the time to explain it and we appreciate Sen. Holdman's consideration and his rigorous review of these issues.

Rep. Anderson stated that after hearing the discussion today, I'm sure that everyone can get together before we come to the Summer Meeting and hash this out so that we can be ready then to put this in to some further motion. I'm counting on the groups here today to do that's o that when we come back during the summer you call can come and say "we are together and we're ready." So whatever you have to do to get it together, we're counting on you to do that so that we can be more prepared for Summer Meeting. Sen. Holdman thanked Rep. Anderson and stated that hopefully we can get something resolved by the Summer.

DISCUSSION ON DEVELOPMENTS IN CALIFORNIA'S LIFE INSURANCE POLICY LAPSE LAWS

Rep. Anderson stated that next on our agenda is a presentation on developments in California's life insurance policy lapse laws. In your binders on page 144 is a bulletin from the California Insurance Department that provides some brief background on this issue.

Tiger Joyce, President of the American Tort Reform Association (ATRA) thanked the Committee for the opportunity to speak about something that I hope you can help us solve which is what we see as a new litigation frontier dealing with lapse litigation. Earlier in my career I was counsel to a Committee in the U.S. Senate. It seems to me this is an ideal issue for legislators to make sure that they make good policy here and not leave this issue to the courts and I'll offer a little bit of thought about this and why I'm

here to talk about this issue. I will just say at the outset that out of all the people at this panel and I suspect all in this room I am the least expert in insurance statutes, regulations and policy, but I'm here because this has moved into at least here in California the arena of my organization, ATRA. I'm hoping that all of you will reclaim this so that it doesn't become an issue for my organization going forward. I think it's especially appropriate that we're having this discussion here in California because the litigation that has been our focus has taken place here in California and it emanates from statutory changes that were made with regard to lapse policy by the legislature a little over a decade ago and you can see this was designed to ensure that there aren't inadvertent lapses of policy. And my organization takes no issue with that and extending the grace period as my slide here says but I would particularly point to the third point which is notices must be given at least 30 days before termination for non-payment of premiums.

Well like everything this has found its way into the courts and I think there are two major cases and I'll walk through these very briefly. *McHugh v. Protective Life* is relatively new but interestingly the trial court and appellate court rounds of this litigation dealt with whether the 2012 statutory changes that went into effect a decade ago applied to cases that were entered into prior to the statute. The statute was silent about that. But the trial court and the appellate court both were of the view that the statute was prospective so the changes didn't apply to existing policies and importantly also the insurance commissioner or at least the staff of the insurance commissioner here in California supported that view and communicated that to insurers based on the information that we have. Now, the California Supreme Court came to a different conclusion on retroactivity and that attracted a lot of attention and I think gave rise to further issues including what we would call strict liability and that really is the question of whether any violation of this statute automatically creates liability or whether injury must be proven which is typically the case. I think lawyers at least back when I went to law school, that's what we were educated on and a recent appeals court decision took up that specific matter in the *McHugh* case and interestingly the court seemed to suggest that it does not establish the so-called legal strict liability and that's important. However, because it was a very fact-specific case the court made it clear this was not to be a legal precedent. Ultimately this is going to go back to trial and presumably it may find its way back to the California Supreme Court.

Now the next case is very similar, *Thomas v. State Farm Life Insurance Company*, the difference is that this came through the federal courts. You can see here from my slide, because the company did not fully comply with the terms of the 2012 statute, the two policies issued in 2008 and for which premiums were not paid in 2016 did not lapse. So where does this leave us? Rather than walk through a lot of different cases I'm going to just quickly highlight something that a law firm here in California has concluded about both *McHugh* and *Thomas* looking at them recognizing these are the relevant cases. Can the insurer of such policies in this case ever terminate them for failure to pay premium? And the answer here is assuming that the insured is also the policy owner the holdings in both those cases would seem to apply that in fact no, these policies can never lapse for non-payment.

Now I don't know about you and again I'm not the expert here but I actually earlier this year terminated a life insurance policy and it was fairly straightforward to do. To me it's no different than handling a mortgage or handling the lease of a car or any number of

contractual arrangements but as you can see here as this law firm concluded because the insurer can never actually provide the owner the requisite 60 day grace period or provide notice of a pending lapse “30 days prior to the effective date of termination” it's just not possible is what they conclude. Now I don't know about you, that just doesn't strike me as particularly good policy. So where does this go? What happens here? This is what we call the playbook of the plaintiff's bar. It's an invitation to litigation. It's an invitation to handle matters that really don't belong in the courts. As I said, in so many instances this should be just simple matters of resolving contractual cases. Now what are the key elements? I should make an addition here when we say here litigation in the number one judicial hellhole, I should update that my organization puts out a report on the worst litigation jurisdictions in the country and actually right now Georgia is the number one hellhole. I was there a couple weeks ago celebrating two national championships in football. I reminded them they're also the worst litigation jurisdiction in the country. But California until this past December actually had that unique attribute. No proof of actual injury is required. For where does the litigation stand, I should have said this a moment ago in the aftermath of these two lawsuits, it's a mess. It's unclear at best. And one of the most significant questions is whether to bring a successful case does someone actually have to prove that they suffered an injury? I don't know the answer to that. And that's a matter I think for the courts to look at. And then the last point that I would make as a general matter is on retroactivity. Retroactive application of changes in statutes and regulations unless expressly indicated fundamentally disadvantages defendants in civil litigation in any number of areas. It's something that we feel quite strongly about.

So where are we? The last we looked there were about 20 class actions that have already been filed here in California. And what does that mean? That means you're going to see advertising, recruiting candidates for these class actions. And my organization tracks how much is spent on advertising you can see that on the screen. Nearly $600,000,000 was spent just on television. That doesn't get into social media and any other number of tactics that are used. Another factor that's going to come into play is third party litigation funding and these are the large scale investors who see a big return on investment in mass torts litigation that you see around the country, multidistrict litigation and class action. And then the last point that I would make is simply that you pick your venue. Favorable venues yield the best possible results. So a few conclusions that I would make. First off, a basic point is that we believe that courts should uphold and not rewrite contracts and they should be faithful to the statutes that are enacted. I mention that because there are plenty of legal trends going in the other direction. For those who are lawyers the American Law Institute (ALI) has published a new Restatement on the law of consumer contracts which is basically an open invitation for judges to rewrite contracts and I think insurance contracts are a prime target for that. So those of you who are involved in this policy area should be aware of that. The next point that I would make is no class actions. Every situation we think is different. If I were to allow a policy to lapse it would be different from the next person’s and the notion that they should all be treated the same we think is inappropriate. But probably most importantly is requiring proof of injury. The basic tenant of contract law, tort law, any area of the law is you have to demonstrate that you've been injured and if somebody has been injured by all means they should be allowed to bring a case and they should be allowed to recover.

So for legislators I would make the following specific recommendations. Number one, don't follow the lead of California. If you're going to make these changes make sure that they make sense. You all are the experts but I can imagine that there are any number of ways to make policy on recognizing the different ways that people pay for life insurance policies, the timing and just all the machinations that go into it. Just take that fully into account. Be explicit on these consumer contracts. Courts are not your friend and you can't expect them to fix this. As someone who used to work in the legislature I believe strongly that this is a great area for you to engage in to avoid these kinds of problems. But then the final point that I would make is to recognize that this is a great area for you to legislate and the appropriate individuals to regulate. This is not an area for the courts and certainly not for the plaintiff's lawyers.

Dick Weber, Board Member, Life Insurance Consumer Advocacy Center; President and Lead Consultant for The Ethical Edge, Inc., thanked the Committee for the opportunity to speak and stated that I am a 56 year veteran of the life insurance industry. I was a successful life insurance agent in the first half of my career followed by three years as a home office executive. The second half of my career has been focused on consumers working as a fee only insurance consultant and currently the author of an ongoing column entitled, “In the Clients Best Interest” published in the Journal of Financial Service Professionals. In addition, I'm a consumer representative for the NAIC and serve on the board of the California not-for-profit organization Life Insurance Consumer Advocacy Center or LICAC. I'm here to speak on behalf of consumers. I'm not an attorney so I won't be dealing with legal issues but it's about the dilemma that many policyholders can face especially in older age when personal bills and invoices can temporarily be overlooked or misplaced. It's one thing to miss paying a utility bill. You get reminders over a period of months before the utility is cut off and when payment is restored so is that particular service. This is not true with a missed life insurance premium payment. In some states coverage can be irrevocably lost if payment is not received within 30 days of the billing date.

This can be the case for a policy that's been in effect for decades with tens of thousands of dollars diligently paid in premiums over those many years, suddenly lapse due to a missed bill or an errant delivery of a bill. Reinstatement is possible but only if the insured is in excellent health and this is rarely the case after owning a life insurance policy for many years. Recognizing this problem as Tiger has alluded to California enacted two code sections that were effective January 1, 2013 establishing a 60 day grace period after a missed premium payment and requiring insurers to notify policy owners as well as third parties designated by the policyholder to receive notice along with the policy owner allowing at least 30 days before terminating a policy due to a payment lapse.

In essence this 60 day grace period we really think of as a 30 plus 30 day grace period. The first 30 days is the period in which the carrier is waiting for payment of the premium and if not received the second 30 days for notice to go out to the policy owner and their designee to allow time for an overlooked payment or a misdirected invoice to be discovered and the premium paid. California legislation prevents an insurer from terminating a policy for an unpaid premium as you've been told absent the requisite 30 days notice as just described. And I want to acknowledge the rule doesn't say the insurance company has to provide coverage if premiums aren't paid. It simply adds a layer of security against unnoticed premium notices and the occasional instances where

the premium notice is delivered to the wrong mailing address. LICAC agrees with the California Supreme Court's finding that this important protection should apply to everyone not just for policies purchased since the legislation went into effect, but for all life insurance policyholders regardless of when the policy was purchased. I'm not an attorney, as I've said, so I'm not going to expound on court rulings other than to briefly quote the California Supreme Court's 2021 finding on the issue in which it found that retroactivity of this 30 plus 30 day requirement “fits the provision’s language legislative history and uniform notice scheme and it protects policy owners including elderly hospitalized or incapacitated ones who may be particularly vulnerable to missing a premium payment from losing coverage consistent with the provision’s purpose.” The U.S. Ninth Circuit Court of Appeals also ruled in favor of pre-2013 policyholder plaintiffs in actions against carriers whose terminated policies occurred without honoring the retroactivity.

As I indicated it's not just that a policy owner might overlook a premium notice. I've recently experienced two instances in which carrier records became corrupted and the premium notice was not properly delivered to the policy owner. The insurance agent is usually a consumer's closest connection to the insurer but in this first instance the agent who sold the policy left the business - something that unfortunately happens all too often. Following best practices the carrier transferred the policy to another servicing agent. Fortunately the policy owner realized he hadn't received a timely premium notice and when checking with the new servicing agent who up to that point had no prior conversation with the policy owner, it was discovered that the carrier had inexplicably changed the billing address to North Carolina, a location where the policy owner had never lived. With the extra time required by California the correction was made, the premium was paid and the coverage remained in effect. In the second example several years ago I had a very similar situation with my own coverage. This was for a different carrier but the same problem. It inexplicably changed the address of record to someone of my same name but on the other side of the country. We caught it in time and my point is that these types of situations do occur and the 30 plus 30 time frame provides a critical margin for the time it takes to correct the problem.

A third situation occurred to me just this week by coincidence. I had been named as the third party designee on a policy purchased a number of years ago which had for some reason gone unpaid during the 30 day renewal period. I'm quite certain that without the reminder from me as a designated third party the premium would have gone unpaid and the coverage would have lapsed. Our firm has heard of these mishaps occurring over the years. How often? I can't tell you. One in 100? One in 1,000? We believe that any are way too high given the unique nature of a life insurance policy purchase to provide financial security to a beneficiary, especially when it's so easy to provide for a third party notification and have the time to take corrective action. I believe there are a number of carriers that are generally improving in the area of getting premium notices to the correct owners and providing for the requisite time frame but there are also a number of carriers who are resisting the retroactivity finding of the California Supreme Court and/or attempting to keep such regulations at bay and the need of retroactivity from being enacted in their states. We believe there will always be the occasional misdirected premium notice and elderly policyholders who unintentionally miss making a premium payment and the California's consumer-focused innovation is the only sensible way to handle these situations. It's not an unreasonable burden on insurance companies. That was the conclusion of the California Supreme Court and it's a lifesaver. I guess I can

call it a life insurance saver for those who are having difficulty managing their paperwork. There's approximately $21 trillion dollars of life insurance in effect in the U.S. today owned and paid for the ultimate policy beneficiaries. On behalf of all policy owners we encourage Departments of Insurance and state legislatures to review and emulate California's rules to help keep life insurance policies from inadvertently lapsing. These are consumer-focused requirements that should be in effect in all states so I would suggest you indeed follow the lead of California.

PRESENTATION ON NEW FEDERAL RETIREMENT SECURITY LAW – THE SECURE ACT 2.0

Rep. Anderson stated that last on our agenda today is a presentation on the new federal retirement security law, The Setting Every Community Up for Retirement Enhancement (SECURE) Act 2.0. You can view some of background material on the Act in your binders on page 146.

Kathleen Coulombe, VP, Retirement Security and Principal Deputy, Federal Relations at the ACLI, thanked the Committee for the opportunity to speak and stated that retirement security on the federal level continues to be a bipartisan effort. We've seen two comprehensive retirement bills passed within the past three years, which is somewhat unheard of and so that really demonstrates the need for both continued improvement to the retirement system but also an appetite by lawmakers to continue to legislate in this area. The original SECURE Act was passed and enacted in 2019 and it really focused on expanding access to savers and this included part-time workers, those working for small businesses, and those who hadn't previously had access to retirement plans in the workplace. A pooled employment employer plan arrangement would allow for small employers to pull their resources, achieve economies of scale and to implement a plan in the workplace, something they might not have been previously able to do before. And by our estimates that would create 700,000 new savers alone just through that provision. Fast forward a couple of years to this past December, SECURE 2.0 was enacted and focused improvements really on vulnerable populations that included part-time workers, those at or near retirement, caregivers, women, low and middle income earners and Military spouses just to name a few. The secret sauce really to two huge retirement bills passing the U.S. Congress was there were several elements that helped to achieve that. The first being like I mentioned earlier is bipartisanship. Nearly every provision included had both a Democratic and Republican co-sponsor that championed that provision within the larger package.

We also saw heavy committee engagement with committees of jurisdiction in both the House and Senate working together to pass their perspective packages out of their committees, sometimes unanimously which is sometimes unheard of. The bill was also paid for. So the cost of course is always a factor that we keep our eye on and by paying for the bill we were able to attach that to must pass legislation passing at the end of the respective years. And lastly industry or stakeholder support was key. The ACLI was heavily engaged in the direct advocacy on both bills and really having a lot of different stakeholders at the table help to put some wind in the sails of both those retirement bills. I'll touch briefly on some areas of constituencies that were heavily impacted by provisions within 2.0. The first just being general savers who could benefit now from automatic enrollment which would allow a federal mandate that all new plans have automatic enrollment. As we all know automatic enrollment and auto escalation are key

tools that have increased retirement savers retirement balances and so utilizing this tool for all new plans we think will really make quite a big of an impact. Our estimates look at $34 billion dollars in new savings over the next 10 years alone. Additionally, allowing employers to match what their employees are paying towards their student loans into retirement account allows them to retain and recruit new workers but also to help those folks who may be sidelined paying for those student loans who have not saved yet for retirement to start a retirement plan or to contribute to their retirement plan. Another provision also looked for a way for workers to locate old accounts. When workers transition into new jobs sometimes they forget about accounts and they leave it at the old employer and they may not rollover so the lost and found provision within the bill allows employees to locate any old account that they may have contributed to and ensure that they never lose any of that retirement savings.

I mentioned military spouses - one unique feature of the bill would allow military spouses who historically may move quite a bit with their spouse due to relocations through the military to be vested within an earlier time frame allowing them to have access to those retirement accounts in the workplace. And also something that we saw coming out of COVID, we saw a lot of distributions from retirement accounts and to kind of combat that there were several provisions that dealt with emergency savings both in a sidecar type model which allowed folks to save in a short term savings account that could rollover ultimately into a long term savings vehicle but also looking at relaxing some of those hardship distribution rules, waiving the penalties associated with those to allow employees to take out a loan or a distribution from their retirement account and be able to pay that back for a short term emergency savings event in their life. We also saw incentives for small businesses, new incentives that would allow those small businesses to offer retirement plans in the workplace. We estimate that will generate at least $20 billion in new savings over the next 10 years. I mentioned a pooled employer arrangement earlier as part of SECURE one, that was expanded to allow 403B plans to also have access to those pooled employer accounts.

I mentioned low and vulnerable constituencies that would be affected by SECURE 2.0. This includes low and middle income earners. They have enhanced what's called the savers credit which wasn't very well known and the utilization wasn't great so they're streamlining that credit and they're also taking some steps to let folks know that's available in a variety of different ways to increase savings rates among low and middle income earners. Those at or near retirement such an important segment sometimes these are women and caregivers who've been out of the labor force - allowing them additional time to save in the retirement accounts by pushing out the required minimum distribution age. SECURE one pushed that to 72.5 and we saw now with SECURE 2.0 the required minimum distribution age is now at 75. We also saw a catch up contribution improvement that allows those 60 and older to contribute up to $10,000 once they reach that age to try to increase the retirement balances as they approach retirement. We estimate that this will help older workers save an additional $8.5 billion dollars over 10 years. So what's next? We're in the implementation phase of SECURE 2.0. That includes a variety of different government agencies including Treasury and the Department of Labor. The effective dates are staggered for the more than 60-plus provisions included in the Act so it will take some time. There's also a need for some technical corrections. An inadvertent drafting error removed a critical paragraph that would allow catchup contributions in general starting off in 2024 so that will have to be remedied either through a government agency or through a technical fix. We think the

latter is more probable. There's several different technical corrections that will need to be made to the bill and we anticipate that will occur by the year's end. So in general I think I'll just leave you with this bill will affect a lot of your constituencies in a very positive way. While it's being implemented the ACLI continues to monitor some of those positive impacts and we are happy to work with you and your staffs to talk through what are some of those benefits for your constituents.

Rep. Anderson thanked Ms. Coulombe and stated that the presentation was very helpful and that I just want to say that I share with young people all the time about what to do when they get on their jobs and I've been blessed to have three jobs that has afforded retirement and one of those jobs was my family business, a furniture and appliance store. And through that I'm now employed by the state of South Carolina and I was able to purchase some years from that retirement account to put into my state retirement account. Another one of my jobs, I had to be on the job for seven years and I worked seven years and three months because everything I put in the retirement, they matched it and so I tried to share with young people to stay on the job long enough that you are vested. And in state government we needed eight years and I'm very happy to see one of my colleagues that served with me in the SC House, we were part of that eight years and being vested in state government. And there were 12 of us that got elected that year and one of the things that we said was that we're going to stay eight years to make sure that we are vested in the state retirement and I've been there now 19 years. But the system works and I share this with young people and everybody to make sure that you are on a job that has a retirement system where you can put in. The key to that is to not just have the job but having it and making sure you put into it. And so I thank you again for your presentation and I'm sure that we will definitely be working on this.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Hackett and seconded by Sen. Holdman, the Committee adjourned at 6:15 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 July 21, 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.

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Belmar, NJ 07719
732-201-4133
CHIEF EXECUTIVE OFFICER: Thomas B. Considine

National Council of Insurance Legislators (NCOIL)

Resolution in Opposition to Potential Rulemaking by the United States Department of Labor (DOL) Fiduciary Rule

****Sponsored by Rep. Carl Anderson (SC)***

****To be discussed during the Life Insurance & Financial Planning Committee meeting on July 21, 2023.***

WHEREAS, the DOL has recently indicated an intention in its regulatory agenda to undertake a rulemaking revising the professional responsibilities of financial professionals providing advice to plan participants ("Fiduciary Rule"); and

WHEREAS, any new rulemaking would likely redefine the circumstances under which providing "investment advice" could give rise to "fiduciary" status under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code (Code); and

WHEREAS, in 2018 the United States Court of Appeals for the 5th Circuit vacated the Fiduciary Rule promulgated by DOL in 2016; and

WHEREAS, the United States Securities and Exchange Commission (SEC) has promulgated Regulation Best Interest to address conflicts of interest in the promotion and sale of similar products it regulates; and

WHEREAS, NCOIL strongly supports the States' rights to regulate their own insurance markets and products, including retirement-related financial products; and

WHEREAS, Congress has affirmed the primary role of State regulators over the business of insurance through various legislative acts, including the McCarran-Ferguson Act and, most recently, the Dodd-Frank Act; and

WHEREAS, the NAIC Best Interest Model Regulation addressing conflicts of interest in the promotion and sale of annuities has been adopted by 39 states; and

WHEREAS, the state-based regulatory structure governing the manufacture, distribution, and sale of retirement-related financial products as enhanced by the NAIC Best Interest Model Regulation is effective and proven; and

WHEREAS, NCOIL believes that consistent with this regulatory framework, financial professionals should always act in the best interests of their client and prospective clients; and

WHEREAS, state insurance regulation has in place ongoing substantive procedures, processes and protocols to license, regulate and supervise insurance agents of retirement related financial products; and

WHEREAS, under the proven State-based legislative and regulatory structure, tens of millions of Americans have been able to receive sound retirement assistance, products and services from financial professionals who have consistently served the best interests of customers; and

WHEREAS, a potential return to the Rule promulgated by the DOL in 2016 would threaten the proven State-based legislative and regulatory structure by imposing a vague and burdensome fiduciary standard on non-fiduciary sales relationships, thereby upending the retirement savings marketplace; and

WHEREAS, recent DOL attempts to enhance its definition of fiduciary advice through sub-regulatory guidance reviving elements of the 2016 vacated rule have been overturned by two recent federal district court decisions, with a third decision pending; and

WHEREAS, rulemaking reviving the Rule promulgated by DOL in 2016 will prevent consumer access to crucial retirement education and services, ultimately harming the people it seeks to aid, as demonstrated in studies conducted on the effects of the 2016 Fiduciary Rule by LIMRA, Deloitte, Quantria for the Hispanic Leadership Fund, and a NAIFA survey; and

NOW, THEREFORE, BE IT RESOLVED, that NCOIL urges the DOL to refrain from further rulemaking that would revive all or parts of the 2016 Fiduciary Rule; and

NOW, THEREFORE, BE IT FURTHER RESOLVED, that NCOIL urges state legislators and other interested stakeholders to join in opposition to any further rulemaking by DOL reviving the 2016 Fiduciary Rule;

AND, BE IT FINALLY RESOLVED, that a copy of this resolution will be distributed to the DOL, state legislative leadership, committee chairs, and members, state regulators, and other interested parties.

ARTICLES OF ORGANIZATION & BYLAWS REVISION COMMITTEE MATERIAL

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
ARTICLES OF ORGANIZATION
AND
BYLAWS

ARTICLES OF ORGANIZATION

PREAMBLE

We, duly elected representatives of the People to the Legislatures of the 50 sovereign States and territories of the United States, the District of Columbia, and the Commonwealth of Puerto Rico, being concerned with the economic and social importance of insurance to our constituents, to the peoples of the States, to all Americans, and to the enterprises and economic resources of our nation and to its strength in world trade and commerce, and seeking a more effective exchange of insurance information among the legislatures of the States, consumers, and other concerned parties; and seeking to provide a forum for legislators to resolve and communicate their positions on insurance and related issues on a State-by-State basis, do hereby proclaim the need for creating and maintaining the resources and capacity of State legislatures to deal with insurance legislation and regulation.

I. NAME

The name of the organization shall be the National Council of Insurance Legislators (hereinafter "NCOIL.")

II. PURPOSE

The general purpose of NCOIL is to advance the knowledge and effectiveness of legislators and legislatures when dealing with matters pertaining to insurance law, participate in the formulation of model legislation addressing insurance and financial services issues, serve as a clearing house for information, reaffirm and advocate for the traditional and proper primacy of the States in the regulation of insurance, prepare special studies on insurance or insurance legislation, disseminate educational materials, communicate positions adopted by NCOIL, and any other activities that will promote the general purposes of NCOIL. These purposes may also extend into these same activities in the other areas of financial services, over which the vast majority of committees of insurance jurisdiction in the legislatures of the 50 states also have oversight.

III. MEMBERSHIP

A. General Membership shall be afforded to all States and territories of the United States, the District of Columbia, and the Commonwealth of Puerto Rico.

B. General Members who remit to NCOIL annual dues (which shall not be prorated) in an amount fixed by the Executive Committee shall be considered to be Contributing States.

C. Each General Member and Contributing State shall be represented by its legislators who are permitted to attend NCOIL meetings and seminars.

D. The Executive Committee may, at any regular meeting, confer the title of "Honorary Member" on any individual who has served in the legislature of a General Member but is no longer a member of the legislature, and who the Executive Committee wishes to recognize for outstanding service to NCOIL, and all registration fees shall be waived for a person so titled, unless such person is employed in or providing services to the insurance industry, in which case no such waiver shall be provided.

E. The Executive Committee of NCOIL shall, in accord with the "Purpose" as stated in Section II of the Articles of Organization, offer affiliate non-voting memberships to comparable legislative organizations in non-United States jurisdictions.

IV. MEETINGS/VOTING

A. NCOIL shall meet at times and places designated by the Executive Committee. Special meetings may be called by the President and also shall be called if requested by ten or more members of the Executive Committee.

B. At any meeting of NCOIL, each Committee member shall be entitled to vote on measures before their Committee.

C. A majority vote of those Committee members present and voting shall constitute the requisite vote necessary on measures before their Committee. No more than four (4) legislators from any one State may vote on any matter before any one Committee.

D. Voting by proxies shall not be permitted.

V. OFFICERS/EXECUTIVE COMMITTEE

A. The officers of NCOIL shall consist of the following six (6) officers: a President, Vice President, Secretary, Treasurer, and two Immediate Past Presidents. No person shall be elected as an officer of NCOIL who is not a member of the Executive Committee.

B. The Executive Committee shall consist of the six (6) officers, (as stated in Article V, Section A) and at least one (1) and not more than four (4) representatives of each Contributing State of NCOIL. New members of NCOIL Contributing States shall be elected by a majority of the Executive Committee Members. Notwithstanding any other provision of the NCOIL Articles of Organization or Bylaws, the chair of the committee responsible for insurance legislation in each legislative house of each Contributing State shall automatically, by the nature of his or her office, be a voting member of the Executive Committee at his or her first meeting. A state committee chair from a Contributing State must attend the Executive Committee meeting at his or her first NCOIL conference to be recognized as a new Executive Committee member. Past Presidents who are still state legislators shall be voting, ex-officio members of the Executive Committee

and shall not constitute a representative of a member State. The President shall not constitute a representative of his state during his term.

C. There may be a Parliamentarian appointed by the President.

D. In addition to the representatives of each Contributing State, the chairs of all NCOIL standing committees, who are not members of the Executive Committee, shall become members of the Executive Committee and shall continue to be members of the Executive Committee as long as they remain as chairs.

E. The Officers of the Executive Committee shall be elected at the annual meeting of NCOIL. Members of the Executive Committee shall be elected at any meeting of the Executive Committee.

F. Persons elected as officers or members of the Executive Committee must be representatives of Contributing States in good standing at the time of their election. The office of an officer or of an Executive Committee member shall be vacant if the member state of which such person is a Legislator ceases to be a Contributing State in good standing, or if the person shall no longer serve in the Legislature.

G. A majority vote of those present and voting at a meeting of the Executive Committee shall constitute the requisite vote necessary to decide any proposition except as otherwise specified in these Articles of Organization.

H. Except as stated in Article V, Section B, A representative of a Contributing State must attend two meetings prior to being considered for membership on the Executive Committee.

I. Each Executive Committee Member must attend at least one NCOIL Conference in person, and one Executive Committee meeting annually by whatever means held, or be excused by the President for good cause shown, or his/her executive committee membership will terminate automatically.

VI. DUTIES OF OFFICERS AND THE EXECUTIVE COMMITTEE

A. The President shall be the highest ranking officer in the NCOIL corporate structure. She or he shall direct the general supervision of the business and affairs of NCOIL, see that all orders and resolutions of the Executive Committee are carried into effect, perform all duties incident to the office of President, perform the usual duties of the presiding officer at the meetings of NCOIL, preside over meetings of the Executive Committee, and appoint Chairpersons of all committees and members of committees in accordance with NCOIL Bylaws and perform such other duties as are provided in the Bylaws.

B. The Vice President shall chair committees and meetings chaired by the President in the absence of the President and shall perform such other duties as are assigned him/her by the President and the Bylaws.

C. The Treasurer shall be entrusted with the receipt, care and disbursement of funds of NCOIL, provided however, that if the Executive Committee shall appoint an Executive Director or CEO, the Treasurer shall coordinate and work with the that appointee in those duties.

D. The Secretary shall have charge of all correspondence to and from NCOIL, manage records of meetings including preparation of the minutes, provided, however, that if the Executive Committee shall appoint an Executive Director or CEO, the Secretary shall coordinate and work with that appointee in those duties.

E. The Executive Committee shall have charge of the management of NCOIL and the direction of its activities. The President shall fill vacancies in the offices of Committee Chairs between annual meetings. The Executive Committee may appoint any individual or organization to function, at its discretion, as Chief Executive Officer or Executive Director. Pursuant to these duties, the Officers, in consultation with appropriate Committee Chairs as needed, shall have, between meetings of NCOIL, the ability to make temporary decisions on behalf of NCOIL pending Executive Committee approval.

VII. AMENDMENTS

These Articles of Organization may be amended or repealed at any meeting of the Executive Committee by a favorable vote of two-thirds of the members present and voting, provided however, that notice and text of any proposed amendments shall be given in summary form to the NCOIL Chief Executive Officer or Executive Director at least thirty (30) days prior to the date of that meeting in accordance with the NCOIL 30-day rule for submission of documents to NCOIL for approval or disapproval, as stated in NCOIL Bylaws, Section III. G. Amendments shall become effective immediately upon adoption unless otherwise provided therein.

VIII. REASONABLE DEPARTURE FROM ARTICLES OF ORGANIZATION

In the event of any emergency resulting from a military or terrorist attack, widespread pandemic, or similar disaster resulting in the declaration of a state of emergency (or similar declaration) by Federal or State officials, reasonable departure from these Articles of Organization shall be permitted upon the Officers and Executive Committee declaring that such action is warranted.

BYLAWS

I. QUORUM

A quorum for any meeting of any committee of NCOIL consists of forty percent (40%) of such members of said committee's roster; however, those members of the committee present may reduce the required quorum percentage for good cause as long as they are meeting with twenty four (24) hours notice to all members with said notice setting forth the date, time and place of such meeting

II. VOTING

A. Voting at meetings of the Executive Committee or any other Committee, whether in person, virtual, or telephonic, shall be by voice vote except that a roll call vote shall be taken at the direction of the Chair or upon the request of a member of that committee in instances where there are dissenting votes.

B. Written Consent in Lieu of Meeting:

1. A decision on any matter previously discussed by the Committee voting, with an opportunity for public comment, and evidenced by the consent in writing (including electronic) of a two-thirds super-majority vote of any Committee shall be as valid as if it had been decided at a duly called and held meeting of that Committee. Each decision consented to in writing may be in counterparts, which together shall be deemed to constitute one decision.

2. Unanimous Consent on any matter previously discussed by the Committee voting, with an opportunity for public comment, as achieved by the lack of objection to a duly valid notice to all Committee members shall also be as valid as if it had been decided at a duly called and held meeting of that Committee.

III. COMMITTEES

A. There shall be an Executive Committee which shall meet at each of the three yearly NCOIL conferences or at the call of the President or upon the written request of ten or more members thereof. Notice shall be given to each member of the Executive Committee setting forth the date, time and place of such meeting.

B. Standing Committees of NCOIL shall be:

1. A Joint State-Federal Relations and International Insurance Issues Committee, consisting of a minimum of seven (7) members with responsibility for representing NCOIL in matters respecting State-Federal relations and international issues related to insurance and coordinating activities of NCOIL relating to Congressional or Federal agency action affecting insurance and the State regulation thereof.

2. A Workers' Compensation Insurance Committee, consisting of a minimum of seven (7) members with responsibility for representing NCOIL in matters respecting workers' compensation insurance.

3. A Property-Casualty Insurance Committee, consisting of a minimum of seven (7) members with responsibility for representing NCOIL in matters respecting property casualty insurance.

4. A Health Insurance and Long-Term Care Issues Committee, consisting of a minimum of seven (7) members with responsibility for representing NCOIL in matters respecting health insurance and long-term care.

5. A Life Insurance & Financial Planning Committee, consisting of a minimum of seven (7) members with responsibility for representing NCOIL in matters respecting life insurance and financial planning.

6. A Financial Services & Multi-Lines Issues Committee, consisting of a minimum of seven (7) members with responsibility for representing NCOIL in matters respecting financial services and matters which cross multiple lines of insurance.

7. An Audit Committee, consisting of a minimum of three (3) members appointed by the President and chaired by the Vice President with the responsibility for arranging for and reviewing the audits of NCOIL funds and making recommendations to the Executive Committee with respect to procedures relating thereto. The Treasurer shall be a non-voting, ex-officio member. The Treasurer may vote if the Executive Committee appoints a Chief Executive Officer or Executive Director under Article VI, E of the Articles of Organization.

8. An Articles of Organization and Bylaws Revision Committee, consisting of at least seven (7) members appointed by the President with the responsibility for reviewing the Articles of Organization and Bylaws of NCOIL at each annual meeting.

9. A Budget Committee, consisting of a minimum of seven (7) members, which shall include the Secretary, appointed by the President and chaired by the Treasurer with the responsibility of developing annual budget proposals pursuant to the process enumerated in these Bylaws. The Treasurer may vote if the Executive Committee appoints a Chief Executive Officer or Executive Director under Articles VI, E of the Articles of Organization.

10. A Nominating Committee, consisting of all NCOIL past presidents, the current NCOIL president, and current standing committee chairs with one year or more of service as a standing committee chair that shall interview potential officers for the upcoming year, report nominations for officers to the annual meeting of NCOIL, and reconvene when there becomes a vacancy among the officers in order to nominate a replacement. A Nominating Committee member seeking to be a candidate for an officer shall recuse herself or himself from Nominating Committee participation; if said candidate is a current officer seeking to advance through the chairs, then recusal is warranted only if she or he has an opponent for the position.

C. The Chair and Vice Chair of any standing or special committee shall be appointed by the President and shall serve at the will of the President. However, beginning in 2022, no legislator shall serve as Chair of any one committee for more than three (3) consecutive years. Only members of Contributing States in good standing are eligible to be Chairs or, Vice Chairs of any standing or special committee. Legislators from Member States may sign up for Committees one (1) through seven (7) listed above.

D. The Chair of any Committee with the approval of the President may appoint a chair and members of task forces and subcommittees to assist in the work of

NCOIL. Only members of Contributing States in good standing are eligible for appointment as a chair of a task force or subcommittee. A task force or subcommittee shall continue in existence until it has accomplished the purposes for which it was created or until the next annual meeting of NCOIL, whichever occurs earlier.

E. All Standing Committees, except the Nominating Committee, shall be continuing committees and the members thereof shall serve one-year terms or until their successors are appointed.

1. Standing Committees shall be open to all NCOIL Member Legislators during an Open Registration period. At the Annual Meeting each year, Standing Committee Registration Forms for the upcoming year shall be available in the registration area, on which NCOIL Member Legislators shall register for the Standing Committees on which they will serve in the upcoming year, whether or not they currently serve on those committees.

2. Standing Committee Open Registration shall remain so until January 15th of the year of committee service. In the period after the Annual Meeting through January 15th NCOIL Member Legislators wishing to serve on Standing Committees but who had not registered during the Annual Meeting shall send an e-mail ~~or,~~ letter or Standing Committee Registration Form to the NCOIL Chief Executive Officer or Executive Director stating the Standing Committee(s) on which she or he will serve.

3. From January 16th through the remainder of the year, NCOIL Member Legislators wishing to serve on Standing Committees shall send an e-mail, ~~or~~ letter or Standing Committee Registration Form to the NCOIL Chief Executive Officer or Executive Director stating the Standing Committee(s) on which she or he wishes to serve, and the NCOIL Chief Executive Officer or Executive Director will present the request to either the Standing Committee Chair or the NCOIL President for Appointment.

F. Special Committees may be created by NCOIL at the annual meeting of NCOIL, by the Executive Committee at any meeting of the Executive Committee, or by the President between meetings of the Executive Committee and of NCOIL. Any action creating a Special Committee shall specify its size and duties, and may specify the manner of appointment of members thereof. A Special Committee shall continue in existence until it has accomplished the purposes for which it was created or until the next annual meeting of NCOIL, whichever occurs earlier.

G. 1. Any resolution or other document submitted to NCOIL for its approval or disapproval shall be submitted and sponsored by a legislator to NCOIL at least 30 days prior to the next scheduled NCOIL Conference or Annual Meeting. A legislator must attend at least one NCOIL conference prior to sponsoring any resolution or other document submitted to NCOIL for its approval or disapproval. If a document or substantive amendment to a document is not submitted prior to the 30-day deadline, it shall be subject to a two-thirds vote for Committee consideration and a separate two-thirds vote for adoption. This section is intended to provide advance notice of the matters and items on which NCOIL will

vote; it is not intended to limit germane amendments that arise during a discussion. Such germane amendments shall not trigger a supermajority vote.

2. Notwithstanding the existence of the requirement that any resolutions or documents be submitted to NCOIL at least 30 days prior to the next scheduled NCOIL Conference or Annual Meeting, such documents may pass through committees to the Executive Committee at a duly called meeting of the Executive Committee. Any resolution or other document properly considered and adopted by an NCOIL Committee shall be referred to the Executive Committee for its consideration and vote. If adopted by the Executive Committee such resolution or other document shall be considered the official NCOIL position on such matter covered.

H. Members of the committee responsible for insurance legislation in each legislative house of each Member state shall be a voting member at his or her first NCOIL conference in meetings of standing committees that he or she has joined.

I. Legislators from Member states who are not members of state committees responsible for insurance legislation shall be eligible to vote on a standing committee of which he or she is a member at her or his second NCOIL conference.

J. NCOIL meetings are open meetings except those involving discussions of the general reputation and character or professional competence of an individual; the legal ramifications of threatened or pending litigation; security issues; price of real estate or professional transactions; and matters involving a trade secret.

IV. FINANCES

The fiscal year of NCOIL shall commence on January 1 of each year and end on December 31 of the same year.

A. The Chief Executive Officer or Executive Director shall submit to the Executive Committee a proposed budget for the ensuing fiscal year 10 days before the annual meeting of NCOIL. The Executive Committee shall have the power to approve, modify or reject, in whole or in part, the budget.

B. The Executive Committee at the annual meeting of NCOIL shall adopt a budget for the ensuing fiscal year.

C. During the fiscal year, the Executive Committee may provide for an increase or decrease of an appropriation. Such increase or decrease shall only be upon the certification by the Committee of the need thereof.

D. The moneys budgeted pursuant to these Bylaws may include money for the retention of staff, the reimbursement of expenses of staff, and the expenses of Legislators for activities on behalf of NCOIL other than expenses of attending regularly scheduled NCOIL meetings.

E. Checks drawn for expenditures of less than one thousand, five hundred ($1,500) dollars shall be signed by the Chief Executive Officer or Executive Director who shall submit a monthly report of all such checks to the President of NCOIL. No more than one such check shall be paid for any one purpose without the prior express written consent of the President. All other checks drawn upon the funds of NCOIL shall be signed by both the Chief Executive Officer or Executive Director and either the President or Vice President. Notwithstanding the foregoing sentence, the NCOIL Officers may approve a system they deem sufficiently secure whereby the NCOIL President approves in writing expenditures other than by the physical signing of the check. Such system shall be endorsed by NCOIL's outside auditor.

F. The Executive Committee shall, at the annual meeting of NCOIL, select an independent auditor who shall review NCOIL's books and accounts for the current fiscal year. The auditor shall submit its report to the Audit Committee by June 30 of the next calendar year. The Audit Committee shall submit its report at the next succeeding meeting of the Executive Committee.

G. In the event that NCOIL shall, for any reason, discontinue its activities and cease to function, any monies remaining in its possession or to its credit after the payment of outstanding debts and obligations shall be distributed in equal shares to the Contributing States of NCOIL in good standing at the time of distribution.

V. RULES OF PROCEDURE

A. Each model act adopted by NCOIL shall be reviewed by the Committee of original reference every five (5) years. The respective Committee shall vote to readopt the model act for an additional five (5) years, readopt the model act for an interim period to allow for additional study or drafting, amend and readopt the model act, or allow the model act to "sunset." Readopted models shall be sent to the Executive Committee for final adoption.

B. The NCOIL committees shall review previously adopted NCOIL model laws in order to provide an appropriate sunset schedule. Such documents shall be reviewed in the following manner: Spring Meeting shall be Life Insurance & Financial Planning Committee and the Health and Long-Term Care Issues Committee. Summer Meeting shall be Workers' Compensation Insurance Committee and Property-Casualty Insurance Committee. The Annual Meeting shall be the Joint State-Federal Relations and International Insurance Issues Committee, Financial Services & Multi-Lines Issues Committee, and Executive Committee. Model laws shall sunset every five (5) years within the Committee. Committees shall have the authority to extend the model laws from meeting to meeting.

C. In any issue not covered by the Articles or Bylaws, Robert's Rules of Order shall be the standard authority.

VI. AMENDMENTS

These Bylaws may be amended or repealed at any meeting of the Executive Committee by a favorable vote of two-thirds of the members present and voting, provided however, that notice and text of any proposed amendments shall be given in summary form to the NCOIL Chief Executive Officer or Executive Director at least thirty (30) days prior to the date of that meeting in accordance with the NCOIL 30-day rule for submission of documents to NCOIL for approval or disapproval, as stated in Section III.G of the Bylaws. Amendments shall become effective immediately upon adoption unless otherwise provided therein.

VII. REASONABLE DEPARTURE FROM BYLAWS

In the event of any emergency resulting from a military or terrorist attack, widespread pandemic, or similar disaster resulting in the declaration of a state of emergency (or similar declaration) by Federal or State officials, reasonable departure from these Bylaws shall be permitted upon the Officers and Executive Committee declaring that such action is warranted.

ARTICLES OF ORGANIZATION/BYLAWS AMENDMENTS

Adopted 4th Annual Meeting, San Francisco, November 28, 1972;
Amended 10th Annual Meeting, Detroit, November 14, 1978;
Amended 11th Annual Meeting, Charleston, November 14, 1979;
Amended 12th Annual Meeting, San Antonio, November 22, 1980;
Amended 16th Annual Meeting, Little Rock, November 17, 1984;
Amended 17th Annual Meeting, Phoenix, November 24, 1985;
Amended 18th Annual Meeting, Nashville, November 16, 1986;
Amended 19th Annual Meeting, Palm Springs, November 18, 1987;
Amended 23rd Annual Meeting, Scottsdale, November 20, 1991;
Amended 24th Annual Meeting, Charleston, November 18, 1992;
Amended 26th Annual Meeting, New York City, November 13, 1994;
Amended 27th Annual Meeting, San Francisco, November 11, 1995;
Amended 28th Annual Meeting, Austin, Texas, November 20, 1996;
Amended 30th Annual Meeting, San Diego, California, November 21, 1998;
Amended 31st Annual Meeting, Orlando, Florida, November 19, 1999;
Amended Spring Meeting, San Francisco, California, February 25, 2000;
Amended 32nd Annual Meeting, New Orleans, Louisiana, November 16, 2000;
Amended Summer Meeting, Williamsburg, Virginia, July 11, 2003;
Amended Summer Meeting, Chicago, Illinois, July 16, 2004;
Amended Annual Meeting, San Diego, California, November 19, 2005;
Amended Summer Meeting, Boston, Massachusetts, July 21, 2006;
Amended Annual Meeting, Napa Valley, California, November 10, 2006;
Amended Summer Meeting, Seattle, Washington, July 21, 2007;
Amended Annual Meeting, Las Vegas, Nevada, November 17, 2007;
Amended Spring Meeting, Washington, DC, March 1, 2008;
Amended Summer Meeting, New York, New York, July 11, 2008;
Amended Annual Meeting, Duck Key, Florida, November 20, 2008;
Amended Spring Meeting, Isle of Palms, South Carolina, March 7, 2010;
Amended Summer Meeting, Newport, Rhode Island, July 17, 2011;
Amended Annual Meeting, Santa Fe, New Mexico, November 20, 2011;

Amended Summer Meeting, Philadelphia, Pennsylvania, July 14, 2013;
Amended Annual Meeting, Nashville, Tennessee, November 24, 2013;
Amended Summer Meeting, Boston, Massachusetts, July 13, 2014;
Amended Annual Meeting, San Francisco, California, November 20, 2014;;
Amended Spring Meeting, Charleston, South Carolina, March 1, 2015;
Amended Summer Meeting, Portland, Oregon, July 14, 2016;
Amended Annual Meeting, Phoenix, Arizona, November 19, 2017;
Amended Annual Meeting, Oklahoma City, Oklahoma, December 8, 2018.
Amended Spring Meeting, Nashville, Tennessee, March 17, 2019
Amended via Conference Call Meeting of Executive Committee, July 1, 2020
Amended Annual Meeting, Scottsdale, Arizona, November 20, 2021
Amended Annual Meeting, New Orleans, Louisiana, November 19, 2022

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
ARTICLES OF ORGANIZATION & BYLAWS REVISION COMMITTEE
NEW ORLEANS, LOUISIANA
NOVEMBER 17, 2022
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Articles of Organization & Bylaws Revision Committee met at The Sheraton New Orleans Hotel on Thursday, November 17, 2022 at 5:00 p.m.

Senator Walter Michel of Mississippi, Acting Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Matt Lehman (IN)
Sen. Shawn Vedaa (ND)
Asm. Kevin Cahill (NY)
Rep. Carl Anderson (SC)

Other legislators present were:

Asm. Ken Cooley (CA)
Rep. Matthew Gambill (GA)
Sen. Paul Utke (MN)
Sen. Jerry Klein (ND)
Asm. Jarett Gandolfo (NY)
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

MINUTES

Upon a Motion made by Asm. Kevin Cahill (NY), NCOIL Vice President, and seconded by Rep. Matt Lehman, NCOIL Immediate Past President, the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's November 19, 2021 meeting.

DISCUSSION AND CONSIDERATION OF PROPOSED AMENDMENTS TO NCOIL ARTICLES OF ORGANIZATION & BYLAWS

Sen. Michel stated that we're here today to discuss and consider some proposed amendments to the NCOIL Articles of Organization & Bylaws. Those amendments can be found on the conference app and on the website and they also appear in your binders starting on page 99. None of these amendments are particularly controversial or transformative. Rather, they represent some minor changes in order to improve the overall operation of the organization. I'll turn things over to Will Melofchik, NCOIL General Counsel, who can go through each amendment.

Mr. Melofchik stated that the first proposed amendment is to section 5.I. of the Articles of Organization. The amendment addresses the required attendance for Executive Committee members at NCOIL conferences in order to remain on the Executive

Committee. The amendment provides a little more flexibility for members to remain on the Executive Committee. Many times, members that attend conferences can't stay the entire conference and have to catch a flight before Executive Committee meeting which is always on the last day of the conference. So this amendment would allow members to stay on the Executive Committee if they attend at least one conference in person per year and one Executive Committee meeting annually, by whatever means held. The "by whatever means held" language is meant to encompass a meeting of the Executive Committee being held via Zoom in between national conferences. Hearing no questions or comments, Mr. Melofchik proceeded to the next amendment.

The next proposed amendment is in section III.B.7. of the Bylaws. The amendment clarifies that members of the Audit Committee shall be appointed by the NCOIL President which would align audit committee membership with budget committee membership and this committee's membership which are populated by members who are appointed by the president. The rationale is that it makes sense that those committees are meant to be populated by members with experience in the organization so they should be appointed by the president. Hearing no questions or comments, Mr. Melofchik proceeded to the next amendment.

The next amendment is to Section III.B.9 of the Bylaws. The amendment would require the NCOIL Secretary to be a member of the Budget Committee and the reasoning is that the Secretary is the officer rank which precedes Treasurer and the Treasurer Chairs the Budget Committee. So the thought is to ensure the Secretary has some experience with the Budget Committee before they serve as chair of that committee the next year. Hearing no questions or comments, Mr. Melofchik proceeded to the next amendment.

The next amendment is to Section III.B.10 of the Bylaws and deals with when recusal is warranted from Nominating Committee matters. The amendment clarifies that if a candidate is a current officer seeking to advance through the chairs, then recusal is only warranted if she or he has an opponent for the position. Hearing no questions or comments, Mr. Melofchik proceeded to the next amendment.

The last amendment is to Section III.G.1 of the Bylaws. The amendment requires a legislator who is seeking to sponsor a Resolution or Model Law to attend at least one NCOIL conference prior to sponsoring. The reasoning for the amendment is that recently, a legislator sponsored a Model at their first conference and we received some feedback that legislators should be more experienced with NCOIL before sponsoring something. Hearing no questions or comments on this amendment, Mr. Melofchik asked if there were any comments or questions on anything stated.

Rep. Carl Anderson (SC) asked whether the amendment dealing with Executive Committee membership means that any one of the three conferences per year can be attended to meet that part of the attendance requirement. Mr. Melofchik replied yes.

Sen. Michel asked if there were any questions or comments on any of the proposed amendments. Hearing none, upon a motion made by Rep. Lehman and seconded by Asm. Cahill, the Committee voted without objection by way of a voice vote to adopt the amendments.

Sen. Michel stated that the amendments will now be presented to the Executive Committee as part of the consent calendar during its meeting on Saturday.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Lehman and seconded by Asm. Cahill, the Committee adjourned at 4:45 p.m.

PROPERTY & CASUALTY INSURANCE COMMITTEE MATERIAL

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
PROPERTY & CASUALTY INSURANCE COMMITTEE
SAN DIEGO, CALIFORNIA
MARCH 11, 2023
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Property & Casualty Insurance Committee met at The Westin San Diego Gaslamp Hotel on Saturday, March 11, 2023 at 9:00 a.m.

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

Other members of the Committee present were:

Sen. Mark Johnson (AR)
Rep. Matt Lehman (IN)
Rep. Rita Mayfield (IL)
Rep. Michael Sarge Pollock (KY)
Rep. Rachel Roberts (KY)
Sen. Roberts Mills (LA)
Rep. Brenda Carter (MI)
Rep. Kevin Coleman (MI)
Sen. Lana Theis (MI)
Sen. Michael Webber (MI)
Sen. Paul Utke (MN)
Asm. Ken Blankenbush (NY)
Asm. Jarett Gandolfo (NY)
Asw. Pam Hunter (NY)
Sen. Bob Hackett (OH)
Rep. Brian Lampton (OH)
Rep. Forrest Bennett (OK)
Rep. Carl Anderson (SC)
Rep. Jim Dunnigan (UT)
Del. Steve Westfall (WV)

Other legislators present were:

Sen. Jesse Bjorkman (AK)
Rep. Denise Ennett (AR)
Rep. Deborah Ferguson, DDS (AR)
Sen. Ricky Hill (AR)
Rep. Reginald Murdock (AR)
Rep. Rod Furniss (ID)
Sen. Win Stoller (IL)
Rep. David LeBoeuf (MA)
Del. Nic Kipke (MD)
Rep. Kelly Breen (MI)
Sen. Mark Huizenga (MI)
Rep. Mike McFall (MI)
Rep. Zach Stephenson (MN)
Rep. Cameron Parker (MO)
Sen. Nellie Pou (NJ)
Rep. Tim Barhorst (OH)
Rep. Mark Tedford (OK)
Sen. Jeremy Cooney (NY)
Rep. Kirk White (VT)

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), NCOIL Secretary, the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Rita Mayfield (IL) 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 November 18, 2022 meeting in New Orleans, LA, and the Committee's February 17, 2023 interim Zoom meeting.

PRESENTATION ON IMPROVING NATURAL DISASTER RESILIENCY EFFORTS

Rep. Jordan stated that we'll start with a presentation on improving natural disaster resiliency efforts. Several states including my home state of Louisiana have enacted laws to encourage homeowners to take steps to strengthen their homes by providing them with insurance discounts if certain standards are met. The laws do vary in terms of methods of encouragement. Some states require the insurer to issue a premium discount if certain standards are met while others including my home state of Louisiana make the discount voluntary. Louisiana also has a program that grants homeowners funding to fortify their home's roofs to certain standards and I think that will be discussed today along with some other things to even strengthen that as well. You can view these different types of laws in your binders starting on page 200 as well as on the website and the app. I will say it's interesting that NCOIL did discuss several years ago a model law similar to Oklahoma's law but that proposal was ultimately withdrawn as a consensus could not be reached. But now with the unfortunate increase in natural disasters this is a very timely topic and I'm glad NCOIL is discussing it again. Before we go any further I'm going to turn things over to Rep. Jim Dunnigan (UT) who would like to make some brief remarks.

Rep. Dunnigan stated that I would just like to say that being from Utah which is a state that's seen an increasing amount of wildfires I'm very interested in the type of policies that you just discussed and I'm looking forward to seeing what other states are doing and learning from that. And I'd be interested perhaps in developing an NCOIL model law that adopts one of the state's approaches so that we can help the states throughout the country.

Roy Wright, President & CEO of the Insurance Institute for Business & Home Safety (IBHS), thanked the Committee for the opportunity to speak and stated that it's good to be back with Rep. Jordan again who was out to visit us at IBHS. IBHS is a 501(c)(3) non-profit that was designed and is funded by the insurance industry to really crash test buildings and understand how they perform. This is our facility in South Carolina where we have the ability to do everything at full scale and subject properties with winds up to category 4 level and see how things play out when you see roofs pop off of homes and the kind of devastation those conditions bring. We're the only place that can test against wildfire embers at full scale there at our facility and understand how that plays. We also have water intrusion pieces and again we take real events and play them in that space. We also do quite a bit of work on hail and how that is subjected on testing various materials that are put onto homes and structures. Not only is that done at the lab it's also done in the field where we deploy teams in severe convective storms looking at the

impacts of hail. Obviously, that drives quite a bit of roof damage. We also deploy teams to see post event things on hurricanes and tornadoes as well as wildfires. Again it has to be that place where the science that can play out in the lab meets reality in the field. We have to keep building those bridges. Specifically, we were charged to address four specific hazards. Wind, rain, hail and wildfire. And so I mentioned earlier we somewhat casually say we crash test buildings, not dissimilar to how the sister organization the Insurance Institute for Highway Safety (IHS) addresses crash testing cars. In order to do that it needs to be done at full scale and subjecting it to the kinds of things that mother nature uniquely can do.

Disasters and their impact continue to have a larger and larger impact on this. This billion dollar weather event, most of the billion dollars is attributed back to what is the insurable loss side of the equation that is then met by the uninsured public infrastructure pieces that the Federal Emergency Management Agency (FEMA) continues to pay for. For someone like myself this has really become a full employment kind of piece because we look at this and as Rep. Dunnigan was mentioning we see this all across the country. We see this with wildfires in the west. We see severe convective storms, tornadoes and other things that play across the Midwest and the East. We look at the impact of hurricanes that work not just the Gulf Coast but all the way up the East Coast. I'm going to turn to the particular pieces here in a moment related to individual elements and how those ultimately play into the insurance world but I want to start with one key element because there is a single piece of legislation that matters more than anything else related to resilience in the states of this country and it deals with how we approach building codes. These states that have adopted them fundamentally change the outcomes of disasters. So those more intense bright blue ones have statewide enforced codes. You have that dull kind of piece where they adopted an aspiration but they have no enforcement. It is simply guidance that is available. And then we have a set of states that have nothing. So you can find those bright blue places on the west coast of the U.S. along with Utah, New Mexico and we go up to Wisconsin. In the Gulf Coast we see Louisiana and Florida and then some pieces that play in the Mid-Atlantic. You say okay well that must be where the disasters play out. That's why they're focused on what does it mean to build to withstand what mother nature can send our way. So going back to 1950 here's your hurricanes, there's your tornadoes, there are your catastrophic wildfires. Unfortunately there is not a correlation between the places where we see these disasters play in the states that are leading by using the very simple straightforward science that goes into building codes.

So understanding that's the best answer we then need to turn to what do we do when we have the absence of strong modern codes and how we supplement that work and that really has become the piece that we have focused on to apply the science through a series of pieces that we have done at IBHS related to hail and the products that can withstand the higher end hail and what we do in high wind events and the places where that could be subjected to with the program we call Fortify and then on the wildfire side how we prepare for this piece. First on hail. Hail accounts for 60% to 80% of the losses that we see from severe thunderstorms across the country and so we have spent an incredible amount of time and effort working on this. This is not one that is actually a life safety hazard but clearly it drives more than $10 billion in insurance claims in any given year. And so we go through and we study the very specific elements related to products that are there some of which are impact rated and say, “oh this will withstand what happens on the hail side of the equation.” We were driven to this because there are a

good number of states that have mandatory discounts tied to these hail related elements. I know you can't see all the details of this from across the room but I'll point to you that there are three different dimensions on the right side and the overall rating that sits there on the left. One gets an excellent green at the top and there were those that have the marginal and poor performances that are there which is to say they could not withstand the very things that they were being sold saying they would withstand. By publishing this we began to see changes in the marketplace. Products were pulled and no longer sold in distribution. New products were put into the marketplace. And so I show you the examples that are here where all but one of these products now meets the good side of the equation, simply shining the lights on it is there. But knowing that we're talking about the point by which direct price consideration needs to be put into place. We must be careful. In this instance an impact rated product was the one that was highlighted. It says, if you do this well then there's going to be a price consideration. Except the product didn't actually do anything. At which point there's not an underwriting basis or an actuarial basis by which you can have that element.

I'm going to turn to the wind side. So, Fortified Home, this is a program that goes back really over the last 15 years. We don't have a lot of time this morning so I will look at some pieces. There are Fortified gold and silver elements that are done at the point of new construction which really says the entire structure will be able to withstand the winds that come, those category three hurricane winds that would come. We look at things related to doors and shutters and openings as well as how the entire building ties together but I want to focus this morning on fortified roof because it's the one element you can do from a retrofit perspective on an existing home and that's what's more broadly going to be available for folks. The Fortified roof has three elements that are required. The first one deals with how the boards underneath are nailed down with ring shank nails so that they will not rip up when the high winds come. Secondly you need to seal the roof deck. So for each one of those 4x8 wooden sheets that are there on a really bad day we are going to lose the shingles. At which point we have water. Water goes between those cracks and just fills up like bathtubs. When you go from a loss of roof cover to water intrusion we see the increase in claim severity go up three to five times. And then how do you lock in the edges so that you're less likely to see those pieces work. So how does this play? In Alabama it was Hurricane Ivan in 2004 that was the catalyst for so much of their change. Ivan, Dennis and Katrina had more than $3 billion worth of loss and so advocates in the insurance community, local leaders as well as the state developed a program related to Fortified that plays in this space. It is multi-prong. I'm going to show you some contrast here in a moment. Yes there is pricing consideration that is in play. And the local building industry began to make this a default in everything they did in terms of new homes. The local counties adopted these pieces into code. And there was a grant program for those in greatest need.

Doing any one of those without the other would not produce the same outcome that we saw. So quickly look at the Alabama piece you go back to 2006 the lawmakers saw a path that is there. At first the discounts were just inside the wind side of the equation in 2008. You then begin to see those pieces play. You see some designation counts that were going. Habitat for Humanity did some initial work in this pace. And then it ended up in the coastal supplement for building code perspectives in 2012. It keeps moving and then in 2015 they added a grant program. Prior to that point there were mandated discounts if the action had taken place and there were still less than 500 designations. That grant program gets laid into place and you begin to see the movement that now

works by which they are approaching 40,000 of these designations in Alabama. It was that collective sense that is there. I'll look just at the southeast on this. We'll look at that number. Then we'll come up here in a second here in terms of where Alabama is at 36,000 designations today. North Carolina has more than 6,000 and they're now some programs that are beginning. We'll hear from others in terms of work that is looking to see this advance in some other states. When we have those elements in place and they lean in we see that it collectively works. We'll keep showing you the Fortified house versus the kind of losses you would see in other dimensions. This one right here is a habitat home. This is in a moderate income neighborhood. This is right after Hurricane Sally. I was in a vehicle with a reporter and we're driving around and she said well which ones are Fortified roofs? I said I've color coded them for you.

Now this was early in COVID so we're all wearing masks at which point you can't quite read the faces of what's going on. She said, "what do you mean?" I said, "the ones with blue tarps are not Fortified." It was that clear. So it's not just a good idea that we talk about. We've then gone and looked at the research in terms of in both North Carolina and Alabama how much difference does it make? We see claims reduction as well as severity in both the elements we saw in Sally as well as North Carolina which has actually seen four events come through on that side of the equation. It's not just for homeowners it can help renters as well. Fortified multi-family is really beginning to gain momentum in this space. We've been working with the Louisiana Office of Community Development. We're really encouraged to see how they are bringing both federal dollars and state pieces together. This program's just been around for a few months and we're already seeing the impact that it has. There are 313 families already in that space and another 2,400 families that are headed towards some pieces that are there. I want to look at this particular small development for multifamily. That was Lockport, Louisiana. It was just finishing up construction as Ida made a direct hit. The eye of the storm went over this community and as we watch these pieces, the highest end of the wind is 135 mph. Only one of those buildings experienced any damage and it lost a few pieces of siding. This was workforce housing. After the event this was the only viable workforce housing within 50 miles. It could withstand the event that is there. And I think this is what's so important we're not going to stop the disasters from coming through. The real key is can we limit its damage and make sure that after folks evacuate they have a place to go back home? When they go back home they go back to school, they go back to work and the economy can move through. This is not just in places like Louisiana, we're seeing it working in Iowa. We're seeing leadership coming out of the federal Home Loan Bank in Dallas and the Connecticut Housing Finance Authority has leaned into this space - it's requiring nudges coming from all of those elements.

Let's turn to wildfire. You look at the intensity that plays out now and we see what happens when a fire gets to one house and how it begins to move. This is in Colorado where we see these pieces play and we see the elements that we look at our facility about the kind of things that happen on the wildfire side of the equation. We're seeing more and more and more of these play out. Unlike other perils, wildfire risk is highly intertwined with those living near you. When a flood comes in it dissipates as it hits more structures. As a wind event comes through if your home is well built and mitigated there may be some debris that moves around but you can be strong while your neighbor is weak. In wildfire this is not true. The structure becomes more fuel. Once it burns it begins to promulgate and move. There's no other natural disasters by which when it hits the built environment it makes it worse the way that we see play in this place. And so it

really requires a system of pieces. We need to incentivize individual homeowners to do the right things, and businesses. But you then have to make sure you're putting the nudges in place at the neighborhood as well as at the community scale. That is so true because you can perfectly mitigate your parcel and your next door neighbor who has excess material there that is welcoming to those embers well once they're burning if you're in a suburban context whatever you've done is insufficient. The fire is coming your way. Similar to Fortify, we've put the science behind wildfire into something we call the Wildfire Prepared home. There's two levels of it. There's the base and then the plus. At the base level of it you have to address the roof. It's the largest place that can accomplish those embers and again those embers regularly pick up and fly a half mile away from the place by which they originate. Occasionally we will see it go as far as two miles away. The good news is that most Americans have class A roofs already. The asphalt shingles like our class A roof and so we've already met that dimension. There's some building features including the vents that let you into the attic and the under crawl space. The biggest element is defensible space. Those areas closest to the structure. This has been work in combination with Cal Fire and the National Fire Protection Association as well as the National Institute of Standards and Technology (NIST) and others. Zone zero it's the five feet closest to your house. Nothing combustible. Think about the normal American landscaping and you put hedges and all kinds of bushes right up close to the house. Well in wildfire prone areas we need to move that stuff five feet away. We need leaning green five to 30 feet but the first five feet you need to make sure that when the embers come and land they extinguish. They don't actually ignite the structure that is there. We have elements in place, California has some pieces they put in through regulation. The Wildfire Prepared designation is one way that folks can meet those as it gets implemented later on in 2023 and into 204.

But it has to be collective in this space. So we go to a place like Paradise, California that experienced the catastrophic campfire and by catastrophic they lost 19,000 structures – 90% of the structures in that community were entirely destroyed. And they have leaned in that space and said okay as we rebuild we need to put the right code pieces in place to make sure that people can withstand what comes their way. So as I wrap up, I think that while insurers all approach pricing and underwriting differently certain basic principles underlie the insurance industry generally. One of them is that price follows risk. Generally speaking, as risk reduces so do the prices. And yet the converse is not also true. Risk does not necessarily follow the price. As we look at different regulatory and incentive programs around the country, discounts alone, whether they're mandatory or otherwise, are not sufficient to drive people to reduce their risk. Remember I showed you Georgia. The Georgia Underwriters Association offers a mitigation discount if they have Fortified designations. There is not a single designation in Georgia. Oklahoma requires discounts for Fortified designations without taking into consideration other policy measures to reduce risk. They're only 18 designations in the state. Some states require discounts for a whole laundry list of mitigation actions and this is really the worst outcome because it becomes a market intervention without verifiable risk reduction and frankly it confuses consumers because they look at a menu and go I'm going to choose two of these things and there's an artificiality that is brought there. We've got to make sure that that science hits that place and fundamentally do it in a way that reduces the risk and as that risk is reduced the price elements will follow. It's what we have seen in Alabama and looking at the program in Louisiana, they are following this kind of model that says it requires more than just one policy lever in order to accomplish the outcome.

Jim Donelon, Louisiana Insurance Commissioner, thanked the Committee for the opportunity to speak and stated that it's always a pleasure for me to have the opportunity to visit with NCOIL on behalf of my state and what we're about but also on behalf of the National Association of Insurance Commissioners (NAIC) where we had a breakfast with your leadership this morning that commented on the excellent relationship that has been built between the NAIC and NCOIL which I really think is beneficial to what I try to do back home. As you know Louisiana is the bullseye. My chief actuary says that on a per capita basis we have been hit by landfall by hurricanes over the past 100 years four times more than Florida and four times more than Texas though they have much larger coastal exposure then we do. As such we have unfortunately developed some expertise in this area and following our second worst hurricane event that hit our state, hurricane Ida a year and a half ago that generated 800,000 claims along with the year before hurricanes Laura, Delta and Zeta. That was over a 13-month period of time and a total of $24 billion dollars in insured losses paid by private insurers as a result of those hurricanes. In our session last year with Rep. Jordan, Vice Chair of our House Insurance Committee, we did a number of band-aids as I refer to them to address lessons learned in the aftermath of particularly the most recent state of hurricanes. Hurricane Laura hit Lake Charles a year and a half ago with 150 mph winds and a year and a day later Hurricane Ida hit Port Fourchon in the center of our coast with similar 150 mph winds. The Weather Service said that those were the second most powerful hurricanes to ever hit Louisiana pointing to what I had never heard of before the Last Island Hurricane of 1856. I've asked how did they measure back in 1856 and it's by digging up residue from a hundred plus years ago. That was a category five hurricane - a category four is plenty bad enough. We don't have to corroborate what the Weather Service says happened 150 years ago but in the last year our department went to the legislature and with their cooperation and frankly action we passed a handful of bills that I'd go like to go over with you quickly as part of my presentation.

We had Senate Bill 264 which Sen. Robert Mills (LA) was instrumental in helping us do without objection which we copied from the state of Florida because we had a spate of insolvencies in the aftermath of those two hurricane seasons. Three of the nine companies that failed were domiciled in our state and failed not because of Laura, Delta and Jada but because of Ida a year later. The next five were domiciled in Florida but had done a lot of property insurance business in other coastal states to include South Carolina, Louisiana and Texas and impacted us dramatically myself included as a policyholder from one of those Florida based companies for the past 10 years with a savings from that company on my home throughout that period of time of $600 a month on identical coverage versus the big national company that I had been insured by until I switched to Southern Fidelity. But what we learned in the aftermath of those failures is that the number one reason for the failure was the ownership going cheap if you will and not buying adequate reinsurance for the book of business and exposure that they took on. Florida had picked up on that five years earlier and had raised their minimum capital and surplus from $2 million to $15 million and we last year raised ours from $3 million to $10 million. It’s not going to solve the problem because typically those failed companies left behind for our guaranty fund $100 million of unpaid claims that the taxpayers ultimately will pick up over the next 10 years but what we hope and expect that $10 million of capital and surplus requirement will do is make those owners more conservative, more prudent, more cautious when they go to the reinsurance marketplace because we are dependent on those small regional carriers in fact my wife I remember 12 years ago when we switched from our national carrier to that small company, she

tells me “well that's great Jim we're going to save $600 a month but I never heard of Southern Fidelity. Are they okay?” And I responded to her nickname “give me a break moms, that's what I do everyday. I'm not about to buy a policy from a company I'm going to put out of business shortly.” And her typical answer was “I guess not” and we made the change. The point being though that we with our exposure need the small regional carriers. For the most part the big national carriers have retreated from coastal exposure, not just in our state. I dare say in the aftermath of Katrina they probably more politely exited our state than they did others. There's some statutory aspects that impact that as well but our workforce, our population needs those small regional carriers and the only way they can take on that exposure - and 30 came to our state since Katrina and only three of ours failed out of those 30 - but the only way they can effectively take on that exposure is to reinsure themselves up to their chin for that risk.

And they do that and they for the most part do it successfully but those nine that failed last year had a common thread of inadequate reinsurance for the risk they took on. We think having $10 million instead of what was actually $5 million on the table when they go to the reinsurance market to protect themselves and their policyholders will result in them being more prudent in that aspect of their business. On January 1st, two months ago, our statewide building code adopted in the aftermath of hurricanes Katrina and Rita and it survived the legislative process because of then Governor Blanco putting up $20 million of her Community Development Block Grant (CDBG) money for assisting the half of our parishes as we call them that did not have inspection services permitting services nor the money to start up those facilities in those parishes that didn't have a building code. And that money survived the attempt the next year to shoot a giant loophole into our new statewide building code adopted in a special session right after Katrina and Rita in 2005. That loophole said that if a contractor self-certified that he had built to the new statewide building code it was good to go and needless to say that would not have worked. We prevailed in a 105 member House by one vote in defeating that provision a year after we had adopted our statewide building code. The latest update was done January 1 of this year. It made up for pausing the every three year international building code standard update required. Because of the pandemic our state had paused that update. They met on January 1 to provide for a second three year update requirement so they did both at the same time so that we are on schedule to maintain the standard of the international building code that we committed to when we passed our building code in 2005. That was a big benefit to our improvement. In fact, Fortified that Mr. Wright was talking about before, with the upgrade to our building code our building code is now 95% of the requirements of Fortified and that's a huge improvement to the insurability of our state.

Senate Bill 412 provided and recreated I should say the Louisiana incentive program offering grants to companies to come write business with requirements for the amount of writing, solvency requirements, monitoring requirements, the staying on the risk for a minimum of five years, doing 50% as a minimum in south Louisiana. And yesterday was the last day and I almost missed my part here yesterday because I was on the phone back home learning of the latest of the nine companies who have come to our state asking for $61 million of grants which is limited to $45 million by the appropriation that we got earlier this year in a special session. But that program was very instrumental in our recovery of our market after Katrina and Rita and will be again with this recreation of that program that has exceeded interest, it has exceeded even the monies that are available for the company's wanting to participate. Senate Bill 198 is what we've

commonly referred to as our three adjuster rule and that one I copied from California who did it several years ago in the aftermath of wildfires where they were struggling with adjusters being churning and turning over as we experienced in the aftermath of Laura and the storms following it. At the third adjuster within a six month period of time the company is required to provide an update in writing or electronically to their policyholder of the status of their claim, provide a primary contact person to that policyholder and a summary of where their claim stands and what it's lacking in order to be successfully concluded. It has worked in California. Now they didn't have 800,000 claims as we did. Mr. Wright said 90,000 in Paradise which is a big event by anybody's standards but we think we can make this work hopefully without a pandemic to prevent churning of adjusters in the next sure to happen catastrophic event.

Senate Bill 163 requires specific disclosure for catastrophic claims process to include and we have adopted it frankly largely based upon what the National Flood Insurance Program (NFIP) provides when they are very helpful to consumers with a how to file and how to process a claim information booklet. And we have copied it and issued it to the companies to use in every homeowner's policy. So explaining things like the supplemental claims process which nobody knows about back in our state. Actual cash value versus replacement cost which very few know about back in our state. What is necessary to document a claim and how to file a complaint – 800,000 claims generated 8,000 formal complaints to our department over those four hurricane events. House Bill 521 is also a good lesson learned – it requires the companies to provide to us at the department before each year's hurricane season a catastrophic response plan to include the list of their contract adjusters that each of the companies has contracted with to adjust claims. These small companies reinsured up to their chins doing exposure on coastal states don't have the army of adjusters that the State Farms and Allstates have all across America to reassign to the aftermath of a disaster so we want to know how the small companies are preparing to handle catastrophic events and be able to compare what one is doing versus the others to know if in fact they do have adequate resources available. And of course the primary focus of this year's upcoming session, House Bill 612 created the Louisiana Fortified homes program to provide grants to homeowners who will either retrofit or build to the new Fortified standards. We're hoping to get to that 35,000 level like Alabama. This bill and regulation mirrors what is in place in Alabama which as Mr. Wright mentioned started in Baldwin and Mobile Counties and has now spread to Montgomery and Birmingham in the center of the state with over 35,000 homes built to that standard.

I'm also vice chair of the NAIC's Climate Risk and Resiliency Task Force which is also generating the technology workstream thereof which I'm the chair of and the pre-disaster mitigation work stream to educate and bring awareness to coverage gaps and pre-disaster mitigation measures and resources and incentivize insurer recognition of enhanced building codes in underwriting and rating. And lastly the NAIC Catastrophe Modeling Center of Excellence just hosted us Southeast Zone Commissioners in Miami at Florida International University, the home to the international Hurricane Center with cat-model instruction and presentations were made over a two-day period of time. That I will tell you is the best NAIC meeting and service that I have seen in my 16 years. It's really going to be helpful to not just Coastal States but earthquake States, Wildfires states and all catastrophes. The Center of Excellence will provide the resources necessary for us to be able to price and quantify the risk and the best approach to addressing those risks.

Sen. Ricky Hill (AR) stated I know it reduces the insurance cost but how much percentage wise does it increase the cost to build a project? Because I know there's got to be some cost increase and I want to see if I can live long enough to make that up. Cmsr. Donelon stated that's the key issue. Retrofitting requires a new roof. You have to take the old roof off and do a whole new roof and the issue in Alabama was initially do we just pay the $2,500 or $3,000 difference in a Fortified roof versus a typical roof or do we give a $10,000 grant to incentivize folks to take the other roof off and replace it with Fortified which really the difference in a new roof is just $3,000 but the cost of the total taking the roof off and putting it back as I did after Ida is about $20,000 typically but the difference in new construction costs Mr. Wright correct me if I'm wrong is $3,000. Mr. Wright replied yes and stated that I think that at the point of new construction these things tend to add only a 2% to 3% cost overall. On the retrofit side for the roof it has to be coincident with a replacement of the roof and the incremental piece they're allowing up to $3,000 in the Alabama space and I think in Louisiana. We often see that the increment actually is less than that amount but it really is the price to put a new roof on that. It's a little more expensive in Louisiana than it might be in some other places depending on size of your roof.

Rep. Carl Anderson (SC) asked Cmsr. Donelon if he heard correctly that he took out a policy with Southern Fidelity? Cmsr. Donelon replied yes. Rep. Anderson stated that I'm in Georgetown in the low country and they dropped us in South Carolina. Cmsr. Donelon stated that they actually went insolvent. That's why you were dropped, me too. I had to revert back to my Army days and go back to USAA when Southern Fidelity failed.

Rep. Jordan stated that as someone who just recently visited IBHS, if you ever get an opportunity to take that tour in South Carolina and see the great work that they're doing you certainly should take that opportunity to do that. I think this issue is one that we're going to continue to discuss as resiliency is a big issue and we'll be discussing it at future NCOIL meetings.

PRESENTATION ON INSURANCE ISSUES RELATING TO CATALYTIC CONVERTER THEFT

Rep. Jordan stated that we'll next hear a presentation on insurance issues relating to catalytic converter theft and I'll just note that I think this is an issue that's becoming very prevalent and I can tell you in Louisiana we've had lots of thefts of catalytic converters. I know it's going on just not there but across the country and hopefully we'll have a step forward with some model legislation for states to follow but for today we'll hear the presentation and determine how to best proceed.

Eric De Campos, Director of Strategy, Policy, and Gov't Affairs at the National Insurance Crime Bureau (NICB), thanked the committee for the opportunity to speak and stated that I'd like to begin by summarizing the threat. So we're talking about catalytic converters; they're exhaust emission control devices designed to reduce emissions. They're located underneath your vehicles and since 2019 we've seen thefts related to these devices skyrocket and there's both the consumer and insurer impact to this. For consumers it's a violation of their personal property and safety. It's a disruption of their daily life. It's a loss of their vehicle during the repair process. For insurers it's the cost of replacement. It's the repair costs associated with incidental damage done to the

vehicles. These thieves are not exactly surgical when they're cutting these devices out from underneath your cars. But moving on to this it's important to look at what's driving these thefts and I'd like to begin by talking about the underlying impact of market forces. Specifically, the prices of precious metals. Catalytic converters have trace amounts of rhodium, platinum and palladium and since 2018 we've seen these prices increase and since COVID they skyrocketed. You can see the price of rhodium increased all the way up to over $18,000 per ounce in 2021 and so market shocks cause disruptions in the supply chain which ultimately results in a used attached catalytic converter being worth several hundreds of dollars on secondary and black markets. And so what does that mean for thefts? Well since 2018 we're seeing thefts either double or quadruple every year from 2018 to 2022 and NICB is still working on data for 2022 but for Q1 and Q2 which we have so far, it already surpasses the halfway mark for 2021 and this is all based on claims data submitted to NICB from our member insurers. And also on the screen here you can see a bar graph outlining the top five states for catalytic converter thefts. We have California, Texas, Minnesota, North Carolina and Washington State and you'll notice that those theft numbers are pretty similar to what we're seeing at the national level. With increased thefts comes second order effects and what that means is violence that's inflicted on innocent consumers, bystanders. In fact there's a famous case out of Texas of an off-duty Harris County Sheriff's deputy who was killed trying to prevent a catalytic converter theft from happening at a shopping center and unfortunately when folks are at the wrong place at the wrong time or even if they decide to step in to prevent the theft from happening that can result in serious bodily harm, serious injury and unfortunately in certain cases in death as well.

There's also a financial impact, specifically to companies that have large commercial fleets. For example Amazon - if Amazon parks their delivery trucks in a concentrated area that makes for an easy target for catalytic converter thieves who can swoop in and steal multiple converters all within a short amount of time. We're also seeing thieves becoming more organized with criminal rings stretching multiple states. In fact there's a case that the Department of Justice (DOJ) is looking on forfeitures of over half a billion dollars related to a criminal ring stretching from California to New Jersey and it includes states listed in that top five list that I previously mentioned. So how are states responding to this? Well before 2020 35 states already had some form of laws in the books for scrap metal and that's because scrap metal yards, recyclers, processors they're usually the ones who purchased used detached catalytic converters because they have the capability to extract those precious metals and recycle them into new products. In 2019 we started seeing an uptick in legislation being introduced that was focused specifically on catalytic converter thefts. So you've got just a summary here of increased metal prices, increase thefts and now we're seeing more bills being introduced to address this threat. From 2020 we saw 12 bills introduced in 2021 that's skyrocketed to 64 and then that doubled again in 2022 and when we're looking at the bills being introduced there are four themes here. One is scrap yard regulations so some examples of that are prohibiting cash transactions or making sure that transactions take place at a fixed business location. Another is buyer and seller restrictions so we're specifying who can buy and sell used attached catalytic converters. In some states that's restricted to regulated entities and in others you and me can sell used detached catalytic converters as long as we have the documentation to show that we lawfully owned that device. The third theme here is a presumption of guilt. That is something that we've seen introduced in a couple of jurisdictions. What that means is if I'm driving around with 10 catalytic converters in my trunk and I don't have documentation to show that I own them

it can be presumed that their stolen. This is a tool for law enforcement to help stem the rise of catalytic converter thefts. And then finally and perhaps most importantly, there are new criminal statutes. Unfortunately, catalytic converter theft generally falls under a state's theft statutes which are tied to the dollar amount of the item that's stolen. Well that doesn't account for the total loss for a catalytic converter theft and as I mentioned earlier that includes the replacement costs, the incidental damage, the threat to consumers - the cost that insurers have to face. A new criminal statute would provide and account for the total loss associated with a catalytic converter theft. So, NICB has been lobbying on this issue for several years now. We've lobbied on 55 bills and then we've seen 26 of them enacted. We've actually had the opportunity to work on some bill language with some sponsors and some jurisdictions and just to give you an example of some of the bills that were recently enacted in the last couple of years. Senate Bill 70 in Louisiana is a good example of a bill that established a new criminal statute for catalytic converter thefts. In Mississippi we have regulations on transactions for the purchasing and sale. And in Kentucky and Texas bills were enacted that established record-keeping requirements for catalytic converter transactions. And this is important because it increases the paper trail and helps law enforcement with their investigations of thefts. So as we move on to 2023 I want to quickly show that QR code you can scan that you'll see the list of bills that NICB is tracking and engaging on for catalytic converter legislation introduced this year. And so far we're looking at 74 bills introduced. And then there's a map there that shows the jurisdictions where they're being filed. I'm also happy to follow up after this with that QR code if folks have a hard time scanning that.

And just a couple examples of some bills that we're seeing introduced, Senate Bill 60 in Georgia is a good example of a bill that establishes registration requirements for purchasing catalytic converters. It prohibits cash transactions and establishes those record keeping requirements. We actually testified in person in Georgia in support of this bill. And then in Virginia we have Senate Bill 1135. This is a great example of a bill that raises criminal penalties up to a felony for a catalytic converter theft and then you'll also notice that presumption of guilt provision in there as well. So we're seeing all this legislation introduced at the state level. I'm happy to say that there's also legislation introduced at the federal level. NICB worked with Congressman Jim Baird on introducing the Preventing Auto Recycling Theft (PART) Act in 2022. We also had the opportunity to work with stakeholders and in other industries and you'll notice three themes. Some of them should sound familiar for what we're seeing at the state level. Strengthening criminal laws and penalties, regulating catalytic converter purchases, and also this third item of vehicle identification number (VIN) stamping. And what the federal bill does is it introduces a VIN stamping grant program to incentivize folks to bring in their vehicles so that way we can etch a serial number or VIN number on their catalytic converters and that does a couple of things. One, it deters criminals because now you have a catalytic converter that can be more easily tracked and flagged when they're trying to be sold on a secondary market. And then in addition to that it also provides law enforcement with yet again more information to be able to not only investigate these thefts but also potentially even recover the stolen items.

NICB is also working on model legislation on catalytic converter theft and we're using some of the provisions that we're seeing at the state and federal level to establish a model bill that we're hoping to be able to have a more extended conversation in the near future on. But the four themes of this model bill that we're working on is: establishing a new criminal statute so finally making it a separate crime in statute; buyer and seller

regulations - I won't rehash some of the themes but one additional example in there is establishing a holding period for a catalytic converter transaction so holding the consideration or the payment for that transaction for a few days and that's designed to deter those petty crooks from trying to make a quick buck off of a stolen catalytic converter; increased criminal penalties - so elevating these up to at least a felony and associated fines in terms of imprisonment; and the VIN stamping program - establishing entities like local law enforcement agencies to be able to host these VIN stamping events and encouraging folks to get out there and get your catalytic converter stamped.

Rep. Rita Mayfield (IL) stated that as you know we did pass legislation on this in Illinois but I did have a question on your VIN stamping program. You know how we feel in Illinois about doing grants. I need a line item to help do that. But why couldn't the manufacturer just automatically stamp that VIN on there when they're building the car? Mr. De Campos stated that we've had conversations with manufacturers and this topic did come up during discussions for the federal legislation but right now we want to focus it as a state issue and working it on encouraging folks to be able to work with their local law enforcement agencies and other stakeholders within the states to have their vehicles brought in and stamped at that point. So essentially making it a choice for them. Rep. Mayfield asked what is the approximate cost per vehicle to have that done? Mr. De Campos stated that is an excellent question and I'm happy to follow up with you after this in order to provide that information.

Rep. Tim Barhorst (OH) asked what the results have been in states that have enacted these types of laws. Mr. De Campos stated that it's still very early but and there's a lot of variation that we're seeing state by state. However, what we are seeing is increased deterrence. What we are seeing is improvement in tools that are available to law enforcement and prosecutors to be able to try these theft cases. We're also seeing a lot of activity coming on with combating organized criminal rings as you've seen or as you may have seen on those slides with what we're seeing not only at the DOJ but also at the state level as well. So we're starting to see some results and there's a lot more to come as well, especially when we can start establishing some more uniform guidelines on the legislation and providing the necessary tools that we need to combat this issue.

Rep. Jordan thanked Mr. De Campos and stated that these are issues that will continue to discussed in the future. If you have any questions, certainly you can reach out to me or to NCOIL staff and we'll be happy to try to answer them for you.

DISCUSSION AND CONSIDERATION OF NCOIL INSURANCE UNDERWRITING TRANSPARENCY MODEL ACT

Rep. Jordan stated that last on our agenda today is the consideration of the NCOIL Insurance Underwriting Transparency Model Act (Model), sponsored by Rep. Matt Lehman (IN), NCOIL Immediate Past President. As you likely know, Rep. Lehman has been working very hard on this and has been working up until this very moment on this issue and I think we're finally at a point now where the model is ready for a vote. You can see the model on the website and the app and your binders on page 196. Before we hear from our speakers today, I'm going to turn it over to Rep. Lehman for comments.

Rep. Lehman stated that I'm not going to go through the whole path that this thing has taken but I will say this on a point of kind of personal privilege here, in looking around this table and seeing a lot of new faces I think that is a fantastic advancement for NCOIL. So I do want to for those who have not been a part of this process just to give you a brief background. This was an issue that first presented itself probably the last five to six years where we began to see more and more insurance companies moving to artificial intelligence (AI) and moving to new models of writing insurance. I had a bill actually in Indiana back in 2022 and we pulled that bill and brought it to NCOIL and worked on that through 2022 and then in New Orleans this past November we said let's try to find a solution. We filled a bill in Indiana and that became the new NCOIL model. There are some changes I'm going to walk through briefly but I will say that I think that what we've been hearing over the last several years and what we've been seeing at NCOIL has been that this is not a fad. This is not a trend. I refer to it kind of as this is the new motor vehicle record (MVR). This is the new comprehensive loss underwriting exchange (CLUE). This is a new credit model. This is here to stay. And I think NCOIL needs to be the leader on getting our hands around the use of AI and data. I said when I was in leadership at NCOIL that NCOIL's focus is to build the foundations. We do not narrow this down to the exact language every state should pass. We build a good foundation and let the states add the trim and the color of the walls etc. So, I'm going to walk you through a little bit some key changes on this model from the time we started. I'm going to walk you through that and I do have a couple of things I would like to add to this as an amendment and I'll cite those as I go through this.

Since the last time we met we have removed declinations from the scope of the model. We are saying that this applies to any homeowner or auto insurance policy that's currently enforced at a renewal, etc. We changed "adverse action" to "material change" which that sounds generic but it really is more of the true thing and that is you're actually changing my policy. It can't be interpreted as an adverse action but it's really more of a material change. There was some concern on a couple of pieces that you might hear from the panelists dealing with non-renewal or cancellation or reductions in coverage because currently in Indiana and other states there are restrictions around what you have to disclose for non-renewal and cancellation. One of the things we want to be very clear of is we don't want to be duplicative so we did put into here language on the Federal Fair Credit Reporting Act saying if you're already indicating someone for that you don't have to do this as well. That may be in your state an issue around reduction or non-renewal and again I'm going to leave it in the model because I do think that's something that you need to look at your state on a piece by piece basis so I'm going to leave it in there for now. Next, regarding the terms that the model does not include, we put a list together over time, things like if it's insured initiated. If I increase my coverage they're going to actually increase my premium more than the filed rates of this in the state, then you do not have to disclose that. One thing I'd want to have some discussion around and at this time I didn't put it in the model - I think there needs to be some discussion around a lot of companies are doing homeowner inspections. We just saw a great presentation on Fortified and if they come out and they make changes to their policy based on those inspections then I don't think this would apply. The concern I think I've heard from some is companies can come out on a regular basis and continue to make changes and stay underneath that percentage. So at the present time I think it's something you can discuss back in your states. It could be an annual inspection type of thing, maybe that would work versus I can do 20 inspections and change every time and not hit that level. So that was a concern and I think it's something we can discuss.

There are a couple of drafting notes in the Definitions section, one on the application of declinations. As you know we talked in New Orleans and there were some who felt like it really should belong in there. I'm modeling this more or less on what we were able to be successful with in Indiana and Indiana that was not something we're going to be successful with. So it's not in the model but again that is something that I think you can take up with your state. On the transparency requirements, we do say that you shall provide a written notice to the insured and explain the principal factors and if you want more information then they can provide you with a written request and you can see the data in front of you. One change I would like to make on this relates to notification to a producer and I would like to add that such notification may be provided to the producer via the insurer's portal for producer communications. I'm an insurance agent and a lot of us get our data not through so much an email or mail but we get it through our portal that we get updated every day. Next, section 5(f) relates to requirements for the written notice that explains the material change and what you have to do is you must be sufficiently clear to the insured and use language sufficiently specific indicating things and you must include a description of the principal factors most heavily weighed. This model from the time we began has hinged on that sentence. We've gone from five points to ten points to different numbers of data. I think what we've ended up with is your state can set a number you want to set but for the sake of the model I think we're focusing on the most heavily weighed. We want to know what's moving the needle. So the key portion of that is the principal factors most heavily weighed.

And one other thing I'd like to change is an amendment in section 5(f). Currently, it says that the written notice "may" provide a point of contact. We want to be very clear that you "must" provide a point of contact so if I send you that written notice there has to be some data on there as to how I can contact you. I think that was always the intent but I think it needs to be clear that you must have that point of contact on that. So I would like to change that from a "may" to a "must." Again, from a drafting note standpoint we have in here that in your state you can look at whether there should be a specific number of principal factors disclosed but again the key here has always been those most heavily weighed. For the rest of the model we put some provisions around the Commissioner being able to set rules in this space and then an effective date can be when you feel like your state can implement this with some of the changes to those data models. The goal when we started this has always been and I think I started the presentation two years ago with, I have to have a reason and I can't keep telling my clients "I don't know." As a professional agent when people say, "why did my rate change by 14%?" - I can't say, "I don't know." I think this model starts us down that path. This is good transparency and sets that foundation. And the public wants transparency. With lack of transparency comes mistrust. And so I think as we talked yesterday about what's happening with personal data, we're on the cusp of a lot of things around gathering, collecting, holding and the use of personal data. I think this starts us in that narrow vein of insurance and I'd be happy to answer questions and would ask your support of this model.

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 this has been a long and painstaking process and this document here represents a compromise and there are some things in here that frankly our business people are going to find challenging to put in place. There are some things here which are probably good public policy. But I think at the end of the day one of the things that Rep. Lehman

has pointed out is that this is a beginning. We are starting to get our arms around this whole transparency issue. Getting our arms around different expectations. Some of the amendments that Rep. Lehman has suggested we think are good ones. We still have remaining concerns with some of the language in this proposal but on the other hand one of the things I can say is that it has been an exhausting two year effort on the part of the interaction and there have been a lot of different viewpoints expressed. A lot of different changes have been made. We appreciate the interaction that we have had with Rep. Lehman and with others who have had different points of view. This is probably about as good as it's going to get. So with that I know that there are other issues and other concerns. And I think I'll leave my comments at that and we'll move forward as the discussion goes.

Jon Schnautz, Ass't VP of State Affairs at the National Association of Mutual Insurance Companies (NAMIC) thanked the Committee for the opportunity to speak and stated that back at the November meeting in New Orleans we had three major issues at that point that let us to oppose the model. I'm happy to report that two of those have been addressed fully and that this model I think is safe to say from our perspective is much better than it was at any earlier stage. The position I think we find ourselves in today given the significant changes that have been made and the understandable desire by Rep. Lehman to move forward on this is that we do not oppose NCOIL's adoption of the model. I do also think that as this goes forward and we see how this fits into the web of existing state laws that are out there on the subject, we might find ourselves even in a position to support some version of this concept. I will briefly touch on a couple reasons why we don't find ourselves in the position to endorse it today. First, I mentioned we have three issues and that two of them had been resolved. The math suggests there's one remaining and that is the language around the disclosure itself, what actually has to be disclosed. On that issue the language that NAMIC's members preferred was based on something taken from the NCOIL Model Act Regarding the Use of Credit Information in Personal Insurance. As Rep. Lehman alluded to some of that language was taken but the other language that was in the earlier version of the model, minus the specific number of factors, is also still in the model and our members remain much more comfortable with the credit model framework for reasons I can go into if there are questions on that point.

Second, the experience since November I think, at least for me, has been instructive in terms of what state laws are already out there on this subject. Rep. Lehman alluded to the existing Indiana law. I think that issue is going to be addressed in Indiana and the issue here for us is one of the points for example on the Fair Credit Reporting Act provision that we have tried to make from the beginning is avoiding, I don't want to say duplicative notice because if it was truly duplicative you could just say, "okay well you have to give the same notice twice", is that really that big of a deal? It's really overlapping notices that say different things, that require different things that we do not want in any state law anywhere frankly. I think that's going to be fixed in the bill in Indiana and we appreciate that. The approach that the model takes though as we read it is sort of a layering approach. It basically says if there's existing law on this this goes on top of that and both apply and from our perspective that is still problematic. Briefly I will say in my home state of Texas I will bashfully admit I didn't know this in November, but I've since found out we have an existing notice and have to give a reason requirement on request for cancellations and non-renewals already. If this bill was introduced there I

think we would be suggesting amending that statute or trying to align the two but not just putting one on top of the other.

And finally, sort of along the lines of that same point, back in November I think the very first thing I said to the committee was that our main concern was value. It's not that this isn't doable, at least for large companies. It's what is the value balance of doing it? What's the value of the policyholder versus the cost to the company which is ultimately going to be borne by all policyholders? I will say I think without betraying any secrets the industry right now as a whole is extremely sensitive to cost increases, perhaps historically so. To give one example there's a bill set for hearing in Texas next week. It's one of my ex-boss's bills so that's always interesting but I'm going to oppose it and all the bill does is increase the non-renewal notice time frame. Not reasons, just the time frame. That sounds very simple. I can explain why it's more complicated than it sounds if you'd like. It's good practice for the hearing next week. But even something as simple as that is a concern to our members. I know from the feedback I've received from them. And this model for all its virtues is exponentially more complicated than that. So I think that just provides some context to where we are. To end on I think a hopeful note, I do want to say we are really grateful for what Rep. Lehman has done to this model. It is in a lot better shape and I think as Mr. O'Brien alluded to and as Rep. Lehman did too, this is probably not the end of anything. This is probably part of an ongoing conversation and we intend to remain part of it.

Wes Bissett, Senior Counsel of Gov't Affairs for the Independent Insurance Agents and Brokers of America (IIABA) thanked the Committee for the opportunity to speak and stated that I think you said it and summed it up perfectly a few minutes ago when you said that this proposal is ready for a vote. And in the strongest possible terms when you come to vote we hope that vote will be a yes vote. I'd like to make four points with regard to this proposal. First, in our view there is a clear and overdue need for this and value in doing this. As Rep. Lehman said the underwriting process in personal lines in recent years has become increasingly complex. Insurers are using new types of data, complex models, analytics in ways that they've never done before. And those innovations are positive but one of the consequences of that is that the rating process is far less intuitive than it used to be. Not that long ago it was pretty simple. If you had a spate of recent accidents you could expect your rates to go up. If you added a teen driver to your auto policy you could expect your rates to go up. But what we see today is that large increases are oftentimes counterintuitive. Consumers don't understand why they've had a 15% increase and their agents can't explain it to them. And oftentimes when those agents go to the companies asking for an explanation, the company contacts that they have can't explain those either and that's a frustrating outcome and respectfully not a good thing either. So all this model does at the end of the day and it's not complex and it doesn't impose a lot of costs on companies, it merely requires companies to say to the consumer if you have questions about a significant rate increase you have the ability to ask for more basic information about that. That's all it does. There's also a need for this because individual states and the NAIC are beginning to act in this space and some of those proposals are going far beyond this proposal that you have before you today and some of the proposals are very troublesome and frankly unreasonable. What we believe should happen is that there ought to be a thoughtful pragmatic solution to this issue that's frankly legislative based. We don't need unilateral regulator action in this area and I think the balance that's been achieved here is the appropriate one and one that ought to be acted on.

Secondly, I'd say that this proposal is very reasonable. It does strike a balance. There's nothing draconian in here or unreasonable. It simply brings some basic transparency to the process if you actually ask for it. In most cases consumers probably won't ask for it and so there's not this significant cost that maybe some have suggested. It only applies if you're non-renewed or if you get an individualized 10% rate increase or more and not even 10% total, 10% above the base rate increase that would apply in a particular state. And there's lots of reasons why this is important and why there's value in this. Consumers ought to have a basic understanding of why their rates have increased especially if that's a dramatic rate increase. And this would give them the ability to rectify any mistakes in the information that was used if it was incorrect or incomplete so they can act to improve those outcomes. And frankly it helps restore faith and trust in the insurance rate making process, something that there are increasingly questions about today. This would hopefully restore that faith and trust. I appreciate the work that's gone into making this a reasonable and tailored proposal. Third, I'd say this is also not a novel or new concept - in the banking context for many years federal law in the form of the Equal Credit Opportunity Act and regulation B has had a framework exactly like this. If you get denied a loan or a loan changes you have the ability to request this exact type of information. So there's a clear Federal banking parallel. There's also an insurance parallel - when insurers began using credit information 20 years ago NCOIL adopted a comprehensive credit model and one of the things in that said if there is an adverse action taken you can get information about the reasons for that. So in the banking context you can get this information. If insures take an adverse action based on credit information you can get sort of basic information about the reasons why. And all this does is kind of bring things up to date given the new underwriting factors that exist. Finally, I'll say even if you don't intend to bring this back to your state we would still urge you to offer a yes vote today. There is significant and sufficient interest among many states in this and we need a thoughtful pragmatic narrowly tailored legislative based response for those policymakers that want to address this issue in their state. So again I appreciate the hard work that Rep. Lehman, the NCOIL staff, and my industry colleagues have put into this and strongly urge you to provide a yes vote today.
Robert Herrell, Executive Director of the Consumer Federation of California (CFC), thanked the Committee for the opportunity to speak and stated that I'll be speaking this afternoon on a couple of items as well. I know one of the things that NCOIL tries to do is bring in some local regional folks so let me just spend about 30 seconds on a little bit of California context and then I'll pivot directly to the model in front of us. In California you have prior approval in the auto context and in the homeowners context. That's important. That's a major consumer reform that happened in 1988. There's a much longer story behind that, five initiatives on the same ballot at the same time and the only one that was successful was the one that added that prior approval and also reduced rates in some cases. So there's a long history. There's been work done by other organizations about the savings to consumers pursuant to that. So that's part of the context. Secondly, to get a little more specific and I appreciate at the beginning of this session talking about some of the natural disasters and some of the work that has been done in Louisiana and elsewhere, California will face earthquakes which is obviously a different type of insurance. We just recently had a very wet winter, we faced a blizzard notification which is exceedingly rare in California and you've had some roofs collapse for example because of the weight of snow and things like that. Things that are not very common especially since we have been in a multi-year drought and are now maybe just getting out of it. But the other thing I want to point out is in 2018 when I worked for the

California Department of Insurance, I worked there for almost six years is a Deputy Commissioner, we sponsored a bill authored by then state Senator Ricardo Lara, now California's insurance Commissioner, that was very important and it allowed the Commissioner the authority after you have for example wildfires or some other disaster, particularly it's been used in the wildfire context, to identify by ZIP codes areas in which the insurers are not allowed for a year to decline or to non-renew. That important buffer zone has been really critical when you think about the context of disasters especially out here in California where you've had a lot of wildfires. Paradise came up earlier and that whole town basically was decimated.

So that context I think is relevant to then pivoting to what Rep. Lehman is trying to do here with this model. I'll be brief and pivot to some additional thoughts. In the model that is available, and I have not been involved in a lengthy period of time in this so I come in at this relatively new and I appreciate Rep. Lehman's modifications with agent notification and things like that, there are some drafting notes. And generally speaking I think the view of CFC and the view of other consumer organizations would be give consumers actionable understandable information when something happens. I think that's such a foundational principle here that ought to underly everything that we do in this area. For example, one of the cost limitations is that a lot of people won't ask for the explanation. I would add declinations to the scope of the model. I know that's an issue that has come up in some of the debate. I would add that. Tell me why. Give consumers the information that they are so desperately seeking so they can understand and act on it. I just think that's so fundamental to what we ought to be doing here. So the drafting notes I think are very helpful. This is a good first step don't get me wrong but I do think that what I sort of heard reading between the lines a little bit is that the insurance industry and your state reserves the right to oppose any bill that you propose in this area and may do so depending on what's going on. So you'll have to obviously fight those battles within your respective state legislatures and work with your respective Commissioners. Also, make the explanation automatic. Don't force the consumer to have to ask. And this says in writing. Make it easy for them such as a hyperlink or a form that they can just fill out to find out. Or better yet, tell them. Tell them what you know. In California we dealt with FireLine scores and things like that where some companies just automatically if the numbers the wrong number you get declined with no explanation. We had literally state legislators get denied and they couldn't find out. Legislators who were insurance agents. So, the principal factors I think is important to be included in your respective states. Try to get more information out there. The retroactivity really isn't an issue here because these are policies that renew every six months or a year so pretty quickly you get everyone up to speed. I'm happy to answer any questions but that's our general sense – a good step in the right direction but try to strengthen it so that consumers understand what's going on. Give them actionable, reasonable, understandable information.

Asw. Pam Hunter (NY), NCOIL Treasurer, stated that she doesn't necessarily have a question but rather a comment. I know we've been having this conversation for several years and regarding Mr. Herrell's comments, I do think that it is important to bring it back to the consumer level. I think a written request is something outside the scope of what many of my constituents would be doing quite honestly. I do think that we've come a long way in this conversation for the past couple years and I appreciate the work. I think that if we were to bring this back to New York with this model we would probably be adding a lot more stuff in there relative to not making it so difficult for a consumer to

have to get that information. Insurance is very confusing and complex to many folks and being able to I think use actionable and understandable information is important and I think that's something that we need to make sure that we are incorporating. So I appreciate those comments.

Rep. Jim Dunnigan (UT) stated that he had a question for Mr. Schnautz – Mr. Bissett mentions that the model really doesn't require you to do much if the consumer doesn't ask for it. So what is your concern? I understand the concern about expenses but do you see it that it does require you to do stuff if the consumer doesn't ask for it? Mr. Schnautz stated that the model goes two ways on that. The company can just provide the reason without waiting for a request or it can wait for a request. So it is true that the company could just say well if we don't get requests we're not going to respond to them. From a company management perspective though they have to be prepared to do it. They have to have a process to do it so they could do that two ways. They could say well it's too expensive and our IT Department says it'll cost however many dollars we're just going to do it manually for requests. That's a little bit dicey because you don't know how many you're going to get and any manual process is going to take a lot of time to comply with. So they're going to have a choice there. Do they program it or do they take a chance that they don't get that many requests? But either way there are issues to deal with there. It's not just oh well it's on request maybe we won't get any. You have to be prepared to comply with the law if and when you get requests.

Rep. Dunnigan thanked Rep. Lehman for his work on this and stated that it seems that one of the concerns is the disclosure not following the credit models. Is there a reason that you didn't follow the credit model disclosure and went down a little bit of a different path? Rep. Lehman stated that I think a lot of that was I think the credit model, if you look at what that's based on it's on one factor. There's many factors that go into a credit model but it's purely around using that piece of credit as the factor. What we're seeing here is they're using multiple data points and so they could be using social media data, they can be using buying habits, obviously they'd be using driving habits. They formulate all that into what we call the black box you might say and what we're looking at is where the credit model might take in pieces of data it sends out one piece. This is sending out multiple pieces of that data which is why we started with a number of factors because we want to make sure people are clear as to what's driving this, what's making this change? Because another thing is we want people to be able to correct inaccurate data so if I know what's driving this and you're more specific to those principal factors I can maybe address those changes. That's why we didn't just mirror it exactly. We actually went to be a little bit broader. Rep. Dunnigan asked Rep. Lehman to speak to layering - what if a state already has something on this. It doesn't sound like there's an exemption in the model for if it's already being done or something similar is being done. Are you concerned about layering? Rep. Lehman replied yes and stated that I think that's why you have to go state to state. I think the issue around even non-renewals and cancellations, as Mr. Schnautz stated he was surprised that Texas has that. Well Indiana has had it for decades, requiring the if you send a non-renewal notice you have to be specific as to why you are non-renewing. You have to be specific to why you're canceling. Cancellations are very thin and that is usually non-payment or a material change in your exposure whereas non renewal can be from multiple reasons. And so it's still in here because I think if you don't address that in your state you need to. You can do it through this or you can do it through other sections of your code. So I think that from a duplicative standpoint, what we don't want to do is if I have to notify you

because of one factor, it’s clear why I'm doing this and it's under the credit scoring issue or under a non-renewal issue. If I'm already being very clear why I'm doing that I've got to send that notice out. Then you don't need to comply with this section of that code as well. So it would not be sending out two notices.

Sen. Lana Theis (MI) thanked everyone for their comments and stated that coming from Michigan where this particular market has gone through some dramatic turbulence of late, I'm concerned about injecting yet one more aspect into the equation that is going to be something that insurers are going to end up having to try to figure out beyond all of the stuff with the changes that we made legislatively and with the court cases that are still up in the air. Has anybody done the math on what this might actually end up costing our insurers? Mr. O’Brien stated that I’m going to try to answer your question but I'm also going to go beyond that just a little bit. This is going to be expensive to implement and there are going to be significant operational hurdles and that will obviously have to be put into the legislative mix as this model or something based on it is put before the legislature. I'm going to borrow Mr. Herrell's words, this was a very thoughtful and engaged process and there was a lot of consideration that went into various things. We came to a place where we thought we're trying to put in place something that will provide consumers with actionable information that they can use regarding their insurance policies and perhaps change things or do things differently in order to impact their rate. We're trying to also balance that with as I mentioned the very significant expense and operational concerns in terms of putting this in place. There was a debate concerning whether to have this as an automatic type of thing that gets sent out to everybody. In some ways, for some companies, that might be easier for them to accomplish in their systems. But on the other hand after all the other notices it becomes white noise. So some of the drafting decisions in some of the policies in here after extensive discussion reflect some policy choices that you could make a credible argument for the other way around as well. For example going back to Rep. Lehman's amendment that was put in place just a few minutes ago concerning inspections. You can make an argument about inspections and the impact that an inspection is going to have and there could be something that would result from that inspection. So is there really a need to have a notice? Maybe yes, maybe no. I can tell you it's not going to be cost effective for any company to do multiple inspections on a property during the course of a year or a lot of companies will do it every couple of years, stuff like that. So at the end of the day this is a compromise with a capital C. There's a lot in here that we could live with, there's a lot of things that we think are going to be challenging for us. Similarly, from the consumer protection point of view you could go completely the other way but we're trying to thread the needle on a practical solution.

Mr. Herrell stated that insures know when and why you're denied or non-renewed. So I think the cost will be a lot less than sometimes the sky is falling things that you sometimes hear. That's not to say that there won't be any cost. I'm neither naïve nor unsympathetic about that. The other thing I would just note and I don't mean this in a disrespectful way, carved out of this is anything that relates to an increase in the insurer’s filed rate plan. Now most states don't have prior approval so the insurer’s filed rate plan once it's finalized and is in place, that's exempted. You've just exempted out probably a big chunk of the people who should get this information and would want and need this information. I find it ironic that insurers are using a lot of big data and AI as Rep. Lehman mentioned and the files on consumers are extensive and to be candid a little bit scary but when they're asked to tell you something that you could actually take

action upon as a consumer all of a sudden it's oh my God we can't do that or it's going to be too expensive. So I would like to just put that in some perspective.

Sen. Theis asked for any of the states that have implemented this, has there been any legal liability where the consumer disagreed with what it was that the insurer was informing them of and then turned around and sued as a result? Mr. Herrell stated that I think that would depend on whether you're in a mandatory issue situation or not. Off the top of my head I know that in California you don't have mandatory issue and so what we've seen in the face of wildfires is insurers, as the Wildland Urban Interface area (WUI) has shown, have pulled out of areas where they're worried about their risk profile. So I think mandatory issue has a lot to do with how that question gets answered and to my knowledge it's very rare to see mandatory issue anywhere in this country. Rep. Jordan stated that other speakers can answer that questions with a yes, no, or I don't know. Mr. Schnautz stated that this model hasn't been adopted anywhere. Rep. Jordan stated so that's a no. Rep. Jordan then recognized Rep. Lehman for closing comments.

Rep. Lehman thanked everyone for their input on this. A couple things I just want to bring up related to points that were made. One is I think we give a lot of leeway to the Department of Insurance that promulgates rules and so you're going to have to be very clear during that process. Also, this has not been implemented in any state and Indiana is the first state to really adopt something close to this. It's in the Senate now and it's going to probably be changed as I'm hearing but I'd also say NCOIL passes models that we think are good longer term. If it doesn't fit your state right now, don't implement it in your state right now but I think we have to get the template out there and then have that discussion. Regarding the issue of we're carving out a huge chunk of people from the filed rates, again I'll use Indiana as an example. I would say over the last five years our rates in Indiana have basically stayed fairly flat. We've got some small increases here or there but really we have a very competitive market. So my focus wasn't on showing everything but simply saying if you're going to be outside that competitive market an individual disclosure applies. That's why it's the 10% above those filed rates. I do think the market is responding to the competition. These are the outliers. And with that I'd appreciate the Committee's support.

Rep. Jordan stated that before I make some brief comments I'm going to just remind you that we're going to have I think two amendments to vote on. So we're going to vote on the amendments first and then on the model with the amendments if they pass. Per the NCOIL bylaws only members of the committee are allowed to vote so if you're not a member of the committee you won't be allowed to vote. That being said, I am going to start by agreeing with Mr. O'Brien. I think this model is a compromise with a big C. I want to thank Rep. Lehman again for all the hard work that he's done on it because I will tell you I'm the one that thinks it has been compromised on the other side. I certainly think it should apply to declinations as well. And let me just give some context to where we are on this and it sort of disappoints me to hear some of the folks in the industry against this but again I won't let the perfect be the enemy of the good. On May 25th of I believe 2020 there was the death of George Floyd ironically in Minneapolis where our next meeting will be held. Under the leadership of Rep. Lehman he started the NCOIL Special Committee on Race in Insurance Underwriting. From that in part is where this model emanates from and I don't want that to be lost on anybody because it's three years later and now things somewhat go back to normal because at the time everybody in the industry was talking about diversity, equity and inclusion and some of the things

that we could do to make things better and more transparent. And I think this is an effort by Rep. Lehman to try to reach that. So from that perspective I would hate for the perfect to be the enemy of the good and let this model fail and I would certainly hope that everyone would vote for it. That being said again I don't want it to be lost that it is a big compromise and as someone who participated in that aforementioned committee along with others I don't want that work to be for naught.

So with that being said I just want to be clear we have two amendments to consider, one relating to the notice to agents being made through the portal, and the other is changing “may” to “must” regarding providing a point of contact. Rep. Lehman replied that is correct. Rep. Jordan stated that he will entertain a motion for those amendments. Upon a Motion made by Rep. Michael Sarge Pollock (KY) and seconded by Rep. Forrest Bennett (OK), the Committee voted without objection via a voice vote to adopt the amendments.

Rep. Jordan then stated that he will entertain a Motion to adopt the model as amended. Upon a Motion made by Rep. Bennett and seconded by Rep. Pollock, the Committee voted to adopt the model as amended via a voice vote. There were two voice votes in opposition to the Motion.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Bob Hackett (OH) and seconded by Del. Steve Westfall (WV), the Committee adjourned at 10:30 a.m.

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CHIEF EXECUTIVE OFFICER: Thomas B. Considine

National Council of Insurance Legislators (NCOIL)

Proposed Amendments to NCOIL Model State Uniform Building Code

Proposed Amendments are sponsored by Rep. Jim Dunnigan (UT) and are to be discussed during the NCOIL Property & Casualty Committee on July 22, 2023

SECTION 1.

A. Beginning January 1, 20XX, property insurance companies shall provide a premium discount or insurance rate reduction to any owner who builds or locates a new insurable property in the State of XXXXXXXXX if the insurable property is certified as being constructed in accordance with the standards set forth in subsection B of this section. Insurance companies shall be required to offer such a premium discount or rate reduction only when the insurer determines they are actuarially justified and there is sufficient and credible evidence of cost savings, which can be attributed to the construction standards set forth in subsection B of this section. In addition, insurance companies may also offer additional adjustments in deductible, other risk differentials, or a combination thereof, collectively referred to as other adjustments.

B. To obtain the premium discount, rate reduction, or other adjustment provided in this section, an insurable property in this state shall be certified as constructed in accordance with the FORTIFIED Home High Wind and Hail Standards as may from time to time be adopted by the Institute for Business and Home Safety or a successor entity. An insurable property shall be certified as conforming to the FORTIFIED Home High Wind and Hail Standards only after evaluation and certification by an evaluator certified pursuant to the FORTIFIED Home High Wind and Hail Standards.

C. An owner of insurable property claiming a premium discount, rate reduction, or other adjustment pursuant to this section shall maintain sufficient certification records and construction records including, but not limited to, a certification of compliance with the FORTIFIED Home High Wind and Hail Standards provided in subsection B of this section, receipts from contractors and receipts for materials. The records shall be subject to audit by the Insurance Commissioner, or his or her representatives, and copies of any

such records shall be presented to the insurer or potential insurer of a property owner before the premium discount, rate reduction, or other adjustment becomes effective for the insurable property.

D. Insurers that write policies that are subject to the premium discount or rate reduction required by this section shall submit a rating plan certified by their actuary as actuarially justified providing for the premium discount or rate reduction described in this section. A premium discount, rate reduction, or other adjustment shall only apply to policies that provide wind or hail coverage and to that portion of the premium for wind or hail coverage. A premium discount, rate reduction, or other adjustment shall apply exclusively to the wind and hail premium applicable to improved insurable property. If an insurer already offers an actuarially justified hail resistance discount, that discount shall be deemed as having met the requirements of this act as it pertains to hail-related discounts or rate reductions and no additional hail-related discount or rate reduction shall be required. If an insurer already offers an actuarially justified discount for IBHS FORTIFIED Home standards, that discount shall be deemed as having met the requirements of this act as it pertains to wind-related discounts or rate reductions and no additional wind-related discount or rate reduction shall be required. Insurers shall apply any applicable premium discount, rate reduction or other adjustment to the wind and hail premium at the policy renewal that follows the submission of the certification to the insurer. At the time of a policy renewal for which a premium discount, rate reduction, or other adjustment has previously been made, the insurer may request documentation or recertification that the fortified standards as described in subsection C of this section continue to be met. In addition to the requirements of this section, an insurer may voluntarily offer any other mitigation adjustment that the insurer deems appropriate.

SECTION 2.

A. Beginning January 1, 20XX, property insurance companies shall provide a premium discount or insurance rate reduction to any owner who retrofits an insurable property in the State of XXXXXXXXX if the insurable property is certified as being retrofitted in accordance with the standards set forth in subsection B of this section. Insurance companies shall be required to offer a premium discount or rate reduction only when the insurer has deemed the adjustments to be actuarially justified and there is sufficient and credible evidence of cost savings, which can be attributed to the construction standards set forth in subsection B of this section. In addition, insurance companies may also offer additional adjustments in deductible, other risk differentials, or a combination thereof, collectively referred to as other adjustments.

B. To obtain the premium discount, rate reduction, or other adjustment provided in this section, an insurable property shall be retrofitted to the FORTIFIED Home High Wind and Hail Standards, as may from time to time be adopted by the Institute for Business and Home Safety (IBHS) or a successor entity. Wind-Zone-3-HUD-Code manufactured homes installed on a permanent foundation and retrofitted as defined in the FORTIFIED Home High Wind and Hail Standards, as may from time to time be adopted by the Institute for Business and Home Safety or a successor entity, shall be eligible for

the premium discount or rate reduction provided in this section. An insurable property shall be certified as conforming to FORTIFIED Home High Wind and Hail Standards only after evaluation and certification by an evaluator certified pursuant to the FORTIFIED Home High Wind and Hail Standards.

C. An owner of insurable property claiming a premium discount, rate reduction, or other adjustment pursuant to this section shall maintain sufficient certification records and construction records including, but not limited to, a certification of compliance with the FORTIFIED Home High Wind and Hail Standards as provided in subsection B of this section, receipts from contractors, and receipts for materials. The records shall be subject to audit by the Insurance Commissioner, or his or her representatives, and copies of any such records shall be presented to the insurer or potential insurer of a property owner before the premium discount, rate reduction, or other adjustment becomes effective for the insurable property.

D. Insurers that write policies that are subject to the premium discount or rate reduction required by this section shall submit rating plans certified by their actuary as actuarially justified providing for the premium discounts or rate reductions described in this section. A premium discount, rate reduction, or other adjustment shall only apply to policies that provide wind or hail coverage and to that portion of the premium for wind or hail coverage. A premium discount, rate reduction, or other adjustment shall apply exclusively to the wind and hail premium applicable to improved insurable property. If an insurer already offers an actuarially justified hail resistance discount, that discount shall be deemed as having met the requirements of this act as it pertains to hail-related discounts or rate reductions and no additional hail-related discount or rate reduction shall be required. If an insurer already offers an actuarially justified discount for IBHS FORTIFIED Home standards, that discount shall be deemed as having met the requirements of this act as it pertains to wind-related discounts or rate reductions and no additional wind-related discount or rate reduction shall be required. Insurers shall apply the premium discount, rate reduction, or other adjustment to the wind premium at the policy renewal that follows the submission of the certification to the insurer. At the time of a policy renewal for which a premium discount, rate reduction, or other adjustment has previously been made, the insurer may request documentation or recertification that the fortified standards as described in subsection C of this section continue to be met. In addition to the requirements of this section, an insurer may voluntarily offer any other mitigation adjustment that the insurer deems appropriate.

SECTION 3.

For the purposes of this act, the term "insurable property" includes single-family residential property. Insurable property also includes modular homes satisfying the codes, standards or techniques as provided in Section 1 or 2 of this act. Manufactured homes or mobile homes are excluded, except as expressly provided in subsection B of Section 2 of this act.

SECTION 4.

This act shall only apply to new insurance policies written, or existing policies renewed, on or after January 1, 20XX.

SECTION 5.

The Insurance Commissioner shall promulgate such rules as are necessary to implement and administer this act.

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CHIEF EXECUTIVE OFFICER: Thomas B. Considine

NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

Model State Uniform Building Code

Readopted by the NCOIL Executive Committee on July 15, 2012, and by the Property-Casualty Insurance Committee on July 13, 2012. First adopted by the Executive Committee on March 3, 2007, and by the P-C Insurance Committee on March 2, 2007. Re-adopted by the NCOIL Property & Casualty Insurance Committee on July 12, 2018 and the NCOIL Executive Committee on July 15, 2018
Sponsored by Rep. George Keiser (ND)

**To be considered for re-adoption during the Property & Casualty Insurance Committee meeting on July 22, 2023.*

****Proposed amendments sponsored by Rep. Jim Dunnigan (UT)***

Section 1: Purpose

A. This Act provides for the adoption, updating, amendment, interpretation, and enforcement of a single, unified state building code that applies to the design, construction, erection, alteration, modification, repair, or demolition of public or private buildings, structures, or facilities in this state to provide effective and reasonable protection for public safety, health, and general welfare at reasonable costs, and establishes a Building Code Commission to effect those ends.

B. This Act establishes statewide building standards that would take effect one (1) year after enactment. For hurricane, flood, and seismic exposure areas in the state, the Act requires that such high-hazard areas implement those standards no later than 90 days following enactment.

C. This Act is intended to permit the fullest use of modern technical methods, devices, and improvements; encourage the use of standardized construction practices, methods, equipment, materials, and techniques; and eliminate restrictive, obsolete, conflicting, and unnecessary building regulations.

D. This Act provides that local governments shall have the authority to enforce the [insert state] Uniform Building Code.

Section 2: State Building Code Commission

A. A Building Code Commission shall be established in the [insert appropriate state agency] to perform the following functions in establishing and administering the state's Uniform Building Code program:

1. review, modify, update, and promulgate the building codes referenced below in accordance with provisions of this Act and the Administrative Procedures Act of this state

2. promulgate rules and regulations to modify portions of the [insert state] Uniform Building Code as provided by this Act

3. review and update the [insert state] Uniform Building Code at least every three (3) years

4. establish qualifications for personnel responsible for inspection and enforcement of the [insert state] Uniform Building Code

5. adopt rules and regulations prescribing minimum standards for administration and enforcement of the [insert state] Uniform Building Code

6. assist counties and municipalities in establishing programs to ensure consistent, effective, and efficient administration and enforcement of the [insert state] Uniform Building Code

7. develop, and in conjunction with counties and municipalities, disseminate training and education programs for code officials and contractors and programs to raise homeowners' awareness of steps that they may take to enhance the safety, comfort, value, and livability of buildings

8. review all requests from municipalities or counties for variation from the [insert state] Uniform Building Code to determine which variations, if any, are justified by local conditions and may be enacted after a finding on the record that modification does not diminish structural integrity or stability to affect the public health, safety, and welfare

9. provide interpretations of contested provisions of the [insert state] Uniform Building Code

10. in conjunction with appropriate state, municipal, or county government agencies, resolve requirements of those agencies that conflict with the application or enforcement of the state Uniform Building Code

Section 3: Commission Membership

A. The Building Code Commission shall consist of 16 members appointed by the governor, subject to Senate confirmation, who each will serve for a period of four (4) years. Members shall be appointed within 15 days of the effective date of this Act. Initial appointments shall be staggered, with six (6) appointments for a two (2) year period; six (6) appointments for a three (3) year period; and three (3) appointments for a four (4) year period. Vacancies shall be filled for the remainder of an unexpired term.

B. The Commission shall consist of:

1. an architect licensed in this state

2. a structural engineer licensed in this state

3. a mechanical or electrical engineer licensed in this state

4. a general contractor doing business in this state

5. a residential contractor doing business in this state

6. a municipal administrator, manager, or elected official

7. a county administrator, manager, or elected official

8. a representative of the State Fire Marshall

9. a certified code enforcement official

10. a representative of the plumbing industry doing business in this state

11. a representative of the electrical industry doing business in this state

12. a representative of the mechanical or gas industry doing business in this state

13. a representative of the manufactured housing industry

14. a disabled person

15. a representative of the property-casualty insurance industry

16. a representative of the general public

Section 4: Commission Administration

A. The Commission shall:

1. convene within 45 days of the effective date of this Act

2. elect from its members a chairman

3. meet at least four (4) times a year

a. at the call of the chair

b. at the request of a majority of its membership

c. at the request of the [insert appropriate state agency]

d. or at such times as may be prescribed by the Commission's rules

B. Members shall be notified in writing of the time and place of a regular or special meeting at least seven (7) days in advance of the meeting. A majority of members of the Commission shall constitute a quorum.

C. The Commission and its members shall be immune from personal liability for actions taken in good faith in the discharge of their responsibilities. The state shall hold the Commission and its members harmless from all costs, damages, and attorney fees arising from claims and suits against them with respect to matter to which immunity applies.

D. Members of the Commission shall receive per diem or other compensation for their duties on the Commission, as determined by state policy.

Section 5: State Uniform Building Code

A. The Commission, pursuant to the State Administrative Procedures Act, shall adopt a State Uniform Building Code to take effect within one (1) year of the effective date of this Act.

B. The State Uniform Building Code shall contain or incorporate all laws and rules that pertain to and govern the design, construction, erection, alteration, modification, repair, and demolition of public and private buildings, structures, and facilities and the enforcement of such laws and rules, except as otherwise provided in this Section.

C. The provisions of this Act shall not apply to structures that are constructed on a farm, other than residences or structures attached to them.

D. The Commission shall adopt a State Uniform Building Code by reference to the latest editions of the following nationally recognized codes and the standards for the regulation of construction within this State: building, residential, existing buildings, gas, plumbing, mechanical, electrical, fire, and energy codes as promulgated, published, or made available by the International Code Council, Inc. and the National Electrical Code as published by the National Fire Protection Association. The appendices of the codes

provided in this Section may be adopted as needed, but the specific appendix or appendices must be referenced by name or letter designation at the time of adoption.

E. The Commission may modify the selected model codes and standards as needed to accommodate the specific needs of this state provided that modifications do not diminish structural integrity or stability to affect the public health, safety, and welfare.

F. Counties and municipalities, upon review and approval by the Commission, may adopt amendments to the technical provisions of the State Uniform Building Code that apply solely within their jurisdictions and that provide for more stringent requirements than those specified in the State Uniform Building Code.

G. The Commission shall review and update the State Uniform Building Code ~~at~~ to maintain a code version that is no older than four (4) years old~~least every three (3) years~~.

H. To the extent that federal regulations preempt state and local laws, nothing in this chapter shall conflict with the federal Department of Housing and Urban Development (HUD) regulations regarding manufactured housing construction and installation.

Section 6: State Building Code Provisions Addressing Catastrophic Hazards—Wind, Flood, and Seismic

A. Wind and flood mitigation requirements prescribed by the ~~2006 or later~~ most current version of the International Building Code and ~~2006 or later~~ most current version of the International Residential Code are adopted by this Act and shall apply within [insert appropriate areas of state] and seismic requirements by the 2006 or later most current version of the International Building Code and the ~~2006 or later~~ most current version of the International Residential Code shall apply within [insert appropriate areas of state].

B. Wind, flood, and seismic code provisions shall be enforced no later than 90 days from the effective date of this Act. If counties or municipalities are unable to enforce the provisions of this Section, the [insert appropriate state agency] shall enforce the provisions.

C. The [state agency] may establish contract agreements with counties, municipalities, and third party providers in order to provide enforcement of this Section.

Section 7: Enforcement

A. Notwithstanding any other law to the contrary, all counties and municipalities in this state shall enforce only the State Uniform Building Code as provided for in this Act, including enforcing any more stringent county or municipal standards as authorized under Section 5(F).

B. The Commission shall promulgate rules and regulations prescribing minimum standards for administration and enforcement of the State Uniform Building Code.

C. Such rules and regulations shall address the nature and quality of enforcement and shall include, but not be limited to, the frequency of inspections; number and qualifications of staff, including qualifications required for inspectors; required minimum fees for administration and enforcement; adequacy of inspections; adequacy of means for insuring compliance with the Uniform Code; and procedures whereby any provision or requirement of the State Uniform Building Code may be varied or modified, subject to requirements of this Act.

D. Municipalities and counties may establish agreements with other governmental entities of the state to issue permits and enforce building codes in order to provide the services required by this Act.

E. The Commission may assist in arranging for municipalities, counties, or consultants to provide the services required by this Act to other municipalities or counties if a written request from the governing body of such municipality or county seeking assistance is submitted to the Commission.

Section 8: Penalties

Should any building or structure be maintained, erected, constructed, reconstructed, or its purpose altered, so that it becomes in violation of the State Uniform Building Code, either the county or municipal enforcement officer or the [insert appropriate state agency] may, in addition to other remedies, institute any appropriate action or proceeding in order to:

A. prevent the unlawful maintenance, erection, construction, reconstruction, or alteration of the building/structure's purpose, or to prevent overcrowding

B. restrain, correct, or abate the violation, or

C. prevent the occupancy or use of the building, structure, or land until the violation is corrected

Section 9: Effective Date

This Act shall take effect upon enactment.

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National Council of Insurance Legislators (NCOIL)

Public Adjuster Professional Standards Reform Model Act

Sponsored by Rep. Michael Meredith (KY)
Co-sponsored by Rep. Matt Lehman (IN) – NCOIL Immediate Past President

Draft as of June 20, 2023. To be discussed during the Property & Casualty Insurance Committee meeting on July 22, 2023.

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Section 1. Title

This Act shall be known and cited as the "[State] Public Adjuster Professional Standards Reform Act."

Drafting Note: This Model Act is primarily intended to amend each state's statutory code that sets forth licensing and other professional standards for public adjusters.

Section 2. Application for License

(1) Except as provided in this section and xxxxx, no person shall in this state act as or hold himself, herself, or itself out to be an independent, staff, or public adjuster unless then licensed by the department as an independent, staff, or public adjuster.

(2) (a) An individual applying for a resident independent, staff, or public adjuster license shall make an application to the commissioner on the appropriate uniform individual application and in a format prescribed by the commissioner.

(b) An applicant under paragraph (a) of this subsection shall declare under penalty of suspension, revocation, or refusal of the license that the statements made in the application are true, correct, and complete to the best of the individual's knowledge and belief.

(c) Before approving an application submitted under paragraph (a) of this subsection, the commissioner shall find that the individual to be licensed:

1. Is at least eighteen (18) years of age;

2. Is eligible to designate [State] as the individual's home state;

3. Is trustworthy, reliable, and of good reputation, evidence of which shall be determined through an investigation by the commissioner;

4. Has not committed any act that is a ground for probation, suspension, revocation, or refusal of a license as set forth in xxxxxx;

5. Has successfully passed the examination for the adjuster license and the applicable line of authority for which the individual has applied;

6. Has paid the fees established by the commissioner pursuant to xxxxx; and

7. Is financially responsible to exercise the license.

(3) (a) To demonstrate financial responsibility, a person applying for a public adjuster license shall obtain a bond or irrevocable letter of credit prior to issuance of a license and shall maintain the bond or letter of credit for the duration of the license with the following limits:

1. A surety bond executed and issued by an insurer authorized to issue surety bonds in [State], which bond shall:

a. Be in the minimum amount of fifty thousand dollars ($50,000);

b. Be in favor of the state of [xxxxxx];

c. Specifically authorize recovery of any person in [State] who sustained damages as the result of the public adjuster's erroneous acts, failure to act, conviction of fraud, or conviction for unfair trade practices in his or her capacity as a public adjuster; and

d. Not be terminated unless written notice is given to the licensee at least thirty (30) days prior to the termination; or

2. An irrevocable letter of credit issued by a qualified financial institution, which letter of credit shall:

a. Be in the minimum amount of fifty thousand dollars ($50,000);

b. Be subject to lawful levy of execution on behalf of any person to whom the public adjuster has been found to be legally liable as the result of erroneous acts, failure to act, conviction of fraud, or conviction for unfair practices in his or her capacity as a public adjuster; and

c. Not be terminated unless written notice is given to the licensee at least thirty (30) days prior to the termination.

(b) The commissioner may ask for evidence of financial responsibility at any time the commissioner deems relevant.

(c) If the evidence of financial responsibility terminates or becomes impaired, the public adjuster license shall:

1. Automatically terminate; and

2. Be promptly surrendered to the commissioner without demand.

(4) (a) A business entity applying for a resident independent or public adjuster license shall make an application to the commissioner on the appropriate uniform business entity application and in a format prescribed by the commissioner.

(b) An applicant under paragraph (a) of this subsection shall declare under penalty of suspension, revocation, or refusal of the license that the statements made in the application are true, correct, and complete to the best of the business entity's knowledge and belief.

(c) Before approving an application submitted under paragraph (a) of this subsection, the commissioner shall find that the business entity:

1. Is eligible to designate [State] as its home state;

2. Has designated a licensed independent or public adjuster responsible for the business entity's compliance with the insurance laws and regulations of [State];

3. Has not committed an act that is a ground for probation, suspension, revocation, or refusal of an independent or public adjuster's license as set forth in xxxx; and

4. Has paid the fees established by the commissioner pursuant to xxxxxx.

(5) For applications made under this section, the commissioner may:

(a) Require additional information or submissions from applicants; and

(b) Obtain any documents or information reasonably necessary to verify the information contained in an application.

(6) Unless denied licensure pursuant to xxxxx, a person or business entity who has met the requirements of subsections (2) to (5) of this section shall be issued an independent, staff, or public adjuster license.

(7) An independent or staff adjuster may qualify for a license in one (1) or more of the following lines of authority:

(a) Property and casualty;

(b) Workers' compensation; or

(c) Crop.

(8) Notwithstanding any other provision of this subtitle, an individual who is employed by an insurer to investigate suspected fraudulent insurance claims, but who does not adjust losses or determine claims payments, shall not be required to be licensed as a staff adjuster.

(9) A public adjuster may qualify for a license in one (1) or more of the following lines of authority:

(a) Property and casualty; or

(b) Crop.

(10) Notwithstanding any other provision of this subtitle, a license as an independent adjuster shall not be required of the following:

(a) An individual who is sent into [State] on behalf of an insurer for the sole purpose of investigating or making adjustment of a particular loss resulting from a catastrophe, or for the adjustment of a series of losses resulting from a catastrophe common to all losses;

(b) An attorney licensed to practice law in [State], when acting in his or her professional capacity as an attorney;

(c) A person employed solely to obtain facts surrounding a claim or to furnish technical assistance to a licensed independent adjuster;

(d) An individual who is employed to investigate suspected fraudulent insurance claims, but who does not adjust losses or determine claims payments;

(e) A person who:

1. Solely performs executive, administrative, managerial, or clerical duties, or any combination thereof; and

2. Does not investigate, negotiate, or settle claims with policyholders, claimants, or their legal representatives;

(f) A licensed health care provider or its employee who provides managed care services if the services do not include the determination of compensability;

(g) A health maintenance organization or any of its employees or an employee of any organization providing managed care services if the services do not include the determination of compensability;

(h) A person who settles only reinsurance or subrogation claims;

(i) An officer, director, manager, or employee of an authorized insurer, surplus lines insurer, or risk retention group, or an attorney-in-fact of a reciprocal insurer;

(j) A United States manager of the United States branch of an alien insurer;

(k) A person who investigates, negotiates, or settles claims arising under a life, accident and health, or disability insurance policy or annuity contract;

(l) An individual employee, under a self-insured arrangement, who adjusts claims on behalf of the individual's employer;

(m) A licensed agent, attorney-in-fact of a reciprocal insurer, or managing general agent of the insurer, to whom claim authority has been granted by an insurer; or

(n) 1. A person who:

a. Is an employee of a licensed independent adjuster, is an employee of an affiliate that is a licensed independent adjuster, or is supervised by a licensed independent adjuster, if there are no more than twenty-five (25) persons under the supervision of one (1) licensed individual independent adjuster or licensed agent who is exempt from licensure pursuant to paragraph (m) of this subsection;

b. Collects claim information from insureds or claimants;

c. Enters data into an automated claims adjudication system; and

d. Furnishes claim information to insureds or claimants from the results of the automated claims adjudication system.

2. For purposes of this paragraph, "automated claims adjudication system" means a preprogrammed computer system designed for the collection, data entry, calculation, and system-generated final resolution of consumer electronic products insurance claims that complies with claim settlement practices pursuant to xxxxx.

(11) Notwithstanding any other provision of this subtitle, a license as a public adjuster shall not be required of the following:

(a) An attorney licensed to practice law in [State], when acting in his or her professional capacity as an attorney;

(b) A person who negotiates or settles claims arising under a life or health insurance policy or an annuity contract;

(c) A person employed only for the purpose of obtaining facts surrounding a loss or furnishing technical assistance to a licensed public adjuster, including photographers, estimators, private investigators, engineers, and handwriting experts;

(d) A licensed health care provider or its employee who prepares or files a health claim form on behalf of a patient; or

(e) An employee or agent of an insurer adjusting claims relating to food spoilage with respect to residential property insurance in which the amount of coverage for the applicable type of loss is contractually limited to one thousand dollars ($1,000) or less.

(12) Notwithstanding any other provision of this subtitle, a license as a staff adjuster shall not be required of an employee or agent of an insurer adjusting claims relating to food

spoilage with respect to residential property insurance in which the amount of coverage for the applicable type of loss is contractually limited to one thousand dollars ($1,000) or less.

(13) For purposes of this section, except as otherwise provided in subsection (15) of this section, "home state" means any state or territory of the United States or the District of Columbia in which an independent, staff, or public adjuster:

(a) Maintains his, her, or its principal place of residence or business; and

(b) Is licensed to act as a resident independent, staff, or public adjuster.

(14) Temporary registration for emergency independent or staff adjusters shall be issued by the commissioner in the event of a catastrophe declared in [State] in the following manner:

(a) An insurer shall notify the commissioner by submitting an application for temporary emergency registration of each individual not already licensed in the state where the catastrophe has been declared, who will act as an emergency independent adjuster on behalf of the insurer;

(b) A person who is otherwise qualified to adjust claims, but who is not already licensed in the state, may act as an emergency independent or staff adjuster and adjust claims if, within five (5) days of deployment to adjust claims arising from the catastrophe, the insurer notifies the commissioner by providing the following information, in a format prescribed by the commissioner:

1. The name of the individual;

2. The Social Security number of the individual;

3. The name of the insurer that the independent or staff adjuster will represent;

4. The catastrophe or loss control number;

5. The catastrophe event name and date; and

6. Any other information the commissioner deems necessary; and

(c) An emergency independent or staff adjuster's registration shall remain in force for a period not to exceed ninety (90) days, unless extended by the commissioner.

(15) (a) As used in this subsection, "home state" has the same meaning as in subsection (13) of this section, except that for purposes of this subsection the term includes any state or territory of the United States or the District of Columbia in

which an applicant under this subsection is licensed to act as a resident independent, staff, or public adjuster if the state or territory of the applicant's principal place of residence does not issue an independent, staff, or public adjuster license.

(b) Unless refused licensure in accordance with xxxxx, a nonresident person shall receive a nonresident independent, staff, or public adjuster license if:

1. The person is currently licensed in good standing as an independent, staff, or public adjuster in his, her, or its home state;

2. The person has submitted the proper request for licensure and has paid the fees required by xxxxx;

3. The person has submitted, in a form or format prescribed by the commissioner, the uniform individual application; and

4. The person's designated home state issues nonresident independent, staff, or public adjuster licenses to persons of [State] on the same basis.

(c) The commissioner may:

1. Verify an applicant's licensing status through any appropriate database, including the database maintained by the National Association of Insurance Commissioners, its affiliates, or subsidiaries; or

2. Request certification of an applicant's good standing.

(d) As a condition to the continuation of a nonresident adjuster license, the licensee shall maintain a resident adjuster license in his, her, or its home state.

(e) A nonresident adjuster license issued under this subsection shall terminate and be surrendered immediately to the commissioner if the licensee's resident adjuster license terminates for any reason, unless:

1. The termination is due to the licensee being issued a new resident independent, staff, or public adjuster license in his, her, or its new home state; and

2. The new resident state or territory has reciprocity with [State].

Section 3. Public Adjuster and Insured Contract Requirements

(1) (a) Except as provided in paragraph (b) of this subsection, a public adjuster shall not provide services to an insured until a written contract with the insured has

been executed on a form that has been pre-filed with and approved by the commissioner.

(b) The commissioner may approve a form that allows a public adjuster to be compensated for services provided to an insured prior to the execution of a written contract in emergency circumstances.

(c) A contract between a public adjuster and an insured in violation of paragraph (a) of this subsection shall not be enforceable in this state.

(d) A form pre-filed with the commissioner by a public adjuster for approval under paragraph (a) of this subsection shall be subject to disapproval by the commissioner at any time if the form is found to:

1. Violate any provision of this chapter;

2. Contain or incorporate by reference any inconsistent, ambiguous, or misleading clauses; or

3. Contain any title, heading, or other indication of its provisions which is:

a. Misleading; or

b. Printed in a size of typeface or manner of reproduction so as to be substantially illegible.

(e) A contract between a public adjuster and an insured that was executed on a form that was pre-filed with and approved by the commissioner under paragraph (a) of this subsection prior to a disapproval of the form under paragraph (d) of this subsection shall be enforceable to the extent allowed by:

1. Ordinary principles of contract; and

2. Any applicable state or federal laws implicated by the contract.

(2) A public adjuster shall ensure that all contracts between the public adjuster and the insured for services are in writing and contain the following terms:

(a) The legible full name of the adjuster signing the contract, as specified in the department's licensing records;

(b) The adjuster's permanent home state business address and phone number;

(c) The license number issued to the adjuster by the department;

(d) A title of "Public Adjuster Contract";

(e) The insured's full name, street address, insurer name, and policy number, if known or upon notification;

(f) A description of the loss or damage and its location, if applicable;

(g) A description of services to be provided to the insured;

(h) The signatures of the adjuster and the insured;

(i) The date the contract was signed by:

1. The adjuster; and

2. The insured;

(j) Attestation language stating that the adjuster has a letter of credit or a surety bond as required by xxxxx;

(k) The full salary, fee, commission, compensation, or other consideration the adjuster is to receive for services, including but not limited to:

1. If the compensation is based on a percentage of the insurance settlement, the exact percentage, which shall be in accordance with Section xxx of this Act;

2. The initial expenses to be reimbursed to the adjuster from the proceeds of the claim payment, specified by type, with dollar estimates; and

3. Any additional expenses, if first approved by the insured;

(l) A statement that the adjuster shall not give legal advice or act on behalf of or aid any person in negotiating or settling a claim relating to bodily injury, death, or noneconomic damages;

(m) The process for rescinding the contract, including the date by which rescission of the contract by the adjuster or the insured may occur; and

(n) A statement that clearly states in substance the following: "Complaints regarding this contract or regarding the public adjuster may be filed with the consumer protection division of the [State] Department of Insurance."

(3) (a) Compensation provisions in a contract between a public adjuster and an insured shall not be redacted in any copy of the contract provided to the commissioner.

(b) A redaction prohibited under paragraph (a) of this subsection shall constitute an omission of material fact in violation of xxxx and xxxx.

(4) A contract between a public adjuster and an insured shall not contain any contract term that:

(a) Allows the adjuster's percentage fee to be collected when money is due from an insurer, but not paid;

(b) Allows the adjuster to collect the entire fee from the first check issued by an insurer, rather than as a percentage of each check issued by an insurer;

(c) Requires an insured to authorize an insurer to issue a check only in the name of the adjuster;

(d) Imposes collection costs or late fees;

(e) Allows the adjuster's rate of compensation to be increased based on the fact that a claim is litigated; or

(f) Precludes the adjuster from pursuing civil remedies.

(5) Prior to the signing of a contract with an insured, a public adjuster shall provide the insured with a separate disclosure document regarding the claim process that states the following:

"Property insurance policies obligate the insured to present a claim to his or her insurance company for consideration. Three (3) types of adjusters may be involved in the claim process as follows:

1. "Staff adjuster" means an insurance adjuster who is an employee of an insurance company, who represents the interest of the insurance company, and who is paid by the insurance company. A staff adjuster shall not charge a fee to the insured;

2. "Independent adjuster" means an insurance adjuster who is hired on a contract basis by an insurance company to represent the insurance company's interest in the settlement of the claims and who is paid by the insurance company. An independent adjuster shall not charge a fee to the insured; and

3. "Public adjuster" means an insurance adjuster who does not work for any insurance company. A public adjuster works for the insured to assist in the preparation, presentation, and settlement of the claim, and the insured hires a public adjuster by signing a contract agreeing to pay him or

her a fee or commission based on a percentage of the settlement or another method of payment.

The insured is not required to hire a public adjuster to help the insured meet his or her obligations under the policy, but has the right to hire a public adjuster. The insured has the right to initiate direct communications with the insured's attorney, the insurer, the insurer's adjuster, the insurer's attorney, and any other person regarding the settlement of the insured's claim. The public adjuster shall not be a representative or employee of the insurer. The salary, fee, commission, or other consideration paid to the public adjuster is the obligation of the insured, not the insurer."

(6) (a) A contract between a public adjuster and an insured shall be executed in duplicate to provide an original contract to:

1. The public adjuster; and

2. The insured.

(b) A public adjuster's original contract shall be available at all times for inspection by the commissioner without notice.

(7) Within seventy-two (72) hours of entering into a contract with an insured, a public adjuster shall provide the insurer:

(a) A notification letter that:

1. Has been signed by the insured; and

2. Authorizes the public adjuster to represent the insured's interest; and

(b) A copy of the contract.

(8) (a) The insured shall have the right to rescind a contract with a public adjuster within three (3) business days after the date the contract was signed.

(b) A rescission of a public adjuster contract shall be:

1. In writing;

2. Mailed or delivered to the public adjuster at the address in the contract; and

3. Postmarked or received within the three (3) business day period.

(9) If an insured exercises the right to rescind a contract under subsection (8) of this section, anything of value given by the insured under the contract to the public adjuster shall be returned to the insured within fifteen (15) business days following receipt by the public adjuster of the rescission notice.

Section 4. Insured's rights -Written notice requirement -Duties of public adjuster

(1) A public adjuster shall give an insured written notice of the insured's rights under this section and Sections 2 and 4 of this Act.

(2) A public adjuster shall ensure that:

(a) Prompt notice of a claim is provided to the insurer;

(b) The property that is subject to a claim is available for inspection of the loss or damage by the insurer; and

(c) The insurer is given the opportunity to interview the insured directly about the loss or damage and claim.

(3) A public adjuster shall not restrict or prevent an insurer or its adjuster, or an attorney, investigator, or other person acting on behalf of the insurer, from:

(a) Having reasonable access, at reasonable times, to:

1. The insured or claimant; or

2. The insured property that is the subject of a claim;

(b) Obtaining necessary information to investigate and respond to a claim; or

(c) Corresponding directly with the insured regarding the claim, except a public adjuster shall be copied on any correspondence with the insured relating to the claim.

(4) (a) A public adjuster shall not act or fail to reasonably act in any manner that obstructs or prevents the insurer or its adjuster from timely conducting an inspection of any part of the insured property for which there is a claim for loss or damage.

(b) Except as provided in paragraph (c) of this subsection, a public adjuster representing an insured may be present for the insurer's inspection.

(c) If the unavailability of a public adjuster, after a reasonable request by the insurer, otherwise delays the insurer's timely inspection of the property, the

insured shall allow the insurer to have access to the property without the participation or presence of the public adjuster in order to facilitate the insurer's prompt inspection of the loss or damage.

(5) A public adjuster shall provide the insured, the insurer, and the commissioner with a written disclosure concerning any direct or indirect financial interest that the adjuster has with any other party who is involved in any aspect of the claim.

(6) A public adjuster shall not:

(a) Participate, directly or indirectly, in the reconstruction, repair, or restoration of damaged property that is the subject of a claim adjusted by the adjuster;

(b) Engage in any activities that may be reasonably construed as a conflict of interest, including, directly or indirectly, soliciting or accepting any remuneration of any kind or nature;

(c) Have a financial interest in any salvage, repair, or any other business entity that obtains business in connection with any claim that the public adjuster has a contract to adjust; or

(d) 1. Use claim information obtained in the course of any claim investigation for commercial purposes.

2. As used in subparagraph 1. of this paragraph, "commercial purposes" includes marketing or advertising used for the benefit of the public adjuster.

(e) File a complaint with the commissioner on behalf of an insured alleging an unfair claim settlement practice unless the insured has given written consent for the public adjuster to file the complaint on the insured’s behalf.

Section 5. Requirements for Funds Received or Held by Public Adjuster

(1) All funds received or held by a public adjuster on behalf of an insured toward the settlement of a claim shall be:

(a) Handled in a fiduciary capacity; and

(b) Deposited into one (1) or more separate noninterest-bearing fiduciary trust accounts in a financial institution licensed to do business in this state no later than the close of the second business day from the receipt of the funds.

(2) The funds referenced in subsection (1) of this section shall:

(a) Be held separately from any personal or nonbusiness funds;

(b) Not be commingled or combined with other funds;

(c) Be reasonably ascertainable from the books of accounts and records of the public adjuster; and

(d) Be disbursed within thirty (30) calendar days of any invoice received by the public adjuster upon approval of the insured or the claimant that the work has been satisfactorily completed.

(3) A public adjuster shall maintain an accurate record and itemization of any funds deposited into an account under subsection (1) of this section in accordance with xxxxxx.

Section 6. Fees and Commissions for Public Adjuster

(1) Except as provided in subsection (2) of this section:

(a) Any fee charged to an insured by a public adjuster shall be:

1. Based only on the amount of the insurance settlement proceeds actually received by the insured; and

2. Collected by the public adjuster after the insured has received the insurance settlement proceeds from the insurer;

(b) A public adjuster may receive a commission for services provided under this subtitle consisting of:

1. An hourly fee;

2. A flat rate;

3. A percentage of the total amount paid by the insurer to resolve a claim; or

4. Another method of compensation; and

(c) A public adjuster:

1. Shall not charge an unreasonable fee; and

2. May charge a reasonable fee that does not exceed:

a. For non-catastrophic claims, fifteen percent (15%) of the total insurance recovery of the insured; and

b. For catastrophic claims, ten percent (10%) of the total insurance recovery of the insured.

(2) If an insurer, not later than seventy-two (72) hours after the date on which a loss or damage is reported to the insurer, either pays or commits in writing to pay the policy limit of the insurance policy to the insured, a public adjuster shall:

(a) Not receive a commission consisting of a percentage of the total amount paid by the insurer to resolve a claim;

(b) Inform the insured that the claim settlement amount may not be increased by the insurer; and

(c) Be entitled only to reasonable compensation from the insured for services provided by the adjuster on behalf of the insured, based on the time spent on the claim and expenses incurred by the adjuster prior to when the claim was paid or the insured received a written commitment to pay from the insurer.

Section 7. Penalties

(1) The commissioner may place on probation, suspend, or may impose conditions upon the continuance of a license for not more than twenty-four (24) months, revoke, or refuse to issue or renew any license issued under this Act, or may levy a civil penalty in accordance with xxxxxx, or any combination of actions for any one (1) or more of the following causes:

(a) Providing incorrect, misleading, incomplete, or materially untrue information in a license application;

(b) Violating any insurance laws, or violating any administrative regulations, subpoena, or order of the commissioner or of another state's insurance commissioner;

(c) Obtaining or attempting to obtain a license through misrepresentation or fraud;

(d) Improperly withholding, misappropriating, or converting any moneys or properties received in the course of doing insurance or the business of life settlements;

(e) Intentionally misrepresenting the terms of an actual or proposed insurance contract, life settlement contract, or application for insurance;

(f) Having been convicted of or having pled guilty or nolo contendere to any felony;

(g) Having admitted or been found to have committed any unfair insurance trade practice, insurance fraud, or fraudulent life settlement act;

(h) Using fraudulent, coercive, or dishonest practices; or demonstrating incompetence, untrustworthiness, or financial irresponsibility; or being a source of injury or loss to the public in the conduct of business in this state or elsewhere;

(i) Having an insurance license, life settlement license, or its equivalent, denied, suspended, or revoked in any other state, province, district, or territory;

(j) Surrendering or otherwise terminating any license issued by this state or by any other jurisdiction, under threat of disciplinary action, denial, or refusal of the issuance of or renewal of any other license issued by this state or by any other jurisdiction; or revocation or suspension of any other license held by the licensee issued by this state or by any other jurisdiction;

(k) Forging another's name to an application for insurance, to any other document related to an insurance transaction, or to any document related to the business of life settlements;

(l) Cheating, including improperly using notes or any other reference material to complete an examination for license;

(m) Knowingly accepting insurance from an individual or business entity who is not licensed, but who is required to be licensed under this subtitle;

(n) Failing to comply with an administrative or court order imposing a child support obligation;

(o) Failing to pay state income tax or to comply with any administrative or court order directing payment of state income tax;

(p) Having been convicted of a misdemeanor for which restitution is ordered in excess of three hundred dollars ($300), or of any misdemeanor involving dishonesty, breach of trust, or moral turpitude;

(q) Failing to no longer meet the requirements for initial licensure; or

(r) Any other cause for which issuance of the license could have been refused, had it then existed and been known to the commissioner.

(2) (a) For any public adjuster or apprentice adjuster supervised by a public adjuster under xxxxx, the commissioner may deny, suspend, or revoke the adjuster's license or impose a fine not to exceed five thousand dollars ($5,000) per act against the adjuster, or both, for any of the following causes:

1. Violating any provision of this chapter;

2. Violating any administrative regulation or order of the commissioner;

3. Receiving payment or anything of value as a result of an unfair or deceptive practice;

4. Receiving or accepting any fee, kickback, or other thing of value pursuant to any agreement or understanding, oral or otherwise, from anyone other than an insured;

5. Entering into a split-fee arrangement with another person who is not a public adjuster; or

6. Being otherwise paid or accepting payment for public adjuster services that have not been performed.

(b) The sanctions and penalties under this subsection shall be in addition to any other remedies, penalties, or sanctions available to the commissioner against a public adjuster or an apprentice adjuster supervised by a public adjuster under xxxxx under this section or any other law.

(3) The license of a business entity may be suspended, revoked, or refused for any cause relating to an individual designated in or registered under the license if the commissioner finds that:

(a) An individual licensee's violation was known or should have been known by one (1) or more of the partners, officers, or managers acting on behalf of the business entity; and

(b) The violation was not reported to the department nor corrective action taken.

(4) The applicant or licensee may make written request for a hearing in accordance with xxxx.

(5) The commissioner shall retain the authority to enforce the provisions and penalties of this chapter against any individual or business entity who is under investigation for or charged with a violation of this chapter, even if the individual's or business entity's license has been surrendered or has lapsed by operation of law.

(6) The sanctions and penalties applicable to licenses and licensees under subsection (1) of this section shall also be applicable to registrations and registrants under xxxxxx.

Section 8. Rules

Pursuant to xxxxx, the commissioner may promulgate administrative regulations necessary for or as an aid to the effectuation of any provision of this Act.

Section 9. Effective Date

This Act shall take effect xxxxxx.

616 Fifth Avenue, Suite 106
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CHIEF EXECUTIVE OFFICER: Thomas B. Considine

National Council of Insurance Legislators (NCOIL)

Catalytic Converter Theft Prevention Model Act

Draft as of June 20, 2023. To be introduced and discussed during the Property & Casualty Insurance Committee on July 22, 2023.

Rep. Tom Oliverson, M.D. (TX) – NCOIL Vice President; Rep. Edmond Jordan (LA) --- Joint Sponsors

Section 1. Title

This Act shall be known and cited as the [State] Catalytic Converter Theft Prevention Act.

Section 2. Definitions

(1) "Catalytic converter" means an exhaust emission control device that reduces toxic gas and pollutants from internal combustion engines.

(2) "Used catalytic converter" means a catalytic converter that has been detached from a motor vehicle as a single item and not as part of a scrapped motor vehicle, or any nonferrous part thereof; but does not include a catalytic converter that has been tested, certified, and labeled for reuse in accordance with the Clean Air Act, Chapter 85 of Title 42 of the United States Code, and all applicable regulations thereunder.

(3) "Covered Activity" means the die or pin stamping of the full vehicle identification number onto the outside of a catalytic converter in a conspicuous manner on motor vehicles in a typed font and covered by applying a coat of high-visibility, high-heat theft deterrence paint.

(4) "Department" means the Department of [XXXX].

(5) "[Law Enforcement] Department" means the Department of [XXXX].

(6) “Eligible Entity” means:

i. State and local law enforcement agencies;

ii. Licensed auto dealers;

iii. Licensed auto repair shops and vehicle service centers; and

iv. Nonprofit organizations established to

(a) assist federal, state, or local law enforcement agencies in the investigation or prosecution of vehicle-related crimes; or

(b) detect, prevent, and deter insurance crime and fraud.

(7) “Person” means any individual, or any corporation, limited liability company, partnership, association, or other group existing under or authorized by the laws of either [State] or the United States.

Section 3. Catalytic Converter Theft

Any person who steals or knowingly and unlawfully takes, carries away, or conceals a catalytic converter from another person’s motor vehicle shall be guilty of a Class [X] felony and shall be sentenced to not more than [XX] years in prison or fined under this Section not more than [XX] dollars, or both.

Section 4. Aggravated Offenses

(a) Any person convicted for an offense committed under Section 3 two or more times previously, upon any subsequent convictions, shall be guilty of a Class [X] felony and shall be sentenced to at least [XX] years in prison or fined under this Section not more than [XX] dollars. Any sentence imposed under this Section must run consecutive to any sentence imposed under Section 3.

(b) Any person convicted for an offense committed under Section 3 while armed shall be sentenced to at least [XX] years in prison or fined under this Section not more than [XX] dollars.

Section 5. Receipt of Stolen Catalytic Converters

(a) Any person who buys, receives, possesses, or obtains control of a stolen catalytic converter, knowing or having reason to believe that the catalytic converter was stolen shall be guilty of a Class [X] felony and shall be sentenced to not more than [XX] years in prison or fined under this Section not more than [XX] dollars, or both.

(b) For the purposes of this Section, the term "stolen property" includes property that is not in fact stolen if the person who buys, receives, possesses, or obtains control of the property had reason to believe that the property was stolen.

Section 4. Limitations on Sales of Used Catalytic Converter

(a) It shall be unlawful for any person engaged in a transaction involving the sale, transfer, purchase, or acquisition of a used catalytic converter to violate subsections (b) through (f) of this Section. Any person who violates this Section shall be guilty of a Class [X] felony and shall be sentenced to not more than [XX] years in prison or fined under this Section not more than [XX] dollars, or both.

(b) Any person who sells or otherwise transfers to another for consideration a used catalytic converter shall be a registered [secondary metals recycler/core recycler/scrap metal dealer/junk yard]; licensed new or used motor vehicle dealer; licensed automotive repair service; motor vehicle manufacturer; licensed automotive dismantler and parts recycler; or licensed distributor of catalytic converters.

(c) Any person identified in subsection (b) of this Section must provide the purchaser or transferee with the following information:

1. a copy of the person's driver's license or nondriver identification card;

2. motor vehicle registration information from the motor vehicle from which the used catalytic converter was taken, including:

i. the make and model of the vehicle;

ii. the vehicle identification number of the vehicle; and

iii. the person's ownership interest in the vehicle;

3. any identifying information of the used catalytic converter, including a part number or other identification number; and

4. the name of the person who removed the catalytic converter or for whom the removal was completed.

(d) Any person described in subsection (b) of this Section must maintain the records described in subsection (c) of this Section for [xx] years.

(e) Any transaction involving the sale, transfer, purchase, or acquisition of a used catalytic converter shall not be by cash. Payment by check may be made payable only to a person described in subsection (b) of this Section.

(f) Any person described in subsection (b) of this Section shall not enter into a transaction described under this Section with any person younger than eighteen years of age.

(g) Any transaction under this Section shall not be between the hours of 9:00 p.m. and 6:00 a.m.

(h) Each used catalytic converter involved in any transaction under this Section shall constitute a separate violation of this Section.

(i) Any person involved in any transaction under this Section shall not provide false, fraudulent, altered, or counterfeit information or documentation as required under this Section. Each instance of false, fraudulent, altered, or counterfeit information or documentation shall constitute a separate violation of this Section.

(j) Any used catalytic converter possessed in violation of this section shall be considered contraband, and is subject to seizure and forfeiture as provided pursuant to [state law § xxx].

Section 5. Recordkeeping Requirements for [Secondary Metals Recycler/Core Recycler/Scrap Metal Dealer/Junk Yard]

(a) Any person registered as [a secondary metals recycler/core recycler/scrap metal dealer/junk yard] under [state law § xxx] involved in any transaction for the sale, transfer, purchase or acquisition of a used catalytic converter shall maintain a record of all such transactions for not less than [XX] years and be made available to any law enforcement officer or state official during usual and customary business hours.

(b) The records required in subsection 5(a) of this Section shall include the following information:

1. the records required under Section 4 of this Chapter;

2. the name and address of the [secondary metals recycler/core recycler/scrap metal dealer/junk yard secondary metals recycler];

3. the name or identification of the employee of the [secondary metals recycler/core recycler/scrap metal dealer/junk yard] executing the transaction;

4. the date and time of the transaction;

5. the weight, quantity, or volume and a description, to include any and all part or identification numbers, of all used catalytic converters involved in a transaction;

6. the amount of consideration in exchange for the transaction;

7. a signed statement from the seller in the transaction stating that he or she is the rightful owner or is authorized to sell the used catalytic converter being sold; and

8. a digital photograph or video recording of the person delivering the used catalytic converter or receiving consideration for the used catalytic converter delivered in which the person's facial features are clearly visible and a photograph or video recording of the used catalytic converter as delivered or sold is identifiable. The time and date shall be digitally recorded on the photograph or video recording.

(c) Any transaction for the sale, transfer, purchase or acquisition of a used catalytic converter must occur at a fixed business address of the [secondary metals recycler/core recycler/scrap metal dealer/junk yard], as registered with the Department of [XXXX], that is a party to the transaction.

(d) Before each transaction, the [secondary metals recycler/core recycler/scrap metal dealer/junk yard] recycler, including any agent, employee, or representative thereof, shall:

1. verify, by obtaining the applicable documentation, that the person selling or transferring the used catalytic converter acquired it legally and has the right to sell or transfer it;

2. retain a record of the applicable verification and other information required under this Section; and

3. note in the business records of the [secondary metals recycler/core recycler/scrap metal dealer/junk yard] any obvious markings on the used catalytic converter, such as paint, labels, or engravings, that would aid in the identification of the catalytic converter.

(e) Any person who violates this Section shall be guilty of a Class [X] felony and shall be sentenced to not more than [XX] years in prison or fined under this Section not more than [XX] dollars, or both.

Section 5. Vehicle Identification Number Stamping Grant Program

(a) Not later than one year after the date of enactment of this Act, the [Law Enforcement] Department shall establish a program to provide grants to eligible entities to carry out covered activities, excluding wages, related to catalytic converters.

(b) To be eligible for a grant under this section, an eligible entity shall submit an application at such time, in such manner, and containing such information as the [Law Enforcement] Department may require.

(c) Any covered activity shall be carried out at no cost to the owner of the vehicle being stamped.

(d) In awarding grants under this section, the [Law Enforcement] Department shall prioritize eligible entities operating in the areas with the highest need for covered activities, including the areas with the highest rates of catalytic converter theft, as determined by the [Law Enforcement] Department.

(e) The [Law Enforcement] Department shall create a restricted account known as the "Vehicle Identification Number Stamping Grant Program Fund" which shall be funded by money received through enforcement actions pursuant to this Chapter; and shall be used to disburse grants to eligible entities.

Section 5. Preemption

This Act shall take precedence over any and all local ordinances governing catalytic converter transactions. If any municipal or county ordinance, rule or regulation conflicts with the provisions of this Act, the provisions of this act shall preempt the municipal or county ordinance, rule or regulation.

Section 6. Enactment

This Act shall take effect and be in force from and after [XXXX].

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CHIEF EXECUTIVE OFFICER: Thomas B. Considine

NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

Consumer Protection Towing Model Act

Adopted by the NCOIL Property & Casualty Committee on July 12, 2018 and the NCOIL Executive Committee on July 15, 2018
Sponsored by Rep. Matt Lehman (IN)

****To be considered for re-adoption during the Property & Casualty Insurance Committee on July 22, 2023***

Table of Contents

Section 1. Title

This Act shall be known and cited as the [State] Consumer Protection Towing Act.

Section 2. Purpose

The purpose of this Act is to establish minimum standards for towing vendor services and to promote fair and honest practices in the towing service business.

Section 3. Definitions

For purposes of this Act:

"Automobile club services" - shall include, but not be limited to, the assumption of or reimbursement of the expense or a portion thereof for towing of a motor vehicle, emergency road service, matters relating to the operation, use, and maintenance of a motor vehicle, and the supplying of services which includes, augments, or is incidental to theft or reward services, discount services, arrest bond services, lock and key services, trip interruption services, and legal fee reimbursement services in defense of traffic related offenses.

"Recovery service" - a form of towing service which involves moving vehicles by the use of a wheel-lift device, such as a lift, crane, hoist, winch, cradle, jack, automobile ambulance, tow dolly, or any other similar device.

"Emergency towing" – the towing of a vehicle due to a motor vehicle accident, mechanical breakdown on public roadway or other emergency related incident necessitating vehicle removal for public safety with or without the owner's consent.

"Flat bed (Roll-back) service" - a form of towing service which involves moving vehicles by loading them onto a flat-bed platform.

"Government agency towing" – the towing of government-owned or government controlled vehicles by the government agency that owns or controls them.

"Law enforcement towing" – the towing of a vehicle for law enforcement purposes other than "seizure towing." The term includes towing for law enforcement purposes that is performed by a towing company under a contract with the State, a local unit, or a law enforcement agency of the State or local unit; or on behalf of the State, a local unit, or a law enforcement agency of the State or local unit.

"Motor vehicle" – any vehicle that is manufactured primarily for use on public streets, roads and highways (not including a vehicle operated exclusively on a rail or rails); and has at least four (4) wheels.

"Owner" - the person or entity to whom a motor vehicle is registered, or to whom it is leased, if the terms of the lease require the lessee to maintain and repair the vehicle, or a person or entity that holds a lien on the motor vehicle. For the purposes of this Act, a rental vehicle company is the owner of a motor vehicle rented pursuant to a rental agreement.

"Owner requested towing" – the request to tow a vehicle by or on behalf of the vehicle owner or operator.

"Private property towing" – the towing of a motor vehicle, without the owner's consent, from private property on which the motor vehicle was illegally parked, or for which some exigent circumstance necessitated its removal to another location.

"Rental vehicle company" – any person or organization, or any subsidiary or affiliate, including a franchisee, in the business of renting vehicles to the public.

"Seizure towing" – the towing of a motor vehicle for law enforcement purposes involving the maintenance of the chain of custody of evidence, or forfeiture of assets.

"Storage facility" – any lot, facility, or other property used to store motor vehicles that have been removed from another location by a tow truck.

"Tow truck" - a motor vehicle equipped to provide any form of towing service, including recovery service or flat bed service.

"Tow truck operator" – an individual who operates a tow truck as an employee or agent of a towing company.

"Towing company" - any service, company or business that tows or otherwise moves motor vehicles by means of a tow truck or owns or operates a storage lot. A towing business, service or company shall not include an automobile club, car dealership or insurance company.

Section 4. General Provisions

The provisions of this Act shall be applicable to any entity or person engaging in, or offering to engage in, the business of providing towing service in the State of XXXX. The provisions of this chapter shall not apply to vehicles towed into the State of XXXX or through the State of XXXX if the tow originates in another jurisdiction.

The provisions of this Act are not applicable to the towing of motor vehicles by or on behalf of an "automobile club", car dealership or insurance company.

The provisions of this Act are not applicable to "government agency towing", the towing of government-owned or government controlled vehicles by the government agency that owns or controls them.

The provisions of this Act are not applicable to "seizure towing", the towing of a vehicle for law enforcement purposes.

The provisions of this Act confer exclusive regulatory jurisdiction to the [regulatory body] in the State of XXXX over the towing and storage services of towing companies and vehicle storage companies. The [regulatory body] shall establish a complaint mechanism for consumers and insurers.

In addition to any penalty imposed under Section 12 of this Act, any for-hire motor carrier engaged in the towing of motor vehicles who violates this Act is subject to sanctions imposed by the [regulatory body] in the State of XXXX.

Section 5. Emergency Towing

A. This Section applies to a towing company that engages in, or offers to engage in, emergency towing. Prior to removing a vehicle from a tow truck under this section, a towing company shall take photographs, video or other visual documentation to evidence the vehicle damages, debris, damaged cargo or property, and complications to recovery process.

B. Except as provided in Section 5(C), a towing company shall not stop, or cause a person to stop, at the scene of an accident or near a disabled motor vehicle:

(1) if there is an injury as the result of an accident; or

(2) for the purpose of:

(i) soliciting an engagement for emergency towing services;

(ii) moving a motor vehicle from a public street, road, or highway; or

(iii) accruing charges in connection with an activity in subsection (i) or (ii)

C. A towing company may stop, or cause a person to stop, at the scene of an accident or near a disabled motor vehicle under the circumstances, or for any of the purposes, described in Section 5(B) if:

(1) the towing company is requested to stop or to perform a towing service by a law enforcement officer or by authorized state, county, or municipal personnel;

(2) the towing company is summoned to the scene or requested to stop by the owner or operator of a disabled vehicle; or

(3) the owner of a disabled motor vehicle has previously provided consent to the towing company to stop or perform a towing service.

(4) the towing company has reasonable belief that a motorist is in need of immediate aide. The towing company may not offer towing services in this circumstance unless conditions C(1), C(2), or C(3) of this section are met.

D. Except as provided in Sections 5(E) and (F), the owner or operator of a disabled motor vehicle may:

(1) summon to the disabled motor vehicle's location the towing company of the owner's or operator's choice, either directly or through an insurance company's or an automobile club's emergency service arrangement; and

(2) designate the location to which the disabled motor vehicle is to be towed. However, if the location designated by the owner or operator is not a storage facility owned or operated by the towing company, the owner or operator must make arrangements for payment to the towing company at the time the towing company is summoned.

E. Section 5(D) does not apply:

(1) in any case in which the owner or operator of a disabled motor vehicle:

(a.) is incapacitated or otherwise unable to summon a towing company; or

(b.) defers to law enforcement or to authorized state, county, or municipal personnel as to:

(i) the towing company to be summoned; or

(ii) the location to which the disabled motor vehicle is to be towed; or

(2) in the event of a declared emergency

F. The authority of an owner or operator of a disabled vehicle to summon the towing company of the owner's or operator's choice under Section 5(D) shall be superseded by a law enforcement officer or by authorized State, county, or municipal personnel if the towing company of choice of the owner or operator:

(1) is unable to respond to the location of the disabled motor vehicle in a timely fashion; and

(2) the disabled motor vehicle is a hazard; impedes the flow of traffic; or may not legally remain in its location in the opinion of the law enforcement officer or authorized state, county, or municipal personnel.

G. If a disabled motor vehicle is causing or poses a safety hazard to any of the parties at the scene of the disabled motor vehicle, the disabled motor vehicle may be moved by a towing company to a safe location after being released by a law enforcement officer or by authorized state, county, or municipal personnel for that purpose.

H. If a towing company is summoned for emergency towing by the owner or operator of a disabled motor vehicle, the towing company shall make a record, to the extent available, consisting of:

(1) the first and last name, and telephone number of the person who summoned the towing company to the scene;

(2) the make, model year, vehicle identification number, and license plate number of the disabled motor vehicle.

I. If a towing company is summoned for emergency towing by a law enforcement officer or by authorized state, county, or municipal personnel, the towing company shall make a record, to the extent available, consisting of:

(1) the identity of the law enforcement agency or authorized state, county, or municipal agency, requesting the emergency towing;

(2) the make, model, year, vehicle identification number, and license plate number of the disabled motor vehicle.

J. A towing company shall maintain a record created under Sections 5(H) or (I) and provide said record to a law enforcement agency upon request from the time the towing company appears at the scene of the disabled motor vehicle until the time the motor vehicle is towed and released to an authorized third party. A towing company shall also retain a record created under Sections 5(H) or (I) for a period of two (2) years from the date the disabled vehicle was towed from scene and, throughout said two (2) year period, make the record available for inspection and copying, not later than two (2) business days after receiving a written request from a law enforcement agency, the attorney general, the disabled motor vehicle's owner, or an authorized agent of the disabled motor vehicle's owner.

K. A towing company that performs emergency towing under this Act must properly secure all towed motor vehicles and take all reasonable efforts to prevent further damage (including weather damage) or theft of all towed motor vehicles, including a motor vehicle's cargo and contents.

Section 6. Commercial Private Property Towing

A. This Section applies to a towing company that engages in, or offers to engage in, private property towing. This Section does not apply to the towing of a motor vehicle from a tow-away zone that is not located on private property. Prior to removing a vehicle from a tow truck under this section, a towing company shall take photographs, video or other visual documentation to evidence the vehicle damages, debris, damaged cargo or property, and complications to recovery process.

B. The owner of private property may establish a tow-away zone on the owner's property. A property owner that establishes a tow-away one under this Section shall post at the location of the tow-away zone a sign that is clearly visible to the public. The sign

must include a statement that the area is a tow-away zone, pertinent contact information, and a description of any persons authorized to park in the area.

C. A towing company that tows a motor vehicle under this Section shall ensure that the motor vehicle is towed to a storage facility that is located within twenty-five (25) miles of the location of the tow-away zone from which the motor vehicle was removed, or, if there is no storage facility located within twenty-five (25) miles of the location of the tow-away zone, to the storage facility nearest to the tow-away zone. ***Drafting Note: Depending on the population density of a State, legislators may consider altering this distance.***

D. If the owner or operator of a motor vehicle that is parked in violation of a tow-away zone arrives at the location of the tow-away zone while the motor vehicle is in the process of being towed, the towing company shall give the owner or operator either oral or written notification that the owner or operator may pay a fee in an amount that is not greater than half of the amount of the fee the towing company normally charges for the release of a motor vehicle. Upon the owner's or operator's payment of the amount specified, the towing company shall release the motor vehicle to the owner or operator, and give the owner or operator a receipt showing the full amount of the fee of the towing company normally charges for the release of a motor vehicle, and the amount of the fee paid by the owner or operator.

E. Not later than two (2) hours after completing a tow of a motor vehicle from private property, a towing company shall provide notice of the towing to the law enforcement agency having jurisdiction in the location of the private property.

F. A towing company that performs private property towing under this Section shall properly secure all towed motor vehicles, and take all reasonable efforts to prevent further damage (including weather damage) or theft of all towed motor vehicles, including a motor vehicle's cargo and contents.

G. This Section does not affect a private property owner's rights under [insert State Statute with respect to abandoned motor vehicles] with respect to abandoned vehicles on the property owner's property.

Section 7. Estimates and Invoices for Towing Services

A. Prior to attaching a vehicle to a tow truck, the towing company shall furnish the vehicle owner, if the owner is present at the scene of a disabled vehicle, a rate sheet listing all rates for towing services included but not limited to, all rates for towing and associated fees, cleanup charges, labor, storage, and any other services provided by the towing company. A charge in excess of what is reflected on the rate sheet for any service shall be deemed excessive as described in Section 10A. The rate sheet shall also be posted at the towing company's place of business and be made available upon request to consumers.

B. An itemized invoice of actual towing charges assessed by a towing company for a completed tow shall be made available to the owner of the motor vehicle or the owner's authorized agent, which may be an insurance company, not later than one (1) business day after the tow is completed, or the towing company has obtained all necessary information to be included on the invoice, including any charges submitted by subcontractors used by the towing company to complete the tow – whichever occurs later.

C. The itemized invoice required by this Section must contain the following information:

a. an invoice number

b. the location from which the motor vehicle was towed;

c. the location to which the motor vehicle was towed;

d. the name, address, and telephone number of the towing company;

e. a description of the towed motor vehicle, including the:

(i) make;

(ii) model;

(iii) year;

(iv) vehicle identification number; and

(v) color

f. the license plate number and state of registration for the towed motor vehicle;

g. the cost of the original towing service;

h. the cost of any vehicle storage fees, expressed as a daily rate;

i. Other reasonable fees;

j. the costs for services that were performed under a warranty or that were otherwise performed at no cost to the owner of the motor vehicle.

D. Any reasonable service or fee in addition to the services or fees described in Section 7C, must be set forth individually as a single line item on the invoice required by this section, with an explanation and the exact charge for the service or the exact amount of the fee.

E. A copy of each invoice and receipt submitted by a tow truck operator in accordance with Section 7 shall be retained by the towing company for a period of two (2) years from the date of issuance. Throughout said two (2) year period, the copy of each invoice and receipt shall be made available for inspection and copying not later than two (2) business daysafter receiving a written request for inspection from:

a. a law enforcement agency;

b. the attorney general;

c. the prosecuting attorney or city attorney having jurisdiction in the location of any of the towing company's xxx State business locations;

d. the disabled motor vehicle's owner; or

e. the agent of the disabled motor vehicle's owner.

Section 8. Notice Requirements

A. Within two (2) business days of commencement of towing, the towing company or storage facility must commence a search of the National Motor Vehicle Title Information Systems data base, to obtain the last state of record of the vehicle and then obtain the most current name and address of the person who owns or holds a lien from the State's agency responsible for maintaining motor vehicle title data or an authorized vendor providing real time access to that state database, by electronic means, if available. No storage charges beyond the initial two (2) business days charge will accrue until the notice requirement has been met. If a state does not have a mechanism to provide the above requested information electronically, then the tow company will make all reasonable efforts to obtain the vehicle owner and lien holder information.

B. Upon obtaining the name and address of the owner and lienholder of the motor vehicle, written notice shall be given directly to the owner and lienholder, and, if known to the towing service or storage facility, the insurer of the vehicle, by certified mail with delivery confirmation within five (5) business days unless the ownership information could not reasonably be obtained within that time. Notice to the owner or insurer shall contain the following:

a. The date and time the vehicle was towed;

b. The location from which the vehicle was towed;

c. The name, address, and telephone number where the vehicle will be located;

d. The location, address and phone number where payment and business transactions take place if different from business address;

e. The name, address and phone number of the towing company or storage facility;

f. A description of the towed vehicle including but not limited to the make, model, year, vehicle identification number and color of the towed vehicle;

g. The license plate number and state of registration of the towed vehicle.

C. If the search result under Section 8(A) is a corporately owned vehicle then the above notice shall be sent to the state corporate address listed on the registration. The vehicle must be held for up to 60 days in order for the vehicle owner to retrieve the towed vehicle. The rate charged must be comparable to the standard daily rate. If at any time more than one vehicle owned by the same corporation is under your control each vehicle shall be processed under a separate transaction.

Section 9. Releasing Towed Motor Vehicles

A. This section applies to towing companies that tow and store motor vehicles, and to storage facilities that store motor vehicles towed by a towing company, regardless of whether the towing company and the storage facility are affiliates.

B. Upon payment of all costs incurred against a motor vehicle that is towed and stored under this Act, the towing company or storage facility shall release the motor vehicle to:

a.) a properly identified person who owns or holds a lien on the motor vehicle; or

b.) a representative of the responsible insurance company and the insurance representative provides proof of such, or, the owner of the motor vehicle approves release of the vehicle to the insurance company representative.

C. An owner, a lienholder, or an insurance company representative has the right to inspect a motor vehicle under normal business hours before accepting return of the motor vehicle under this Section.

D. A towing service or storage yard must accept payment made by any of the following means from a person seeking to release a motor vehicle under this Section: cash; insurance check; credit card, debit card, money order, or certified check.

E. Upon receiving payment of all costs incurred against a motor vehicle, a towing service or storage yard shall provide to the person making payment an itemized receipt that includes the information set forth in Section 7, to the extent the information is known or available.

F. A towing service or storage yard must be open for business and accessible by telephone during normal business hours. A towing service or storage yard must provide a telephone number that is available on a twenty-four (24) hour basis to receive calls and messages from callers, including calls made outside of normal business hours. All calls made to a towing service or storage yard must be returned within twenty-four (24) hours from the time received. However, if adverse weather, an act of God, an emergency situation, or another act over which the towing service or storage yard has no control prevents the towing service or storage yard from returning calls within twenty-four (24) hours, the towing service or storage yard shall return all calls received as quickly as possible.

Section 10. Fees

A. A towing company shall not charge a fee for towing, clean-up services and/or storage of a vehicle that is excessive or unfairly discriminatory.

B. All services rendered by a tow company, including any warranty or zero cost services, shall be recorded on an invoice. The towing company or the owner or operator of a tow truck shall maintain the records for two (2) years, and shall make the records available for inspection and copying upon written request from law enforcement.

C. A towing company shall furnish a copy of its rate sheet as provided in Section 7A to (insert relevant regulatory body)

Section 11. Tow Company Certificate Requirements

Drafting Note: States that already have a towing certification process in place may wish to supplement its relevant insurance code or regulations with this Section.

A. The [regulatory body] shall approve an application for a towing company certificate or certificate renewal, and shall issue or renew a certificate, provided the applicant submits to the [regulatory body] a completed application on a form prescribed by the [regulatory body], and also pays the application fee set by the [regulatory body].

B. If applicable by state law, an application shall include:

    a. The applicant's workers' compensation coverage.

    b. The applicant's unemployment compensation coverage.

    c. The financial responsibility of an applicant relating to liability insurance or bond requirements according to state XXXX.

C. The applicant must not have been convicted of fraud or had a civil judgment rendered against it, in the past 5 years, for fraud nor has any officer, director or partner of an

applicant that is a corporation or partnership during officer's, director's or partner's tenure.

Section 12. Prohibited Acts

A. A towing company shall not do any of the following:

a. falsely represent, either expressly or by implication, that the towing company represents or is approved by any organization which provides emergency road service for disabled motor vehicles.

b. require an owner/operator of a disabled motor vehicle, to preauthorize more than 24 hours of storage, or repair work as a condition to providing towing service for the disabled vehicle.

c. charge more than one (1) towing fee when the owner/operator of a disabled vehicle requests transport of the vehicle be towed to a repair facility owned or operated by the towing company

d. tow a motor vehicle to a repair facility, unless either the owner of the motor vehicle of the owner's designated representative gives consent, and, the consent is given before the motor vehicle is removed from the location from which it is to be towed. This prohibition does not apply to a storage yard that has a repair facility on the same site so long as the vehicle is not moved into the repair facility without consent as stated above.

B. A towing company or a storage facility shall not do any of the following:

a. upon payment of all costs incurred against a motor vehicle that is towed and stored under this Act, refuse to release the motor vehicle to a properly identified person who owns or holds a lien on the motor vehicle, or a representative of the responsible insurance company.

(i) However, a towing company or storage facility shall not release a motor vehicle in any case in which a law enforcement agency has ordered the motor vehicle not to be released, or in any case in which a judicial order countermands its release.

b. refuse to permit a properly identified person who owns or holds a lien on a motor vehicle, or a representative of the responsible insurance company to inspect the motor vehicle before all costs incurred against the motor vehicle are paid or the motor vehicle is released.

c. charge any storage fee for a stored motor vehicle with respect to any day on which release of the motor vehicle, or inspection of the motor vehicle by the owner, lienholder, or insurance company, is not permitted during normal business hours by the towing company or storage facility.

Section 13. Penalties and Enforcement

Drafting Note: Legislators should consider provisions that establish rules that allow for the [regulatory body] to be responsible for the administration and enforcement, including inspections, investigations, penalties, and license revocations, of all towing businesses and towing service storage lots in the state of XXXX.

Drafting Note: Legislators should further consider provisions allowing for an independent cause of action for insurers to recover a motor vehicle that has been towed and subject to an unreasonable billing by the tower for any excessive towing/storage charges.

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NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

Model Act Regarding Auto Airbag Fraud

Adopted by the NCOIL Executive Committee on November 22, 2009. Re-adopted by the NCOIL Property & Casualty Insurance Committee on July 12, 2018 and the NCOIL Executive Committee on July 15, 2018

**To be considered for re-adoption during the Property & Casualty Insurance Committee on July 22, 2023.*

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Section 1. Purpose

Airbag system fraud is a public safety concern for consumers and the automobile insurance system. Efforts to combat this problem—one that could place innocent consumers at risk of serious bodily injuries—have been piecemeal. This model is intended to address the issue in a coordinated way. It is through this collective effort that consumers will be protected and the integrity of the restraint system assured.

Section 2. Summary

The Act establishes criminal penalties for fraudulent installation or reinstallation of an airbag, with more severe penalties for persons whose airbag fraud results in serious injury or death; requires that any person engaged in the business of purchasing, selling, or installing an airbag maintain detailed records of airbags they purchase, sell, or install; mandates that any person engaged in the business of installing an airbag submit an affidavit to a vehicle owner saying that an airbag was installed properly; requires a

person repairing a vehicle to affix a permanent dashboard label disclosing that a salvaged airbag had been used; establishes that police accident reports must note whether an airbag deployed; and provides that a person trading or selling a motor vehicle must disclose whether an airbag is inoperable.

Section 3. Definitions

A. "Airbag" means any component of an inflatable occupant restraint system that is designed in accordance with federal safety regulations for the make, model, and year of the vehicle to be installed and to operate in a motor vehicle to activate, as specified by the vehicle manufacturer, in the event of a crash. Airbag components include but are not limited to sensors, controllers, wiring, and the airbag itself.

B. "Light manipulating system" means anything that would mask or cause the inaccurate indication of the airbag system status, condition, or operability.

C. "Person" means any natural person, corporation, partnership, unincorporated association, or other entity.

D. "Salvaged airbag" means an OEM non-deployed airbag that has been removed from a motor vehicle for use in another vehicle.

Section 4. Installation or reinstallation of any false airbag; deceptive trade practices; criminal liability

A. It is a deceptive trade practice when:

1. a person installs or reinstalls, as part of a vehicle inflatable occupant restraint system, any object in lieu of an airbag, including any light manipulating system

2. a person sells or offers for sale any device with the intent that such device will replace an airbag in any motor vehicle if such person knows or reasonably should know that such device does not meet federal safety requirements

3. a person sells or offers for sale any device that when installed in any motor vehicle gives the impression that a viable airbag is installed in that vehicle, including any light manipulating system

4. any person intentionally misrepresents the presence of an airbag when one does not exist

B. Any person who violates this section is guilty of a felony and, upon conviction thereof, shall be punished by a fine of not less than $ ____ and not more than $ ____ per violation, or imprisonment in [insert facility] for up to ____ year(s), or both.

C. A person whose violation of subsection A(1) of this section results in serious bodily injury or death shall be imprisoned for not more than _____ years or fined not more than $_____, or both.

Section 5. Airbag antitheft

A. Purchase, sale, or installation of new or salvaged airbag; records

1. Any person engaged in the business of purchasing, selling, or installing salvaged airbags shall maintain a manual or electronic record of the purchase, sale, or installation, which must include the identification number of the airbag; the vehicle identification number of the vehicle from which the salvaged airbag was removed; the name, address, and driver's license number or other means of identification of the person from whom the salvaged airbag was purchased; and, in the event that the salvaged airbag is installed, the vehicle identification number of the vehicle into which the airbag is installed. No new or salvaged airbag shall be sold or installed which is or has been subject to a specific manufacturer's or appropriate authority's notice of recall.

2. In the case of a new replacement airbag, any person engaged in installing any airbag shall maintain the name and tax identification number of the supplier of the airbag and record the vehicle identification number of the vehicle into which the airbag is installed, as well as the identification number of the airbag being installed. Additionally, the airbag identification of the previously deployed airbag being replaced shall be recorded. Upon request of any law enforcement officer of this state or other authorized representative of the agency charged with administration of this section, the installer shall produce such records and permit said agent or police officer to examine them.

3. Any person who installs a salvaged airbag in a vehicle shall apply a permanent, durable label that clearly states that the vehicle contains a salvaged airbag. Such label must be permanently installed on the dashboard of the vehicle. Any person who removes such a label shall be guilty of a criminal offense.

4. Any person who sells a salvaged airbag or who installs a salvaged airbag must disclose to the purchaser and vehicle owner that the airbag is salvaged.

5. The person who installs a new or salvaged airbag shall submit an affidavit to the vehicle owner or their representative stating that the replacement airbag had been properly installed.

6. All records must be maintained for not less than five years following the transaction and may be inspected during normal business hours by any law enforcement officer of this state or other authorized representative of the agency charged with administration of this section.

7. Upon request, information within a portion of such record pertaining to a specific transaction must be provided to the insurer and the vehicle owner.

8. Persons engaged in the business of selling salvage airbags shall comply with regulations developed by the [insert appropriate state agency].

9. State rules regarding the sale of salvaged airbags shall include but not be limited to the following standards:

a. identification of the supplier of the unit

b. identification of the recipient vehicle, including VIN, year, make, and model

c. identification of the airbag module cover color (and color code if available)

d. identification of the donor vehicle, including VIN, year, make, and model

e. supplier's internal stock number or locator number

f. indication of source of interchange information (i.e. interchange manual/part number, OEM info, etc.)

g. a supplier certificate indicating that all the requirements of the inspection protocol have been successfully achieved and identifying the person who completed the inspection

h. a document containing the vehicle description including the year, make, and model for which the airbag system component is required when being sold to the end-user

10. Salvage airbags conforming to such standards shall be accompanied by a Certificate of Conformance which shall be retained by the installer.

Drafting Note: Each state should consider allowing the regulator to adopt a protocol to insure that only salvaged airbags that have met specific criteria are used.

B. *Prohibition; penalties*

1. It is unlawful for any person to knowingly possess, sell, or install a stolen airbag; an airbag from which the manufacturer's part number labeling and/or VIN has been removed, altered, or defaced; or an airbag taken from a stolen motor vehicle. Any person who violates this paragraph commits a felony of the [insert degree].

2. Any person who fails to maintain complete and accurate records, to prepare complete and accurate documents, to provide information from such record upon request, or to properly disclose that an airbag is salvaged, as required by this Act, commits a misdemeanor.

Section 6. Accidents; police authorities report

Any automobile vehicle accident report that is filed by the appropriate law enforcement agency shall clearly contain a notation as to whether the automobile's airbag or inflatable restraint system had been deployed in the accident.

Drafting Note: Airbag systems often contain seatbelt pretensioners that, once deployed, must be replaced in order to restore the integrity of the airbag system. In some crashes, the pretensioners will deploy in conjunction with the airbags and in other crashes the pretensioners will deploy even if the airbag does not. Because law enforcement officers may miss the pretensioner deployment if it is not accompanied by release of an airbag, officers should be educated to recognize and report that a pretensioner has deployed and must be replaced.

Section 7. Sale or trade of motor vehicle with an inoperable airbag

A. Any person selling or trading a motor vehicle who has actual knowledge that the motor vehicle's airbag is inoperable shall notify the buyer or the person acquiring the trade, in writing, that the airbag is inoperable.

B. A person who violates subsection A of this section is subject to civil and/or criminal prosecution at the selection of the state.

Section 8. Severability

If any section, paragraph, sentence, clause, phrase, or any part of this Act passed is declared invalid, the remaining sections, paragraphs, sentences, clauses, phrases, or parts thereof shall be in no manner affected and shall remain in full force and effect.

Section 9. Effective Date

This Act shall take effect on [insert months] following enactment of the bill.

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NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

Model Act Regarding Disclosure of Rental Vehicle Damage Waivers

Adopted by the NCOIL Executive Committee on March 1, 2008. Re-adopted by the NCOIL Property & Casualty Insurance Committee on July 12, 2018 and the NCOIL Executive Committee on July 15, 2018
Sponsored by Sen. Alan Sanborn, MI

****To be considered for re-adoption during the Property & Casualty Insurance Committee on July 22, 2023***

Section 1. Purpose
The purpose of this Act is to amend a state's general business/consumer protection law to require that rental vehicle companies make certain disclosures to consumers prior to offering optional rental vehicle damage waivers.

Section 2. Definitions
For the purposes of this Act, the following terms mean:

A. Damage waiver—a provision in an agreement in which a rental vehicle company agrees, for a fee, to waive any claims against a renter of a motor vehicle for any damage to (including loss of use), or theft of, the motor vehicle that occurs during the term of the rental agreement, provided the rental motor vehicle is being operated in accordance with the terms and conditions of the rental agreement.

B. Rental agreement—a written agreement that contains the terms and conditions governing the use of a rented motor vehicle by a consumer for a period of not more than 60 days. The term includes any additional or supplemental agreements executed as part of the rental agreement.

C. Rental vehicle company—any person or organization, or any subsidiary or affiliate, including a franchisee, in the business of providing rental vehicles to the public from locations in this state

Section 3. Disclosure Requirements
The general business/consumer protection act of the State of [insert state] is hereby amended to include the following:

A. A rental vehicle company shall not offer a damage waiver to a consumer as an optional provision in a rental agreement for a motor vehicle unless the rental agreement contains all of the following statements:

1. the purchase of a damage waiver is optional

2. the purchase of a damage waiver is not required to rent a motor vehicle
3. the renter may wish to contact his or her insurance representative or credit card company to obtain some or all of the following information:

a. his or her coverage or protection, if any, for damage to or theft of a rented motor vehicle

b. the amount of his or her insurance deductible or out-of-pocket risk for filing a claim for damage to, or theft of, a rented motor vehicle

B. At each place of business in this state at which the rental vehicle company rents motor vehicles to consumers, the rental vehicle company must have written materials or brochures readily available that contain all of the statements described in Paragraph A.

Section 4. Effective Date
This part shall take effect [60 days] after enactment.

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NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

Model Anti-Runners Fraud Bill

Adopted by the NCOIL Executive Committees on July 11, 2003. Readopted on July 8, 2005, and November 20, 2010.
Re-adopted by the NCOIL Property & Casualty Insurance Committee on July 12, 2018 and the NCOIL Executive Committee on July 15, 2018

**To be considered for re-adoption during the Property & Casualty Insurance Committee on July 22, 2023.*

Section 1: Definitions

As used in this section, the following terms have the meanings given:
(a) "Provider" means an attorney, health care professional, an owner of a health care practice or facility, or any person employed or acting on behalf of any of the aforementioned persons.

(b) "Public Media" means telephone directories, professional directories, newspapers and other periodicals, radio and television, billboards, and mailed or electronically transmitted written communications that do not involve in-person contact with a specific prospective client.

(c) "Runner," "capper," or "steerer" means a person who for pecuniary benefit, whether directly or indirectly, or in cash or in kind, procures or attempts to procure a client, patient or customer at the direction of, request of, or in cooperation with a Provider whose intent is to seek to obtain benefits under a contract of insurance or to assert a claim against an insured or an insurer for providing services to the client, patient or customer. The term does not include a person who procures clients, patients or customers through the use of Public Media.

Section 2: Penalties

Whoever employs, uses, or acts as a Runner, Capper, or Steerer for the intent of seeking to falsely or fraudulently obtain benefits under a contract of insurance or to falsely or fraudulently assert a claim against an insured or an insurer for providing services to the client, patient or customer is guilty of a felony and may be sentenced to _____ and to a fine of not more than $_____.

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National Council of Insurance Legislators (NCOIL)

Property/Casualty Insurance Domestic Violence Model Act

Adopted by the Property-Casualty Insurance and Executive Committees on March 1, 1998; readopted on July 13, 2005; July 11, 2003; July 8, 2005; and November 20, 2010. Re-adopted by the NCOIL Property & Casualty Insurance Committee on July 12, 2018 and the NCOIL Executive Committee on July 15, 2018

**To be considered for re-adoption during the Property & Casualty Insurance Committee on July 22, 2023.*

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Section 1. Legislative Intent

The purpose of this Act is to prohibit unfair discrimination by property-casualty insurers on the basis of domestic violence.

Section 2. Scope.

This Act shall apply to all insurers issuing or renewing a policy of property-casualty insurance in this state.

Section 3. Definitions

A. "Abuse" means bodily injury as a result of battery.

B. "Innocent co-insured" means an individual who did not cooperate in or contribute to the creation of the loss.

C. "Insured" [insert state definition].

D. "Insurer" [insert state definition].

E. "Policy" [insert state definition].

Section 4. Prohibited Discriminatory Acts Relating to Property-Casualty Insurance

A. No insurer shall use the fact that an applicant or insured incurred bodily injury as a result of a battery committed against him or her by a spouse or a person in the same household as the sole reason for rating or underwriting decisions.

B. Where a policy excludes property coverage for intentional acts, the insurer shall not deny payment to an innocent co-insured who did not cooperate or contribute to the creation of the loss if the loss arose out of a pattern of criminal domestic violence and the perpetrator of the loss is criminally prosecuted for the act causing the loss. Payment to the innocent co-insured may be limited to his or her ownership interests in the property as reduced by any payments to a mortgage or other secured interest.

Section 5. Effective Date

This Act is effective [insert date], and applies to all action taken on or after the effective date, except where otherwise explicitly stated.

GENERAL SESSION MATERIALS – THE ONGOING EFFORT TO ACHIEVE MENTAL HEALTH PARITY

Kentucky HB 208 will be referenced during the mental health parity session – click here to access the bill

EXECUTIVE COMMITTEE MATERIAL

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
EXECUTIVE COMMITTEE
2023 NCOIL SPRING MEETING – SAN DIEGO, CA
MARCH 12, 2023
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Executive Committee met at the Westin San Diego Gaslamp Quarter in San Diego, CA on Sunday March 12, 2023 at 10:45 AM (EST).

NCOIL President, Representative Deborah Ferguson, DDS (AR), Chair of the Committee, presided.

Other members of the committee present:

Rep. Matt Lehman (IN)	Asw. Pamela Hunter (NY)
Rep. Brenda Carter (MI)	Sen. Bob Hackett (OH)
Sen. Paul Utke (MN)	Del. Steve Westfall (WV)

Other legislators present were:

Sen. Jesse Bjorkman (AK)	Sen. Nellie Pou (NJ)
Rep. Mark Tedford (OK)	

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. Paul Utke (MN), NCOIL Secretary, and seconded by Asw. Pamela Hunter (NY), NCOIL Treasurer, the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a motion made by Del. Steve Westfall (WV) and seconded by Rep. Brenda Carter (MI) the Committee voted without objection by way of a voice vote to approve the minutes of the Committee's November 19, 2022 meeting in New Orleans.

NEW EXECUTIVE COMMITTEE MEMBERS

Rep. Ferguson stated that 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, Sen. Jesse Bjorkman (AK), Chair of the AK Senate Labor & Commerce Committee and Sen. Nellie Pou (NJ), Chair of the NJ Senate Commerce Committee should be added to the NCOIL Executive Committee.

Upon a motion made by Rep. Carter and seconded by Sen. Bob Hackett (OH), the Committee voted without objection by way of a voice vote to add Sen. Bjorkman and Sen. Pou, to the Executive Committee.

FUTURE MEETING LOCATIONS

Rep. Ferguson stated that as we look ahead to the rest of 2023, the Summer Meeting will be in Minneapolis, MN from July 19th-22nd and the Annual Meeting will be in Columbus, OH from November 15th-18th. For 2024, the Spring Meeting will be in Nashville, TN from April 11th – 14th, the Summer Meeting will be in Costa Mesa, CA from July 17th – 20th and the Annual Meeting will be in San Antonio, TX from November 21st – 24th.

ADMINISTRATION

Will Melofchik, NCOIL General Counsel, stated that there were 317 total registrants for the Spring Meeting including 53 legislators from 23 states and of that number there were 19 first time attendee legislators from 11 states. Additionally, 9 Insurance Commissioners participated with 12 total insurance departments represented.

Mr. Melofchik gave the 2022 end of year unaudited financials through December 31st showing revenue of $1,695,091.10 and expenses of $1,364,041.28 leading to a surplus of $331,049.82. He also stated that invoices have started to be sent out for state dues payments this past week so they should appear in mailboxes soon. NCOIL staff is optimistic that the organization will have a solid year of dues payments and is hopeful to add a state or two to the list of Contributing States.

CONSENT CALENDAR

Rep. Ferguson noted that the consent calendar includes committee reports including resolutions and model laws adopted and re-adopted therein, as well as ratification of decisions made and actions taken by the NCOIL Officers and staff in the time between Executive Committee Meetings.

The Consent Calendar included:

- The Property & Casualty Insurance Committee adopted the NCOIL Insurance Underwriting Transparency Model Act.
- The Health Insurance & Long Term Care Issues Committee re-adopted the NCOIL Pharmacy Benefits Manager (PBM) Licensure and Regulation Model Act.
- Ratification of decisions made and actions taken by the NCOIL Officers and staff in the time between Executive Committee Meetings.

Rep. Ferguson asked if any Committee member wanted anything removed from the consent calendar. Hearing no such requests, upon a motion made by Asw. Hunter and seconded by Del. Westfall, the Committee voted to adopt the consent calendar without objection by way of a voice vote.

OTHER SESSIONS

Rep. Ferguson stated that the Institutes Griffith Foundation held a legislator luncheon during which Rob Hoyt, Ph.D., Chair & Professor of Risk Management & Insurance at the University of Georgia, gave a great presentation titled “Understanding the Economics of the Insurance Market”.

There were also two interesting and timely general sessions including: the first session in a year-long special series of general sessions on Environmental, Social and Governance (ESG) policy; and a session titled “Liability Insurance for Gun Owners: Is it Time?”

Featured speakers included: Brigadier General Peter Cross of the California National Guard who got the meeting off to a great start at the Welcome Breakfast; and San Diego Mayor Todd Gloria who gave a tremendous keynote address at the luncheon.

RESOLUTION RECOGNIZING NCOIL PAST PRESIDENT FORMER ASSEMBLYMAN KEN COOLEY (CA) AS AN HONORARY MEMBER OF NCOIL

Rep. Ferguson stated that she would like to offer a Resolution Recognizing NCOIL Past President Former Assemblyman Ken Cooley (CA) as an Honorary Member of NCOIL (Resolution) sponsored by herself, Rep. Tom Oliverson, M.D. (TX), NCOIL Vice President, Asw. Hunter, Sen. Utke, Rep. Matt Lehman (IN), NCOIL Immediate Past President, Sen. Travis Holdman (IN), NCOIL Immediate Past President, and Asm. Tim Grayson (CA). Rep. Ferguson then read aloud the Resolution.

Rep. Ferguson then said that on a personal note, the highest honor her dad could say about anyone is that “he’s a fine man” and that is how she feels about former Asm. Cooley. She mentioned that she appreciates how thoughtful and diplomatic he is and that he is an example of how all legislators should serve in their respective legislatures.

Rep. Lehman thanked former Asm. Cooley for his service to NCOIL and said that he learned a lot from him as he thinks through issues in a pragmatic way and looks forward to filling his shoes as NCOIL Immediate Past President.

The Hon. Tom Considine, NCOIL CEO, stated that it was a pleasure professionally and personally to benefit from former Asm. Cooley’s advice and stewardship during his presidency and that no one came to the job more prepared and with more diligence than him. Cmsr. Considine stated that he treasures former Asm. Cooley’s time as NCOIL President and thinks he is a wonderful man and public official and is happy he is still in our midst here at NCOIL.

Upon a Motion made by Asw. Hunter and seconded by Rep. Lehman, the Committee voted without objection to adopt the Resolution by way of a voice vote.

ANY OTHER BUSINESS

Teresa Casey, Administrator of the Industry Education Council (IEC) said the IEC has proposed a topic that may be good for a Griffith Institutes legislator luncheon or NCOIL general session. The topic deals with inflation both on the claims side and investment side and that topic will be submitted in writing to Mr. Melofchik.

Rep. Ferguson concluded by stating that she's heard such positive things about this meeting both in terms of the great panels and great participation including 19 first time legislator attendees.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Carter and seconded by Del. Westfall, the Committee adjourned at 11:15 a.m.