30 DAY MATERIALS AND TENTATIVE GENERAL SCHEDULE
NCOIL SUMMER MEETING
JULY 14 - 17, 2021

As of June 15, 2021, and Subject to Change

Westin Boston Waterfront Hotel
Boston, Massachusetts

NCOIL SUMMER MEETING
Boston, Massachusetts
July 14 - 17, 2021
TENTATIVE SCHEDULE

WEDNESDAY, JULY 14th

Audit Committee (Members Only)	4:15 p.m.	-	5:00 p.m.
Budget Committee	5:00 p.m.	-	5:30 p.m.
Welcome Reception	6:00 p.m.	-	7:00 p.m.

THURSDAY, JULY 15th

Registration *Exhibits Open: 9:00 a.m. – 5:00 p.m.*	7:00 a.m.	-	5:00 p.m.
Welcome Breakfast	8:15 a.m.	-	9:45 a.m.
Networking Break	9:45 a.m.	-	10:00 a.m.
Workers' Compensation Insurance Committee	10:00 a.m.	-	11:15 a.m.
Health General Session Developments in Medical Treatment for Obesity	11:15 a.m.	-	12:30 p.m.
The Institutes Griffith Foundation Legislator Luncheon	12:30 p.m.	-	1:30 p.m.

Special Committee on Race in Insurance Underwriting	1:30 p.m.	-	2:45 p.m.
Networking Break	2:45 p.m.	-	3:00 p.m.
Joint State-Federal Relations and International Insurance Issues Committee	3:00 p.m.	-	4:15 p.m.
Life Insurance & Financial Planning Committee	4:15 p.m.	-	5:30 p.m.
Adjournment	5:30 p.m.		
CIP Member & Sponsor Reception	5:30 p.m.	-	6:30 p.m.

FRIDAY, JULY 16TH

Registration *Exhibits Open: 8:00 a.m. – 4:00 p.m.*	8:00 a.m.	-	4:00 p.m.
Financial Services & Multi-Lines Issues 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: In light of the positive feedback from recent Meetings, there will be no Legislative Micro Meetings. However, there will be a room available throughout the duration of the conference for informal meetings.

General Session The Delicate Balance of Legislative Oversight	1:30 p.m.	-	2:45 p.m.
Networking Break	2:45 p.m.	-	3:00 p.m.
Property & Casualty Insurance Committee	3:00 p.m.	-	4:30 p.m.
Adjournment	4:30 p.m.		

SATURDAY, JULY 17TH

Registration *Exhibits Open: 8:00 a.m. – 11:00 a.m.*	8:00 a.m.	-	11:00 a.m.

NCOIL Innovation Series Cyber Insurance: The Challenges of Ransomware and Beyond	9:00 a.m.	-	10:15 a.m.
Networking Break	10:15 a.m.	-	10:30 a.m.
Health Insurance & Long Term Care Issues Committee	10:30 a.m.	-	12:00 p.m.
Business Planning Committee and Executive Committee	12:00 p.m.	-	1:00 p.m.

******Please note all speakers listed are scheduled to speak as of June 15, 2021. There will be modifications between now and the start of the Meeting.******

******Note: In light of the positive feedback from recent meetings, there will be no Legislative Micro Meetings. However, there will be a room available throughout the duration of the conference for informal meetings.******

WEDNESDAY, JULY 14, 2021

Audit Committee (Members Only)
Wednesday, July 14, 2021
4:15 p.m. – 5:00 p.m.

Chair: Asm. Ken Cooley (CA) – NCOIL Vice President
Vice Chair: Rep. Richard Smith (GA)

Budget Committee
Wednesday, July 14, 2021
5:00 p.m. – 5:30 p.m.

Chair: Asm. Kevin Cahill (NY) – NCOIL Treasurer
Vice Chair: Sen. Neil Breslin (NY)

1.) Call to Order/Roll Call
2.) 2022 Budget Planning Discussion
3.) Any Other Business
4.) Adjournment

Welcome Reception
Wednesday, July 14, 2021
6:00 p.m. – 7:00 p.m.

THURSDAY, JULY 15, 2021

Welcome Breakfast
Thursday, July 15, 2021
8:15 a.m. – 9:45 a.m.

1.) Welcome to Boston
2.) ***Hon. Tom Considine***
    Introductory Comments from NCOIL CEO
3.) ***Rep. Matt Lehman (IN)***
    a.) President's Welcome
    b.) New Member Welcome and Introduction
4.) Any Other Business
5.) Adjournment

Networking Break
Thursday, July 15, 2021
9:45 a.m. – 10:00 a.m.

Workers' Compensation Insurance Committee
Thursday, July 15, 2021
10:00 a.m. – 11:15 a.m.

Chair: Rep. Tom Oliverson, M.D. (TX)
Vice Chair: Sen. Paul Utke (MN)

1.) Call to Order/Roll Call/Approval of December 11, 2020 and April 16, 2021 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, Executive Director, Regulatory Business Management – National Council on Compensation Insurance (NCCI)
3.) Using Workers' Compensation Data and Systems to Improve Safety and Health

Steve Wurzelbacher, PhD, CPE, ARM, Director - Center for Workers' Compensation Studies (CWCS), National Institute for Occupational Safety and Health (NIOSH), Centers for Disease Control and Prevention (CDC)

4.) Consideration of Re-Adoption of Model Laws
   a.) Trucking/Messenger Courier Industries Workers' Comp Model Act – Originally Adopted 3/6/11; Readopted 7/17/16
   b.) Model Agreement Between Jurisdictions to Govern Coordination of Claims and Coverage – Supported 7/22/06, 7/17/11, 7/14/16
   c.) Model State Structured Settlement Protection Act (NSSTA/NASP Compromise Model) -- Supported 2/27/04, 7/22/06, 7/17/11, 11/20/16
5.) Any Other Business
6.) Adjournment

Health General Session
Developments in Medical Treatment for Obesity
Thursday, July 15, 2021
11:15 a.m. – 12:30 p.m.

Moderator: Asw. Pam Hunter (NY)

Angela Fitch, MD, FACP, FOMA
Associate Director
Massachusetts General Hospital Weight Center

Joe Nadglowski
President & CEO
Obesity Action Coalition (OAC)

The Institutes Griffith Foundation Legislator Luncheon
Thursday, July 15, 2021
12:30 p.m. – 1:30 p.m.

Special Committee on Race in Insurance Underwriting
Thursday, July 15, 2021
1:30 p.m. – 2:45 p.m.

Chair: Sen. Neil Breslin (NY)

1.) Call to Order/Roll Call/Approval of December 9, 2020, March 5, 2021, April 15, 2021 and June 18, 2021 Committee Meeting Minutes
2.) Continued Rating Factor/Disparate Impact Discussion
3.) Any Other Business
4.) Adjournment

Networking Break
Thursday, July 15, 2021
2:45 p.m. – 3:00 p.m.

Joint State-Federal Relations & International Insurance Issues Committee
Thursday, July 15, 2021
3:00 p.m. – 4:15 p.m.

Chair: Sen. Bob Hackett (OH)
Vice Chair: Sen. Roger Picard (RI)

1.) Call to Order/Roll Call/Approval of April 16, 2021 Committee Meeting Minutes
2.) Discussion on Implementation of the Safeguarding Tomorrow through Ongoing Risk Mitigation (STORM) Act and Potential NCOIL Model Act
Roderick Scott, Board Chair – Flood Mitigation Industry Association (FMIA)
3.) The National Flood Insurance Program's (NFIP) New Rating Methodology - Risk Rating 2.0: Equity in Action
Tony Hake - Federal Emergency Management Agency (FEMA)
4.) Discussion on the Protecting the Right to Organize (PRO) Act (H.R. 842/S.420)
Catherine Fisk, Barbara Nachtrieb Armstrong Professor of Law – UC Berkley School of Law
National Association of Insurance and Financial Advisors (NAIFA) Representative
5.) Any Other Business
6.) Adjournment

Life Insurance & Financial Planning Committee
Thursday, July 15, 2021
4:15 p.m. – 5:30 p.m.

Chair: Asw. Maggie Carlton (NV)
Vice Chair: Rep. Wendi Thomas (PA)

1.) Call to Order/Roll Call/Approval of April 16, 2021 Committee Meeting Minutes
2.) Discussion on Implications of Colorado Supreme Court Decision Amica Life Insurance Company v. Wertz on the Interstate Insurance Product Regulation Commission (IIPRC)
The Hon. Mary Jo Hudson, Partner – Squire, Patton, Boggs; Former Ohio Insurance Director

3.) Update on The Setting Every Community Up for Retirement Enhancement (SECURE) Act 2.0 and Other Federal Retirement Initiatives
Bradford Campbell, Partner – Faegre, Drinker, Biddle & Reath, LLP
4.) Life & Health Insurance Guaranty Associations: What are they? How have they responded to COVID? How do they interact with captive insurance laws?
National Organization of Life & Health Guaranty Associations (NOLHGA) Representative
5.) Any Other Business
6.) Adjournment

CIP Member & Sponsor Reception
Thursday, July 15, 2021
5:30 p.m. – 6:30 p.m.

FRIDAY, JULY 16, 2021

Financial Services & Multi-Lines Issues Committee
Friday, July 16, 2021
9:00 a.m. – 10:30 a.m.

Chair: Rep. Edmond Jordan (LA)
Vice Chair: Rep. Jim Dunnigan (UT)

1.) Call to Order/Roll Call/Approval of April 16, 2021 Committee Meeting Minutes
2.) Continued Discussion on NCOIL Remote Notarization Model Act (Including Live Demo of Remote Notarization)
Rep. Edmond Jordan (LA) – Sponsor
Nicole Booth, EVP, Public Affairs – Notarize
Jacqueline Phillips, Director of Notary Engagement and Education – Notarize
3.) Continued Discussion on NCOIL Uniform Captive Insurer Model Act
Sen. Jason Rapert (AR) – NCOIL Immediate Past President – Sponsor
Richard Smith, President – Vermont Captive Insurance Association
Sandy Bigglestone, CPA, CFE, CPM, APIR, Director of Vermont Captive Insurance Division
4.) Update and Review on State Insurance Regulatory Sandboxes
Rees Empey, Director of State Gov't Affairs – Libertas Institute
Kevin Gaffney, Deputy Commissioner of Insurance – Vermont Department of Financial Regulation
5.) Any Other Business
6.) Adjournment

Networking Break
Friday, July 16, 2021
10:30 a.m. – 10:45 a.m.

NCOIL – NAIC Dialogue
Friday, July 16, 2021
10:45 a.m. – 12:00 p.m.

Chair: Asm. Ken Cooley (CA) – NCOIL Vice President
Vice Chair: Rep. Martin Carbaugh (IN)

1.) Call to Order/Roll Call/Approval of April 16, 2021 Committee Meeting Minutes
2.) Environmental, Social, and Governance (ESG) Issues
    a.) NAIC Special Committee on Race in Insurance
    b.) Regulating Climate Change Risks
3.) Review of International Monetary Fund (IMF) 2020 Financial Sector Assessment Program (FSAP) Review of the U.S. Financial Regulatory System
4.) Update on Proposed Changes to SSAP No. 71
5.) Discussion on Federal Insurance Office (FIO) Request for Information (RFI) Regarding Personal Auto Insurance Market
6.) Discussion on NAIC Long Term Care Insurance Multi-State Rate Review Framework
7.) Any Other Business as Time Permits
    a.) State Adoption of Amended NAIC Credit for Reinsurance Models
    b.) Affordable Care Act (ACA) Regulatory Issues
    c.) Accelerated Underwriting Definition
8.) Adjournment

Luncheon with Keynote Address
Friday, July 16, 2021
12:00 p.m. – 1:30 p.m.

Note: In light of the positive feedback from recent meetings, there will be no Legislative Micro Meetings. However, there will be a room available throughout the duration of the conference for informal meetings.

General Session
The Delicate Balance of Legislative Oversight
Friday, July 16, 2021
1:30 p.m. – 2:45 p.m.

Moderator: Asm. Ken Cooley (CA) – NCOIL Vice President

Ben Eikey
Manager
State Training and Communications
Levin Center at Wayne State Law

The Honorable Ed McBroom
Chair
Michigan Senate Oversight Committee

John Sylvia
Director - Performance Evaluation and Research Division (PERD)
West Virginia Legislative Auditor's Office

Networking Break
Friday, July 16, 2021
2:45 p.m. – 3:00 p.m.

Property & Casualty Insurance Committee
Friday, July 16, 2021
3:00 p.m. – 4:30 p.m.

Chair: Rep. Bart Rowland (KY)
Vice Chair: Sen. Vickie Sawyer (NC)

1.) Call to Order/Roll Call/Approval of April 18, 2021 Committee Meeting Minutes
2.) Property & Casualty Insurance Guaranty Funds: What are they? How have they responded to COVID? How do they interact with captive insurance laws?
Roger Schmelzer, President & CEO - National Conference of Insurance Guaranty Funds (NCIGF)
Barbara Cox, Counsel - NCIGF
3.) Developments in Post-Disaster Claims Handling Legislation
Amy Bach – Executive Director – United Policyholders
Rep. Pam Marsh (OR) – Chair, Oregon House Committee on Energy and Environment
4.) Update on NCOIL Fairness for Responsible Drivers Model Act
Sen. Shawn Vedaa (ND) – Sponsor
5.) Discussion on Warranty Legislative and Regulatory Landscape
Greg Mitchell, Esq. – Frost Brown Todd, LLC
Eric Arnum, Editor - Warranty Week
6.) Measuring Risk Post-COVID
David Dean, Chief Strategy Officer – Strategic Risk Officers
Gary Preysner, Partner – Ironwood Consulting Group

7.) Consideration of Re-adoption of Model Law - Property/Casualty Flex-Rating Regulatory Improvement Model Act: Adopted by the Executive Committee on February 27, 2004, and readopted on November 20, 2011 and July 17, 2016.
8.) Any Other Business
9.) Adjournment

SATURDAY, JULY 17, 2021

NCOIL Innovation Series
Cyber Insurance: The Challenges of Ransomware and Beyond
Saturday, July 16, 2021
9:00 a.m. – 10:15 a.m.

Moderator: Rep. Bart Rowland (KY)

John Pendleton
Director
Financial Markets & Community Investment
U.S. Government Accountability Office

Justin Herring
Executive Deputy Superintendent
Cybersecurity Division
New York Department of Financial Services

Matthew McCabe
Senior Client Advisor
Marsh

Peter Halprin, Esq.
Partner
Pasich, LLP

Dr. Josephine Wolff
Assistant Professor of Cybersecurity Policy
The Fletcher School – Tufts University

Networking Break
Saturday, July 17, 2021
10:15 a.m. – 10:30 a.m.

Health Insurance & Long Term Care Issues Committee
Saturday, July 17, 2021
10:30 a.m. – 12:00 p.m.

Chair: Asw. Pam Hunter (NY)
Vice Chair: Rep. Deborah Ferguson (AR)

1.) Call to Order/Roll Call/Approval of April 17, 2021 Committee Meeting Minutes
2.) Continued Discussion on NCOIL Telemedicine Authorization and Reimbursement Model Act

Asw. Pam Hunter (NY) – Sponsor
Quest Analytics Representative
America's Health Insurance Plans (AHIP) Representative

3.) Continued Discussion on NCOIL Model Act Regarding Air Ambulance Patient Protections
Rep. Deanna Frazier (KY); Rep. Tom Oliverson, M.D. (TX); Del. Steve Westfall (WV) – Sponsors
Global Medical Response (GMR) Representative
Chris Brady, General Counsel – Air Methods Corporation (AMC)

4.) Introduction and Discussion of NCOIL Accumulator Adjustment Program Model Act
Rep. Deborah Ferguson (AR); Sen. Jason Rapert (AR), NCOIL Immediate Past President; Rep. George Keiser (ND); Asw. Pam Hunter (NY) – Sponsors
All Copays Count Coalition Representatives: Kollet Koulianos, Senior Director of Payer Relations - National Hemophilia Foundation; Stephanie Hengst, Manager of Policy & Research - The AIDS Institute
AHIP Representative

5.) Consideration of re-adoption of NCOIL Employer-Sponsored Group Disability Income Protection Model Act (Originally adopted November, 2016; temporarily re-adopted April, 2021)
6.) Any Other Business
7.) Adjournment

Business Planning Committee and Executive Committee
Saturday, July 17, 2021
12:00 p.m. – 1:00 p.m.

Chair: Rep. Matt Lehman (IN) – NCOIL President
Vice Chair: Asm. Ken Cooley (CA) – NCOIL Vice President

1.) Call to Order/Roll Call/Approval of April 18, 2021 Committee Meeting Minutes
2.) Future Meeting Locations
3.) Administration
a.) Meeting Report
b.) Receipt of Financials and Audit
c.) Consideration of Audit
4.) Consent Calendar – Committee Reports Including Resolutions and Model Laws Adopted/Re-adopted Therein
5.) Other Sessions
a.) Legislator Luncheon
b.) General Sessions
c.) Featured Speakers
6.) Any Other Business
7.) Adjournment

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CHIEF EXECUTIVE OFFICER: Thomas B. Considine

National Council of Insurance Legislators (NCOIL)

Remote Notarization Model Act

***Draft as of June 15,~~March 16~~, 2021.**
***To be discussed during the Financial Services & Multi-Lines Issues Committee on July 16~~April 17~~, 2021.**

***Sponsored by Rep. Edmond Jordan (LA)**

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

(A) As used in this section:

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

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

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

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

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

"Notarial act" means any official act performed by a notary public appointed pursuant to the provisions of the [State notary law], or otherwise qualified and commissioned as a notary public in this State, or performed by an officer authorized to take oaths, affirmations and affidavits under […] or to take acknowledgments under […]. "Notarial act" shall include the following: taking acknowledgments; administering oaths and

affirmations; executing jurats or other verification; taking proofs of deed; and executing protests for non-payment.

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

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

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

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

(1) the notary public or officer:

(a) has personal knowledge of the identity of the individual appearing before the notary public or officer, which is based upon dealings with the individual sufficient to provide reasonable certainty that the individual has the identity claimed;

(b) has satisfactory evidence of the identity of the remotely located individual by oath or affirmation from a credible witness appearing before the notary public or officer; or

(c) has obtained satisfactory evidence of the identity of the remotely located individual by using at least two different types of identity proofing;

(2) the notary public or officer is reasonably able to confirm that a record before the notary public or officer is the same record in which the remotely located individual made a statement or on which the remotely located individual executed a signature;

(3) the notary public or officer or a person acting on their behalf creates an audio-visual recording of the performance of the notarial act; and

(4) for a remotely located individual who is located outside the United States:

(a) the record:

(i) is to be filed with or relates to a matter before a public official or court, governmental entity, or other entity subject to the jurisdiction of the United States; or

(ii) involves property located in the territorial jurisdiction of the United States or involves a transaction substantially connected with the United States; and

(b) the act of making the statement or signing the record is not prohibited by the foreign state in which the remotely located individual is located.

(C) If a notarial act is performed under this section, any required certificate shall indicate that the notarial act was performed using communication technology.

(D) A notary public appointed pursuant to the provisions of the [State notary law], or otherwise qualified and commissioned as a notary public in this State, or an officer authorized to take oaths, affirmations and affidavits under […] or to take acknowledgments under […], a guardian, conservator, or agent of such person or, if such person is deceased, a personal representative of the deceased person, shall retain the audio-visual recording created under paragraph (3) of subsection B. of this section or cause the recording to be retained by a repository designated by or on behalf of the person required to retain the recording. Unless a different period is required by rule adopted pursuant to subsection G. of this section, the recording must be retained for a period of at least seven~~10~~ years after the recording is made.

(E) (1) Notwithstanding the provisions of the [State administrative procedures act], to the contrary, the State Treasurer may, in her discretion, adopt rules or append provisions to the manual distributed pursuant to section [State notary law] as necessary to implement the provisions of this section, which rules or appended provisions may include the means of performing a notarial act involving a remotely located individual using communication technology; standards for communication technology and identity proofing; and standards for the retention of an audio-visual recording created under paragraph (3) of subsection B. of this section.

(2) Before adopting, amending, or repealing any such rule or appended provision pursuant to this subsection, the State Treasurer shall consider the most recent standards regarding the performance of a notarial act with respect to a remotely located individual promulgated by national standard-setting organizations such as the Mortgage Industry Standards Maintenance Organization and the recommendations of the National Association of Secretaries of State.

(F) This act shall take effect immediately.

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National Council of Insurance Legislators (NCOIL

Telemedicine Authorization and Reimbursement Act (TARA)

Sponsored by Asw. Pam Hunter (NY)

Discussion Draft as of August 25th, 2020

To be ~~introduced and~~ discussed during the NCOIL Health Insurance & Long Term Care Issues Committee meeting on July 17, 2021~~April 17, 2021~~~~December 10, 2020.~~ ~~September 26, 2020~~

Table of Contents

Section 1. Title.

This act shall be known as and may be cited as the Telemedicine Authorization and Reimbursement Act.

Section 2. Purpose

The Legislature hereby finds and declares that:

(A) The advancements and continued development of medical and communications technology have had a profound impact on the practice of medicine and offer opportunities for improving the delivery and accessibility of health care, particularly in the area of telemedicine.

(B) Geography, weather, availability of specialists, transportation, and other factors can create barriers to accessing appropriate health care, including behavioral health care, and one way to provide, ensure, or enhance access to care given these barriers is through the appropriate use of technology to allow health care consumers access to qualified health care providers.

(C) There is a need in this state to embrace efforts that will encourage health insurers and health care providers to support the use of telemedicine and that will also encourage all state agencies to evaluate and amend their policies and rules to remove any regulatory barriers prohibiting the use of telemedicine services.

(D) The need to access health care services is compounded by the challenges associated with COVID-19, as consumers are experiencing the negative effects the pandemic has on physical, mental, and emotional health that will extend into future years.

(E) Access to telemedicine is vital to ensuring the continuity of physical, mental, and behavioral health care for consumers during the COVID-19 pandemic and responding to any future outbreaks of the virus.

Section 3. Definitions

(A) “Telemedicine” means the delivery of clinical health care services by means of real time audio only telephonic conversation, two-way electronic audio visual communications, including the application of secure video conferencing or store and forward technology to provide or support healthcare delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient’s health care while such patient is at an originating site and the health care provider is at a distant site; consistent with applicable federal law and regulations; unless the term is otherwise defined by law with respect to the provision in which it is used.

(B) “Telehealth” means delivering health care services by means of information and communications technologies consisting of telephones, remote patient monitoring devices or other electronic means which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient’s health care while such patient is at the originating site and the health care provider is at the distant site; consistent with applicable federal law and regulations; unless the term is otherwise defined by law with respect to the provision in which it is used.

(C) “Store and forward” transfer means the transmission of a patient’s medical information from an originating site to the provider at the distant site without the patient being present.

(D) “Distant site” means a site at which a health care provider is located while providing health care services by means of telemedicine or telehealth; unless the term is otherwise defined with respect to the provision in which it is used.

(E) “Originating site” means a site at which a patient is located at the time health care services are provided to him or her by means of telemedicine or telehealth, unless the term is otherwise defined with respect to the provision in which it is used; provided, however, notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties.

Section 4. Coverage of Telemedicine Services

(A) Each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for the cost of such health care services provided through telemedicine services, as provided in this section.

(B) An insurer, corporation, or health maintenance organization shall not exclude a service for coverage solely because the service is provided through telemedicine services and is not provided through in-person consultation or contact between a health care provider and a patient for services appropriately provided through telemedicine services.

(C) An insurer, corporation, or health maintenance organization shall not require a covered person to have a previously established patient-provider relationship with a specific provider in order for the covered person to receive health care services provided through telemedicine services; however, the establishment of a patient-provider relationship shall not occur via an audio-only telephonic conversation..

(D) An insurer, corporation, or health maintenance organization shall reimburse the treating provider or the consulting provider for the diagnosis, consultation, or treatment of the insured delivered through telemedicine services on the same basis that the insurer, corporation, or health maintenance organization is responsible for coverage for the provision of the same service through in-person consultation or contact.

(E) An insurer, corporation, or health maintenance organization may offer a health plan containing a deductible, copayment, or coinsurance requirement for a health care service provided through telemedicine services;, however, such deductible, copayment, or coinsurance shall be combined with the deductible, copayment, or coinsurance applicable to the same services provided through in-person diagnosis, consultation, or treatment.

(F) No insurer, corporation, or health maintenance organization shall impose any annual or lifetime dollar maximum on coverage for telemedicine services other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered

under the policy, or impose upon any person receiving benefits pursuant to this section any copayment, coinsurance, or deductible amounts, or any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the policy, contract, or plan.

(G) The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, or extended in [State] on and after January 1, 20__, or at any time thereafter when any term of the policy, contract, or plan is changed or any premium adjustment is made.

(H) This section shall not apply to short-term travel, accident-only, limited or specified disease, or individual conversion policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

(I) Nothing shall preclude the insurer, corporation, or health maintenance organization from undertaking utilization review to determine the appropriateness of telemedicine services, provided that such appropriateness is made in the same manner as those determinations are made for the treatment of any other illness, condition, or disorder covered by such policy, contract, or plan. Any such utilization review shall not require prior authorization of emergent telemedicine services.

Section 5. Limited Telemedicine License

An applicant who has an unrestricted license in good standing in another state and maintains an unencumbered certification in a recognized specialty area; or is eligible for such certification and indicates a residence and a practice outside [State] but proposes to practice telemedicine only across state lines on patients within the physical boundaries of [State], shall be issued a license limited to telemedicine by the [State] Medical Board. The holder of such limited license shall be subject to the disciplinary jurisdiction of the [State] Medical board in the same manner as if (s)he held a full license to practice medicine.

Section 6. Rules

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

Section 7. Effective Date

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

Section 8. Severability

If any provision of this Act is held by a court to be invalid, such invalidity shall not affect the remaining provisions of this Act, and to this end the provisions of this Act are hereby declared severable.

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National Council of Insurance Legislators (NCOIL)

Model Act Regarding Air Ambulance Patient Protections

Sponsored by Rep. Deanna Frazier (KY); Rep. Tom Oliverson, M.D. (TX) and Del. Steve Westfall (WV)
Draft as of November 9, 2020. To be ~~introduced and~~ discussed during the Health Insurance & Long Term Care Issues Committee on July 17, 2021~~April 17, 2021~~~~December 10, 2020.~~

AN ACT to amend the insurance law, in relation to private air ambulance services and consumer protections

Section 1. Section (X) of the insurance law is amended by adding a new subsection (X) to read as follows:

(a) An air ambulance service or other entity that directly or indirectly, whether through an affiliated entity, agreement with a third party entity, or otherwise, solicits air ambulance membership subscriptions, accepts membership applications, or charges membership fees, is an insurer.

(b) An air ambulance membership shall be considered insurance and an insurance product and may be considered secondary insurance coverage or a supplement to any insurance coverage and shall be regulated accordingly by the State Department of Insurance;

Section 2. Air Ambulance Patient Billing Protections:

(a) An air carrier operating air ambulance operations shall, within one year of enactment of this Act, implement a patient advocacy program, which shall include, at a minimum, the following components:

(1) A dedicated patient hotline number and dedicated patient resource email address to process patient billing and claims, and to address patient questions, complaints and concerns;

(2) A dedicated patient advocacy page on the air medical provider's website that is clearly marked as the “patient portal” or “patient advocacy” page, which is easily navigated to and contains clearly-written and comprehensive resources for patients, including:

(A) A layperson's explanation of what to expect during the claims process,

(B) Frequently asked questions and answers,

(C) Frequently used forms,

(D) Information regarding the air ambulance provider’s financial assistance or charity care program, and

(E) Additional resources for patients, including but not limited to contact information for the DOT Consumer Affairs Division, state and federal health and insurance regulatory agencies and departments, and other health consumer informational resources;

(3) Dedicated individuals assigned to review patient complaints and disputes about air ambulance billing and to respond to patients, governmental agencies and any other concerned parties no later than 3 months from the date the complaint is received;

(4) The inclusion of the patient hotline number and email address required by paragraph (1) and patient advocacy webpage address required by paragraph (2) on all patient communication materials, including but not limited to websites, brochures, letters, invoices or billing statements that are sent to or made available to patients;

(5) Mandatory yearly patient advocacy training for all air medical provider personnel who have direct interaction with patients and/or their family members via written, verbal or electronic communications; and

(6) A financial assistance or charity care program to assist patients suffering financial hardship with resolving any unpaid balance owed to the air medical provider.

(b) This provision shall not be enforced in a manner that conflicts with federal law, including the federal preemption of state regulation of air carriers.

Section 3. Consumer disclosures.

(a) An entity selling air ambulance membership products shall make the following general disclosures in writing in bold type and not less than twelve (12) point font on any advertisement, marketing material, brochure or contract terms and conditions made available to prospective members or the public:

(1) if eligible and covered by Medicaid or Medicaid managed care, the prospective member is already covered with no out of pocket cost liability for air ambulance services.

(2) if eligible and covered under Medicare and/or a Medicare supplemental plan, the prospective member might already be covered for air ambulance services and should consult with a representative of the Medicare program or a representative of their Medicare Advantage or Medicare Supplemental Plan to determine the level of existing coverage they have for air ambulance and out of pocket costs and whether their plan provider recommends additional supplemental insurance coverage.

Section 4. This act shall take effect one year after enactment.

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National Council of Insurance Legislators (NCOIL)

Fairness for Responsible Drivers Model Act

***Sponsored by Sen. Shawn Vedaa (ND)**
***Draft as of March 16th, 2021.**
***To be ~~introduced and~~ discussed during the Property & Casualty Insurance Committee on July 16~~April 18~~, 2021.**

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Section 1. Title

This Act shall be known and cited as the "[State] Fairness for Responsible Drivers Act."

Section 2. Application

This Act applies to a civil action brought to recover damages for injury to or the death of a person, or damage to property, resulting from a motor vehicle accident.

Section 3. Definitions

(A) "Noneconomic damages" means costs for the following:

(1) Physical and emotional pain and suffering.

(2) Physical impairment.

(3) Emotional distress.

(4) Mental anguish.

(5) Loss of enjoyment.

(6) Loss of companionship, services, and consortium.

(7) Any other nonpecuniary loss proximately caused by a motor vehicle accident.

(B) The term “Noneconomic damages” does not include costs for the following:

(1) Treatment and rehabilitation.

(2) Medical expenses.

(3) Loss of economic or educational potential.

(4) Loss of productivity.

(5) Absenteeism.

(6) Support expenses.

(7) Accidents or injury.

(8) Any other pecuniary loss proximately caused by a motor vehicle accident.

Section 4. Prohibition on Recovery of Noneconomic Damages

(A) A person who was an uninsured motorist and who sustained bodily injury or property damage as the result of a motor vehicle accident may not recover noneconomic damages for the person's bodily injury or property damage.

(B) The personal representative of a person who was an uninsured motorist and who died as the result of a motor vehicle accident may not recover noneconomic damages under [insert citation to state wrongful death statute] for the person's death.

(C) The provisions of this Section shall not apply to an uninsured motorist who at the time of the automobile accident has failed to maintain coverage for a period of 45 days or less and who had maintained continuous coverage for at least one year immediately prior to such failure to maintain coverage.

Section 5. Exceptions

The prohibition against the recovery of noneconomic damages in Section 4 does not apply if the person who is liable for the injury, damage or death:

(A) was driving while under the influence of an alcoholic beverage or controlled substance;

(B) acted intentionally, recklessly, or with gross negligence;

(C) fled from the scene of the accident; or

(D) was acting in furtherance of an offense or in immediate flight from an offense that constitutes a felony.

Section 6. Effective Date

This Act shall take effect _____.

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National Council of Insurance Legislators (NCOIL)

Employer-Sponsored Group Disability Income Protection Model Act

Adopted by the NCOIL Health, Long-Term Care & Retirement Issues Committee on November 19, 2016 and the NCOIL Executive Committee on November 20, 2016. Temporarily re-adopted by the Health Committee on April 17, 2021 and the Executive Committee on April 18, 2021. To be considered for re-adoption during the Summer Meeting on July 17, 2021.
Sponsored by Rep. George Keiser (ND)

Section 1. Purpose

The legislature finds that this state's residents, government, taxpayers, employers, workers, and their families share a common interest in protecting workers' income against the effect of disabling illness and injury. It is therefore the intent of the Legislature to provide tax incentives to encourage employers to establish group disability income protection plans for their employees and to enroll eligible employees in those plans.

Section 2. Definitions.

A. "Group disability income protection plan" means a group short-term disability policy and/or a group long-term disability policy instituted by an employer to provide income benefits to employee(s) unable to work for an extended period of time due to illness or accident.

B. "Employer" means [reference to applicable definition found in existing state code].

C. "Employee" means [reference to applicable definition found in existing state code].

Section 3. Tax Incentives for Employer Establishment of Disability Income Protection Plan

A. An employer in this state, who establishes a group disability income protection plan after the effective date of this Act, shall be allowed a credit against annual state income tax liability in an amount equal to 25 percent of the costs of establishing and administering a group disability income plan for employees.

B. Amounts paid by an employer to defray disability income protection plan premiums shall not be included in costs when calculating the amount of tax credit allowed.

C. An employer who has established a group disability income protection plan for employees may claim tax credit under this section for no more than three years.

Section 4. Employer Tax Incentives for Employee Enrollment in Disability Income Protection Plan

A. An employer in this state, who establishes a group disability income protection plan for employees after the effective date of this Act, or re-opens an existing plan for new enrollees, shall be allowed a credit against annual state income tax liability in an amount of $100 for each employee newly enrolled in such group disability income plan.

B. For purposes of calculating an employer's tax credit under this Act, only employees enrolled for the entire tax year and employees newly enrolled upon becoming eligible and enrolled through the end of the tax year shall be considered enrolled.

C. Under this Section, an employer may receive a credit against annual state income tax liability of not more than $10,000 for any tax year.

D. Under this Section, an employer may receive a credit against annual state income tax liability for no more than three years.

[Drafting Note: If state financial resources require a more limited tax credit, either Section 3 or Section 4 could be eliminated.]

Section 5. Effective Date

This Act shall become effective on _____.

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National Council of Insurance Legislators (NCOIL)

Uniform Captive Insurer Model Act

***Sponsored by Sen. Jason Rapert (AR)**
***Draft as of June 15, 2021. To be discussed during the Financial Services & Multi-Lines Issues Committee meeting on July 16, 2021.**

Table of Contents

Section 1. Title

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

Section 2. Purpose

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

B. This Act shall not apply to the formation of foreign captive insurance companies.

Section 3. Definitions

(1) "Agency captive insurance company" shall mean an insurance company described in paragraphs (2) a. and b. of this section:

a. An insurance company that is owned or controlled by an insurance agency, brokerage or reinsurance intermediary, or an affiliate thereof, or under common ownership or control with such agency, brokerage or reinsurance intermediary, and that only insures the risks of insurance or annuity contracts placed by or through such agency, brokerage or reinsurance intermediary; or

b. An insurance company that is owned or controlled by a marketer or producer of service contracts and/or warranties, and that only insures or reinsures the contractual liability arising out of such service contracts or warranties sold through such marketer or producer.

c. For the purposes of this paragraph (2), "common ownership or control" shall mean ownership of 10 percent or more of the voting securities of a person or such other form of ownership or control as the Commissioner may approve.

(2) "Alien captive insurance company" means any insurance company formed to write insurance business for its parents and affiliates and licensed pursuant to the laws of an alien jurisdiction which imposes statutory or regulatory standards in a form acceptable to the commissioner on companies transacting the business of insurance in such jurisdiction.

(3) "Association" means any legal association of persons that has been in continuous existence for at least 1 year or such lesser period of time approved by the Commissioner, the association members of which, or which does itself, whether or not in conjunction with some or all of the association members:

a. Directly or indirectly, own, control or hold with power to vote all of the outstanding voting securities or other voting interests of, or have complete voting control over, an association captive insurance company; or

b. Constitute all of the subscribers of an association captive insurance company organized as a reciprocal insurer.

(4) “Association captive insurance company” means any captive insurance company that insures risks of the Association Members of the association and any of their affiliated companies.

(5) “Association member” means any person that belongs to an association.

(6) “Branch business” means any insurance business transacted by a branch captive insurance company in this state.

(7) “Branch captive insurance company” means any alien captive insurance company licensed by the commissioner to transact the business of insurance in this state through a business unit with a principal place of business in this state. A branch captive insurance company is a pure captive insurance company with respect to operations in this state, unless otherwise permitted by the commissioner.

(8) “Branch operations” means any business operations of a branch captive insurance company in this state.

(9) “Capital and surplus” means the amount by which the value of all of the assets of the captive insurance company exceeds all of the liabilities of the captive insurance company, as determined under the method of accounting utilized by the captive insurance company in accordance with the applicable provisions of this chapter.

(10) “Captive insurance company” means any pure captive insurance company, association captive insurance company, agency captive insurance company, sponsored captive insurance company, industrial insured captive insurance company, special purpose captive insurance company, special purpose financial captive insurance company, series captive insurance company, or risk retention group, whether domestic, foreign or alien, or branch captive insurance company, licensed under the provisions of this chapter.

(11) “Commissioner” means the Insurance Commissioner of this State or the Commissioner’s designee.

(12) “Domestic” means formed under the laws of this State.

(13) “Foreign” means formed under the laws of any state.

(14) “General account” means all assets and liabilities of a protected cell captive insurance company not attributable to a protected cell.

(15) “Industrial insured captive insurance company” means any captive insurance company that insures risks of the industrial insureds that comprise the industrial insured group and any of their affiliated companies.

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

a. Directly or indirectly, own, control, or hold with power to vote all of the outstanding voting securities or other voting interests of, or have complete voting control over, an industrial insured captive insurance company; or

b. Constitute all of the subscribers of an industrial insured captive insurance company organized as a reciprocal insurer.

(17) "Organizational documents" means the documents that must be submitted to form a captive insurer in this state and obtain a Certificate of Authority.

(18) "Parent" means a person that directly or indirectly owns, controls, or holds with power to vote more than 50 percent of the outstanding voting securities or other voting interests of a pure captive insurance company.

(19) "Participant" means a person or an entity, authorized to be a participant under this Act, and any affiliate of a participant, that is insured by a protected cell captive insurance company, if the losses of the participant are limited through a participant contract.

(20) "Participant contract" means a contract by which a protected cell captive insurance company insures the risks of a participant and limits the losses of each such participant to its pro rata share of the assets of one (1) or more protected cells identified in such participant contract.

(21) "Person" means a natural person, partnership (whether general or limited), trust, estate, association, corporation, limited liability company, statutory trust, business trust, custodian, nominee or any other individual or entity in its own or any representative capacity, in each case whether domestic, foreign, or alien.

(22) "Protected cell" has the meaning given such term in this Act.

(23) "Protected cell" means a separate account established by a protected cell captive insurance company formed or licensed under this chapter, in which an identified pool of assets and liabilities arc segregated and insulated by means of this chapter from the remainder of the protected cell captive insurance company's assets and liabilities in accordance with the terms of one (1) or more participant contracts to fund the liability of the protected cell captive insurance company with respect to the participants as set forth in the participant contracts.

(24) "Protected cell assets" means all assets, contract rights, and general intangibles identified with and attributable to a specific protected cell of a protected cell captive insurance company.

(25) “Protected cell captive insurance company” means any captive insurance company:

(a) ln which the minimum capital and surplus required by this chapter are provided by one (1) or more sponsors;

(b) That is formed or licensed under this chapter;

(c) That insures the risks of separate participants through participant contracts; and

(d) That funds its liability to each participant through one (1) or more protected cells and segregates the assets of each protected cell from the assets of other protected cells and from the assets of the protected cell captive insurance company’s general account.

(26) “Protected cell liabilities” means all liabilities and other obligations identified with and attributed to a specific protected cell of a protected cell captive insurance company.

(27) “Pure captive insurance company” means any captive insurance company that insures risks of its parent and any of such parent’s affiliated companies and any controlled unaffiliated business.

(28) “Series” means a series established under this Act, or corresponding law of another state.

(29) “Series captive insurance company” means a series which has received a certificate of authority pursuant to this chapter.

(30) “Special purpose captive insurance company” means any person that is licensed under this chapter and designated as a special purpose captive insurance company by the Commissioner.

(31) “Special purpose financial captive insurance company” means a captive insurance company that is granted a certificate of authority under this Act.

(32) “Sponsor” means any person or entity that is approved by the commissioner to provide all or part of the capital and surplus required by this chapter and to organize and operate a protected cell captive insurance company.

(33) “Sponsored captive insurance company” means a captive insurance company, including a special purpose financial captive insurance company as defined in this Act:

a. Of which the minimum capital and surplus required by this Act is provided by 1 or more sponsors;

b. That is licensed under the provisions of this Act;

c. That insures the risks of its participants only, through separate participant contracts; and

d. That funds its liability to each participant through 1 or more protected cells and segregates the assets of each protected cell from the assets of other protected cells and from the assets of the sponsored captive insurance company's general account.

(34) "State" means the State of _____, and "state" means any other state, district, commonwealth or possession of the United States of America.

Section 4. Name

No captive insurer shall adopt a name that is the same, deceptively similar, or likely to be confused with or mistaken for any other existing business name registered in this state nor any name likely to mislead the public.

Section 5. Requirements and Limitations of Captive Insurance Company

(1) Any captive insurance company, when permitted by its organizational documents, may apply to the commissioner for a license to do any and all insurance comprised in this Act; provided, however, that:

(a) No pure captive insurance company shall insure any risks other than those of its parent and affiliated companies or a controlled unaffiliated business or businesses;

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

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

(d) No captive insurance company shall provide personal motor vehicle or homeowner's insurance coverage or any component thereof;

(e) No captive insurance company shall accept or cede reinsurance except as provided in this Act.

(f) Any captive insurance company may provide excess or stop-loss accident and health insurance, unless prohibited by federal law or the laws of the state having jurisdiction over the transaction;

(2) Except as provided in this Act, no captive insurance company shall transact any insurance business in this state unless:

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

(b) Its board of directors or committee of members or managers or, in the case of a reciprocal insurer, its subscribers' advisory committee holds at least one (1) meeting each year in this state;

(c) It maintains its principal place of business in this state; and

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

(3) In order to receive a license to issue policies of insurance as a captive insurance company in this state, an applicant business entity shall meet the requirements of this subdivision (3):

(a) The applicant business entity shall submit its organizational documents to the commissioner. If the commissioner approves the organizational documents, then the commissioner shall issue a letter to the applicant certifying the commissioner's approval. The applicant business entity shall submit the organizational documents, along with a copy of the approval letter issued by the commissioner, and the required filing fees for organizational documents prescribed to the Secretary of State for filing. Upon filing the organizational documents, the secretary of state shall issue an acknowledgment letter to the applicant. The applicant business entity shall submit a copy of the acknowledgment letter relative to the applicant's organizational documents issued by the secretary of state to the commissioner.

(b) The applicant business entity shall also file with the commissioner evidence of the following:

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

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

(iii) The overall soundness of its plan of operation;

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

(v) Such other factors deemed relevant by the commissioner in ascertaining whether the applicant business entity will be able to meet its policy obligations.

(c) No less than the amount required by Section 6 shall be paid in by the applicant business entity and deposited with the Commissioner. In the alternative, an irrevocable letter of credit in that amount and acceptable to the commissioner shall be filed with the commissioner.

(4) Information submitted pursuant to this subsection (4) shall be and remain confidential, and shall not be made public by the commissioner without the written consent of the captive insurance company, except that:

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

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

(ii) The information sought is unavailable from other non-confidential sources; and

(iii) A subpoena issued by a judicial or administrative officer of competent jurisdiction has been submitted to the commissioner.

(b) The commissioner shall have the discretion to disclose such information to a public officer having jurisdiction over the regulation of insurance in another state; provided, that:

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

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

Section 6. Capital and Surplus Requirements

(1) No captive insurance company shall be issued a license unless it possesses and maintains unimpaired paid-in capital and surplus of:

(a) In the case of a pure captive insurance company, not less than two hundred fifty thousand dollars (State Specific);

(b) In the case of an association captive insurance company, not less than five hundred thousand dollars (State Specific);

(c) In the case of an industrial insured captive insurance company, not less than five hundred thousand dollars (State Specific);

(d) In the case of a protected cell captive insurance company, not less than two hundred fifty thousand dollars (State Specific).

Drafting Note: *These specific amounts do not serve as an endorsement and are included only to represent what one state, Tennessee, has chosen for capital and surplus requirements. States may wish to consider their own capital and surplus requirements.*

(2) The commissioner may prescribe additional capital and surplus based upon the type, volume, and nature of insurance business to be transacted.

(3) Capital and surplus shall be in the form of cash, or cash equivalent, or an irrevocable letter of credit issued by a bank approved by the commissioner.

Section 7. Formation

(1) A pure captive insurance company may be incorporated as a stock insurer with its capital divided into shares and held by the stockholders, as a nonprofit corporation with one (1) or more members, or as a limited liability company.

(2) An association captive insurance company, an industrial insured captive insurance company, or a risk retention group may be:

(a) Incorporated as a stock insurer with its capital divided into shares and held by the stockholders;

(b) Incorporated as a mutual corporation;

(c) Organized as a reciprocal insurer in accordance with chapter 16 of this title; or

(d) Organized as a limited liability company.

(3) A captive insurance company incorporated or organized in this state shall have not less than three (3) incorporators or three (3) organizers of whom not less than one (1) shall be a resident of this state.

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

(5) In the case of a captive insurance company formed as a:

(a) Corporation, at least one (1) of the members of the board of directors shall be a resident of this state;

(b) Reciprocal insurer, at least one (1) of the members of the subscribers' advisory committee shall be a resident of this state; and

(c) Limited liability company, at least one (1) of the members or managers shall be a resident of this state.

Section 8. Organizational Documents

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

Section 9. License Suspension/Revocation

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

(1) Insolvency or impairment of capital or surplus;

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

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

(4) Failure to comply with its own charter, bylaws or other organizational document;

(5) Failure to submit to or pay the cost of examination or any legal obligation relative to an examination, as required by this chapter;

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

(7) Failure otherwise to comply with the laws of this state.

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

Section 10. Investments

No pure captive insurance company, industrial insured captive insurance company, protected cell captive insurance company, incorporated cell captive insurance company or special purpose financial captive insurance company as defined in this Act shall be subject to any restrictions on allowable investments; provided, that the commissioner may prohibit or limit any investment that threatens the solvency or liquidity of any such company. Companies under this section (1) must file with the commissioner a statement of investment policy approved by its governing body that describes the types of investments that the company may elect to undertake and may not make investments that materially deviate from the statement of investment policy that is on file with the commissioner.

Section 11. Reinsurance

(1) Any captive insurance company may provide reinsurance as authorized by this title on risks ceded by any other insurer.

(2) Any captive insurance company may take credit for the reinsurance of risks or portions of risks ceded to reinsurers complying with this title. If the reinsurer is licensed as a risk retention group, then the ceding risk retention group or its members must qualify for membership with the reinsurer. The commissioner shall have the discretion to allow a captive insurance company to take credit for the reinsurance of risks or portions of risks ceded to an unauthorized reinsurer, after review, on a case by case basis. The commissioner may require any documents, financial information or other evidence that such an unauthorized reinsurer will be able to demonstrate adequate security for its financial obligations.

(3) In addition to reinsurers authorized by this title, a captive insurance company may take credit for the reinsurance of risks or portions of risks ceded to a pool, exchange or association to the extent authorized by the commissioner. The commissioner may require any documents, financial information or other evidence that such a pool, exchange or association will be able to provide adequate security for its financial obligations. The commissioner may deny authorization or impose any limitations on the activities of a reinsurance pool, exchange or association that, in the commissioner's judgment, are necessary and proper to provide adequate security for the ceding captive insurance company and for the protection and consequent benefit of the public at large.

(4) Except where specifically provided otherwise, insurance by a captive insurance company of any workers' compensation or accident and health qualified self-insured plan of its parent and affiliates shall be deemed to be reinsurance.

Section 12. Taxes - To Be State Specific

Section 13. Rules; Risk Management Function

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

Section 14. Rules

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

Section 15. Recognition in Other States

Notwithstanding anything in this Act to the contrary, a captive insurance company duly licensed in this State shall be recognized as a captive insurance company in foreign states provided it meets the capital and surplus requirements of such foreign state.

Section 16. Visits by Commissioner; audits

(1) At least once every three (3) years, and whenever the commissioner determines it to be prudent, the commissioner shall visit each captive insurance company and thoroughly inspect and examine its affairs to ascertain its financial condition, its ability to fulfill its obligations and whether it has complied with this chapter. The commissioner may extend such three-year period to five (5) years; provided, that the captive insurance company is subject to a comprehensive annual audit by independent auditors approved by the commissioner during such five-year period. The comprehensive audit shall be of a scope satisfactory to the commissioner. The expenses and charges of the examination shall be paid by the captive insurance company.

(2) All examination reports, preliminary examination reports or results, working papers, recorded information, documents and copies thereof produced by, obtained by or disclosed to the commissioner or any other person in the course of an examination made under this section are confidential and are not subject to subpoena and may not be made

public by the commissioner or an employee or agent of the commissioner without the written consent of the captive insurance company, except to the extent provided in this subsection (2). Nothing in this subsection (2), shall prevent the commissioner from using such information in furtherance of the commissioner's regulatory authority under this title. The commissioner shall have the discretion to grant access to such information to public officers having jurisdiction over the regulation of insurance in any other state or country, or to law enforcement officers of this state or any other state or agency of the federal government at any time, only if the officers receiving the information agree in writing to maintain the confidentiality of the information in manner consistent with this subsection (2).

Section 17. Dividends, payment out of capital or surplus

No captive insurance company shall pay a dividend out of, or other distribution with respect to, capital or surplus without the prior approval of the commissioner. Approval of an ongoing plan for the payment of dividends or other distributions shall be conditioned upon the retention, at the time of each payment, of capital or surplus in excess of amounts specified by, or determined in accordance with formulas approved by the commissioner. A captive insurance company may otherwise make such distributions as are in conformity with its purposes and approved by the commissioner.

Section 18. Violations, authority of commissioner

If, after providing notice consistent with the process established by applicable law and providing the opportunity for a contested case hearing held in accordance with the Uniform Administrative Procedures Act, the Commissioner finds that any insurer, person, or entity required to be licensed, permitted, or authorized to transact the business of insurance under this chapter has violated any provision of this chapter or any rule or regulation authorized by this chapter, the commissioner may order:

(a) The insurer, person, or entity to cease and desist from engaging in the act or practice giving rice to the violation;

(b) Payment of a monetary penalty of not more than (_____) for each violation, but not to exceed an aggregate penalty of (_____), unless the insurer, person, or entity knowingly violates a statute, rule or order, in which case the penalty shall not be more than (_____) for each violation, not to exceed an aggregate penalty of (_____). This subdivision (b) shall not apply where a statute or rule specifically provides for other civil penalties for the violation. For purposes of this subdivision (b), each day of continued violation shall constitute a separate violation; and

(c) The suspension or revocation of the insurer's, person's, or entity's license.

Section 19. Severability

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

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National Council of Insurance Legislators (NCOIL)

Accumulator Adjustment Program Model Act

Sponsored by Rep. Deborah Ferguson (AR); Sen. Jason Rapert (AR); Rep. George Keiser (ND); Asw. Pam Hunter (NY)

Draft as of June 15th, 2021. To be discussed during the Health Insurance & Long Term Care Issues Committee meeting on July 17, 2021.

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Section 1. Title

This Act shall be known and may be cited as the "[State] Accumulator Adjustment Program Act."

Section 2. Legislative Purpose

(A) The legislature finds that cost sharing assistance is indispensable to help many patients with rare, serious, and chronic diseases afford out-of-pocket costs for their essential, often lifesaving, medications.

(B) The legislature further finds that patients need cost sharing assistance because of the high out-of-pocket cost of medications.

(C) The legislature further finds that when patients face unexpected charges during the plan year, they are less likely to adhere to their medication regimen.

(D) The legislature further finds that lack of patient adherence to needed medicines leads to potential negative health consequences for the patients, such as unnecessary emergency room visits, doctors' visits, surgeries, and other interventions.

(E) The legislature further finds that patients are only able to use cost sharing assistance after they have met requirement(s) for coverage of their medication. Requirements for coverage can include the medication's inclusion on the patient's formulary and utilization management protocols, such as prior authorization and step therapy.

(F) The legislature further finds that health insurers and pharmacy benefit managers (PBMs) have implemented programs, such as accumulator adjustment programs, to restrict cost sharing assistance from counting towards a patient's deductible or annual out-of-pocket limit.

(G) The legislature further finds that as a result of an accumulator adjustment program, a patient is required to continue to make payments even if the patient has already hit an out-of-pocket limit when including cost sharing assistance. As such, the cost sharing assistance depletes leaving the patient responsible for paying the full deductible and meeting the annual out-of-pocket limit for a second time. This means accumulator adjustment programs limit the benefit patients receive from copay assistance programs.

(H) The legislature further finds that patients often are not aware of the inclusion of accumulator adjustment programs in their health plan contracts. Patients tend to learn about these types of programs when they attempt to obtain their medication after their cost sharing assistance has run out, whether at the pharmacy, infusion center, or at home through the mail.

(I) The legislature further finds that accumulator adjustment programs allow health insurers and PBMs to "double dip" by accepting funds from both the cost sharing assistance program and the patient beyond the original deductible amount and the annual out-of-pocket limit.

(J) Therefore, the legislature declares it a matter of public interest that health insurers and PBMs must count any amount paid by the patient or on behalf of the patient by another person towards a patient's annual out-of-pocket limit and any cost sharing requirement, such as deductibles.

Section 3. Definitions

(A) "Cost sharing" means any copayment, coinsurance, deductible, or annual limitation on cost sharing (including but not limited to a limitation subject to 42 U.S.C. §§ 18022(c)

and 300gg-6(b)), required by or on behalf of an enrollee in order to receive a specific health care service, including a prescription drug, covered by a health plan, whether covered under the medical or pharmacy benefit.

(B) "Carrier" OR "Insurer" OR "Issuer" means [cross-reference state insurance statutes and use their existing definitions], and shall include, but not be limited to any health insurance company, nonprofit hospital and medical service corporation, managed care organization, and, to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health benefit plan offered by public and private entities. For the purposes of this section, "insurer" does not include self-insured employer plans governed by the Employee Retirement Income Security Act of 1974 (ERISA) (Pub.L. 93–406, 88 Stat. 829, as amended).

(C) "Commissioner" means the state insurance commissioner.

(D) "Health Plan" means a policy, contract, certificate, or subscriber agreement entered into, offered, or issued by a health insurance issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services.

(E) "Person" means a natural person, corporation, mutual company, unincorporated association, partnership, joint venture, limited liability company, trust, estate, foundation, nonprofit corporation, unincorporated organization, or government or governmental subdivision or agency.

(F) "Pharmacy Benefit Manager" means any person or business who administers the prescription drug or device program of one or more health plans on behalf of a third party in accordance with a pharmacy benefit program. This term includes any agent or representative of a pharmacy benefit manager hired or contracted by the pharmacy benefit manager to assist in the administering of the drug program and any wholly or partially owned or controlled subsidiary of a pharmacy benefit manager.

Drafting Note: Use existing statutory definitions of "health plan" and "pharmacy benefit manager" when possible.

Drafting Note: If "person" is already in the state's definition, that includes corporation. Otherwise, can remove "by another person."

Section 4. Cost-Sharing Requirements

When calculating an enrollee's overall contribution to any out-of-pocket maximum or any cost-sharing requirement under a health plan, a [CARRIER/INSURER/ISSUER] or pharmacy benefit manager shall include any amounts paid by the enrollee or paid on behalf of the enrollee by another person.

Section 5. Rules

The commissioner shall promulgate rules necessary to carry out this Act.

Section 6. Enactment

(A) This section shall apply with respect to health plans that are entered into, amended, extended, or renewed on or after January 1, 202##.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
SPECIAL COMMITTEE ON RACE IN INSURANCE UNDERWRITING
TAMPA, FLORIDA
DECEMBER 9, 2020
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Special Committee on Race in Insurance Underwriting met at the Tampa Marriott Water Street Hotel on Wednesday, December 9, 2020 at 9:30 A.M. (EST). This was the first of two meetings held that day. The second meeting convened at 2:00 P.M. (EST) and is documented in a separate set of minutes.

Senator Neil Breslin of New York, Chair of the Committee, presided*.

Other members of the Committee present were (* indicates virtual attendance via Zoom):

Sen. Jason Rapert (AR)
Asm. Ken Cooley (CA)*
Rep. Matt Lehman (IN)
Rep. Edmond Jordan (LA)*
Rep. George Keiser (ND)*
Asw. Maggie Carlton (NV)*
Asm. Kevin Cahill (NY)*
Asw. Pam Hunter (NY)*
Sen. Bob Hackett (OH)*

Other legislators present were:

Sen. Mike Gaskill (IN)
Rep. Peggy Mayfield (IN)*
Rep. Jim Gooch (KY)*
Sen. Shawn Vedaa (ND)
Rep. Wendi Thomas (PA)*
Rep. Joe Schmick (WA)*

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Tess Badenhausen, Assistant Director of Administration, NCOIL Support Services, LLC

OPENING REMARKS

Rep. Matt Lehman (IN), NCOIL President, thanked everyone for participating and stated that he is extremely proud to serve as President of NCOIL as the organization takes strides to show leadership on these very important issues, and is delighted and thankful that Senator Breslin agreed to serve as Chair of this Committee. Having conversations like these that the Committee will have today is not easy. But NCOIL cannot sit idly while decisions that can have a huge impact on constituents and the state-based system of insurance regulation in general are made without input from state insurance legislators. Indeed, state legislators are those that have been vested with the authority to make such decisions pursuant to the McCarran-Ferguson Act enacted 75 years ago. In that regard, Rep. Lehman thanked all the interested parties that reached out with constructive feedback on the Committee's work and determined that getting involved with the Committee is the best way to proceed. Rep. Lehman also thanked his fellow

Officers for agreeing to serve on this Committee, as well as the other legislators that volunteered to do so.

In terms of a timeline for this Committee, in Rep. Lehman's discussions with Senator Breslin, they both agreed that there won't be any votes on anything today and the Committee will have to meet again to finalize any work product. Whether that will be via one or multiple Zoom meetings following this meeting, or convening again at the March meeting – or both or neither – will need to be determined depending on how the conversations go today. Rep. Lehman closed by stating that Zoom meetings can be difficult but everyone needs to be patient and wait for their turn to speak. Also, if anyone has any plans on trying to interrupt anyone speaking or providing purely opinion testimony that is not rooted in the law or any data, they are warned that such actions will not be entertained. NCOIL will not tolerate attacks on any individuals or organizations, period.

Sen. Neil Breslin (NY), Chair of the Committee, stated that he wishes he could be there but there is currently a big crisis in NY – a multi billion dollar deficit and while NY isn't unique among states with that problem he had to stay in NY. Sen. Breslin stated that NCOIL deserves credit for taking a lead in discussing these topics. They topics are not addressed at particular companies or people but its really a self assessment and self evaluation to take as much input as possible from as many people in the industry, legislators and consumer representatives. Rep. Lehman has done so much for NCOIL over the years and now as President he is continuing that. NCOIL has done a good job in preparing for this meeting today. Several conversations have taken place leading up to this to set up parameters and this meeting is critically important.

With regard to the McCarran-Ferguson Act, NCOIL has a long history supporting that. NCOIL testified in Congress several years ago regarding that Act and there are periodically attacks on the Act. Federal legislation has been introduced that seeks to intrude on the state based system. NCOIL stands firmly in the belief that unfair discrimination in any and every form is wrong and that is especially true for racial discrimination because of the abhorrent history involved. Forming this committee shows commitment to reviewing the insurance regulatory system in order to determine whether current practices exist in the system that disadvantage people of color because of their status while recognizing that changes in the industry system including determinations regarding rating variables must ultimately be made in a state legislative forum. Sen. Breslin stated that everyone should be familiar with the committee charges but he will review them now.

The Committee is charged with: taking testimony, discussing, and defining the term "proxy discrimination" – an undefined term that has been used by many when discussing insurance rating, and has even been included in regulatory-related documents; and discussing the wisdom of certain rating factors being used in insurance underwriting, such as zip code, and level of education. Sen. Breslin stated that he looks forward to the discussions today to hearing from the speakers. The first panel will provide an overview of the statutory insurance ratemaking framework.

OVERVIEW OF INSURANCE RATEMAKING STATUTORY FRAMEWORK

Laura Foggan, Esq., Partner at Crowell & Moring, LLP, stated that she appreciates the opportunity to speak to the committee and outline the statutory framework governing

insurance ratemaking as part of the overall hearing. Racial injustice has been thrust into the forefront of our minds and our experiences in 2020 by a series of devastating events and the public policy goals of eliminating racial bias and discrimination are being revisited throughout society including in the insurance system and insurance community. As state insurance legislators you have a key role to paly in addressing race and racial justice in the insurance system and this includes the responsibility being advanced by NCOIL and this Committee to examine insurance underwriting fairness.

Later panels today will focus on the definition of "proxy discrimination" and specific rating factors in underwriting. This panels charge is to provide a grounding for further discussion for an overview of the insurance ratemaking statutory framework and in the testimony that follows I therefore describe the current framework and how applicable standards for ratemaking work under current law. To begin with, the state statutory standards established by state legislatures govern insurance ratemaking. Insurer conduct in ratemaking is also overseen by state regulators based on the authority delegated to them to implement these state insurance laws. This reflects the McCarran-Ferguson Act and the delegation to the states of primary responsibility for regulating insurance in this country. While there is some variations in provisions from state to state at their core state laws governing ratemaking forbid insurers from setting rates that are excessive, inadequate or unfairly discriminatory. Those are the core principles in the current statutory framework. Insurance rates cannot be excessive, inadequate or unfairly discriminatory.

Today, our attention is focused laser like on the statutory requirement that rates cannot be unfairly discriminatory. We should begin with recognition of that the term unfairly discriminatory in insurance ratemaking is a term of art. It is a term with a particular and well defined meaning in the context of insurance ratemaking. As the Third Department of the New York Appellate Division said in a case discussing this term: "unfair discrimination is a word of art used in the field of insurance which in a broad sense means the offering of sales to customers in a given market segment identical or similar products at different probable costs." In insurance ratemaking, unfair discrimination is price discrimination that is setting a higher rate for an insurance purchase or group of purchasers that is not actuarially justified by a difference in the cost of providing insurance.

The fundamental concept of the state statutes governing insurance ratemaking is that the rates that insurers set must rest on cost based pricing. Cost based pricing is also known as risk based pricing. The state statutes governing insurance ratemaking make this clear. For instance, the Louisiana statute explains "unfairly discriminatory does not refer to rates that produce different premiums for policyholders with different loss exposures so long as the rate is actuarially justified and reflects such differences with reasonable accuracy." The Nevada statute provides "one rate is unfairly discriminatory in relation to another in the same class if it clearly fails to reflect equitably the difference in expected losses and expenses." The Minnesota statute says the same as do a great number of statutes and almost all use the terms inadequate excessive and unfairly discriminatory.

Courts agree that unfair discrimination is a term of art in the statutory framework governing insurance ratemaking. The Maryland Court of Appeals, MD's highest court, said that unfair discrimination as the term is employed by the insurance code means discrimination among insureds in the same class based on something other than

actuarial risk. The Massachusetts Supreme Court, MA's highest court, made clear that the intended result of the risk classification process is that persons of substantially the same risk will be grouped together paying the same premiums and will not be subsidizing insureds who present a greater hazard. Understanding that unfair discrimination has a particular meaning in the statutory framework governing insurance rates is important. As many commentators have observed, all insurance rating depends on discrimination and differentiation of groups based on actuarial factors. Discrimination in setting insurance rates is expected and necessary. It is unfair under the core legislative framework only if it is statistically, that is actuarially, justified.

Statutes governing underwriting practices set out the principle that unfair discrimination prohibits insurers use of a differentiation that is not actuarially justified. In other words, when a rating factor's predictive value is shown then insurers reliance on that factor is fair under the statutes. As the Massachusetts Supreme Court put it "the basic principle underlying statues governing underwriting practices is that insurers have the right to classify risks and to elect not to insure risks if the discrimination is fair. The intended result of the process is that persons of substantially the same risk will be grouped together." This statutory approach is the framework of cost based or risk based pricing. When actuarial justification for use of a classification is shown, then use of the factor is permitted because there has been a legislative judgment in favor of risk based pricing. The legislative standard reflects a basic belief that price should reflect cost. So, in the insurance context this means that there has been a legislative judgment that tying price to risk is equitable and fair. This legislative judgment makes sense. Not only is there a broad societal norm that you should pay for the costs of what you get but risk based pricing is also consistent with how an efficient market works.

In a competitive marketplace an insurer wants to price its coverage as accurate as possible. It will not use a characteristic with no predictive power in underwriting. Insurers are incentivized to charge different premiums to individuals who pose different predictive risks. This is desirable because charging the same price to individuals with different risks can generate a moral hazard problem where an insured with an undesirable risk profile purchases more insurance and it can encourage adverse selection where a lower risk individual elects not to purchase coverage which has become too expensive – the price is too high because the premium subsidized the riskier actor grouped with the lower risk one. Allowing insurers to set rates and prices in accordance with risk avoids these hazards. That makes the marketplace more efficient and decreases the risk of insurer insolvency.

In short, there is strong public policy supporting the statutory framework of risk based pricing. The existing statutory framework also includes certain protections against injustice in insurance underwriting. For insurance, one fundamental protection against injustice in the risk based system is the requirement of actuarial justification for any factor used to discriminate among insurance purchases. A rate based on any risk classification must predict future costs associated with the risk transfer. There must in other words be a business justification for using the classification. An insurer may not rely on a factor or characteristic due to animus or bigotry. Only a characteristic with predictive power in underwriting is permissible under a risk based pricing system. The rate produced must be an actuarially sound estimate of the expected value of all future costs associated with the risk transfer.

Under current law, there are also some protections against injustice in legislation that specifically prohibits the use of race, religion and national origin as factors in setting rates. Sate legislatures have passed laws forbidding the use of underwriting classifications that are abhorrent to public policy such as discrimination in rates based on race, religion and national origin. Some states have outlawed other rating factors on public policy grounds as well. There are for instance state laws forbidding insurers from setting rates based on sexual orientation, gender or genetic traits. Through public policy determinations made by state legislatures these laws provide an added measure of protection against rating factors that have been found to violate social justice norms even if those factors may have a predictive value in underwriting.

One of the panels that follows will discuss factors that may have a disparate impact on racial and ethic minorities or economic disadvantaged groups. When the benefits of predictive value of such classification are outweighed by social justice considerations, they may be an appropriate candidate for legislative action. The legislative process provides a check on the underwriting process by setting standards after informed discussion of public policy concerning rating factors and an analysis of the actuarial significance of the pricing factor at issue and consideration of all interests at stake. These can be difficult questions because risk based pricing is designed to achieve legitimate busines purposes by tying risk to the price of insurance through actuarial science, by making pricing rational and by protecting against insurer insolvency.

You will also hear testimony about the definition of proxy discrimination. The NCOIL staff's proposed definition of that term can serve to quell confusion about the meaning of this term which recently has appeared in discussions about insurance underwriting particularly in relation to AI and algorithmic protections. Existing law forbids discrimination by using a characteristic without predictive power or a characteristic prohibited by law. If an insurer used a proxy for the purpose of discriminating based on a prohibited rating factor that conduct I submit would be forbidden under existing law. Nevertheless, this could be clarified through the NCOIL staff definition of proxy discrimination.

Whether underwriting decisions are made by humans or machines based on prohibited characteristics or factors chosen as proxies for them, intentional discrimination in underwriting based on race, religion or national origin is not lawful. The existing statutory framework for insurance ratemaking can and should be applied to stop discrimination based on race and consistently within this framework there is also precedent for legislative review and necessary action to address other rating factors that may violate public policy norms. Addressing racial injustice and providing financial protection against risks in a way that is actuarially sound, affordable, sustainable, responsible and accessible for all customers is important and I look forward to further discussion today about race in underwriting and the legislative framework for insurance ratemaking.

Birny Birnbaum, Director of the Center for Economic Justice (CEJ), thanked the Committee for the opportunity to speak and stated that for background purposes, he served as Chief Economist at the TX office of public insurance counsel (OPIC) and then associate commissioner for Policy and Research at the Texas Department of Insurance (TDI). He has deep technical, regulatory and policy experience. For the past 30 years, he has served as an expert witness and consultant to public agencies and consumer organizations on, among other things, unfair discrimination in insurance. He received

his training in economic and statistical analysis at the Massachusetts Institute of Technology.

He stated he has no financial interest in the outcome of today's deliberations. He serves pro bono as the Director of the Center for Economic Justice as a consumer representative. As always, if there any doubts about the evidence and arguments he presents, he requested to be challenged on it and engaged. Mr. Birnbaum spoke a little bit about the Center for Economic Justice. They work on insurance issues because insurance is a miraculous tool for individual and community economic development and well-being and because insurance is the most important tool for resiliency and sustainability. They work on economic and racial justice in insurance to help make insurance available and affordable to the communities most in need of these essential financial tools.

So, lets talk about fair and unfair discrimination in insurance. First, discrimination is not a dirty word. Fair discrimination in insurance is important. Our focus today is on distinguishing between fair and unfair discrimination and how systemic racism in society leads to unintentional unfair discrimination in insurance against communities of color. The word unintentional is very important. Generally, fair discrimination means that there is an actuarial basis for treating individual consumers or groups of consumers differently. We find this in rating statutes and unfair trade practices (UTP) statutes. Rating statutes typically define two types of unfair discrimination. One is actuarial meaning that there must be an actuarial basis for distinctions among groups of consumers. The second type is discriminating on the basis of a protected class characteristic regardless of actuarial basis. The UTP statutes typically define unfair discrimination based on a protected class characteristic. Both the NCOIL P&C Insurance Modernization Act and NAIC P&C Model Rating Law and state laws reflect these two types of unfair discrimination. NCOIL P&C modernization says "For the purpose of this Act, "Unfairly discriminatory" refers to rates that cannot be actuarially justified. It does not refer to rates that produce differences in premiums for policyholders with like loss exposures, so long as the rate reflects such differences with reasonable accuracy." And "No rate in a competitive market shall be considered unfairly discriminatory unless it violates the provisions of section 6(B) in that it classifies risk, on the basis of race, color creed, or national origin. Risks may be classified in any way except that no risk may be classified on the basis of race, color, creed, or national origin.

Similarly, the NAIC P&C model rating law says "Unfair discrimination exists if, after allowing for practical limitations, price differentials fail to reflect equitably the differences in expected losses and expenses." And "Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in
hazards or expense provisions, or both. Such standards may measure any differences among risks that can be demonstrated to have a probable effect upon losses or expenses. No risk classification, however, may be based upon race, creed, national origin or the religion of the
insured."

The second type of unfair discrimination is discriminating on the basis of a protected class characteristic regardless of actuarial basis. So even if an insurer found an actuarial basis for using race as a factor in marketing, underwriting, claims settlement or

antifraud, the laws prohibit that. And it is not just related to rating. If you were to discriminate in claims settlement on the basis of race that would also be a violation. You'll note that neither model mentions the word "correlation." The reason that correlation is not mentioned is because the actuarial standard requires more than a correlation. A correlation is simply a relationship between two things. But that relationship may not be reliable. The correlation may be spurious, which means that the relationship is random and temporary. Like the example on slide 8 which shows an almost perfect correlation between the divorce rate in Maine and the per capita consumption of margarine. No one would suggest that this historical relationship is anything more than an anomaly and is reliable to predict the future.

Slides 9 and 10 show a spurious correlation in insurance. In the early 1990's, when Mr. Birnbaum was in TX working on these issues a company filed for a homeowners discount based on tenure with the company. The insurer presented a chart similar to the one on slide 9 showing a correlation – a declining loss ratio for policyholders with each additional year with the company. So, somebody who is with us for 5 years has a much lower loss ratio than someone with us for 1 year so we want to offer a tenure discount. It turned out that this was a spurious correlation because the data combined renters and homeowners insurance. When you looked at them separately you found that renters insurance was a consistently higher loss ratio than homeowners insurance. What happens is that with each year more and more renters drop off the book of business whereas homeowners tend to stay on longer. So, what the original chart was showing was simply a growing percentage of homeowners in the book of business with each year of tenure.

There's another important reason why a simple correlation does not meet the statutory rate standards and why insurers don't rely on simple correlations to develop prices. The reason is that various risk characteristics are correlated with one another. Here, we look at correlations between driver age and auto claims and marital status and auto claims and vehicle age and auto claims. Each of these represents a one-to-one relationship – a univariate analysis meaning one variable to predict the outcome. But since we are looking at each predictive variable separately and because the three predictive variables are highly correlated with one another, when we add the variables, we don't have an accurate indication because of overlap among the predictive variables. Stated differently, driver age is not only predicting auto claim frequency, but also predicting marital status. So, what insurers have done for at least the last 30 years is develop new techniques to address problems with univariate analysis. Insurers use a variety of techniques to eliminate correlations among predictive variables in order to isolate each individual predictive variable's unique contribution to explaining the outcome.

So, to give you an idea of where we are at now, a simple correlation is to today's insurance algorithms as a paper plane is to a Boeing 787. On slide 13, I list some of the techniques used by insurers. Each month, the NAIC Casualty and Actuarial Task Force holds a "book club" with a presentation on new techniques insurers are using for pricing. Here are some recent techniques presented: Families of Generalized Linear Models (Variations on Multiple Regression); Gradient Boosting Models; Machine Learning; Hyperparameter Tuning; Neural Networks; Generative Adversarial Networks. Accordingly, the concept of simple correlations, if it ever existed, is simply outdated.

So, how does a multivariate analysis work? Here's a simple illustration of a multivariate model. Let's create a simple model to predict the likelihood of an auto claim: $b0 + b1X1$

+ b2X2 + b3X3 + e = y. X1, X2 + X3 are the predictive variables trying to predict y. Say that X1, X2 + X3 are age, marital status and credit score and we are trying to predict y – the frequency of an auto claim. Let's assume that all three Xs are statistically significant predictors of the likelihood of a claim and the b values are how much each X contributes to the explanation of claim. The important thing is that by analyzing these predictive variables simultaneously, the model
removes the correlation among the predictive variables. By analyzing them simultaneously we're better able to get the unique and independent contribution of each variable to explaining the outcome.

How do we even improve the multivariate analysis. Here is what insures so. Suppose an insurer want to control for certain factors that might distort the analysis? For example, an insurer developing a national auto insurance pricing model would want to control for different state effects like different age distributions, different minimum limits requirements and differences in jurisprudence. An insurer would add one or more control variables. They add another variable to the model and in this case lets call it "state." By including State as a control variable, the correlation of the Xs to State is statistically removed and the new b values are now the contribution of the Xs, independent of their correlation to State, to explaining the likelihood of a claim. So the fact that one state has a much older population than another wont distort the outcomes.

Let's get to the issue of proxy discrimination, a concept the Committee is familiar with because when state legislatures develop legislative districts – for state and federal legislators – they use proxies to identify how people will vote. The party in power seeks to maximize the number of districts whose voters will likely vote for members of their party. So, this is not a radical concept by any stretch of the imagination. But lets look at proxy discrimination against a protected class in insurance. The terms "proxy discrimination against a protected class" and "disparate impact" mean the same – discriminating on the basis of a protected class characteristic using a proxy for the protected class characteristic. I hope we agree that denying coverage or otherwise discriminating against consumers because they are Black Americans or Evangelical Christians is unfair discrimination in insurance. Suppose now that we are in an era of Big Data where insurers have access to massive amounts of personal consumer information, that I found a perfect proxy for either of these protected class characteristics and the effect is identical to discriminating directly on the basis of the protected class characteristics. Should a regulator stop the use of these proxy variables on the basis of discriminating against a protected class? The insurance industry says no – the regulator has no such authority but that of course defeats the purpose of the statutory prohibition against discriminating against protected classes. Regulators disagree with the industry on that position as well.

So, what is systemic racism and how does that play into this? Insurance company CEO's recognize the impact of systemic racism. For example the CEO of American Family said "Floyd's death in Minneapolis is the latest example of "a broken society, fueled by a variety of factors but all connected by inherent bias and systemic racism. Society must take action on multiple levels and in new ways. It also requires people of privilege—white people—to stand up for and stand with our communities like we never have before." So, why do state and federal laws prohibit discrimination on the basis of race? The earlier speaker stated it is because it is abhorrent. Is it just because it offends us? The answer is of course not – it is much deeper than that. Justice Kennedy for the Majority in the U.S. Supreme Court's 2015 Inclusive Communities Opinion

upholding disparate impact as unfair discrimination under the Fair Housing Act said "recognition of disparate impact liability under the FHA lays an important role in uncovering discriminatory intent but it also permits plaintiffs to counteract unconscious prejudices and disguised animus that escape easy classification as disparate treatment." So, here, Justice Kennedy is saying that just looking at intentional discrimination – disparate treatment – was not enough. Prohibitions against unfair discrimination on the basis of race require analysis of disparate impact. Justice Kennedy understood that the legacy of historical discrimination continues today in systemic ways. In some cases directly, some cases, indirectly, unconsciously, and unintentionally.

We continue to see those legacies today – directly and indirectly. Policing and criminal justice; housing; and impacts of COVID. The prohibition against discriminating on the basis of race regardless of actuarial basis in insurance laws is also a recognition of intentional discrimination. Insurance is not immune to systemic racism. There are examples of practices that clearly have a disparate racial impact because they rely upon data in development of the algorithms that are highly biased on the basis of race. But, we have a solution and the solution is not an either or – it's not down to a choice between prohibiting a factor or permitting a factor. The tool to identify unintentional discrimination or proxy discrimination against protected classes is disparate impact analysis. Disparate impact is both the standard for determining whether proxy discrimination is present and a methodology for identifying and minimizing that proxy discrimination within that risk based framework of insurance. So, if we go back to the model earlier – if we put in race as a control factor instead of state we now are able to remove the correlation between our predictive variables and rates. What this does is minimize the racial bias while managing the risk and focus of insurance. In fact, by eliminating correlations with race, we improve risk based pricing.

There is a long history and many approaches to identifying and minimizing disparate impact in employment, credit and even in insurance but the general principle is to identify and remove correlations between protected class characteristics and the predictive variables. So, what if X1, X2 and X3 are not perfect proxies for race, but are somewhat of a proxy for race? Then, the disparate impact analysis – and our simple model – removes that correlation and the remaining values for b1, b2 and b3 are the unique contributions of each predictive variable to explaining the outcome. The result is more – not less – accurate cost-based or risk-based analysis. Why is it reasonable and necessary to recognize disparate impact as unfair discrimination in insurance? There are at least three reasons. First, it makes no sense to permit insurers to do indirectly what they are prohibited from doing directly. If we don't want insurers to discriminate on the basis of race, why would we ignore practices that have the same effect? Second, it improves risk-based and cost-based practices. Third, in an era of Big Data, systemic racism means that there are no "facially-neutral" factors. The big data mining activities often reflect and perpetuate historical patterns of inequity.

Mr. Birnbaum stated that he would like to finished by emphasizing that some of the things that insurers do is a function of their models not trying to predict risk but trying to predict non risk outcomes. Here are some quotes from what insurance executives have told investment analysists. In 2005, the CEO of Allstate explained how they identify the right and wrong types of consumers. Here, he was talking about the use of credit scoring. "Tiered pricing helps us attract higher lifetime value customers who buy more products and stay with us for a longer period of time. That's Nirvana for an insurance

company. Tiered pricing has several very good, very positive effects on our business. It enables us to attract really high quality customers to our book of business. The key, of course, is if 23% or 20% of the American public shops, some will shop every six months in order to save a buck on a six-month auto policy. That's not exactly the kind of customer that we want. So, the key is to use our drawing mechanisms and our tiered pricing to find out of that 20% or 23%, to find those that are unhappy with their current carrier, are likely to stay with us longer, likely to buy multiple products and that's where tiered pricing and a good advertising campaign comes in." These statements were made in the Stone Age of Big Data – 2005.

In 2017, the CEO of Allstate said the "universal consumer view" keeps track of information on 125 million households, or 300 million-plus people. "When you call now they'll know you and know you in some ways that they will surprise you, and give them the ability to provide more value added, so we call it the trusted adviser initiative." Just last month, Progressive's CEO in response to a question from an investment analyst said "yes, we have -- we do incentives and we have different commissions based on the type of customer that we get in namely preferred." So, there are a number of practices that raise concerns about proxy discrimination on the basis of race. One is the increasing use of customer lifetime value scores. By definition, these are algorithms used by insurers that use non cost factors to differentiate among consumers and the factors and data reflect bias against communities of color. Credit based insurance scores reflect that consumer credit data has a disproportionate bias on the basis of race. With criminal history scores, you just have to read some of the DOJ reports on discrimination in policing and you know that criminal history scores will also be based on bias data.

So, what are the benefits and costs of requiring insurers to test for and minimize disparate impact? If racial and economic justice are a priority, if cost-based insurer practices are a priority, if closing the protection gap and making insurance more affordable and available in traditionally underserved communities, then the benefits of requiring insurers to test for and minimize disparate impact far, far outweigh the costs. While there are examples of disparate impact claims brought against insurers under the federal Fair Housing Act that have resulted in improved risk-based pricing, for example challenges based on age and value of the home, industry has not been able to cite a single example of a successful disparate impact claim that has harmed risk-based pricing.

Mr. Birnbaum stated that he would like to close by stating that it is not only reasonable and necessary to test for disparate impact in pricing but in every aspect of an insurers operations. Today's Big Data algorithms and variety of marketing channels give insurers – like other businesses – the ability to micro-target consumers. This ability to micro-target gives insurers the ability to attract or discourage customers even before the pricing stage. Perhaps the area of must concern for us is with claims settlement and antifraud. The goal here is not to punish insurers, but to engage insurers in efforts to identify and minimize systemic racism. We don't claim that insurers are looking for ways to indirectly discriminate against communities of color. Rather, it's about getting insurers to examine their practices for unintentional discrimination and to change those practices within the risk-based framework of insurance. Disparate impact analysis improves, not harms, risk-based practices.

I began by talking about why CEJ works on insurance issues – because insurance is a fundamental economic development and resiliency tool for individuals, businesses and communities. Just as lenders and employers are required to test for unintentional discrimination on the basis of race, so should such testing be part of the DNA of insurers. It is not a great burden on insurers to consider racial impacts as they develop algorithms for marketing, pricing, claims settlement and antifraud. The goal is not to eliminate rating factors, but to eliminate the unneeded racial impact of those factors – it's not a binary choice. The draft amendments to the NCOIL P&C Insurance Modernization Model law fails because it refers only to intentional proxy discrimination. The entire premise of disparate impact analysis is to unearth unintentional discrimination.

Dr. Lawrence "Lars" Powell, Director at the University of Alabama Center for Insurance Information and Research (Center), stated that the Center solves insurance problems with research and education. Dr. Powell stated that the first piece of data he brought is a picture that maps more than 4,000 gatherings of the Black Lives Matter (BLM) movement just in 2020 in the U.S. Nearly every population center in the country is represented and he is not sure if it's gathered scientifically but there is no reason to believe its wrong and it suggests that the problem is important. This is an important part in the history of the country where we have opportunities to make changes where we have the attention of people at all levels of gov't and its important that we move now to improve on this important area. Like with the pandemic what we hear is that we should follow science and data and that is what I want to bring today. As a spoiler on conclusions, while the industry is not perfect the science data of which he is aware of and works with on a daily basis don't currently indicate big problems in insurance especially how it is underwritten and priced.

Dr. Powell stated that he will cover incentives, safety – which is something not often discussed with insurance underwriting and pricing but the two are very much aligned – and evidence. Starting with insurance incentives, if you start with a dollar bill because as an economist that is probably what you would expect him to say is that the only thing an insurance company cares about is making a profit or increasing some sort of performance measure. At the highest level that is true but insurance companies are also run by people and people are imperfect. We have seen over history examples of people bringing their own prejudices and biases into businesses even the insurance business. As long as people are performing functions of companies it is something we need to be vigilant of and investigate and when we find something such as unfair discrimination it is important that we act on it and make sure it doesn't continue. As more transactions begin to occur without people touching them, we have less opportunity to inject our personal biases although there is a possibility of bringing in historical biases that show up in the data. Dr. Powell stated that didn't pay super close attention to Mr. Birnbaum's presentation but he bets he said that. Dr. Powell is not dismissing that but as AI and data analysts get better those are things that we can detect and get rid of in processes like claims and underwriting and customer service

We talked about insurance rating laws and I will restate that the law in all states state that insurance rates need to be accurate and reflect price or reflect risk and cost. This is not something we want to change. Fair discrimination is what makes insurance work. If we cannot classify policyholders or risks into like categories and charge premiums that are commensurate with that risk then the insurance mechanism breaks down and we lose this very economically necessary part of our economy and our daily lives. One thing I want to give you as not my opinion but just some math is that if members of a

protected class have more insured losses than people who do not belong to that class, the use of accurate rating variables will cause protected classes to have higher average insurance premiums. I haven't seen any evidence that shows protected classes are more likely to crash a car because they belong to a protected class. That would be hard to accept. This is largely driven by location. Where you live and where you drive are among the, if not the most, predictive factor for rating auto insurance. It is also very predictive of rating for homeowner or property insurance.

One of the things that we hear as an objection to these measures such as location that result in having people pay more is why don't we just look at the way people drive and use driving variables. So, if you crash your car your rate goes up. There is a great reason – it is because these observed driving behaviors don't provide much information at all. We don't get a very complete picture of how people drive or their propensity to crash just by looking at driving factors. The info they do produce is produced quite slowly over time. For example, if we look at the very worst class of drivers – the riskiest class such as 15 year old males who were just licensed to drive – 20% of that class crashes their car in a given year. The graphic shows that 20% crash and 80% don't crash and you could just as easily say if you're only using driving factors that you have 20% who are correctly classified and 20% who are misclassified. That is in the riskiest group and the one it might be most important to classify.

What about the average driver – the average driver has a 3.5% chance of crashing in a given year so it is going to be quite awhile before we know much at all about these average drivers but we do know these things. We know a lot about people and their propensity to crash because we have these continuous and instant measures of the likelihood of crashing such as where you live and where you drive and your insurance based credit score and age. Driving history is a factor but is actually not as predictive as people think. So, in a lot of ways these arguments about driving history and driving factors and the complaints about non-driving factors is very much a red-herring. It is something you can say that gets uninformed people very interested in helping you make a case.

Lets talk about driving actors. The best driving factors are telematics. If you really want your insurance company to know just how you drive and rate you based on that – that option is available. The last data he could find shows about 5% of current insured drivers take up this option of having a telematic on their cell phone or using the thing to plug into your car. Maybe people aren't aware of this and maybe there needs to be a better job in explaining it. As someone who has turned on the TV in the last 10 years, I have seen a commercial for this. They don't hide this very well that you can get different telematics form different insurers but the reason why this matters and why we don't want to give up on risk based pricing and having accurate insurance pricing is because when the price is less than the risk that its covering your incentive to take risk or care increases. You don't have this marginal incentive of if I don't drive safely I will have to pay more for my insurance. Or my insurance price isn't that high so if it goes up what's the big deal. Indeed, we find that people are able to drive a lot better than they do on average. We know that by looking at telematics. During the 6 months when the device is in your car and you are being evaluated as a driver, people crash much less and drive more carefully. Nobody is surprised by this and it is funny that a lot of people probably think they may not want the device because they don't want to drive the speed limit and brake very carefully especially if they are late to work one day.

Its better to have incentives that make people want to drive better and safer. I am not just saying this because I think it is intuitive and makes sense although I do think its intuitive and makes sense. There are several very well known peer reviewed published academic articles that find that less accurate prices cause losses to increase. More people crash their cars and more people are injured on the job when regulations say you cannot raises rates for whatever reason – when rates don't follow risk. It increases the overall cost and it increases the number of people that have their property damaged, injured and who die. These are good reasons to stick with risk based pricing.

So, what do we do if we don't like to see a differential between some classes and others in crashes. We don't want to see anyone crash. Lets address losses. I do a lot of work with transportation engineers doing some cross disciplinary work and they say it seems silly to change the price of insurance when the losses are there and we have these levers we can pull to decrease the losses. Lets go to these places where people are driving and crashing and replace stop signs with stop lights and add turn lanes and replace the most dangerous intersections with roundabouts. Data shows that such things reduce crashes and save lives. Another issue that my traffic engineering colleagues have found is that some of the differences across groups by a protected class or by income is vehicle maintenance. Driving on tires that you know are going to pop or bust if you get on a highway and go 70 mph is a guaranteed crash and if you don't evaluate the tread on your tires which is a very simple thing to do and there are several public education programs that have spread awareness of things like tire tread and vehicle maintenance and it has shown to make a big difference in the reduction of crashes.

Dr. Powell stated that a handful of studies have come up in the last 5 years that claim to find unfair discrimination and all of the studies have something in common and that is that they don't control appropriately or accurately for the risk of loss. I want to walk through these methodological problems because this is the science that we talk about and want to talk about and address. The way that these studies define risk has been a problem. In some instances they define good drivers and then compare good drivers to bad drivers. In some instances they look at small zip codes where you expect to have a large variation in outcomes and then compare those small zip codes to large zip codes where you don't have a credible number and a lot of the time it is comparing the premium per car without taking into consideration the loss ratio.

Lets start with the Massachusetts Attorney General report in 2018. Nothing about it was dishonest or disingenuous but the skillset that you have to have in order to do a study on something like this is unique. There are not a lot of people that get a Ph.D. anything but especially in risk and insurance. The report compared the zip codes with the highest minority population with the zip codes with the lowest minority population. In a control for loss they go from all drivers on one side to experienced drivers which is drivers with more than 6 years of driving experience and then experienced drivers with excellent driving records which is people that haven't had a moving violation or a crash in 6 years. We just covered this on another slide but what they conclude is that even good drivers are charged more and they imply that is based on their membership in a protected class.

If we do a little math, lets assume that there is a 10% chance of any driver in this high risk location crashing per year. So over 6 years if we do the math with a 10% chance of loss about 53% of people would have had a claim or moving violation and that leaves 47% of people that are still high risk drivers but haven't been identified by this metric yet.

So, what's going on is that we are choosing an excellent driver as one of the bad drivers who hasn't had a loss yet. We don't have to call them a bad driver - you could be a good driver who drives in high risk locations so you are more likely to crash. Because you haven't crashed doesn't necessarily make you less likely to crash going forward. There is about a 50% chance you wouldn't have crashed if 6 years of not crashing is the entirety of your risk measure. Moving onto a study done by ProPublica I believe in 2017, the paper looks at zip codes and defines zip codes as being a minority zip code or non minority or white zip code. A graphic from the study shows premiums on the y axis and losses on the x axis. We see that the minority trend is higher but what's going on here? The line that follows the white neighborhoods goes up with losses and then it goes down. This is Geico and suggesting that Warren Buffet doesn't like to make money because he has chosen to charge white neighborhoods less. That doesn't pass the sniff test. If that was the case it would be abhorrent and we would want to do something about it but we should be open to the idea that maybe something else is going on.

A doctor from the Missouri DOI who I believe has PhD in math or statistics produced a response to this where he takes the same data and makes a different chart. The ProPublica study draws its conclusions within those two red lines that go straight up and down between $250-$400 of loss per year so they have already thrown out the bulk of these non-minority neighborhoods where you see before that a red line in upward trends where premiums tend to appear to depend very much on loss. So you throw all those out and then you look at those only where there appears to be a negative relationship between losses and premiums for the non minority neighborhoods. So, what we have going on here is lets say a zip code has a set number of cars in it – there is a number of vehicles you have to have to get to what is called credibility in a number. When you look at these small zip codes if you have say 50 cars in a zip code and 10 of them have a loss one year and then one of them have a loss for 3 or 4 years well if you happen to catch the year when there were 10 losses the losses per car are going to be really high but their expected risk is going to be really low so you get these observations that are far to the southeast of the chart.

You also see some that are very high on the premiums and very low on the loss and the demographics work out this way that in high minority zip codes you have densely populated places with very credible data and you see again about the same upward trend and relationship between loss and premium. What's also instructive here is that when you look at where the overall result is coming from – its southeast of the blue line because anything below that line is losing money. I find it difficult to say the insurance industry has a systemic problem because they are trying to lose money on a lot of zip codes because they have more white people in them. That seems farfetched and I don't know what brings people to that conclusion. It seems much more obvious that we have a credibility problem with the data. The Missouri doctor went on to perform his own analysis where he pulled a lot of zip codes together by minority population percentage. He pulled 5 years of data together and looked at the loss ratio and what he found was a negative correlation between a minority percentage of the population and price meaning the higher the minority population as percentage of population in a zip code the smaller is the price they pay relative to the loss. That is what the law suggests we are after when we price insurance.

To summarize, its an important topic and I'm not here to minimize it but there are ways that these things happen. Its not impossible to have unfair discrimination in insurance because while insures have an incentive to be accurate they are also run by people who

are imperfect and could potentially impose their own biases and prejudice on the outcome. We're right to be here and vigilant about it but the data that I have seen does not show it there in a measurable and detectable manner. Rating laws require accurate prices and that is a good thing because accurate risk based prices improve the safety of people who are driving or owning homes, etc. The studies' math that claims to show unfair discrimination, every one I have found and reviewed, and I am happy to review others, does not control well for risk and vice versa – every study that controls well for risk does not find unfair discrimination. That's what the data shows. If data showed different then I would be the first person to bring this to your attention and say we need to do something about but its not there.

Dr. Powell stated that there were one or two things heard in the earlier presentations that in the risk of accuracy and data based conclusions he would like to comment on. One of things heard was that if we went through an exercise of removing intentionally the correlation between race or any other protected class and losses when making insurance rates assuming the correlation exists. We were told that makes rating models more accurate. That is simply false. That is taking information out of the model and making it less accurate. That is said unequivocally and is a mathematical identity and not his opinion. It does not improve risk based pricing. Another thing heard was that its inappropriate to have membership in a protected class correlate with prices. Well, we have legally and for the better carved out race and religion and ethnicity as predictors of loss or rates and we have not carved them out as correlates. Like an earlier slide said, if there are differences in losses then any accurate rating variable is going to produce a difference in premium. The purpose of not using membership in protected classes in rating is so that you cant just arbitrarily say well, lets make this group pay more. It makes it impossible to do this and it means you have to correlate things with loss and that is what the whole actuarial process and whole rate review process that the laws govern follows – making sure that these factors are correlative with losses and premiums reflect losses.

Lastly, the amount by which any variable that is used in insurance ratemaking whether it be credit scoring or criminal history or age or anything else – the amount by which that affects the price of insurance is not arbitrary. Its based on how these measures vary with insurance losses. We saw an impressive list of methodologies that insurance companies use to make sure those correlations are isolated and that they are accurate. It seems that some folks want to say that they are used for proxies for something else – its used as an accurate rating variable and if we want rates to be accurate so that we have better safety and outcomes that people see as fair then that is the way the insurance mechanism works best. It is not an arbitrary amount by which we can increase someone rates because they are in a protected class – its all based on the correlation with losses.

Rep. Lehman stated his question is wrapped into a statement. Dr. Powell made a statement that the best indicator of rate is telematics. If that is in fact the case, it leads to the death of the law of large numbers and if we move in that direction does it not send many of these issues by the wayside because the data is purely focused on how someone drives? Rep. Lehman then addressed Mr. Birnbaum's statement about data mining and Rep. Lehman stated that he looks at it as insurers are getting more and more data to try and be accurate in rating but how does that differ from what Apple and Google and Amazon do? They know everything about you with regard to purchasing habits and other things. So, is this something unique to the insurance industry? With all

due respect to Mr. Birnbaum, he made it sounds like wanting the best consumer is a bad thing. Every entity out there does the same thing whether it be retail or services industries.

Mr. Birnbaum stated that the difference between insurance companies doing data mining and Amazon and others is that Amazon and others aren't required to do cost based pricing. They can use data mining to extract profits from any group of consumers they want. The part that's relevant for insurance is that its not that data mining is bad in terms of identifying cost drivers – it becomes bad where the data mining is used on non cost factors. So, when you look at things like customer lifetime value scores or price optimization scores those aren't based on risk or cost factors they are based on non cost factors that are highly correlated with race and that is where the problem comes in. In terms of the other issue raised in terms of does this eliminate the law of large numbers, there is a distinction between an insurance company that insurers 1 million vehicles and by insuring 1 million vehicles they have the law of large numbers. When it comes to then assigning premiums to different vehicles within that pool, that's where they want to identify people who are more risky than other and issuing higher premiums for that. But, assigning premium to different groups of consumers doesn't violate the law of large numbers because you have a book of business that is 1 million.

The other thing Mr. Birnbaum wanted to respond to quickly was some of the strawman arguments that Dr. Powell made and it is not clear what the point was because he made a number of arguments that no one else is really arguing and then he attempts to refute the strawman arguments. One was that some people want insurers to ignore some variables and give up on risk based pricing. No one is really arguing to eliminate risk based pricing or practices. Consumer and civil rights groups are arguing that unintentional discrimination on the basis of race harms both communities of color and risk based pricing and we also argue against the use of non risk related factors in pricing – practices like customer lifetime value scores.

Dr. Powell criticizes various studies showing racial impacts of insurer pricing and claims that the studies fail because losses aren't considered. There are two problems with that argument. First is that the studies do control for loss because they use price to reflect losses just as insurers do. They control for losses by saying that the only factors we are going to vary are the particular attributes under consideration like credit score or gender and they hold everything else constant. Dr. Powell makes some basic mistakes – he equated a higher loss ratio with lower price. In fact, a higher loss ratio may reflect higher prices because it is in a higher claims area. The other mistake he makes is that every study that controls for risk does not find unfair discrimination – that is simply false. The Texas and the FTC studies on credit scores both found a disparate impact as well as a relationship between credit scores and risk of loss.

So, there are a number of problems the most important of which is a claim that any time you add a variable to a model it improves the accuracy of the model. That is not true from a statistical standpoint. And most important, insures introduce variables into models to increase the accuracy of the models yet with the specific intent of not to deploy that variable. So, the idea of using control variables that Dr. Powell said was wrong is in fact a solid and used statistical technique. In fact, insurers presented the use of control variables in their presentations to CASTF. So, although Dr. Powell raises a number of interesting issues it is generally unclear what his point is because the arguments that he is refuting are arguments that Mr. Birnbaum does not know anyone is

making and it doesn't really address the issue of how do you attack unintentional discrimination on the basis of race in insurance. His solution seems to be ignore it because insurers don't discriminate and in fact there is plenty of evidence to show that there is that type of unintentional discrimination.

Rep. Lehman stated that he would like an answer to his telematics question. Dr. Powell stated that one of the things that Mr. Birnbaum mentioned which is correct is that there are a lot of people with cars that buy insurance – something like 220 million vehicles insured in the U.S. So, even if we start classifying people by telematics and all these minute variables about how they drive it still doesn't make an individual label for every person. You are still classifying people into similar groups you just have a lot more information about how they drive. The concern about micro-segmentation is not that its unreasonable – we could see an issue where there are so many classes that the usefulness of those classes in a statistical sense breaks down and the law of large numbers doesn't apply as readily although you don't have to have exactly the same thing in every class for the law of large numbers to work but at that point it is not clear how the insured benefits from using it. If for some reason we are able to identify a person who is 100% likely to go out and cause a multi car fatality crash then I would say that is a great thing and we should make sure they don't drive. We're not there yet and if we were to get there technologically then we would have to make some important choices about how we deploy those things. In response to Mr. Birnbaum's comments, Dr. Powell said that he is certain what he said is right and that Mr. Birnbaum is wrong and that he would be happy to provide more detail on that if requested.

Rep. Lehman stated that he looks forward to discussing the issues surrounding telematics further. Sen. Breslin noted that reasonable minds can differ on these issues and he thanked the three speakers for their remarks.

Asm. Kevin Cahill (NY), NCOIL Treasurer, thanked the speakers and stated that they bring up some interesting points. Asm. Cahill stated that he would like to reflect upon what happens in the NY Assembly Insurance Committee during his experience as Chair of said Committee. Often times when colleagues come to him from one end of the spectrum and ask for specific measures to be implemented under the law he tells them that insurance starts with math. We always start with math and then layer on top of that our policy but we can never ignore the math. That doesn't mean that we have to slavishly adhere to the math it means that we recognize that insurance is based on math and we cant put insurance companies in a position where they will absolutely lose money if we expect them to continue to exist. It is in that context that he offers his comments today.

Asm. Cahill stated that he does not want to have a two person debate be the center of today's meeting but Dr. Powell did preface his comments by saying he didn't pay much attention to Mr. Birnbaums presentation and then preceded to argue against some of the arguments Mr. Birnbaum raised so it is perfectly legitimate for Mr. Birnbaum to respond in kind. Asm. Cahill stated that he would like to ask Mr. Birnbaum a question regarding a term he has used a couple of times when it comes to discrimination. He talked about systematic discrimination and unintentional discrimination and harmful discrimination. Would a more appropriate term be passive rather than unintentional discrimination because of those of us who are determined to say everything is fine and there is no problem we are not doing anything on unintentional we are simply not doing anything.

Mr. Birnbaum stated that is a really good characterization of the issue and it is probably best illustrated in the difference in how unfair discrimination is treated in insurance from other financial service or employer issues. If you are a lender or employer you have to proactively test your processes to look for unintentional or proxy discrimination. With insurance there is no requirement for that so insurers simply don't engage in that process. Referencing back to presentations that different companies make to the CASTF book club in which they talk about their various algorithms and techniques, one presentation was by a company that engaged in telematics. After the presentation I asked if they did any testing to see if the offer of the telematics was unbiased so that the data gathering wasn't biased and did you test the algorithms to see if there was any bias on the basis of race. They replied no since they are not required to do that. That gets at a passive discrimination that Asm. Cahill referred to which is that we are not asking companies to abandon risk based pricing we are asking companies to invigorate risk based pricing by looking at these passive correlations and passive discrimination on the basis of race that nobody wants but you have to take action to see if it exists.

Asm. Cahill thanked Mr. Birnbaum for his comments and stated that he wants to make sure that there is an understanding of what the industry is responsible for and what legislators are responsible for are not exactly the same thing. Yes, insurance companies should maximize profits for shareholders or mutual benefit holders or whatever their corporate structure is and they should also ensure they maintain appropriate reserves and are solvent and able to pay claims. Legislators are required to layer policy on top of that and recognize that when we do so we do so in a way that overcomes systemic and passive discriminatory issues in the system. We do it with great frequency and regularity. If we didn't we wouldn't have flood insurance and we wouldn't have homeowners insurance for a lot of people. In trying to reflect upon the presentations, Asm. Cahill stated that he is getting the impression that to sum up, the point is being made by some is that here is no problem. If that is what is being said, Asm. Cahill asked for remarks as to where there is room for improvement and where legislators can step in to fix whatever may be broken.

Ms. Foggan stated that she thinks there are solutions in existing law that are perhaps being overlooked to some extent. There are tools that are available that do prohibit discrimination and are available for regulators to review circumstances where intentional discrimination is happening whether it is happening based on direct use of a classification or whether it is happening based on purposeful use of a proxy with the intention of discriminating so I think there is something to be said there about existing tools not being perhaps fully utilized. I also think that there are dialogues going on between regulators and companies about new algorithms that are being proposed and innovations in insurance rating and those dialogues are important and they are the start of figuring out how innovation may affect insurance going forward. A cautionary note is to keep in mind the fact that sometimes some solutions that are proposed may stifle that innovation. We have instances where restrictions on rating factors may stifle the usage. These are areas where very serious thought needs to be given to any other action that would be taken.

Ms. Foggan further stated that it is important to reinforce that the actuarial justification standard is a very important standard and there were a lot of comments made about the idea that factors that are not risk based are being used and to the extent that is true and the factors are not actuarially justified I think they are forbidden under current standards and that is something that can and should be pursued. That is a point that perhaps is

lost that in risk based pricing by definition insurers are responsible for providing a justification for use of a factor and that is the actuarial justification for the use of a factor.

Dr. Powell stated that one of things that we have seen some positive benefits from on a small scale is that his Center teamed up with a financial literacy effort from another place on campus where they go into underserved or underprivileged communities and run a financial literacy program that is pretty well attended. Dr. Powell's staff added a portion to that where they would walk people through the process of shopping for insurance online. It doesn't take very long and a lot of them will do it right there with provided tablets and computers and then Dr. Powell's staff will follow up with them months later to see whose insurance premiums have gone down or up and the results were very good. With limited resources that was able to be done in about 5 or 6 counties in Alabama and there is a lot of promise there. The very best consumer tool in many cases for resolving an insurance problem is the ACORD application or going to the market and seeing if you can find a company that has an appetite or a preference for your risk. When you align with the optimal company you will often get the optimal result. Dr. Powell stated that he is happy to share the data from that and would encourage folks in other states to consider this sort of thing especially if threre is an existing financial program to piggy back on.

Rep. George Keiser (ND) stated that he is good friends with Mr. Birnbaum and has been debating these issues on the national scene for a couple of months now and they have different perspectives certainly. One of the points that needs to be made is that all insurance is intentionally discriminatory. There isn't an insurance product that isn't. You can look at me and see that based on my age that if I want to buy life insurance or long term care insurance today the premium is going to be significantly higher than for other folks in this group except for perhaps the Chair. It is discriminatory and I am going to pay a higher premium and it is justifiable. That is a critical point. Mr. Birnbaum did an excellent job in showing the multivariate analysis design. I know you are not statisticians but It is imperative that you understand that given any set of data regardless of how large it is – it still represents that data has 100% variability. We can factor off different parts of it into their contribution to that total variability. That is the x1, x2, x3, x4 categories. The key there is that in reality given the law of large numbers that was referred to earlier you can have a correlation of 0.1 even 0.5 that if your sample size is large enough it can be statistically significant. If a company chooses to use that variable for underwriting they are going to lose a lot money because it is not contributing to the overall risk in a significant manner.

To understand its contribution to overall risk you use the coefficient of determination which is the r factor squared. A 0.1 correlation may be statistically significant. It will account for $1/100^{th}$ of the variability in that data. So, that is the risk side of going too far and why I support the original model which is intentional discrimination. The reality is, I am going to be able with the law of large numbers to show a statistically significant correlation between race and almost any variable in that factor cluster. So, I can show it and argue that is disparate impact and we shouldn't be using that factor. That will totally disrupt the underwriting process and be entirely on the defensive and will eliminate the opportunity for a lot of creative function in the future. I encourage the Committee to understand the impact of limiting factors because they may have a relatively minor correlation but statistically significant correlation with disparate impact or a minority group. Rep. Keiser asked Mr. Birnbaum to comment on that.

Mr. Birnbaum stated that it has been an honor to know and work with Rep. Keiser over the years and he appreciates him digging into some of the details of the statistical analysis of a multivariate analysis. The one area where Mr. Birnbaum disagrees is that if you start with a bunch of variables in lets say a credit scoring model with credit scoring vendors. They look at all of the factors that are in a consumer credit report and transform that into 300-400 different variables and then they data mine the different variables to find the ones that are most predictive and then they analyze those that are most predictive simultaneously because they want to make sure that the variables aren't replicating one another. They want to identify the unique contribution of one particular credit variable to another so that when you look at the credit scoring models that companies submit they only have about 10-15 variables out of the possibility of 300-400 and the reason that they do that is because just adding variables doesn't necessarily help. But when they do the analysis they analyze all the variables simultaneously so the disparate impact analysis that I showed – lets take 3 scenarios.

The first scenario is if one variable is a perfect proxy for race. In that case when you insert race that initial variable turns out to not be predictive because all its doing is predicting race and its not predicting claims. Now lets try a second scenario where there is some correlation between that variable and race but there is some correlation between that variable and the outcome. In that case what the model does is reduce or changes the contribution of that first variable to eliminate the correlation with race and leaves the unique contribution of that variable. All of this is by way to explain that by introducing race and doing disparate impact analysis you are not eliminating factors unless they are truly perfect proxies for ace. What you are doing is minimizing the unintentional or passive discrimination Asm. Cahill talked about and you are improving the risk based pricing of those remaining factors because you are identifying and isolating the unique contribution of that factor to predicting that outcome and hopefully that outcome is expected claims.

Mr. Birnbaum stated that he agrees with Rep. Keiser 1000% in that insurance is all about fair discrimination and all about identifying the most and least risky consumers to not only price it accurately but to give consumers the right price signals so that they can engage in loss prevention activities. Remember that insurance is the most important tool that we have to promote loss mitigation and loss prevention. That is why for example people are charged more for having a DUI or having accidents and that is why people have discounts for having hail or wind resistant roofs. That is all part of the insurance mechanism and that is why we work so hard on insurance because it helps people get more resilient and communities more resilient. It is not just for protecting loved ones its for making sure you can recover when that inevitable catastrophic event occurs.

The Committee then took a 10 minute break.

DISCUSSION ON DEFINITION OF PROXY DISCRIMINATION

Professor Anya Prince at the University of Iowa College of Law thanked the Committee for the opportunity to speak on these important topics. Prof. Prince stated that through the last panel we heard the perspective of insurance regulation both historically and up to today. However, we are at a moment in history that challenges us to reexamine some of these frameworks in light of changing norms. In the past few years there has been a growing recognition of the need to address concerns of systemic racism throughout our

society and additionally there has been an increase in the use of AI and big data in both insurance and beyond. Increased use of this technology however raises concerns that past historical harms will be perpetuated if technology is not introduced with care. As has already been spoken about several times today, AI raises a host of concerns from bias in data to transparency. While all of these concerns are essential to address today I would like to use my time to talk about one very particular concern of AI defined one particular way and that is proxy discrimination.

Prof. Prince stated that if further reference is needed she will be pulling her remarks from a paper she wrote with Prof. Dan Schwarcz regarding proxy discrimination in the age of AI and big data. This is not an issue unique to insurance – the paper was written about the problem at large in society but Prof. Prince said she will focus in on the insurance implications. Regarding the definition of proxy discrimination, as discussed, part of proxy discrimination does tie into disparate impact that is the use of a facially neutral trait in an algorithm that disproportionately harms a protected class but as noted in the paper we don't think that is all of the definition. The definition also has to include that the usefulness and predictive power of the proxy variable comes from the fact that it is correlated to a legally protected characteristic. Notably, in the paper, disparate impact and proxy discrimination are not completely synonymous but rather proxy discrimination is a specific subset of disparate impact.

Before proceeding with examples, Prof. Prince noted that this is a gross oversimplification of these problems given the complexities of multivariate analysis. Lets say that a life insurer is using an algorithm in their model and they find that somebody's Facebook likes are predictive of mortality. There is not anything in particular that would make us imagine that Facebook likes are actually causative of mortality and we may find by digging in deeper that the reason that Facebook likes is predictive of mortality is actually because its proxying for race and that can come up in all sorts of protective traits. We can think of auto insurance where if you are using all sorts of big data in underwriting such as receipts form men's clothing stores which is predictive of auto claims and then you find out that its not that you shop at a men's clothing store but that its predictive because of its tie to gender. In both of those examples it is because they are correlated to the protected trait that's really important and the second part of that is that the protected trait is indeed predictive of auto claims and mortality for all sorts of problematic social reasons in the past. That is the issue to focus on.

Prof. Prince then discussed a chart to contextualize the definition of proxy discrimination within the framework that was talked about in the previous panel about disparate impact laws and disparate treatment laws. Our legal frameworks take into account both disparate impact and disparate treatment although traditionally disparate impact is not traditionally a claim within the insurance realm. We define proxy discrimination really in the middle of disparate impact and disparate treatment – a subset of disparate impact. We can think of intentional proxy discrimination with insurers historically actively using race or actively using something like redlining to proxy intentionally for race. But that is not the problem we are seeking to address in this context. What we are worried about is unintentional proxy discrimination because of the use of certain algorithms. A couple of things to note from that chart is that proxy discrimination is conceptualized as a subset of disparate impact claims but also it shows why its incredibly important not to limit a definition of proxy discrimination to only intentional decisions. Algorithmic proxy discrimination is not intentional discrimination but will engender the very same problematic outcomes as direct intentional proxy discrimination. Additionally, our

definition of proxy discrimination is in some ways distinct from broader disparate impact conceptualizations. For example, disparate impact law allows a defense for legitimate and acceptable business purposes. Since our definition of proxy discrimination assumes that the proxy trait is predictive, the current disparate impact framework may not address the harms in algorithmic proxy discrimination however neither would a disparate treatment framework – this is a new legal problem that arises uniquely out of the use of big data and algorithms.

Our thesis in the paper is that where the law removes the ability to consider a protected trait that is directly predictive of an outcome of interest, algorithmic proxy discrimination is inevitable and this is why this is such a thorny issue in the context of race because we want to have a society where we are not taking race directly into account and proxy discrimination effects may add that effect back into the system. This is notably true even when an insurer utilizing the technology has no intention of discriminating. It is an aspect of the technology that will occur unless corrected for. Prof. Prince stated that she understands that the second half of the day will focus on discussions of specific rating factors and this conversation is incredibly important but if proxy discrimination is not defined to include unintentional algorithmic discrimination then any of the predictive rating factors discussed this afternoon can easily be replaced by an algorithm with enough big data. Additionally, algorithms can be utilized for many different aspects of insurance from marketing to fraud detection to ratemaking. Thus, the problems of algorithmic proxy discrimination extend beyond just ratemaking.

As described by Ms. Foggan, there are many times where insurance laws remove the ability of insurers to use traits that are indeed predictive such as race and gender and other protected traits in state insurance codes. We've decided as a society that those are not acceptable to use even though they are predictive of mortality even though they have some actuarial justification. In other contexts federally we have the Genetic Information Nondiscrimination Act (GINA) and the Affordable Care Act (ACA) that does the same thing in health insurance. This really pits the definition of social discrimination against unfair discrimination as was laid out in the last panel and the question is how do we treat this algorithmic proxy discrimination. Do we think of it more like social problematic discrimination or do we think of it more like unfair discrimination where as long as there is actuarial justification then it is ok. Where the law removes the ability to consider protected traits that are directly predictive, algorithmic proxy discrimination is inevitable.

So what? Why do we care if it is inevitable? There is a lot of conversation that has occurred today to this point. If its predictive of risk then shouldn't we allow insurers to use all sorts of variables as long as they are predictive of risk? Prof. Prince stated that she would argue no if that predictive power is actually the remanent of a predictive power of a protected trait. Our law and society has passed laws that prevent insurers from using certain protected traits because doing so is viewed as being unacceptable and unfair. There are other times where the law disallows insurers from using a predictive trait to encourage socially beneficial actions such as recording incidences of intimate partner violence. Proxy discrimination must be defined to acknowledge the inevitability that an algorithm when given enough big data will find a proxy variable to stand in for a trait that is predictive of the outcome of interest even if that trait is disallowed to be considered.

In our paper we lay out several possible solutions to the problems of proxy discrimination each with varying levels of effectiveness and some of which have been implemented in state insurance regulations to date. Given time constraints I wont go over them in much detail but I am happy to answer questions. What's important to note is that these solutions are difficult for individual insurance companies to implement on their own without legislation encouraging that. Preventing an algorithm from proxying for a protected trait may make it slightly less predictive depending on how you look at it which was part of the conversation between Dr. Powell and Mr. Birnbaum but this is just as true for removing the protected trait itself from consideration. Our social discrimination laws make insurance prediction less accurate and we do that because we don't think that is what society should do so if we then don't allow that predictive power to be proxied for it also may make that a little less efficient and that can be an ok thing because we have already decided that we shouldn't take into account race in underwriting. Because, for race and other protected traits we as a society have already determined that this is a necessary and acceptable tradeoff.

Prof. Prince stated that she would like to highlight ethical algorithms which is a movement in computer science and there is a lot of literature on this on all sorts of contexts including insurance and as shown earlier by Mr. Birnbaum controlling for protected traits in models does two things. It narrows the predictive power of a variable to its unique contributions so if you add a protected trait into the model the variable that is left that is proxying for race will only have the predictive power unique to it. Additionally, if the protected trait is not predictive of the outcome then the corrected variable will stay as powerful as it was before so this is how its not exactly the same as disparate impact because its not just that the variable has a connection to the protected trait but its taking some of its predictive power from that protected trait. As noted by Dr. Powell it is really important to test these as not all insurance models are going to have this problem if its tested for but we need to be able to have insurers actually do that to make sure that there is not socially unfair discrimination in our society.

Prof. Prince stated that that at the very minimum proxy discrimination must be defined to include unintentional algorithmic discrimination or else even the impact and success of our existing anti-discrimination laws are threatened. As such, the current draft definition in the NCOIL Model is insufficient to address the harms because it includes intentional substitutions of a neutral factor but does not address how algorithms will do that just by the nature of the fact that they are algorithms trying to predict the best that they can. Those arguing against inclusion of definitions of proxy discrimination in insurance argue that it may take away predictive power in insurance decisions. However, under our definition of proxy discrimination the actuarial value that the definition would control for comes directly from a protected trait. Without this an algorithm would theoretically be able to use any trait even if it is 100% predictive of race but entirely unpredictive of the outcome of interest once race is taken into account. We advocate for no more than for someone's race or other protected trait from playing any actuarial role in insurance decisions just as what is intended by many state anti discrimination laws. The increasing use of AI demands us to ensure that our existing legal framework address insurance issues of fairness in our systems. Prof. Prince thanked the Committee and stated she looks forward to questions.

Claire Howard, Senior VP, General Counsel & Corporate Secretary at the American Property Casualty Insurance Association (APCIA), thanked the Committee for the opportunity to speak and stated that APCIA represents over 1000 member companies

who together provide 60% of the home, auto and business insurance and reinsurance in the U.S. APCIA understands the time is now to publicly recognize and address the profound problem with social racial and income quality that exists in our country. We also understand that substantive and durable solutions require the commitment and participation of the various sectors in America's economy including insurance and where necessary gov't action through legislation. We believe achieving substantive and durable solutions for the persistent problem of inequity requires certain things form all stakeholders in other words from the people, sectors and institutions affected.

Developing substantive and durable solutions requires debate, understanding, compromise and thoughtful public policymaking. Thoughtful policymaking requires the participation of stakeholders who are willing to identify the interest they hold in common who will think more broadly and creatively than they have historically which will provide objective support for their position and who will compromise to support public policy that fairly balances their divergent interests to avoid unintended consequences with a more detrimental affect on society as a whole. You need all of that to succeed and APCIA's members stand ready to engage with you in that way.

The specific question on this panel that APCIA has been asked to address is how to define proxy discrimination. You have APCIA's Nov. 5 letter on that subject in your pre-meeting materials in which we cite authority for the declarative statements included in that letter. I'll address certain points in the letter and I am happy to respond to questions after. I'll begin with the top line – NCOIL's staff efforts for defining proxy discrimination has significant merit and comports with well established case law and discrimination principles. APCIA looks forward to working with NCOIL on any refinements NCOIL chooses to make in that definition. My remarks this morning will explain why APCIA supports NCOIL's approach.

In the context of the business of insurance, statutory rating standards have for decades universally prohibited rates that are excessive, inadequate, or unfairly discriminatory as has been well described by others this morning. The term unfairly discriminatory is universally defined as treating policyholders with similar risk profiles differently. This statutory formulation is otherwise known as risk based pricing. Its purpose in large part is to balance policyholder interest in rates that fairly reflect the risk they present and the coverage they purchase on one hand with the industry interests in solvency which requires price to match risk on the other hand. At the end of the day a solvent industry ensures competition and competition promotes availability and affordability of insurance products. Risk differentiation is at the heart of risk based pricing and state rating statutes across the country.

If we think about risk differentiation with policyholders interests in mind, APCIA's position is that the more factors that are considered the less impact any single factor has on pricing or underwriting outcomes. Thinking about risk differentiation from the insurer perspective, the more factors the more precise that the prediction of risk helping to ensure solvency in the aggregate. As insurers compete using their specific set of rating factors, policyholders have more choice. A definition of proxy discrimination must preserve the ability to differentiate among risks for the purpose of meeting policyholder expectations and ensuring a solvent industry. This is not to be understood as an argument for no change because its been that way for so long. Rather we urge policymakers to consider the history and role of state rating statutes and the unintended consequences of enacting an inconsistent definition for proxy discrimination will have on

an essential element of the business of insurance namely risk differentiation and risk based pricing. The approach to defining proxy discrimination proposed by NCOIL staff addresses these concerns. There are two broad categories of discrimination claims and they are first international discrimination in which intent is the primary focus and second is disparate impact discrimination where intent plays no role at all.

A form of intentional discrimination is the legal theory known as disparate treatment which includes proxy discrimination. The similarity in name only to the unintentional form of discrimination called disparate impact can create confusion. In the insurance context, disparate treatment occurs when an insurer treats a policyholder less favorably than others because of the policyholders membership in a protected class. Proxy theory was adopted by the courts as an element of disparate treatment discrimination to recognize that a policy should not be allowed to use a technically neutral classification as a proxy for evading the prohibition against intentional discrimination. Because intent is a primary focus on disparate treatment cases when relying on proxy theory a plaintiff must demonstrate that the defendant was motivated by a discriminatory purpose in choosing a proxy about which the plaintiff complains.

As a form of intentional discrimination, disparate treatment challenges including those that rely on proxy theory ask one question – is there sufficient evidence, either direct or circumstantial, that defendant was motivated by discriminatory purposes in choosing the challenged proxy. If the answer is yes, then the challenged policy must be eliminated. Because defendant's intent is an essential element, plaintiff is entitled to equitable relief and attorney fees but also punitive and compensatory damages depending on the underlying facts of the case. It is very important to distinguish between intentional discrimination, its manifestation as disparate treatment and its analog in proxy discrimination which is a tool for a subset of intentional discrimination and separate that from disparate impact.

In contrast, disparate impact discrimination is inherently different form intentional or proxy discrimination. Disparate impact involves policies that are technically neutral like disparate treatment, but unlike disparate treatment they are not motived by discriminatory purpose although unintentional disparate impact discrimination involves a policy that has an adverse effect on a protected class that is not otherwise justified by a valid business interest. Federal courts applying disparate impact analysis ask a series of three questions. First, does the challenged policy have an adverse effect on a protected class. If the answer is yes then courts ask a second question – is there a valid interest served by the challenged policy. If the answer to that is yes then the final question is whether there is an alternative that serves the same valid interest with less disparate impact and at less cost. If no such alternative exists, then the challenged policy stands and the claim fails. Because intent plays no role, directly or indirectly, in disparate impact claims courts may award equitable relief and attorney fees but not compensatory or punitive damages – a distinguishing element separating from intentional discrimination and disparate impact discrimination and separating it from proxy discrimination. While disparate impact has been used in federal housing law, no state has adopted it as an insurance standard. Moreover, it entails an entirely different analysis than proxy discrimination as NCOIL has implicitly recognized in its proposed definition. Efforts to conflate disparate impact and proxy discrimination which is an element of disparate treatment should be rejected.

In conclusion, NCOIL's approach to defining proxy discrimination prohibits choosing a technically neutral factor that singles out a protected class for the purpose of depriving a policyholder of an insurance related benefit. This definition allows the industry to continue to differentiate among risks as long as the choice of a risk factor is not based on membership in a protected class. To do otherwise would be to take proxy discrimination out of the category of intentional discrimination where it resides currently under the law and place it in the category of unintentional discrimination and in doing so applied to the business of insurance where it has never been applied before by any state legislature.

Said another way, application of proxy theory in the insurance context would conflict with current state law that requires risk differentiation to balance the interests of policyholders and insurers alike and would likely require an overhaul of the underlying statutory framework – namely the prohibition that rates are excessive, inadequate or unfairly discriminatory. The approach for defining proxy discrimination proposed by NCOIL staff is consistent with current law and therefore is an approach APCIA supports. While these remarks address the issue of proxy discrimination, APCIA believes consumers are best protected and they derive the most benefit through robust private market competition and which risk based pricing incorporating a multitude of relevant rating and underwriting factors ensures rates match risk. Thank you for your time and for a deliberative and thoughtful approach addressing these public policy concerns embedded in this critical issue.

The Honorable Nat Shapo, Former Director of the Illinois Department of Insurance, thanked the Committee for the opportunity to speak. Jumping right in, a lot of what he will say is in the paper he wrote which is in the pre-meeting materials. The two points that are most relevant from the paper are, with respect to proxy discrimination, he doesn't think its necessary to define the term. Most state laws now protect social classes and the language in those statutes is generally something to the effect that it prohibits discrimination based on or based upon or some variation of the protected characteristic. I think that such language properly understood is broad enough to sweep in proxy discrimination. I believe the term proxy and its dictionary definition and the way its usually used in the law encompasses an element of intent. If the use of a proxy is intended to sweep in a protected class then that should be seen as "based on" or "based upon" a protected class. Therefore, it can and should be seen as already prohibited under the law.

Also, I don't think we've seen evidence of a significant problem to date with proxy discrimination. Generally, I think policymaking usually reacts to established problems and without establishment of the problem I submit the possibility that it may not be necessary to pursue a proxy discrimination definition but that is obviously the Committee's prerogative and it should proceed as it deems bets. When talking about definitions of proxy discrimination, I think that in the case of actually defining the term the biggest focus should be that it is intentional discrimination – the intent to use an otherwise neutral factor as a proxy for a protected class. The language NCOIL should pursue should be a strict attempt and carefully worded so as to avoid leakage into the concept of disparate impact. The dividing line I think is that intent is intent and effect is effect. They are different concepts and one should be able to draw a line between the two with careful wording. The difference between proxy discrimination defined by intent and disparate impact defined by effect is real and understandable and a well crafted

definition could achieve that. I think the NCOIL staff definition accomplishes that well and I would commend that as an excellent starting point for discussion.

Moving away from that language, there is a concern that such a definition could lead to a slippery slope of a law going towards disparate impact. So, I think the policy choice that I'm getting at is proxy discrimination defined by intent or disparate impact defined by effect. This is a well put together panel that has sketched out different viewpoints on that and today's presentations will be very helpful in framing committee member's views on how to proceed. The CEJ and Prof. Prince gave very well argued presentations and they are essentially advocating for a disparate impact standard. They presented their positions very well and if you are in favor of a disparate impact standard then they have sketched out what that would be. Dir. Shapo stated that he argues against a disparate impact standard here and supports a true intent based proxy discrimination definition. Disparate impact is bad policy in the business of insurance and as referred to in his paper and the NAIC amicus brief to The Supreme Court of the United States (SCOTUS) which is probably the most well articulated written document he has seen that sketches out the principles of why disparate impact does not work well in the insurance context. The NAIC told SCOTUS "in insurance, discrimination is not necessarily a negative term so much as a descriptive one." That goes to Rep. Keiser's earlier point.

The NAIC said "for insurance, fair discrimination is not only permitted but necessary" – again echoing Rep. Keiser. "It promotes insurer solvency through appropriate risk classification and accurate pricing of insurance." That is a very nice and straightforward explanation. The NAIC also said "rationally based neutral risk selection criteria promote insurer solvency through appropriate risk classification and accurate pricing of insurance." That gets to the policy rationale behind the risk based pricing standard. Its good public policy because its good for the public because insurer solvency is in all policyholders interest. Setting those public policy parameters, NAIC then concluded that "the disparate impact approach overthrows state laws that allow insurers to use rationally based neutral underwriting guidelines." The NAIC then got back to policy reasons saying "of concern to state regulators is that improper underwriting can result in the following – an insurer can become insolvent or a potential insured could be improperly discriminated against." So, there are two major policy concerns there. One is solvency by having accurate pricing and the other is the fairness norm of people paying into the company based on their likelihood of taking out through a claim.

Dir. Shapo stated that he believes the NAIC is correct in both those public policy statements and the resulting law. That basically comes down to the idea that disparate impact is incompatible with basic insurance principles. In insurance you have one core standard of risk based pricing and that is actuarial justification and that applies to every rating factor. The exceptions to that rule are codified statutorily with enumerated exceptions such as race, religion or national origin. Those are specific factors that are exempted from the core standard. An insurer can manage risk this way and knows that it is supposed to use factors that follow cost based pricing. It follows this rule and follows the enumerated exceptions to that rule in the code. It's a manageable and rationale system. It is much more difficult to manage risk if you have a second sweeping factor on top of the risk based pricing standard and that's what disparate impact would be. Disparate impact would apply to every rating factor so you would have a cost based pricing standard on every rating factor and then a disparate impact standard on every rating factor and I think that's what the NAIC was concerned about when it wrote about the negative consequences of disparate impact. An insurer cant manage risk that way.

The insurance industry is about predictability. The current system promotes predictably with one standard and codified exceptions. A system where you have two standards at once would be destabilizing for the industry and the opposite of predictable.

Dir. Shapo then discussed a few points made in the earlier presentations which illustrate the divide for policymakers to make their decision. In Mr. Birnbaum's presentations on slide 24 there was a question why is it reasonable and necessary to have disparate impact defined as unfair discrimination in insurance and the answer was that in an era of big data systemic racism means that there are no facially neutral factors. I think that is well articulated but it also sets the dividing line between his position and my position. If you have literally no facially neutral factors, if that's your starting point for discussion, then you are looking at that proverbial slippery slope on disparate impact that you will have no clear standards and no understandable guidelines and every rating factor will be immediately presumptively suspect in that way. If insurers are expecting a challenge on every factor in that way because there are no facially neutral characteristics then in the end you are looking in the end at a qualitatively different industry with different standards and I don't think we've had evidence presented here of a problem in this industry of a system that's not working well and that is biased against protected classes. As a matter of public policy I think that is not preferred.

Dir. Shapo stated that he read Prof. Prince and Prof. Schwarcz's paper as a slightly different take instead of a totally equivalency between proxy discrimination and disparate impact and that instead proxy discrimination is a subset. On slide 4 of Prof. Prince's presentation defining algorithmic proxy discrimination: "Use of a facially-neutral trait in an algorithm that disproportionately harms a protected class; and Usefulness (predictive power) of the facially-neutral trait arises from its correlation with a legally-prohibited characteristic." I think that this is the crux of one of the main premises of the paper and is a poor theme and is a diving line between the two different approaches. To me I start from the premise that if a factor is predictive then the value comes from that predictiveness. It is going down a slippery slope to start questioning whether the predictive value comes from the protected class status. If a factor is predictive then it is predictive and that's the core rule. Insurers don't use factors because they correlate with a protected class – they don't care. Insurance is objective and insurers don't even know the protected class status of their customers. It is important to note the difference to what we have been watching on TV this year. The allegations we've seen in terms of systemic racism usually has to do with something like a policeman or a job interview or a doctor treating the person in front of them differently when they see the person's skin color. Insurers don't do this and cant do it as they don't know the protected class status of their customer and they don't care as their incentive is to price as accurately as possible so that they can have the most financially sound risk pool.

In my paper I quoted something from the credit scoring debate at the NAIC in 2001. The Chair of the NAIC market conduct committee asked proponents of a disparate impact standard for credit scoring – "why would insurers use credit scores if they did not work?" To me that is the crux of my position – insurers are using the factors they use because they work and work means they predict loss. A factor doesn't work if it predicts a protected class it works if it predicts loss. Sometimes a factor might correlate with a protected class but the predictive value of the factor comes from its predictive value not because the insurer is seeking to discriminate against a protected class.

I think there was an allusion in the MO DOI study which responded to a media report of surcharges based on a protected class and the MO DOI did a very careful study on that and found that there was not a protected class surcharge and said "higher rates for urban areas seem to be entirely accounted for by higher payouts." Again, predictive value comes from predictive value not from protected class correlation. I again reference the key question from the NAIC debate – why would insurers use in that case credit scoring and in this case any factor that doesn't work. The MO study and all evidence such as Dr. Powell's indicate that insurers use factors because they work not because they correlate with a protected class. Thus, I support an intent standard for proxy discrimination and getting back to the bottom line here in reviewing the NCOIL staff definition it is a thoughtfully crafted draft and if you choose to produce a model law to codify a proxy discrimination standard this is the appropriate and worthy starting point. Dir. Shapo thanked the Committee for its time and consideration.

Paul Graham, Senior VP, Policy Development at the American Council of Life Insurers (ACLI), thanked the Committee for the opportunity to speak. ACLI represents 280 member companies that account for 94% of the assets in the life insurance industry. I note that a lot of what we have talked about this morning is the perspective from the P&C side of things so my remarks may sound a bit different for a number of reasons that we will get into. Mr. Graham began with some background before discussing proxy discrimination. It is important that as part of this life insurers recognize the past that we've had from a discrimination standpoint and we can go back to the 1800s and show that life insurance companies were blatantly discriminating against black Americans by either reducing the face amounts that were paid out as death benefits or denying commissions for policies sold to black Americans. Even in the 1940s 40% of companies were not selling policies to black Americans. Starting at around 1948 the civil rights movement prompted leading companies to adopt race-merged tables and it took all the way until the 1980s to get to the point that any and all race based policies have been eliminated. With a past like that we did end up settling suits that addressed those discriminatory policies in the early 2000s.

Needless to say that is not a great past when it comes to discrimination but it is important to now talk about today. Mr. Graham stated that in listening to the earlier presentations he was envious that they had a lot more information available to them on the P&C side of things because there is a lot more info collected regarding rates and prices. That is not the case on life insurance so ACLI had to purchase the 2018 Macro Monitor Household Survey and all of the info shared today is a result of ACLI analysis of those survey results. First of all the most important stat to show is that 56.8% of all U.S. households own life insurance, while 55.9% of black American households own life insurance. So, there is not really any evidence of from that standpoint that there is a difference whether you are a black or white American of having access to insurance products. Furthermore, the coverage ratio which is defined as the median in-force face amount divided by median income is nearly identical for black American households – 160% coverage vs. 162% coverage. That is an important statistic because as everybody knows as income goes up so do face amounts and so while there is some stats you can find that might lead you to believe that black Americans are not purchasing as much life insurance as white Americans its really a function of their income and not a function of availability and any kind of discriminatory practices.

One thing that is very noticeable is that black American households are more likely to own whole life insurance (22%) than white American households (19%). Where you find

an interesting gap is actually the group insurance side of things where black American households are less likely to own group insurance (34%) than white American households (40%). That is an interesting fact because there is a later slide that shows that younger black Americans are less likely to own insurance than white Americans when they're young and its likely because they are not having access to group insurance but as I think most of us know group insurance doesn't have any medical underwriting and its not really a discriminatory pricing structure so everybody that's within a group is getting the same insurance rate of coverage. I point this out because it cannot be a function of any kind of discrimination that the younger black American households don't have as much insurance.

Another thing to point out which is very interesting is that black American households have utilized the policy loan features at a much greater amount than white American households - 7% to 2%. The importance of that is that life insurance has given black American households access to low cost loans which they might not have in absence of owning a life insurance policy so the industry takes pride that the policy loan feature has allowed black American households access to cash that they might not otherwise have had. The last thing to point out in terms of where we are today is that black American households trust their life insurance agents in the event of their death. More than 80% agreed or strongly agreed with the statement that "I am confident that should I die my life insurance agent will act in the best interest of my beneficiaries." Only 70% of white Americans agreed or strongly agreed with that statement. That is showing that the interactions that black Americans are having with their insurance companies are in fact good interactions.

The next slide shows the age differences at which black Americans and white Americans own their life insurance. You can see that in early ages white Americans have much more prevalence of ownership but once you get to about age 50, its about equal and then in older ages actually black Americans are maintaining their policies right through their death which may not be the case for as many white Americans. That is important because life insurance is one of the best ways to provide inter-generational wealth transfer and black Americans are definitely taking advantage of that so that they can help the next generations with their own finances. Having said that, I think we can do be better as there are still some gaps and its not just gaps among black Americans. Less than 60% of households of any sort own life insurance and that sort of points to the fact that it is a voluntary market and people don't have to buy life insurance and that distinguishes us somewhat from P&C because there if you own a car you basically have to own car insurance and if you have a house with a mortgage you pretty much have to have home insurance but that is not the case with life insurance as it is something that is a voluntary purchase. We recognize that what we're really trying to do is to expand access to affordable financial security in underserved communities and that is the first principle of ACLI's economic empowerment and racial equity initiative.

The other principles that ACLI is following in that initiative is advancing diversity and inclusion within companies and on corporate boards; achieving economic empowerment through financial education; and expanding investments in underserved communities. So, life insurers are taking seriously the past and the present when it comes to racial inequities and doing what we can to do our part towards solving some of the longstanding problems. Lets talk a little bit about expanding access to affordable financial security in underserved communities. ACLI supports innovation and technologies that are part of the solution by driving expanded consumer access and

consumer affordability in the middle market and underserved communities. At the same time, ACALI supports a regulatory framework that eliminates proxy discrimination in the delivery of life insurance to the consumer. Last but not least, ACLI supports removing unnecessary barriers that may impede the ability of people of color to become licensed by or employed with the insurance industry. As you might know, much of insurance today is still sold across the kitchen table so to speak and having more people of color in the profession of selling will in fact increase access to underserved communities.

The best way that we can think of to drive expanded consumer access in addition to making sure that people of color can become agents is by using accelerated underwriting programs. The life insurance industry believes accelerated underwriting programs using algorithms, artificial intelligence and big data increases accessibility to financial products and can help close the gap between the amount of coverage people need and the amount of the coverage they have today. These programs can help do that by making accurate underwriting decisions faster and simpler and less evasively, which today's consumers demand. To that end we have to make sure that whatever we do regarding defining proxy discrimination and regulating it that we cant be discouraged from employing new tools like artificial intelligence as that would be a bit like the proverbial throwing the baby out with the bath water. It is really important that we keep that in mind and we've seen the direct impact of all of this in 2020 because of COVID we've had less ability for agents to sit across the kitchen table and make sales and while certain life insurance sales have suffered to some degree this year and part of that could be economically rather than the inability to contact people, life insurers have been able to continue their missions of helping peoples financial futures by using a "touchless" underwriting process that includes these underwriting algorithms, AI and big data.

Mr. Graham stated that, again, life insurance is quite a bit different than P&C insurance. Everything that life insurers are doing is a guarantee of long term financial planning and that long term financial protection is only available when we can provide a clear picture of peoples health and other factors that are relevant to mortality and morbidity. We get one chance to make a promise that can last 40 years. That is significantly different than the P&C brethren. Fairness in life insurance pricing also requires that both coverage amounts and premiums be based on sound mortality and morbidity expectations of each individual.

I note that both Prof. Prince and Mr. Birnbaum have suggested that the concept of proxy discrimination is comparable across different types of venues. We've got a proxy discrimination type of law on housing and also for employment law and I would suggest that there is a little bit of difference here because in that type of framework its not a risk of anything you are trying to determine. If there is discrimination in housing its not that you are trying to determine whether somebody is black or white and they are going to do something bad to your apartment – its a lot more driven than dislike of that trait of being black or being a person of color. Its not a function of risk. Discrimination in the life insurance and P&C side of things comes from an assessment of risk. So therefore when you think about the discrimination laws of insurance I would suggest that the discrimination laws are there so that insurance companies are not using race as proxy for risk assessment and that's the importance here. Society didn't say since we've decided that we are not going to discriminate against people of color directly that therefore that means that any risk associated with that particular trait should also be tuned out when doing underwriting. So we have to be very careful.

Mr. Graham stated that the most important thing he wanted to say today is that its very important we understand that underwriting has historically been based on factors correlated to mortality and morbidity rather than causative. We have heard a lot of stuff today about correlation – that is not new. Smoking, diabetes and hypertension don't cause deaths. Lung cancer and kidney failure and strokes do. Smoking, diabetes and hypertension are correlated with those diseases so we have to be careful when talking about correlation. At the same time I can show that diabetes and hypertension are correlated with race but that doesn't mean that insurers shouldn't be able to use that so we have to be careful to focus not on eliminating underwriting variables that are not causative because I think that would eliminate almost all underwriting variables.

ACLI has put together a team of doctors, lawyers, actuaries and data scientists to brainstorm ideas on a regulatory framework that keeps all the advantages of accelerated underwriting programs while identifying and correcting potential misuse of the data. We are serious and want to make sure that happens. So far we have not found evidence that there is currently unfair discrimination or proxy discrimination in the delivery of life insurers' products to the consumer. Life insurers want to keep it that way and want to be transparent with our regulators as new technologies are introduced. One large hurdle in detecting proxy discrimination: Life Insurers do not collect racial information. As a result, it is difficult to get data to study and it makes it difficult to study unintentional discrimination. One thing that that we have determined is that eliminating specific underwriting variables is not likely effective in addressing proxy discrimination in underwriting algorithms. Mr. Graham thanked the Committee for its time and stated that he is happy to answer questions.

Sen. Breslin noted that some legislators had questions for the first panel of speakers that were not addressed due to timing issues so they will be addressed now. Rep. Edmond Jordan (LA) stated that he had a question for Dr. Powell and wanted to start with the premise of what is the purpose of the Committee. If it's just to prove that there is no unfair discrimination based on race then I think we pack it up and go home and complete our work. But if its to really get to the root causes of what's really going on then I think we have to have a different discussion. If it's just to prove that we want to control the narrative and outcome I think we have seen this story before. Rep. Jordan stated that he believes he heard Dir. Shapo state that disparate impact is bad policy. If he didn't say that he can clarify.

Dir. Shapo stated that yes his position is that disparate impact is cognizable in certain statutes that specifically evidence an intent and statutory language that encompasses disparate impact whereas the state unfair discrimination statutes don't have disparate impact language. Rep. Jordan stated he has an issue with that because the message sent to protected classes is that we know that it impacts you adversely but it's not intentional so just live with it. If it's a disparate impact we know that is an adverse impact but if you are telling me that no harm no foul since it is not intentional then I don't know necessarily where we go with that because to say that there is no evidence that the system is not working well I would contend that the system is working juts as it was intended to work and that's the problem. If we are going to look at the history of insurance, it was involved in the slave trade. Insurance gave plantation owners the right to insure African Americans as property so if we are going to ignore that and think that protected classes are going to think that this is an industry that has our best interests at heart, then we are fooling ourselves.

If we are doing this because of some response to the pandemic or response that we saw with Floyd and we're going to ignore the systemic issues that deal with systemic racism then I'm really just not sure what we're doing. It reminds me of when we talk about police misconduct in the first place. We have been complaining about that for years and now all of a sudden that people can see it, it becomes an issue and then it causes all of these companies to reevaluate what they are doing to have diversity to deal with insurance. I heard Dr. Powell state that if you are a good driver in a bad area you are going to pay higher rates. I think that ignores all of the history of African American soldiers who fought in WW2 who didn't have access to the GI bill and redlining and Jim Crow and white flight. There are a host of issues that we are not even touching and all of these issues have some underlying factor as it goes into these rates. If we are not going to set the table correctly to make sure that we are starting with the right narrative and right premise then it reminds me of the narrative that crack addiction is a crime and opioid addiction is a disease. We can justify whatever we want to justify along the way and if that's what we are doing that's fine. I appreciate everything talked about thus far but I haven't really heard any solutions to the problem and again, to admit that there might be disparate impact is to me to admit that protected classes are going to be adversely affected but since we cant prove its intentional then the system works just great.

Sen. Breslin stated that this Committee cannot solve 250 years of wrongs. We are an insurance organization and trying to analyze and review the conduct of the insurance industry in particular and to see if there is racism and if there is to correct it. Sen. Breslin stated that he appreciates Rep. Jordan's comments and would welcome talking with him after the Committee.

Dir. Shapo stated that he appreciates Rep. Jordan's comments and brought up a lot of important issues. To be clear, I'm not saying that there is no place for trying to address these concerns. My argument, which is in my paper that discussed more issues than proxy discrimination, is that the system has mechanisms to try and address social unfairness. First and foremost would be the ability to prohibit or restrict rating factors that are found to be socially unfair and where the social unfairness is deemed by policymakers as outweighing the social fairness of actuarial justification. That is why race is expressly prohibited under the law despite the fact that it in the past was used as a predictive factor. It has been determined that the use of race is more socially unfair than the social fairness of its actuarial justification and the law prohibits it and that's based on the public policy reasons largely stated by Rep. Jordan. The system is always there for a policymaker to put a bill in if they think that in individual rating factor is excessively unfairly discriminatory in the way it falls on a protected class. There has been discussion in some submissions here and elsewhere about things like criminal history scores and other things that could lead to bad outcomes in that way. A disparate impact standard is not the only way to address social unfairness.

Rep. Jordan stated that he understands that and noted that he is not asking to solve 250 or 400 years of history but what he is saying is that if you are looking at credit scores and crime data and you are not looking at where the wealth gap initiated in the first place then you are ignoring the elephant in the room.

Mr. Birnbaum stated that he would like to reinforce Rep. Jordan's comments. The issue that we're looking at is what is the impact of systemic racism in society on insurance. The black lives matter movement and protest in wake of the Floyd murder was a

recognition that systemic racism purveys all aspects of our society. The effort here should be to look at how does systemic racism invade insurance and what can be done to address systemic racism within the risk based framework. Rep. Jordan is eloquent in talking about how systemic racism impacts a variety of factors that in turn impact insurance availability and affordability for different communities of color. The industry's position now is that yes we'll address this as long as its limited to intentional proxy discrimination. That is just ridiculous and simply says we are not going to do anything about this problem because if you've already banned intentional discrimination and then say we will ban intentional proxy discrimination its one in the same thing. As Dir. Shapo stated, he already believes that regulators have the ability to stop intentional proxy discrimination. To reiterate, if you are serious about really examining systemic racism in insurance then you really have to look at what Asm. Cahill mentioned regarding passive unintentional discrimination that's a result of the legacy of discrimination over the years.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
SPECIAL COMMITTEE ON RACE IN INSURANCE UNDERWRITING
TAMPA, FLORIDA
DECEMBER 9, 2020
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Special Committee on Race in Insurance Underwriting met at the Tampa Marriott Water Street Hotel on Wednesday, December 9, 2020 at 9:30 A.M. (EST). This set of minutes documents the second of two meetings held that day which convened at 2:00 P.M. (EST). The first meeting is documented in a separate set of minutes.

Senator Neil Breslin of New York, Chair of the Committee, presided*.

Other members of the Committee present were (* indicates virtual attendance via Zoom):

Sen. Jason Rapert (AR)
Asm. Ken Cooley (CA)*
Rep. Matt Lehman (IN)
Rep. Edmond Jordan (LA)*
Rep. George Keiser (ND)*
Asw. Maggie Carlton (NV)*
Asm. Kevin Cahill (NY)*
Asw. Pam Hunter (NY)*
Sen. Bob Hackett (OH)*

Other legislators present were:

Sen. Mike Gaskill (IN)
Rep. Peggy Mayfield (IN)*
Rep. Jim Gooch (KY)*
Sen. Shawn Vedaa (ND)
Rep. Wendi Thomas (PA)*
Rep. Joe Schmick (WA)*

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Tess Badenhausen, Assistant Director of Administration, NCOIL Support Services, LLC

RATING FACTOR DISCUSSION

Eric Poe, COO of Cure Auto Insurance (Cure), thanked the Committee for the opportunity to speak and first provided some background on himself because it is relevant for his testimony today. Cure is a regional non profit reciprocal exchange that writes private passenger automobile insurance in NJ and PA. Cure insures about 35,000 vehicles and was founded 30 years ago by his mother who was a Clifford D Spangler awarded actuary and his stepfather who was an insurance commissioner in NJ for two terms for 8 years. The unique background about Cure is that it swims in a very large pool of mammoth multibillion dollar publicly traded companies that are here to make profits while Cure is just managing a non profit reciprocal. Cure does not employ the use of education, occupation or credit scores and is the only carrier in NJ that does not employ the use of credit scores since they were regulatorily allowed in 2003. Mr. Poe stated that he put together his presentation about 16 years ago when the re-entrance of Geico for the first time in 28 years it became known to him that they used education and occupation as primary or sole factors in determining eligibility for

insurance carriers and he spent 16 years crusading around the country testifying in FL, NH, and NJ and PA in order to try and ban this practice and raise more awareness about it.

Mr. Poe stated that he believes these practices are about income discrimination that does have a disparate impact on race and he would like to get to that in this presentation. The first slide talks about what I think everybody understands. There are a lot of factors that we use to determine rates in underwriting. I like to say its just underwriting. As a legislature I think we have made a determination that there is a line we are going to draw on what we are going to allow for those factors and that line was drawn in 1964 with the passage of the Civil Rights Act. Most people might not know this but in the year 2000, the NAIC put together a Working Group of a number of insurance commissioners to study how many life insurance companies were still using race as the basis for their rates. Surprising to most is that they actually found there were a number of life insurance companies that used a proxy for race after the passage of the Civil Rights Act in 1964. So, the insurance industry does have a checkered past regarding this and what they found was previous to the actual passage of the Civil Rights Act, life insurance companies had preferred companies in which they gave only white applicants eligibility into and based on you race if you were black you were ineligible for the companies and given much higher rates and worse benefits.

After the passage of the Civil Rights Act what they found was there was only one change made in the underwriting process and that one change was that they eliminated the question of what is your race and substituted the proxy of what is your highest level of education attained and what is your current occupation. In one real life case study, there was a federal class action case against Monumental Life Insurance Company that is public information about their use of proxies. In that scenario the previous company that they used for blacks they substituted the occupations of busboys, dishwashers, garbage collectors, handymen, janitors and unskilled laborers for what they previously used for the company reserved only for blacks. As you can see for the whites there were occupations like office workers and salesman that required four year college degrees.

Mr. Poe stated that for the first half of this session there has been a debate about what to do in these situations. The bottom line that we need to concede as an industry and the consumer advocates need to concede as well is that higher income drivers produce higher profits to our industry. That is just a given and instead of debating whether or not these are actuarially sound practices I would like to concede it. If we concede that now you see the motive behind anything that is a proxy for income and when you have a proxy for income it is going to have a disparate impact on certain classes. So, instead of us going out as an industry and asking the blunt question of how much money do you make and legislators obviously being shocked at that use of factor as the basis of rates we simply adopt proxies for that. At a certain point when does willful blindness equate to intent and the reality is that there are probably not two betters factors in this country for a proxy for income than a person's education or their occupation.

In a real life example in NJ, it was found that the use of education and occupation alone were used as factors when Geico re-entered NJ. Most people don't know this because most of the companies Cure competes with adopt the same trademark name for various different companies for example most people don't know there is Geico Insurance, Geico Indemnity and Geico Casualty. Each of them has separate base rates and in their world get to actually adopt a separate P&L statement and different rates that they get to

file with the DOI based on those entities as separate companies. What is unbeknownst to most people is that when you apply for insurance on their website they will not and have no regulatory requirement to tell a consumer that they are rejected from the preferred Geico company based on their education and occupation alone. A lot of times people ask why hasn't this been more publicly known and why hasn't there been more uproar from the consumer advocates and its because there is no requirement to notify somebody. Unlike the Fair Credit Reporting Act (FCRA) where there is a requirement to explain to somebody that there has been an adverse decision based on their credit score there is no such legislation on the books in the U.S. that requires insurance carriers to disclose when they are going to reject you on that basis.

So, what happens when a consumer goes there and they don't have a high level of education or a high paying job? They might be rejected and when they are rejected they may have a higher rate than somebody else and they leave the website and go to another company or go uninsured. Mr. Poe then reviewed what was found in NJ with regard to the adoption of Geico's criteria for where they use the criteria for the highest base rate standard company – those people are minimally skilled clerks, assistants, postal clerks and stock clerks. That is directly from the actual filing that was found in NJ in 2004 when they reentered the state which is what spurred a lot of legislation that still hasn't been passed. But, to fast forward, what is the motive? As any industry, the motive is to make profits but it goes beyond more than just profits because what happens that most people don't know is that the terms and conditions of most of Cure's industry competitors require that anybody who simply applies for insurance on their website allows that persons information to be shared with every marketing partner of that company regardless of whether or not they buy a policy.

So, earlier there was a discussion with Mr. Birnbaum about what makes this any different from Amazon or any other industry that is trying to make profit and data mine. First, car insurance is mandated in 48 out of 50 states. You are not mandated to buy widgets on Amazon. Second, they capture your information on Amazon or Best Buy when you choose to buy a product for them. What people don't realize is that by simply trying to save money by going to Geico.com you are giving them the information even if you don't buy a policy to take your credit score, credit report, occupation, lease – everything in your credit report and share it with their marketing partner. You can imagine what that would be worth in terms of finding new leads if you're one of these insurance companies that has a data set that they can exchange to reduce their cost to market to future higher income drivers. So that data set is worth a lot of money and it is different from people who voluntarily buy a product.

So, how do we get this past the legislature? Mr. Poe stated that he has been testifying for 16 years on this and the reason why is that his industry has done a really good job in confusing and re-defining what the term risk really means in all of these regulations. I've heard people sit here and talk earlier about the fact that there are regulations or laws in every state that say you cant use a factor that's not unfairly discriminatory or inadequate or any of these criteria that we have in our state laws. That's true unless its actuarially sound. Well, what does that term actuarially sound mean. If you google that term it has many different definitions but what it essentially means is that you are charging premiums to cover your claims costs and expenses. So, how has the industry been able to pass this with all the regulators in the states over the years? Because now in those laws that say you must show that these factors are correlated to risk, all they do is show a correlation to loss ratios. Loss ratios by definition in the industry is simply a

measurement of profitability. If you have a combined loss ratio of 90% you are making a 10% profit. So, if I take a factor that correlates to loss ratios and that's the only thing I need to show to a legislator or regulator to use it, we cant deny this – the reality is that higher income drivers produce better profitability for the industry so any proxy for income will produce the same results. That is why we are here today because as a legislature as that body of law we are here to determine what is the public policy on this and is this country ok with the fact that we are simply going to discriminate against those that are the poorest yet at the same time mandate insurance in 48 out of 50 states.

The commonsense assumption made in this country all the time is a simple application that if you have more accidents you should be paying higher rates. The largest study on this recently was from Consumer Reports that shows people with DWI's and accidents actually pay less for car insurance in this country than those people who have sub 650 credit scores and that flies in light of all of what we are saying in terms of common sense and that is because higher income drivers result in significantly higher profits for the industry. To prove this, the largest study ever done was by Quality Planning Corporation which I think was in 2004. They studied 1 million car insurance policies and tried to figure out what were the most highest propensity of accidents based on occupations. Surprising to most, after students, doctors, attorneys and architects had the highest likelihood of getting in a car accident than any other occupation which flies in light of other studies done by Consumer Reports, investigative TV and a number of other reports.

So, what is the real life impact? The real life impact is that people in this country who do not have four year college degrees that might have a blue collar occupation like a janitor are going to pay on average depending on what study you look at almost twice as much, in some cases 40% but in other cases 100% in this country depending on what state you live in. For the exact same driver with the exact same driving record with the exact same car, that person who is uneducated and has a lower paying blue collar job could be paying more than twice as much compared to what the other white collar wealthier driver would pay.

The best way to look at this in a microcosm as this is a national coalition of legislators is to see what happened in NJ in a vacuum. In NJ in 2004 there was not a single insurance company allowed to write car insurance based on credit scores, education or occupation – not one carrier in the entire market. From the data that we have right now, from 2007 – 2015 in NJ we have increased our uninsured motorist population by 86% in 8 years. Those uninsured drivers are not people who choose to noy pay their bills – this is an unaffordable product in the marketplace. While people in the industry debate this and there is a bill pending in the NJ Senate to ban the use of credit scores and occupation and education in auto insurance underwriting this is irrefutable evidence of the impact that this has on your own state. Insurance is a necessity in 48 out of 50 states and in those states you will see fines if you don't buy car insurance on the car that you own. More importantly, what most people may or may not know, most states have a bar from you bringing a lawsuit for pain and suffering if you are an innocent victim of a car accident if you have a registered vehicle that does not maintain liability insurance within that state. So, in states like NJ or MI if you are driving without insurance or you have a car that is registered and you don't have liability insurance on it and you are rear ended by the wealthiest person in the world and that person has $1 billion in assets you are not allowed to initiate a lawsuit for pain and suffering as a result of not being able to afford car insurance.

The industry loves testifying against me saying we cant get rid of these factors as they are predictive of loss. They are predictive of probability but what are we talking about here? We are talking about public policy. If you eliminate the practice of the use of these income proxies – obvious income proxies – you are not going to see more people run into trees and rear end people. We are talking about a rating factor here and an underwriting practice. We are not talking about eliminating airbags or blinkers or seatbelts. You are not going to see bigger losses as an aggregate in any state you are in you are just going to simply change the way people are charged for car insurance. Really this is a public policy issue and I think its about time with our social justice movement in this country that we need to pay attention to it. There are two bills one in NJ and one in the federal side sponsored by Senator Cory Booker, and Congresswomen Rashida Tlaib, Bonnie Watson Coleman have introduced and we are hoping that this will finally be the time that public policymakers will finally do what's right.

Roosevelt Mosley, FCAS, MAAA, CSPA, Principal and Consulting Actuary – Pinnacle Actuarial Resources, Inc., thanked the Committee for the opportunity to speak. As a way of background he is a principal and consulting actuary with Pinnacle Actuarial Resources. I have about 27 years of experience in the P&C actuarial space. The first 6 years of that working for insurance companies and the last 21 years spent in consulting. My consulting career has been primarily based in personal lines insurance and has included traditional actuarial work like rating plan development, product management and product development as well as advanced analytics. Our clients include insurance companies, regulators, insurance trade associations and even third party data providers to the insurance industry. The comments I provide today however represent my personal comments not necessarily those of any insurance company or industry group. I appreciate the opportunity to provide an actuarial perspective to this conversation. There has been a lot of discussion today regarding some of the actuarial principles and standards and some of the ways factors are used and justified in the insurance industry so hopefully I can provide some perspective on the actuarial angle on some of these issues.

I am a fellow of the Casualty Actuarial Society (CAS) and a member of the American Academy of Actuaries (AAA) and a certified specialist in predictive analytics so as part of my role I work not only with insurance companies but also with insurance regulators. An example of this is coordinating as part of my work with AAA two day long sessions with the NAIC relating to their summer meeting on predictive analytics and the use of big data. As an actuary I have significant experience in the development and analysis of insurance company rating plans and as requested the focus of my comments today are focused on the use of rating factors in the insurance industry and specifically for personal lines P&C insurance. I will also pick up a little bit on some convos that happened today on the use of telematics and usage based insurance (UBI) for private passenger auto insurance to maybe provide an additional perspective on that. Finally, I'll end with some social considerations that are being discussed by this Committee.

First, to frame and provide some context around this issue I want to provide some background relating to some of the actuarial considerations relating to the use of rating factors. More of this will be provided with some of the AAA representatives so I wont get into all of the details and the points they will make but I believe my remarks will provide some context. Simply put, the use of rating factors in the insurance industry really is to help better determine and allocate the relative cost of insurance for particular policies

with different characteristics ensuring that those premiums are adequately matched with the expected losses. In total, insurance company premiums are set to cover expected losses and this gets into the insurance company solvency that was referenced earlier today but in addition to that the premiums also vary based on the characteristics of the policy to reflect differences in expected potential loss and thus the use of rating factors in the insurance industry is to really help satisfy that particular objective.

In terms of the reasons why companies use them I wont get into great detail as some was already covered this morning but I would point the Committee to a document that was produced by the AAA back in 1988 called the Risk Classifications Statement of Principles and this document was actually produced prior to the establishment of the actuarial standards and the promulgation of actuarial standards of practice. However I think the document does detail a couple of considerations relating to the use of rating factors and risk classifications which I think are important to at least create the backdrop of this discussion. The first reason is really for the overall financial soundness of the company and to a certain extent the insurance industry as a whole. To the extent that premiums are able to be matched with loss and are done so in a way that policyholders are charged premiums that commemorate with their expected loss there is essentially an intrinsic equity that's present in the insurance process and that process will help to avoid issues like anti selectin and protect the financial soundness of both the insurance companies and the insurance industry.

The second reason highlighted by the document is enhanced fairness. When rating factors are associated with the expected loss of insureds, no insured feels like they are either getting a really good or bad deal in terms of the costs they are paying for insurance. When the cost for insurance at least for the perception of the insured is higher than the expected value of that insurance then there are economic considerations that come into play that could begin to impact the financial security of the industry. Third is essentially the economic incentive. For most insurance companies and a lot of companies I worked with there are a couple of objectives that many insurance companies have. One is growth and the second is to be able to do so profitably. To the extent that a better classification plan that is on par with some of the competitors they are facing allows them to do this in a way that doesn't require them to necessarily undercut price and then to be able to grow in a financially responsible way.

To sum up at least the background of why companies use these factors it practically comes down to a reality in todays insurance environment. The complexity of rating especially on the personal lines side has been discussed a bit today but there is one primary theme that underlies that insurance companies are trying to accomplish as it relates to the use of rating factors. Either the company is trying to maintain a proper competitive footing and a proper competitive placement in the industry or attempting to be better at identifying risk and charging for that risk and ultimately driving both growth and profit.

Historically speaking this process was relatively straightforward and transparent. When I began my career in 1993 the key factors used by insurance companies was a relative short list certainly relative to today and they were for the most part fairly standard. In the 1990s some companies began to add additional elements to what they were doing but in essence if I had the characteristics of a policy for an insured that was insured by the company I was working for it was fairly easy to go get a rate filing or get a rate manual from another company and determine what that risk would be charged for that other

company. Obviously a lot of that has changed since then and as companies have begun to add more factors there are a couple of things that have happened. One is that it has become more challenging to understand and how to calculate the rate for risk for a competitor. Also, in order for companies to try and maintain some of the competitive advantage that they are trying to go after, some companies have tried to make it harder for companies to figure out exactly what they are doing – not necessarily hiding it from regulators but more so hiding it from companies and maybe filing some pieces under confidential.

So what began to happen as the world became more complex is that insurance companies that weren't maybe as quickly to recognize some of the additional risk classification that was being incorporated, they began to see the results of that both the ability to write the business and the ability to make a profit and it was essentially a lot of these cosmic forces that drove a lot of these companies to follow suit. I provide that background to help set the stage. Having been a part of this process for the past 27 years you can see the progression of a lot of the complexity that's happened in the industry and a lot of that complication has not necessarily come about because insurers are trying to intentionally be discriminatory but really to either establish, reestablish or improve their competitive standing and thus achieve some of the goals that were just mentioned by the previous speakers.

With that as a backdrop lets move to the idea of how companies support or justify the use of a particular rating factor in most states. There are some exceptions but in most states insurance companies have to file their rating plans with state insurance regulators and they must justify the use of those factors with the regulators. The primary way this happens is with the use of insurance company loss experience. The previous speaker referred to loss ratio. There are also a lot of more complex models discussed earlier today that don't incorporate necessarily at the beginning in terms of the analysis the premiums the companies are charging but are more focused on the likelihood of filing claims and the severity of those claims – more traditionally referred to as a frequency and severity analysis. Those analysis really focus on the risk of loss related to certain risk factors and ultimately then the risk of loss is determined for its companies to the premiums that are currently being charged and premium adjustments are then proposed.

Historically the analysis of these factors did occur in more of a univariate fashion – looking at one factor at a time and using some determinations but over time that has swung to more multivariate analysis – analysis that essentially accommodates or incorporates the fact that the distribution of a particular rating factor characteristic is not independent but actually do correlate. There are also cases where maybe insurance companies don't have sufficient internal experience to support the rating factors that they use either because they haven't necessarily been collecting those factors over time or they just may not have enough data internally to maybe support some of the things that they would like to do. The way that has been handled with regulators is either looking at what competitors are doing with those filings or potentially working with data providers and others to generate aggregate experience.

Ultimately the support of these factors really comes down to this idea that making sure that a factor is actuarially sound. The statement of principles on P&C insurance ratemaking which is a document that was developed by the CAS actually defines what actuarially sound means and essentially sums it up in three principles. That the rate is the estimate of future expected costs, the rate provides for all costs associated with that

transfer of risk, and the rate provides for costs associated with the individual risk transfer. So, if a rate meets those three criteria it is then determined as actuarially sound.

An additional question I was asked was based on a lot of this discussion on rating factors was why do some companies choose not to use particular rating factors. The first reason which has bene highlighted today is that the loss experience doesn't justify the use. There are some companies that have evaluated some of the risk factors that may be used by other carriers and determined that it doesn't impact their book of business the way maybe it has for others and have decided not to use it so there have been cases and examples where we can point to that. The second reason is operational. There may be some things that operationally an insurance company cant do from a systems perspective or another perspective so they choose not to use a risk characteristic. The third reason which will pivot into a couple of additional items is really an internal company decision. A company may decide as the gentleman from Cure indicated that for internal reasons that they don't want to use particular factors. We all may have seen one example of this recently when Root insurance announced that within the next 5 years they will be discontinuing the use of credit based insurance scores. The reason as advertised by Root is not because credit based insurance scores haven't been shown to be related at least to expected loss but because they believe that it's the right thing to do to help to begin to eliminate bias in rating. As part of that action they have also called on other companies to do the same.

Speaking specifically of Root I want to talk briefly about some of the considerations related to UBI. While Root is discontinuing the use of credit based insurance scores its not doing so to be left in a vacuum and without a viable alternative. Root is one of a number of companies that we would classify as telematics only. In order to have insurance with Root you have to agree to have them monitor your driving behavior so every policyholder that purchases insurance from Root will be base rated at least in part on their driving behavior as measured by a mobile app. Specifically, Root monitors mileage, distracted driving, braking, turning and time of day driven. In addition to other companies like Root and Metromile which are telematics only many of the major insurance companies also offer telematics options so customers can choose to sign up for these options and as a result rates are determined at least partially on the monitored driving behavior.

The use of telematics is really more of a direct measure of exposure to loss and really more direct than any of the rating factors we have used in the insurance industry. Historically, and this was a concept that was brought up earlier, many of the raring factors that are used today aren't really direct measures of loss exposure they are really what we call proxy measures and allow us to observe something that is potentially relate to the risk of loss. An example of this is prior claim activity. It is well documented and established that if a policy has a prior claim then the likelihood of that policy having a future claim is higher but having a prior claim doesn't necessarily mean or cause you to have a future claim so that is what we mean by proxy variables. Conversely, telematics isn't a proxy variable its really a direct measure of driving behavior and as a result one of the more powerful variables available for pricing today. Given this, its still true as well that telematics really hasn't necessarily become as widely used as its power may indicate. There are a couple of reasons for this. First, the percentage of policies at least right now being rated using telematics is still fairly low on an industry basis. The companies that are telematics only are still pretty small and currently only make up a

small percentage of the marketplace and even for those companies with options at least historically the take up rate for their policyholders hasn't been substantial.

The COVID pandemic has actually increased that pace and is one of the things that has actually helped with the take up rate but its still going to take some time for that volume to grow. There are two other reasons that I think are even more important. UBI is really still in its infancy as it relates to the portion of the rate that is based on telematics. Even for telematics only carriers, many of them still use traditional risk characteristics and still base a significant percentage of the rate on traditional risk characteristics. As an example, based on Root's website, less than 25% of their rate is impacted on driving behavior so the majority of a rate even for a company like Root is still based on primarily the historical rating approaches. Part of this is due to the fact that it takes time to build up experience to build up the analysis and especially as you are talking about how much can telematics data replace some of the traditional risk characteristics its going to take even longer for companies to continue to build that up. While UBI certainly does provide more of a direct measure there are still some potential challenges as it relates to the bias issues and we can come back to that with questions.

I'll end with a couple of comments related to the race in insurance issues. There have been some efforts in states that have either restricted the use of or actually prohibited the use of certain characteristics. A few states don't allow credit based insurance scores and a few states don't allow gender or marital status so some states have at least in a bit of a one off fashion implemented something to deal with some concerns related to the bias in rating. But as I alluded to earlier and has been stated here today the history of the development of some of the more sophisticated rating has really been a function of better matching premium to loss and really hasn't been an issue related to intentionally attempting to try and proxy or discriminate against particular classes. Having said that, we are now faced as an industry and speaking as part of the actuarial profession there is a potential for unintentional bias that has made its way into our rates. Despite it being unintentional, the potential still exists and so as initiated by NCOIL and NAIC identifying this potential and developing solutions for potentially addressing it is a necessary and significant undertaking. But as has become clear by these discussions and discussions at the NAIC and others this is not going to be easy to solve. Defining the issue, determining at what level that particular either rating factor or approaches are unacceptable and then determining the solution to deal with those unacceptable outcomes are going to take time and are going to take collaboration among everyone.

Thera are a number of potential solutions but each of them has advantages and disadvantages so the proposed solutions need to be carefully considered to make sure they will produce desired results, minimize unintended consequences, and ultimately as issues are discussed I encourage the Committee to partner with industry and the actuarial community to research the issues and determine the extent of the problem and identify proposed solutions. I look forward to the work of this Committee and the opportunity to collaborate and remain available to answer any questions I can.

Tony Cotto, Director of Auto and Underwriting Policy at the National Association of Mutual Insurance Companies (NAMIC), thanked the Committee for the opportunity to speak and stated that on behalf of NAMIC and its more than 1400 local regional and national member companies he appreciates the opportunity to join from Louisville, KY where we are fast approaching 200 consecutive days of protest following the death of Breonna Taylor and just this week our Mayor signed a sweeping Executive Order to join

the fast growing ranks of state and local officials declaring racism a public health crisis. As communities and industries each tackle allegations of racism in their own way we commend NCOIL for engaging on this important topic at hand for the U.S. insurance sector.

Today's session and discussions are critical to the continued evolution and examination of the heart and soul of the insurance business – underwriting, rate making and fair treatment of all policyholders. We look forward to working with you in advancing a constructive dialogue around the entirety of this committee's efforts and applaud your commitment to actuarially sound, data driven policymaking and the fundamental principle of risk based pricing. I also appreciate Asm. Cahill's comments this morning that we have to start these conversations with math. I've seen these ongoing underwriting and rating discussions from many vantage points over the lest decade and a half where I've interacted with many of you as congressional and then NAIC staff then private practice representing carriers then a regulator in KY and now in NAMIC – from any of those views, math is the best place to start. While your counterparts at the NAIC are in the business of regulation and enforcement it must be elected and accountable lawmakers who establish public policy enshrined in the state insurance codes that govern the U.S. system. The laws that members of this body pass in your home states are what ultimately bind insurers and regulators. Although my remarks today are going to focus on rating factors and the use of insurance scores, I'll take a quick opportunity to make some brief broader observations.

First, mutual insurance companies are built on notions of community and inclusivity. The mutual model has a long and proud history of service to minority communities. Second, NAMIC and our members understand that like our legislative bodies and the communities we serve we are stronger when we include diverse backgrounds, skills, knowledge and perspectives of our policyholders, our vendors and our employees. Third and most importantly, NAMIC and its members are adamantly opposed to discrimination on the basis of race and unfair discrimination in general and we support legislative policies to prevent these practices. The elimination of racism improves every aspect of our lives, our relationships, our institutions, and our business communities. With that I will move into my presentation.

Today, I have been asked to provide a brief overview of credit based insurance scoring. For ease of reference to minimize confusion I'm just going to refer to them as insurance scores. As you've already heard from panelists all morning and this afternoon much of the discussion around race in insurance underwriting is rooted in the alleged fairness and validity of rating factors that insurers use and because of this our conversation has to start with why these rating factors even matter. As simple as I can put it – good rating factors are factors that promote accuracy. Rating factors that promote accuracy fuel competition and fuel healthy markets. In turn, those healthy markets increase availability, improve consumer choices and reduce costs. Accuracy promotes competition and healthy markets reduce costs. That's as simple as we can make it. Carriers also have to consider things like credibility, objectivity and other things in concert with actuarial standards and principles. But the bottom line here as policymakers that you have to keep in mind is that when you decide to limit accurate rating factors you are making a tradeoff and that tradeoff is most likely gong to harm small insurers and consumers more than anybody else. The remainder of my remarks are going to be about one of those accurate rating factors – insurance scores.

Many of you have lived through the initial development and the use of these scores since the early 1990s and the development of NCOILs most successful Model on this topic. All the same I thought it would be important to provide a couple of operational notes about insurance scores. First, generally speaking insurance companies purchase these three digit scores from credit reporting agencies. They are end users of an insurance score – they don't develop them by and large. Second, insurance scores are not static – they are snapshots and a picture in time. They change over time as new information is added. Most importantly of all, insurance scores are not credit scores – they are not the same thing. Some of the underlying data is the same but they are not the same thing and not weighted the same way and not used the same way.

To that end I put together a comparison chart putting them right next to each other. These are not the only differences in the scores but they are the ones that seem to come up the most often and cause a lot of confusion. Please focus on the purpose portion because it makes sense and matters what you want to use this score for that you've purchased. Lenders use credit scores because they want to know if they are going to get paid back when they lend money – that's what a credit score is for. An insurance score is not that. Insurers aren't interested in whether or not an insured is going to pay back a loan. They are interested in whether an individual is less or more likely than another individual to experience a loss. Accordingly they are used differently. They are used for rating policyholders and applicants and saying you are more likely than not to have a loss – that is what an insurance score is all about. There are some other points on here regarding whether its determinative and you can use them in isolation and the answer is no – an insurance score is not determinative of whether or not you get a policy an insurance score is not used in isolation its used on combination with the other factors that Prof. Prince and Ms. Mosley have already started talking about a little bit today.

The notion that insurance scores are somehow inherently evil or used in the same way that credit scores were used to prevent people from getting loans is incorrect. Lets talk about what goes into the insurance score and more important lets talk about what doesn't go into the insurance score. This chart here lays out some of the items that go into the score. We've talked a lot today about objective data – these are objective data talking about here when talking about what goes into a score and what does not. They are objectively confirmable data and look at the right column and find that it is chalked full of data that is not used – race, color, national origin – none of those have anything to do with your insurance score. Why? Because your race, color and national origin have nothing to do with how you manage the items that go into your insurance score. Any suggestion to the contrary is deeply offensive. What you look like and where you come from have nothing to do with your insurance score. What you look like and where you come from have nothing to do with whether you pay your bills on time. What you look like and where you come from have nothing to do with how much you use the credit that you have and how responsible you are in your pursuit of new credit. I am happy to tell you that I am a married Hispanic male in KY with a law degree and a 15 year old truck and I work for NAMIC – not one of those things would factor into my insurance score. My insurance score cant tell you any of that because it doesn't matter. What matters is how I behave when people extend me credit.

Next, I'd like to address some of the myths and falsehoods that surround many of the discussions and characterizations of insurance scores. Given this committee's focus lets talk about a claim we've already heard multiple times today that insurance scores are a proxy for race. This particular spurious accusation is in and of itself racist. The

use of these scores is the opposite of racial discrimination because if anything it removes subjectivity and removes an opportunity for racial discrimination by removing subjectivity and removing personal judgment. An insurance score doesn't tell me anything about somebody's race. Insurance scores tell me about behavior.

I haven't heard it yet today but you often hear the notion that consumers don't have any control over their insurance score. Consumers are not some hapless bystanders when it comes to ways that they can improve their insurance score. There are things that we talk about a lot about how can I make it better and what can I do better to lower my rates - pay my bills on time and balance credit mix as not all credit is created equal. A credit card is very different from a mortgage but if you pay down your debts and you don't seek new credit at once in multiple forums or you don't necessarily need or have the capacity to manage there are ways in which consumers can control their insurance scores. I wont march through all of these as you've heard them many times and I'm happy to discuss alter but I do want to hone in on a myth that is a testament to the good work that NCOIL has done and continues to do in this space which is an appreciation and understanding that sometimes life throws you nasty breaking balls and policyholders and insurers need a way to address that. There is the extraordinary life circumstances provisions that are included in the NCOIL Model and that continues to be NCOIL's most successful Model and I think something we've seen throughout COVID responses is that these are extraordinary times and these are what these provisions are for to deal with these extraordinary times and let insurers and policyholders have the flexibility they need to deal with their insurance score issues.

At the beginning of the day Rep. Matt Lehman (IN), NCOIL President, talked about the importance of being data driven and insurance scores have been studied time and time again by independent entities, statisticians, governments, the FTC and the consistent findings across the studies remain that insurance scores are predictive, benefit most consumers, have nothing to do with income level and cannot be used to identify demographic groups which is to say they are not proxies for race. Continued study is a good thing. As the research continues, NAMIC and all of our member companies will continue to review the studies and materials on this and candidly on all rating factors as studies continue to come out as we look at and constantly reassess the value and predictive use of each of these factors. As I wrap up its important to realize that insurance scores work and that benefits consumers. The studies have shown that they benefit the vast majority of consumers and not only a benefit – they are either neutral or beneficial to the vast majority of consumers.

Even some regulators who initially were the most skeptical of insurance scores now accept their validity. That was made clear oddly enough on ' NAIC C committee call when a regulator spoke about having a historical opposition to credit and the use of insurance scores until they saw how they actually work and the fact that they have predictive value. Regulators have come a long way on this and NCOIL has led the way. NAMIC and its members understand that underwriting is a system predicated on and sustained by fair and equal treatment. That means the use of objective standards of risk assessment that apply to every applicant and policyholder. Insurance scores are objective and prohibiting their use will result in higher rates for policyholders of all races. Thirteen years ago Chief Justice John Roberts wrote the way to stop discriminating on the basis of race is to stop discriminating on the basis of race. More recently, the great African American economist Walter Williams who just passed away this week quoted Louisville's own Muhammad Ali in his syndicated column when he said hating people

because of their color is wrong and it doesn't matter which color does the hating it's just plain wrong. We agree and from NAMIC's perspective we are committed to working with you to advance in this area. I am Happy to stick around for questions after the panel.

Marty Young, co-founder of Buckle, thanked the Committee for the opportunity to speak and began with an introduction about himself. He is the co-founder and CEO of Buckle one of the so called insurtechs/fintechs that is part of the movement of digitalized insurance. I come from a background of over 20 years in turnaround restructuring in special situations. I'm known as a chief restructuring officer, COO in companies going through a acute periods of change. I've been involved in and led over $30 billion dollars of transaction value. I'm a West Point graduate, a former U.S. army infantry officer and a Chaplin in the national guard. I am proud to have served in the national guards of MA, NY and currently DE. I am a certified turnaround professional, certified insolvency and restructuring advisor, and have a gov't security clearance. Through my educational background, I have an MBA from the NYU Stern School of Business and a master's degree in operations research from Georgia Tech where I serve on the advisory board of the school of industrial system and engineers of Georgia Tech.

I'll first introduce you to Buckle and then focus more on some of the key issues that the Committee is investigating today and our vantage point that we bring to the conversation. Buckle was founded to provide comprehensive financial services to both gig workers as well as the platforms they work for. So think in terms of Uber drivers, Lyft drivers, Instacart drivers, Amazon drivers – emerging gig economy systems that are evolving. What we saw was that the financial infrastructure needed to provide the insurance and credit for this emerging economy simply didn't exist. What we did was start the process of building the only financial services company solely focused on this new customer segment and system and we built and acquired significant financial infrastructure and we own a 47 state licensed carrier domiciled in IL called the gateway insurance company and we are also in the process of acquiring a couple of additional carriers. We have also built a claims administrator licensed and domiciled in GA, a cell captive carrier in VT and we have numerous strategic partnerships in the reinsurance industry as well as in various types of digital and non digital MGAs. We've assembled a world class mgmt. team including four former senior USAA executives and our goal is to become the USAA of the gig economy and a model very centered in and around serving a group of members that we see is the emerging middle class of the U.S.

So, what is the problem that we are fundamentally solving. That problem is that 40% of American households are subprime and have a 650 or lower credit score and that group of Americans as well as immigrants and other aliens here are all in this sort of group of folks that because of their credit score are heavily penalized in both the credit and insurance industries. The U.S., for the most part, in order to have upward economic mobility, car ownership tends to be one of the key factors in getting that. However, for a subprime household car ownership is also less of a tool of upward mobility and more of a transportation trap. It can often lead to the cycle of economic hardship and cycle of poverty through self reinforcing mechanisms predominantly through credit score. You've already heard several distinguished speakers earlier talk about the issues of credit scores in the insurance industry and from everything we have seen we agree that if you are subprime you are non standard and you can easily pay $50-100 more for your car insurance regardless of where you are in the U.S. Adding insult to injury, many of these folks are also paying 1000% in interest and fees in their auto loan and leases. The

insight we had was that we can help people escape this transportation trap by enabling and supporting gig work at fair prices and effectively move up the socioeconomic ladder.

The way we thought about this was that a person who is subprime in the U.S. – the reason they are such is because predominantly of their income. Nothing drives a credit score more than income. If you have a $15 per hour job in the U.S. you are overwhelmingly subprime. The correlation to hourly wages to credit score is linear across all ages. What we learned was that the folks that are in most need of basically getting a car and moving up the socioeconomic ladder are folks that are making wages in the $10-15 per hour range. If they can somehow move their vehicle which tends to be a very large burden on their lifestyle from a cost to a cost of good sold we can transform the middle class. According to AAA, the cost of owning a car each year is about $9,000 but if you only make $15 per hour you only make $30,000 per year so that means you cant afford $9,000 per year for your car so you end up moving down to the B lots and the non-franchised dealers and the buy here pay here lots and non standard subprime insurance companies and what you see is that because they cant really afford those that a lot of us take for granted in the prime world, they basically have to pay a tremendous amount of extra in terms of their insurance as well as their credit expenses.

What we call this is a credit score tax and this tax because of its impact on insurance and credit results in basically an additional 10-20% more to Uber, Lyft, Doordash and others in their driver supply because the folks driving the gig economy are generally making $10-20 an hour depending on where they are in the U.S. and although their vehicle is being used as a source of revenue generation and things like insurance and even the cost of credit become costs of good sold rather than household costs the reality is that this is squeezing them. Some anecdotes – in Atlanta, GA where we started many of our drivers may have perfect driving records but because third credit score is below 600 they'll pay easily 50-100% more than basically a quoted standard risk. 50-100% more for many of these folks is 11-14% of their annual take home pay so for the folks working in the gig economy the way you have to think about it – your Uber driver that may have gotten you to the conference today is spending 11-14% of their annual take home pay on insurance. When you start adding things like the cost of the car itself and fuel, the tax on the system is absolutely overwhelming. In fact, I submit to you that this credit score tax isn't just detrimental to the drivers but the essential workers in this era of COVID where we all are relying on these drivers to deliver us packages form Amazon and medicines from pharmacies and groceries from Instacart and so on and so forth.

So what's happened is that this credit score tax basically reverberates throughout the entire value chain. In this diagram there are three very distinct demand curves – the rideshare demand curve like Uber and Lyft; the food delivery demand curve which is Grubhub, Uber eats and Doordash and then package delivery demand curve like Amazon and Instacart. Those demand curves intersect the same supply curve because they are all the same drivers. If you look at what's in the supply curve you see sort of the cost of labor but then you start adding in the cost of standard insurance and prime financing.

So as a prime risk as a standard driver my rates are really low. There is a cost of depreciation and maintenance, a cost of insurance that the TNCs have to maintain and then there is an extra cost stuck in the system that is really tied to the credit scores of these drivers. I submit to you that credit score effectively hurts the whole system and if you are a consumer of these services then this cost is basically hurting you as well

because basically if we can eliminate the credit score tax in the system you would see lower costs of rideshare, more work opportunities for gig workers and more revenues for every single TNC.

Our mission is to help people achieve economic freedom and we have eliminated credit score as an underwriting metric from all our underwriting. We don't use credit score. Basically, what we have learned is that by not using credit score and by using very reasonably admitted paper filings with normative factors, nothing crazy that by any means would be controversial, we are able to reduce folks insurance costs by 50% in many cases because of the credit score tax. By doing so this is life changing. Saving $50-100 a month for many people on this call is great but doesn't really move the needle but if you make $15 per hour and $30,000 a year you save $1,200 a year in car insurance, that is transformative. That is the difference between having mac and cheese for dinner and having a sold meal. That's what this is fundamentally about.

The way we approached this was that we realized that in addition to eliminating credit score we also had to re-visit the whole insurance business model. I come from a credit background and have worked with pretty much every major credit institution out there and hedge funds. What I would explain to you is that what the credit industry learned a long time ago was that the idea that somebody would walk into a bank sit down in front of a banker and that banker would make a decision whether or not to issue a loan to that person was a fundamentally flawed model because their bank was trying to maximize the amount of underwriting profit they could make on that person walking through the door. What the banking industry began to realize, and many banks got there before the financial crisis, is that they had to stop focusing on making underwriting profit as fast as possible. The banks that figured that out before 2008 were bullet proof – JP Morgan was bulletproof. Other banks were out there basically trying to make underwriting profit on their borrowers and they ended up in the middle of the financial crisis and some are no longer here today and others have been swallowed up by larger banks. It was decided that credit banks needed to stop focusing on making underwriting profit and focus on the business of originating paper into the capital markets as efficiently as possible.

The model credit paradigm today is you have issuers whether they are credit cards, or car loans or corporates, give investment bankers going out there essentially marketing the book. Yes, banks do originate the paper and they are essential to do that but they actually don't set price, they use the capital market system to set price and they set up servicers to go and do this in scale. To show where we are in 2020, most people on this call today could decide to buy a house and pay a $500 fee to any major bank and get a $500,000 mortgage. If you ask the bank the question who actually is giving out the mortgage they will say it moved out to the market, not the bank. Through this shift in paradigm we are able to sustain it by plugging in effectively all sorts of different balance sheets whether from the Fed, federal gov't or the global capital markets themselves.

The insurance industry, particularly the non-mutuals, need to start thinking this way today and for us to do something so revolutionary like stop using credit scores we had to basically divorce ourselves from the idea that we would make underwriting profit on our members. We would market them and would fairly represent them to the reinsurance industry and let that industry's actuaries do what they do well. In fact, I think the reinsurance industry because they see risk across the entire value chain of all insurers they are actually best situated to set price. Yes, we do have proprietary data and other

tools but by basically acting as a carrier in the model where we are not really making underwriting profit but really marketing the risk profiles of our customers not using credit score into the capital markets in a fee model versus an underwriting model we can bring in market efficiency and eliminate the credit score tax. We have had a tremendous amount of success doing this in Georgia and soon we will launch in most of U.S. in 2021.

Let's talk about the financial infrastructure required to do this. In order to be an actual fiduciary to our members required a whole new framework that we took from modern banking. Most insureds think that the insurance company is their fiduciary agent but nothing is further form the truth. Insurance companies are fiduciaries of the insureds. In fact, insurance agents in many of the exams throughout the U.S. at the state licensing level have questions making sure they understand that they have zero fiduciary duty to the insured – they have 100% fiduciary duty to the insurance company. So, the insurance company in using all these types of underwriting factors are really designed to make as much profit as they can from the insureds. They are thinking the way banking thought 25 years ago and that is not the way it needs to be moving forward. Unfortunately, particularly in the subprime markets a lot of those folks are not well educated and not wealthy and they make huge payments into the insurance industry and they actually believe that insurance companies and agents have their best interest at heart. In this model, we are able to take on that role by basically deconstructing the value chain and setting up a system where we can be their fiduciary and take their data and get into the capital markets and find the best reinsurance structure for them and basically make the market and that's the way modern credit works today and we believe that's the way insurance has to go.

This isn't so much about trying to get to better underwriting factors to get more profit off of insureds but rather redesigning the system as a whole. By doing this we see an opportunity to not just eliminate credit score tax in insurance but also in credit itself. As we build up the platform next to the insurance company which is a credit platform we are getting a lot of interest and traction from the credit markets who agree with us. The idea of using a credit score in order to make a credit decision probably isn't the right way to think about the complex world we live in today. People are complex and their lives are changing. What's happening is that we want to be part of their upward trajectory and encourage and sustain a path toward upward economic mobility. This is less about using credit score and more about creating and enabling a sustainable market driven insurance system.

Dorothy Andrews, MAAA, ASA, Chairperson of the Data Science and Analytics Committee at the AAA, thanked Chairman Breslin and the Committee for the opportunity to appear today to lead off presentations from the AAA. The Academy is the national professional association for actuaries from all practice areas in the U.S. whose mission is to serve the public and the U.S. actuarial profession. The Academy is nonpartisan, objective, and independent. It assists public policymakers on all levels by providing actuarial expertise on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States. In a moment you will also hear from my Academy colleagues, Lauren Cavanaugh and Mary Bahna-Nolan on practice-specific concerns related to your charge. But first, I would like to discuss some of the work and exploratory discussion undertaken by the Academy's Data Science and Analytics Committee, which I chair.

The need for a Data Science and Analytic Committee resulted from the work of the Academy's Big Data Task Force, which was charged to: Understand the impact of big data and algorithms on the role of the actuary; Examine the framework of professional standards to provide guidance for working with these new tools; and work with policymakers and regulators to address issues related to their use. The efforts of task force produced a monograph titled, Big Data and the Role of the Actuary. The charge of the Data Science and Analytics Committee to "To further the actuarial profession's involvement in the use of data science, big data, predictive models, and other advanced analytics and modeling capabilities as it relates to actuarial practice. And, to monitor federal legislation and regulatory activities, and develop comments and papers intended to educate stakeholders and provide guidance to actuaries."

The evolution of the data scientist presents challenges to the actuarial profession. The U.S. Government Accountability Office (GAO) identified a couple of these challenges in the report it issued last year on the benefits and challenges presented by innovative uses of technology. The GAO report states: Models are being developed by data scientists who, unlike actuaries, may not fully understand insurance-specific requirements, such as setting premium rates that are not unfairly discriminatory, and may struggle to measure the impact of new variables used in the models; Data scientists may be unfamiliar with insurance rules and regulations and may not understand how to communicate their work to state insurance regulators. Additionally, data scientists may not adhere to a set of professional standards equivalent in scope and moral and ethical values to those of the actuarial profession. A review of professional standards of organizations such as the American Statistical Association (ASA), the Data Science Association, and the Certified Analytics Professional organization reveals significant differences between their professional standards and those of the American Academy of Actuaries.

The Committee I Chair will develop a Data Science and Analytics Committee Big Data & Artificial Intelligence (AI) White Paper. The purpose of the white paper will be: Demonstrate the high ethical and professional standards that actuaries operate under to deliver value to insureds using objective actuarial, statistical, and AI methods; Discuss the changing nature of actuarial practice and the benefits of big data and predictive algorithms with a growing focus on human behavior to improve risk selection and the customer experience; Examine the work of insurers to control for systemic influences and socioeconomics by rigorously examining and eliminating the potential for biases to impact every step of the modeling process; Consider the willingness of insurers to work with regulators to resolve big data, algorithm, and AI disparate impact concerns and to promote a positive transformation of the insurance industry. It is important to explore resolutions that do not hamper the development of technology that works for the benefit of consumers.

The issue brief is expected to lay out a road map for working with regulators to resolve issues in the following areas: Standards for emerging data sources; Evolution of actuarial standards of practice; Ethical issues related to artificial intelligence models; The reliability and regulation of external data sources; Controlling for systemic influences and socioeconomics; Regulatory concerns impacting the work of the actuary; Impacts of big data to transform the practice of insurance; Behavioral data science impacts on traditional actuarial practice. On this last point, I would like to share a quote from Sherry Turkle of MIT. She states that "Technology does not just change what we do, it changes who we are." This statement reminds us that we have to be mindful and watchful of the

behavioral effects to technology to shape the data we study and the models built upon that data.

Insurance alone cannot solve all the social ills in society, but insurance models certainly should not contribute to them. The committee will provide information to actuaries on protecting consumer data to facilitate that algorithms are: Appropriately transparent; Explainable and interpretable; Free of unfairly discriminatory variables and related proxies; Based on variables with an appropriate relationship to the risk being insured; Appropriately granular to guard against unintended disparate impacts to protected classes; Attended to with human oversight to ensure controls and metrics are in place to monitor the continued fit and appropriateness of models for the purpose they were designed; Validated for quality and reliability by actuaries or experts who understand insurance company target markets, product lines, and insurance liabilities. By providing information in these areas, models can become more accessible for critical review and remediation before being exposed to the public, reducing the likelihood of these models to cause harm.

Finally, because Lauren and Mary in a few moments will be focusing on property/casualty and life actuarial concerns, I would like to spend a moment to relate some of the work the Academy is doing on health equity. While this is an initiative that is being worked on by another group than the one that I chair, I will provide you with just some highlights of this effort; once the Academy has had a chance to publish preliminary outcomes early next year, we can be available to NCOIL to more closely address them with you. This work has been undertaken to further the U.S. actuarial profession's commitment to health equity throughout the health care system by looking at current practices that potentially perpetuate or exacerbate adverse health outcomes experienced by people of color and/or historically underrepresented groups.

Specifically, the work is organized around issues concerning benefit design, provider contracting/network development, pricing, and population health. Questions that are currently being probed include: Does the use of historical data embed disparities in projections? Are assumptions appropriately determined and applied? And what sorts of analyses should be performed to explicitly identify inequities? So, again we will keep NCOIL apprised of the Academy's progress on this work as it progresses. With that, I will conclude my portion of the Academy's prepared remarks and will now recognize my colleague Lauren Cavanaugh.

Lauren J. Cavanaugh, MAAA, FCAS, Vice President, Casualty stated that on behalf of the Casualty Practice Council (CPC) of the Academy, I commend the NCOIL for organizing this exploration of important questions regarding race and insurance. Thank you for inviting me and other representatives of the Academy to share our thoughts with you. I will speak specifically to P/C insurance, while my colleagues will address other practice areas. My comments today will address: Certain actuarial guidance that is relevant to today's discussion; Data quality considerations; Disparate impact analysis; and Use of socioeconomic factors in auto insurance.

First and foremost I'd like to highlight that there is helpful actuarial guidance related to the issues at hand. Mr. Mosley referenced them in his remarks – there are a series of documents called the actuarial standards of practice and they provide guidance on techniques, applications, procedures and methods that reflect appropriate actuarial practices in the U.S. I think it will provide helpful background info to you as you make

certain determinations in the future. One standard I'd like to put particular focus on is the standard on risk classification. This standard provides some perspective on the question of unfair discrimination in rate setting and as the Committee continues to look into these topics I want to note that in order to properly discuss unfair discrimination its important to have a clear definitions of fairness. Fairness is defined in many different ways and what may seem fair to some will seem unfair to others. For U.S. actuaries when we focus only on the question of fair insurance rates we are guided by our actuarial standards and using the risk classification standards in guidance we see that rates within a risk classification system would only be considered equitable or fair if differences in rates reflect material differences in expected cots for those risk characteristics. Mr. Mosley discussed this as well.

What we mean by expected costs is for example in auto insurance that would be the expected cost would be driven by the expected number of auto claims and the average cost if a claim occurs. In order for a particular risk characteristic or classification to be considered fair it would be if that risk characteristic reflected a material difference in expected costs – either the frequency of claims or the average cost if a claim occurred. This is demonstrated if it can be shown that the experience correlates to a particular risk characteristic. There can be significant relationships between risk characteristics and expected outcomes where a cause and effect relationship cannot be demonstrated and that is all included in the risk classification standards and provides a healthy backdrop when you consider the question of fairness in insurance rating.

Others actuarial standards provide helpful guidance on these related topics would include our standard on data quality and I'll speak about that shortly. There are a few others listed in my comment letter. I would like to move to address some of the specific topics being looked at. One area that we think should be addressed is the use of data in these risk classification systems and when I use that term I mean the systems that are used in order to get to the premium. Data available in pricing P&C insurance coverage has been increasing and with that the industry has moved from relatively road rating classifications to increasingly segmented classification structures. Others on the panel have discussed that as well. The actuarial standard on data quality says that an actuary should review data for reasonableness and consistency unless in the actuaries professional judgment such review is not practical or not necessary and oftentimes there are practical limitations to what the individual actuary can do review in the growing volume of available data.

In 2017 and again in 2019 the auto insurance committee of the AAA worked with the NAIC to conduct forums on predictive modeling and in insurance the question of data quality was discussed. One of the ideas that rose from those discussions was a concept of one or more independent third party organizations that could verify and certify the various external databases that might be used by insurers in their predictive models or other data analysis. Of particular interest to this committee are concerns whether some of the external data sets that are being used in risk classification structures might contain hidden biases or serve as proxies for prohibited characteristics. Hidden racial biases or other biases like proxies for prohibited characteristics would be one of the things that a third party organization could look into. Some other related issues that could be addressed with this mechanism would be to address issues of accuracy and relevance of the data – how old is the data being used? When an insurer pulls data from multiple sources related to the same insured name John Smith how certain are we that we are getting the right John Smith. These are all questions on data integrity that may be

addressed by a new way of looking at regulating the way external data resources are used by insurers and we are happy to discuss that further with NCOIL.

Turning to the topic of disparate impact analysis, investigation into whether risk characteristics have a disparate impact on certain protected classes could provide insights into key questions regarding unfair discrimination. For example, it has historically been established that there is a material difference in expected cost for drivers that have no motor vehicle violations versus those that do. If law enforcement practices differ based on race however, risk characteristics that use motor vehicle violation history may have difference expected cost differential for black Americans than for white Americans. We think that looking into this issue of whether there is disparate impact and investigating that might be proper.

I also wanted to mentioned the use of socioeconomic factors in auto insurance ratemaking. As discussed earlier more data has been used and with the advancement of technology risk characteristics that may be more direct indicators of outcomes are increasingly being utilized and we heard a lot about that today. Rating variables that are linked to facts about driving behavior like those derived from telematics like vehicle safety features and UBI may reduce the predictive power of other variables that could be seen as indicating only proximal effect such as insurance scores. While historically those insurance scores have been seen to be very predictive that predictive power may diminish as we use more and more of these other variables. Thank you and that provides an overview of my comments and we look forward to discussing further with you.

Mary J. Bahna-Nolan, MAAA, FSA, CERA, at the AAA, thanked NCOIL and the Committee for providing her the opportunity to present to today. I am Mary Bahna-Nolan, a life actuary and volunteer for the Academy. I would like to reiterate the points of my fellow Academy members, Dorothy and Lauren, that we share the goal of identifying and exploring issues pertaining to race, diversity, and inclusion and ways to address practices that could create barriers to obtaining insurance coverage, or conversely provide incentives for inclusion to, insurance products. My comments will focus more specifically on considerations pertaining to life insurance and life insurance risk selection.

While the issues that the Committee is looking at are transcendent on all lines of insurance, an important issue that distinguishes life insurance from other types of insurance is that the purchase of life insurance is a voluntary transaction between a consumer and an insurance company. Further, the purchase is an independent, or stand-alone decision not mandated as a result of another purchase (e.g. obtaining a mortgage). This emphasizes the importance of the risk selection or the underwriting process to ensure the insurability of the applicant, the suitability of the insurance from both the financial need for the insurance, and the ability to pay for the insurance. As such, the determination of the insurability is often a factor of both medical and nonmedical data.

The risk selection or underwriting process is often only done prior to a policy or contract issuance with rates that are, at some level, guaranteed for the life of the policy or contract and for contracts that are non-cancellable by the insurer, other than for non-payment of premium lack of policy performance. The underwriting process for life insurers has a long history of change as new learnings and research, tools, products,

data, and computing power have evolved. What hasn't changed is that the risk classification process is foundational to the underlying principles of insurance. The purpose of underwriting is to align the risk characteristics with an expected outcome and to group similar risk pools.

The process of risk classification involves gathering data to understand the applicant's unique risk profile, including personal, financial, and health-related data provided by the applicant. In many cases, verification of such data is obtained through additional data sources and/or review of the applicant's medical records. The collection of this data helps to align an applicant's risk profile with the aggregated risk profile used by the insurer in establishing product price for a particular risk class. This risk alignment is often demonstrated by statistical or other mathematical analysis of available data. This data may include direct experience of a carrier or reinsurer, medical or clinical research data, and expert opinion. In the risk selection process, it is common that different paths and/or data elements are gathered for individuals based on what is disclosed on the application or learned throughout the process, the age of the applicants, or the amount of insurance requested.

Throughout the history of underwriting, new data sources and ways to use data have arisen. New data or data sources should be evaluated to assess their impact on risk classification. When new data is evaluated, it is evaluated for its protective value as an additional piece of data or replacement for existing data element(s) in the risk classification process. Mortality studies and/or retrospective studies are often used to assess the value of data that are or can be used for underwriting. Any changes to risk classification systems are evaluated and built into a product's design and pricing. Regulations are in place that govern data that may be used in the underwriting processes such as HIPAA, FCRA, and the Unfair Trade Practices Act.

In life insurance, actuaries and underwriters have different but interdependent roles related to risk classification. Actuaries: Determine insurance pricing and risk pool characteristics; Develop mortality assumptions for each risk pool; Analyze changes to risk classification because of the impact to critical actuarial activities; and Determine policy reserves through modeling and risk management. Underwriters: Follow established risk classification principles that differentiate fairly on the basis of sound actuarial principles and/or reasonable anticipated mortality experience; Are accountable for developing the underwriting process and classifying applicants into risk pools; and Assign risks to groups based on the benefit costs of the risk pool.

Actuaries and underwriters work together to align risk classification with mortality expectations for each risk pool. Changes in the risk selection process are often analyzed to understand the impact a change may have on risk selection and the potential for adverse selection. New data sources are analyzed as to their relevance, credibility, and quality. Analysis around new data inputs includes whether the data is fit for purpose, does not unfairly discriminate or include unintended bias, and appropriately classifies risks. In addition, compliance with existing laws such as HIPAA, FCRA and Unfair Trade Practices is an important consideration in how data is used and provides consumers the ability to know and agree to which data is used in the risk classification process and the ability to dispute inaccuracies in the data.

Recently, there has been an increased effort in the life insurance industry to lessen the more invasive and time-consuming elements of the risk selection processes such as the

collection of bodily fluids (e.g., home office specimens [HOS] and blood) and physical measurements, often collected from a third-party paramedical professional that comes to an applicant's home or place of work. These changes are often described as "accelerated underwriting," and are not limited to the removal of fluids and other measurements. Accelerated underwriting is another part of the ongoing evolution of underwriting. There is often a trade-off between the predictability of mortality experience and evaluation time. Different risk classification methods and tools may impact the overall level of mortality but also the expected pattern of mortality, including the time it takes for the benefits of underwriting to wear off. The use of alternative data, predictive models, and algorithms may be used to reduce the added expected mortality cost from removal of more traditional underwriting data (i.e., fluids). Time is required to understand and realize the true impact of the emerging risk classification methods on the consumer experience.

The use of predictive models and algorithms, along with additional data sources, may be used to forecast probabilistic outcomes around relative mortality or risk. Models incorporate statistics to identify interdependencies among data elements and correlation to the risk characteristics being studied. Algorithmic underwriting is not new to life insurance. Underwriting guidelines have long been based on various algorithms. The use of predictive models and improved computing power has helped to remove some of the human application or judgements in the algorithms historically used. Of particular interest noted by this Special Committee are concerns as to whether the use of alternative, nonmedical data sources and the use of predictive models and algorithms inject hidden biases or serve as proxies for prohibition of risk selection based on protected class information, most specifically race. The use of algorithms or an alternative data source does not remove actuaries or underwriters from adherence to the principles of risk classification; risk classification must be based on sound actuarial principles related to actual or reasonably anticipated experience to assign risks to groups based upon the expected cost or benefit of the coverage or services provided.

There is a strong correlation between socioeconomic factors and mortality/morbidity experience. The racial aspect of socioeconomic differences is systemic beyond insurance application. Life insurers do not collect information or directly use protected class information of race, religion, education, or ethnicity in their risk classification or rate-setting processes. Therefore, additional analysis and judgment is necessary to ensure proxies are not unintentionally discriminatory against one of these protected classes while not removing the ability to correctly identify mortality and morbidity differentials important to the risk classification and risk pools established.

Actuaries are bound by a code of conduct. The purpose of this Code of Professional Conduct is to require actuaries to adhere to the high standards of conduct, practice, and qualifications of the actuarial profession, thereby supporting the actuarial profession in fulfilling its responsibility to the public. Actuarial standards of practice (ASOPs) are developed by the Actuarial Standards Board and are binding on members of the U.S.-based actuarial organizations when rendering actuarial services in the U.S. The Actuarial Standards Board regularly adds and updates ASOPs. Failure to meet applicable standards of practice is a violation of the Code of Professional Conduct that may result in an actuary being brought before the Actuarial Board for Counseling and Discipline ("ABCD"). An adverse ABCD finding can result in discipline ranging from reprimand to expulsion from U.S. based actuarial organizations.

Lauren discussed three of the relevant ASOPs that also apply actuarial standards related to risk classification for life insurance: ASOP No. 12 on Risk Selection, ASOP No. 23 on Data Quality, and ASOP No. 56, which became effective October of this year, on Modeling. In addition, the following are some of the more relevant ASOPs which also apply pertaining to the risk selection process for life insurance and the analysis of data and models in this process: ASOP No. 25, Credibility Procedures; ASOP No. 54, Pricing of Life Insurance and Annuity Products; Setting Assumptions (currently being drafted).

The purpose of ASOP No. 25 is to provide guidance to actuaries with respect to selecting or developing credibility procedures and the application of those procedures to sets of data. This applies to the risk classification process when the actuary is evaluating subject experience for potential use in setting assumptions without reference to other data and in the identification of relevant experience and the selection and implementation of a method for blending the relevant experience with the subject experience, including the relevance and applicability of alternative data sources and model inputs. Such relevant experience should have characteristics similar to the subject experience, where the characteristics the actuary should consider include items such as demographics, coverages, frequency, severity, or other determinable risk characteristics that the actuary expects to be similar to the subject experience. In addition, the ASOP requires consideration for the homogeneity of the data and the actuary should consider the homogeneity of both the subject experience and the relevant experience and consideration that within each set of experience, there may be segments that are not representative of the experience set as a whole.

ASOP No. 54 provides guidance to actuaries when performing actuarial services with respect to the pricing of life insurance and annuity products, including riders attached to such products. This standard is applicable when a product is initially developed or when charges or benefits are changed for future sales. The other ASOP around the setting of assumptions helps to provide guidance when they perform those services around assumption setting which would include the mortality levels the risk categories and risk classification or risk cohorts or pools. As Lauren noted, the full list of ASOPs is extensive, and it is certainly possible that guidance from others not noted above may prove useful to the Special Committee's ongoing discussions. Again, I appreciate having this opportunity to share with NCOIL thoughts on the important issue of race in the risk selection and classification process for life insurance and look forward to working with this Special Committee as you seek to address important questions that have been raised.
Rep. Lehman stated that his question goes to Mr. Cotto and Mr. Poe. When we start talking about all of this data that goes into all of these factors, as the risk expands should that criteria change? For example, I believe with Cure the maximum coverage I can get is $25,000 per person and up to $500,000 per occurrence. Mr. Poe replied no and stated that Cure is statutorily mandated as an admitted carrier and like any other carrier is required to offer up to $250,000 worth of coverage per person on bodily injury – we have all the standard coverages.

Rep. Lehman asked what percentage of Cure's policies are those types of limits. Mr. Poe stated that he would say 75% of Cure's book is state minimum liability coverage because Cure is basically the only insurer that doesn't use credit scores and is the place of last resort of people of lower income. Rep. Lehman stated that his concern deals with more sophisticated buyers and different criteria for higher risks. If a carrier is going to put out for me such as a $500,000 underlying with a $2 million umbrella - if they are

going to put $2.5 million on the line every time my 16 year old gets in the car should there be some criteria to that that's different then someone that's putting out the state minimum limits? The other question deals with data being collected – how much of the data is accessible by me? Clients have asked me in the past if they can take the scoring data that has been collected by the carrier and have access to it when they shop for insurance.

Mr. Poe stated that regarding exposures, that is built into the rates. For every coverage that we offer for every carrier in the country we have a base rate associated for what that coverage is and as you buy more coverage we have a factor that multiples times that base rate. So if you have bodily injury coverage with any company for car insurance you have what's called a filed base rate and lets say its $100. That $100 has to associate with the lowest amount of coverage that you are offering so if its bodily injury coverage and the minimum for the state is $15,000 we actuarially come up with a base rate for $100 for that amount. If you buy $250,000 worth of coverage for bodily injury there will be a multiplier which is what we call a relativity that's multiplied by that $100 so someone with a $250,000 bodily injury limit is going to have a 2.3 and 2.3 times $100 is $230 and that is how we develop the rate.

The problem is that if there is a carrier that only wants to give lower rates to higher income drives you are stuck with that model of always having a base rate of $100 so the only way to eliminate that and give preferred rates to those with higher income is to create multiple affiliates with the same trademark name. That's why in NJ there are two Allstate's, two State Farm's, and three Geico's because that way you can have different base rates based on a criteria like an income proxy that will first be applied to you as a driver. So first you answer the question do you have a four year college degree and a high paying job. If the answer is no then you are only eligible for the higher base rate company so its similar to what we saw in the 1960s with redlining and housing. Regarding what Mr. Cotto testified to just because objective factors are involved in your insurance scores then they are not necessarily having a racial impact to me flies in light of the whole reason why we are having this meeting. Obviously there are proxies to a factor so you might not use race as a question for car insurance but if you have a corollary proxy for race then you can have an effect that would be obviously impacting race which is the whole point of this meeting.

Mr. Cotto stated that he appreciated Mr. Poe's explanation on base rates because that is important to consider. As to the question of whether higher risks have more or higher criteria I think that comes into the policy realm that legislators have to decide. If someone wants additional coverage I think it logically makes sense that you would ask more questions. I think that's the general sound direction to go. In terms of the data question and how much consumer access there is, on the credit side that is governed by federal law and consumers can obtain their credit report and in fact its encouraged that consumers check their credit report regularly to see if there are any mistakes. That's a good thing. If you are getting at whether consumers can see how the rate is calculated and how much each factor weighs the answer to that is no.

Mr. Poe stated that one of the things we've talked about is insurance scores and why it does or doesn't correlate to income. I've sat for hours with statisticians who create the insurance scores – they have to be 90% correlated to credit scores otherwise they wouldn't buy credit scores from the agencies that create them. The differences are very minute. More importantly, what most people don't realize is that when we talk about

credit scores being objective and everyone having an equal opportunity – the highest element if a FICO credit score, 35% of it, has to do whether you pay your bills on time – payment history. Number two is credit utilization, 30%, how much available credit you have and how much you use of that available credit. Your available credit is 100% tied to what you state as your annual income.

The reason why income is so correlated to credit scores is that if you take a poor person and a rich person and they all pay their bills on time then that 35% weight factor has become irrelevant so the second most important factor in your credit score is going to be how much of your available credit is being used right now. And when you are poor and make $30,000 per year they don't give you a $30,000 credit line they give you a $1,000 credit line and if you use $900 of it you are using 90% of your credit limit so your credit score will drop at least 90 points simply because you used $900 of that $1,000 credit line. A lot of people debate whether credit scores correlate to income. That is why they do – because your salary is the basis of credit available.

Rep. Lehman stated that he had to leave the meeting in order to deal with an issue back in Indiana. Rep. Lehman thanked everyone for participating in this process. A lot of information was presented and it was done respectfully. The video and audio recordings will be available on the NCOIL YouTube channel for review. The Committee will discuss next steps once everything is analyzed.

Rep. Edmond Jordan (LA) thanked everyone for presenting today and stated that his question is for Mr. Poe. Regarding lack of notification if an applicant is rejected for insurance, are there any states that in fact require that notification. Secondly, is there any development of some legislation around having access to your insurance score. Mr. Poe there is simply no legislation in any state he is aware of that requires a carrier if it rejects you on the basis of your education or occupation that you get notified of it. The FCRA requires notification of people in writing when you have an adverse decision based on credit. One of the things that happens in NJ with Geico is that you are not allowed to reject a driver based on just their education or occupation alone but Geico complies with that by having three companies in NJ and saying that we are a group of companies so we comply by not as a group rejecting a driver based on education or occupation alone. But they are rejected by each of the preferred companies based on those criteria so they are able to say you are eligible for the third company that we write that complies as a group with the prohibition laws.

Asm. Ken Cooley (CA), NCOIL Vice President, stated that he has a question generally for anyone that wants to answer it. I am going to make an analogy to climate change. Climate change has risen in importance and we have seen companies look at what is the pathway that they can do given their enterprise to do more on climate change and then to promote that fact and tout it and make it part of their narrative. The question would be in this present environment just as we've heard with Buckle and Root what do you think the role of marketplace forces is of companies really trying to do something different to give them an edge. That's not to take away from the analysis today but its more to get at there are plenty of companies out there that actually saw a niche opportunity to do something different than the rest of the marketplace and went after that and excelled big time. We have a competitive marketplace but what are your thoughts that given the current environment like the climate change environment that companies might try to differentiate.

Mr. Poe stated that the reality is that here is no competition for lower income drivers in our marketplace and that is because they produce the highest losses and the highest expenses. The industry can make enough money, billions of dollars, form high income drivers so why would they be in this quadrant. If you talk about Root its early in infancy and has grown exponentially very quickly and we have to wait for loss results to come in. If you look at other companies like SafeAuto they only write in states in which they are permitted to only write the state minimum liability insurance so they cap their total exposure to a certain extent.

In the marketplace we are in there is simply no competition. Mr. Poe stated that 45% of those that leave Cure go uninsured and we are the place of last resort. It simply costs more money to deal with people calling you every day saying I cant make the payment so can I make this. And people that get into car accidents if you are lower income you are going to file every small claim that you can because anything over $500 is something that you cant afford. Wealthier people have $1,000 in their bank account so if they get in a fender bender in a supermarket they can pay $1,000 out of pocket to not file a claim with their insurance company. Its simply not a competitive market in the lower quadrant of say the lower 25% of income earners in the country.

Mr. Birnbaum stated that he would like to tie into the climate change analogy. If you look at what regulators are doing with climate change they are really focusing a lot on company disclosures and asking companies to make climate risk disclosures and those disclosures are public the idea being that by forcing companies to think and act on those issues and then make them public investors and members of the public can evaluate how companies are dealing with the issues. I think that's a really good analogy for how to deal with some of the issues of systemic racism in insurance. Asm. Cooley stated that from a CA perspective there are a lot of companies that are trying to brand themselves in that area and not at the end of a gov't order. Admittedly, someone is not going to be there if they don't think they can make money but if they find a way to do something which takes innovation maybe it does open a path.

Sen. Breslin stated that's a win-win-win if they participate and there should be for the insurer some reward other than profit. At the end of the day there should be some other gov't reward if they are required to turn over their data.

Mr. Young stated that in Buckle's view data is a public good. Our data is really owned by our members. We use our data to go and advocate for our members and get them the best price of insurance in the reinsurance markets. The Buckle insurance model is really built upon the thesis that what drivers need, the bottom third of the socioeconomic specter, is an advocate that can take their data, run market force processes into the capital markets themselves and then basically be that honest broker between the real risk taker which is not the insurance industry. The real risk taker needs to be the reinsurance industry. I've restructured over $30 billion of debt across automotive, financial services, telecommunications, and other industries and my observation of the insurance industry is that we are at the beginning of the restructuring cycle of the insurance industry.

You see the major insurers like State Farm and Geico are not that different from the major banks pre 2008 which were struggling to make underwriting profit and investment returns in order to support large books of business that my not be sustainable in the current model. The key to this is to figure out how do we get the insurance industry out

of insurance the same way that the banks realized they had to get out of writing loans and figure how to create the systems and move the risk out to the markets and change the financial interests and incentives across the entire value chain. Buckle has learned that is the only way to solve the problem for the gig economy and get around the issue of credit score and other factors. To the question of if there is a global warming phenomenon happening in insurance, I would say yes. What you are going to see in the next few years are huge write downs on surplus capital as a result of bad bets on commercial real estate, fixed income instruments, and underwriting. I think if you were to talk to any of the senior executives across the major insurers that they would not publicly acknowledge it but they would probably agree that is the case.

Asm. Cooley asked if any other panelists had any thoughts. Ms. Bahna-Nolan stated that from a life perspective the industry is working very hard to try and find ways to gain access and get to the under and uninsured marketplace. There is a huge gap and huge needs and purpose that life insurance serves. It has been a struggle to try and access that. There are carriers that are making good attempts. Removing some of those barriers and the cost of life insurance and getting that down to something that is reasonable and getting at the barriers to make it easier for individuals to apply and qualify for the insurance is very much front and center. I cant speak for every carrier but can for many in terms of those focus areas.

Asm. Cooley then stated that these are very difficult conversations and he is a lawmaker and believes in the power of gov't to protect people and prod them. At the same time we are talking about how do we change us from where we are to something different. There is no better statement about the process of innovation that I would relate to this conversation than what Thomas Edison said: "There can be no progress until a sufficient umber of people become dissatisfied with the way things are and this can only happen when they are brought to think beyond the limits to which they are accustomed." I see this conversation showing how do you get in the head of the founder of Statefarm that he could approach he insurance marketplace with a template that defied how people thought it had to work and soon had the biggest insurance company in the nation although it had to fight lawyers all the way. I think there is room for prescriptive activity but I also think you need to be thinking beyond the ways of which are accustomed. I think the conversation today and the statements made by Rep. Jordan expressed carefully we have to think beyond those limits and that is very important.

Mr. Mosley stated that as we have discussions like this, variables like credit based insurance scores, education and occupation oftentimes get a lot of the discussion but one of the things that has continued to occur in the insurance industry is the idea of innovation or companies continually trying to improve upon their approach to risk based pricing. Companies didn't find credit based insurance scores put them in and then stop. There has been a continuing push for companies to continue to try and find ways to differentiate themselves and better approach matching premiums to cost and the result of that has been a lot of additional elements and improvement that may not be on the scale of credit based insurance scores but there have been a lot of additional things that have come into play which get at trying to continuing to improve matching price to risk. There may be continuing trouble spots but we need to think about how to better address the issue and not just settle on the status quo. So even beyond those variables that get a lot of attention there is a lot of work in companies going on because if they are successful in doing that it helps them achieve their goals.

Ms. Andrews stated that when we talk about collecting data like race we also have to consider what kinds of abuses can occur as a result of that type of data collection – how is it going to be handled and who is going to be handling it to make sure it's not abused. When it comes to models, building a model is not a perfect science. Two companies can build a model using the exact same variables but if the underlying data is different you can get very different results so its very important when talking about results of models that we understand what the shortcomings of the underlying data is and we're not just making generalizations about one company's models and then applying it across the spectrum.

Mr. Cotto stated that we are all for innovation but the way you do that is not to prohibit things that are accurate predictors. When you prohibit things you risk undermining solvency and you start to raise rates for everybody. Carriers keep getting better and better because they are competitive and want policyholders. Sen. Breslin stated that carriers want more information and it has become more incumbent to make sure the information is protected and used properly. Mr. Cotto agreed.

Sen. Breslin thanked everyone for all of the information today which will give the Committee a great deal to work with to come up with a finished product. Thank you to all of the legislators that participated as well and I look forward to working with everything going forward.

ADJOURNMENT

Upon a Motion made by Rep. Keiser and seconded by Asm. Cooley, the Committee adjourned at 5:00 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
WORKERS' COMPENSATION INSURANCE COMMITTEE
TAMPA, FLORIDA
DECEMBER 11, 2020
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Workers' Compensation Insurance Committee met at the Tampa Marriott Water Street Hotel on Friday, December 11, 2020 at 9:00 A.M. (EST)

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

Other members of the Committee present were (* indicates virtual attendance via Zoom):

Asm. Ken Cooley (CA)*
Rep. Matt Lehman (IN)
Rep. Peggy Mayfield (IN)*
Rep. Joe Fischer (KY)
Rep. Bart Rowland (KY)
Rep. Wendi Thomas (PA)*

Other legislators present were:

Sen. Mike Gaskill (IN)
Sen. Andy Zay (IN)
Rep. Kevin Coleman (MI)
Rep. Michael Webber (MI)
Sen. Shawn Vedaa (ND)
Asm. Kevin Cahill (NY)*
Sen. Bob Hackett (OH)*
Rep. Joe Schmick (WA)*

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Tess Badenhausen, Assistant Director of Administration, NCOIL Support Services, LLC

QUORUM

Upon a motion made by Rep. Matt Lehman (IN), NCOIL President, and seconded by Rep. Bart Rowland (KY), the Committee waived the quorum requirement without objection by way of a voice vote.

MINUTES

Upon a motion made by Rep. Lehman and seconded by Asm. Ken Cooley (CA), NCOIL Vice President, the Committee voted without objection by way of a voice vote to approve the minutes from the Committee's September 25, 2020 meeting.

THE ABC'S ON EXPERIENCE RATING

Gerald Ordoyne, Director of Experience Rating at the National Council on Compensation Insurance (NCCI), stated that he has been with NCCI for almost 25 years and has been working with the experience rating department for the vast majority of that time. Mr. Ordoyne stated that he will discuss today NCCI's experience rating plan and how it

works with the pricing of the work comp program – the specific plan may not apply to all states but the general concepts of experience rating are pretty similar across different jurisdictions. Experience rating is designed to recognize the differences among individual employers with respect to safety and loss prevention. It does this by comparing the experience of individual insureds to the average insured in the same classification such as roofers to other roofers, clericals to other clericals, and retailers to other retailers. Those differences are reflected in the experience rating modification factor and is based on the employer's individual payroll and loss records. That mod factor could result in an increase, called a debit, which is anything over 1.0; a decrease, called a credit, which is anything under a 1.0; or potentially could calculate to be 1.0 which means there would be no change to the premium that the employer was paying for their work comp policy.

If the rating system went no further than simply manual loss rates or manual loss costs that the carrier was applying to the different exposures, then potentially insurance providers could potentially seek out those employers with better than average experience and avoid the employers with worse than expected experience. So, the experience rating mod is really designed as a part of the overall pricing of work comp.

Thirty-five states and D.C. are NCCI states which are the states that participate in NCCI's experience rating manual on both the intra-state and inter-state basis. The difference between intra-state and inter-state rating basis is that if an employer had a single location in lets say one state, Oklahoma, and that is where their operations were then they would be intra-state rated with just their Oklahoma rated experience. But if they had operations in two or more states and those states were NCCI states and Independent Bureau State— Interstate Participant (IP) states, then they would be interstate rated. The IP states have their own independent rating bureaus that handle the intra state rating portion for those employers but they do participate in the interstate rating plan. So, if there was an employer that had operations in both North Carolina and South Carolina, NCCI would calculate a single modification factor that would apply to the exposure/premium in both of those states. That would be true of any combination of the NCCI and IP states.

There are also states that have their own independent rating bureaus but not part of the interstate rating plan so they calculate an single state mod for all employers that do business in that state. There are also states that have a monopolistic state fund so they also don't participate in the interstate experience rating plan. If, for example, an employer had operations in California and Nevada, CA would be responsible for calculating a modification factor for the California experience and NCCI would calculate a modification factor for business operations in Nevada with just the Nevada experience.

Mr. Ordoyne stated that in 2019, NCCI calculated over 1.2 million experience rating modification factors which were calculated for about 740,000 different employers. Of those employers, about 620,000 were intrastate rated employers which means they simply had operations in a single state. Another 120,000 were the interstate rated employers which are those that have interstate operations among any of those 42 states referenced earlier that participate in the interstate rating plan. That is a lot of work and a lot of data the comes into NCCI. Over the years, NCCI has implemented some systems that do the calculations automatically and for the most part about 80% of the mods are calculated without any manual intervention. So, the insurance provider submits the unit data – the audited payroll and loss records – to NCCI and it goes to the upfront editing

process and passes over to the experience rating department and flows through the calculation engine and then the mod factors are processed and distributed to the necessary stakeholders that need that information either from a carrier perspective to apply that modification to the premium or in most states to the employer so they are aware of what the modification factor is going to be for that current year.

Additionally, NCCI also looks at ownership requests which are important because it is how NCCI makes sure it is using the right experience in the calculation of the modification factor. All the ownership information that flows through NCCI is reviewed manually so while there is some automation around the calculation of the mods, all of the ownership is reviewed manually. Mr. Ordoyne stated that with regard to calculating the mod, in the most simplified format, the experience modification factor is really a comparison of employer's actual losses to their expected losses. Their actual losses are those losses that represent both the paid and reserved amount of any claims that may have happened in the experience period. Expected losses are based on the exposure or in most cases the payroll of the employer. The expected losses are really driven by two factors – the amount of payroll the employer has and the type of business and operation that the employer has. Clearly you would think that a construction business is more likely to have claims than a business that only has workers who sit at their desks the majority of the day. The upfront rates are going to be higher for the construction company than they are for an insurance company but the expected losses are going to be higher as well. The expected losses are based on both a combination of overall payroll - the more payroll the more losses you would expect – as well as the type of exposure and the possibility of risks for that employer in that class code.

In the experience rating calculation NCCI typically looks at three years of experience that ends one year prior to the effective date of the mod being calculated. As an example, for those modification factors that have an effective date of 1/1/21, NCCI is going to use a three year window that ends 1/1/20 and will be looking at 2017, 2018 and 2019 policy periods. Not all employers qualify for experience rating. In NCCI jurisdictions, qualification is based on premium and that is the premium generated by the policies that are part of that three year window. It varies by state. The average premium eligibility across NCCI states is about $9,500 in premium annually but it ranges from $5,500 to $13,000 so there are state differentials that come into play.

Starting in 2017, in most states, that premium eligibility is indexed so it has the possibility of increasing as time goes on. It is tied to the U.S. Bureau of Labor Statistics quarterly census of employment and wages. That is looked at on an annual basis and in some cases a state may see a rise in premium threshold and in other years they may not but it is done to keep pace with inflation and make sure those employers that are too small to quality for experience rating aren't being included in the calculation and getting a mod because they probably don't have enough credibility to warrant getting an experience mod factor.

In the calculation of the mod, the actual losses are based on the actual paid and reserved claims that the employer incurred over that three-year window. Those claims that go into the calculation are broken into two pieces. At a point, which is as of 1/1/21, the split point is $18,000 so all claim dollars up to $18,000 are considered primary and they go into the experience modification calculation at 100%. Any claim dollars over $180,000 are going to go into the calculation but at a reduced amount and that amount really depends on the size of the employer and how much payroll they have generated

over the years. That amount can be as low as 4% or potentially as high as 80% depending on their size.

Often times when you talk about experiencing rating the terms frequency versus severity are used. That means primary versus excess portions of the claim. The primary portion represents the frequency and the excess portion represents the severity. Frequency plays a grater weight in the mod calculation than severity. The fact that the claim happened and that it existed is more important than what the overall claim dollars are. That is not to say that the overall claim dollars are not important but they are not quite as important.

For example, if an employer has a $50,000 claim, the first $18,000 would go in at 100% and those dollars over $18,000 would then go in at a reduced amount. Lets say based on their size the weighting factor was 10% so the $32,000 is only going into the mod calculation at $3,200 so the $50,000 claim in the mod calculation is only going to look like $21,200 – the $18,000 primary and the $3,200 excess. The split point, much like the premium eligibility threshold is also now indexed and can be indexed annually. This was some research that was done by NCCI's actuarial department in the early 2010s and went into effect in 2013. NCCI moved what had been a very static split point and indexed it over a couple of years to what the appropriate amount was which was around the $15,000 mark and now it has been indexed based on inflation annually since then and as of 2021 in most states the split point value is going to be $18,000.

Mr. Ordoyne stated that the claims are taken and split into primary and excess but there are also some other limitations that can occur to a claim. In most states, if the claim is medical only then the claim dollars are going to be reduced by 70%. For example, if an employer had a $2,000 medical only claim and there was no loss time and the employee just had to get stitches and didn't miss any time that would be medical only and that $2,000 claim would only go into the mod calculation as a $600 claim, reduced by 70%. Every state has a state per claim accidence limitation. In terms of frequency versus severity, it can get to a certain point where a claim can get be of such size that any dollars above a certain level aren't adding value to the mod calculation. That dollar amount is based on the state data that actuaries look at as part of the loss cost or rate filing and it can vary anywhere from $150,000 to $500,000 based on the state data. For 2020 it looks to be on average around $275,000. So, if for example an employer had an unfortunate claim that was $500,000, that claim with a $275,000 state accident limit would be capped at $275,000 so the $225,000 above that cap are going to be excluded completely. So, $18,0000 of the claim is going into the mod calculation at full weight but the difference between $275,000 and $225,000 is going in at a reduced rate depending on the employer size and anything above the $275,000 is going to be discarded and not used at all.

There is a secondary claim limitation and a state multiple claim limitation which is an added layer of protection for employers. If for example there is a single accident where multiple employees happened to get injured such as an explosion in a warehouse or a car accident, those claims grouped together would be limited to a value and that value is two times the state accident limitation. So, if a state has a $275,000 individual claim accident limitation then the combination of all the claims in that single accident would be limited to $550,000 in the mod calculation and that is important because it adds another layer of protection for the employer.

There has been a lot of talk in the work comp arena about the impact of COVID-19. From an experience rating perspective, a decision was made earlier this year and a filing was made which resulted in an exclusion of COVID-19 claims from the experience modification formula. It was felt that actuarially that information probably didn't add a lot of value because it wasn't going to be a great indicator for potential claim activity in the future. We expect COVID, hopefully, to be a once in a 100 year pandemic and it is not likely that the same type of claim activity is going to occur in three years for the same employer. So, the filing was made and for any claims reported with certain identifiers that were created to identify that claim as a COVID claim which have to do with the accident date (after December 1, 2019) and other things, it would result in that claim being excluded from the work comp experience rating mod calculation. Something similar was done many years ago following 9/11 and all claims associated with that were excluded from experience rating for basically the same reasons as there just wasn't an expectation that it was going to be a good indicator of future claim activity in the near future.

Mr. Ordoyne stated that as a final layer of protection for the employer, there is a maximum debit modification that can be applied. This is a cap on the mod that would limit how high the mod can go for an employer and it is based on size but it is really a protection for smaller employers that maybe just qualified for experience rating and happened to have a couple of unfortunate claims during the experience period. The cap starts at 1.10 and grows based on the size of the employer. Regarding ownership, NCCI does collect ownership information on employers and it is up to the employer to submit that data to NCCI. It is important because experience rating uses the past experience of the business to calculate the mod factor so it is appropriate that NCCI uses all of the experience of that employer. Changes in ownership could impact the experience that is used in the mod calculation and for purpose of experience rating that past experience could be transferred or combined in the mod calculation. Ownership changes vary quite dramatically from a simple name change to sales or some large mergers as well as new entities being formed.

As an example, in each of three examples (three companies), owner A owns a majority of the business. Based on NCCI's experience rating plan manual rules, because that person (a person or entity) owns more than 50% of all three businesses, the experience of all businesses are going to be combined to calculate a single modification actor that would then apply to all of the businesses and that is true regardless of the business operations and how varied they might be. Another example can be used with a sale. If I own a company and sell that to someone else who wants to start operating that business, when that transaction takes place and the business is sold that experience that was generated while I was the owner also transfers to the new owner because the operations haven't changed and the new owner is just taking over the operations – they inherit the experience. So, the person buying the company is buying the experience as well. Also, let's say the person buying the company also owned another company, NCCI would then calculate a combined mod because that person now owns multiple different businesses.

Mr. Ordoyne stated that he would like to point out that this was a very high level of NCCI's experience rating program and NCCI has a lot of other information at NCCI.com. There is a lot of information and webinars that take you through different levels of detail in the calculation and worksheets. There is also a document called the ABC's of Experience Rating that has ben popular over the years and goes into a lot of detail. In

many cases, that document tends to answer a lot of questions that people may have on experience rating.

Rep. Matt Lehman (IN), NCOIL President, stated that he has always wondered how something that happened to one of his clients is handled by NCCI. His client was an auto company, and they were in a not at-fault accident in the course of employment and paid out about $350,000. It was going to be fully subrogated and the carrier took on the obligation but in the meantime, because it was paid out under work comp, his experience rating took a hit and it cost him about $25,000 per year. It was fully subrogated and they got their money back but they are now on the hook paying that mod. Accordingly, Rep. Lehman asked what research NCCI has done with subrogation and reserving because we also see in the market that there will be a claim setup and they will reserve it for $250,000 and if that doesn't get adjudicated, it pays out at $50,000 but that hits their mod at $250,000.

Mr. Ordoyne stated that from a subrogation perspective, there are specific rules in the experience rating plan manual that state if a claim is subrogated, once the carrier is reimbursed they should be submitting correction reports which then lower the claim value down to just whatever the difference was that wasn't subrogated. In Rep. Lehman's example, if all of that was reimbursed, they would submit correction reports back to the original reporting and then NCCI would then be able to go back and revise the mod. In most states, for any reason, the current mod that is in effect today is revised as well as the prior two year's mods. For subrogation, that time period actually expands for potentially up to five years so it would be the current mod and the four year's prior. In Rep. Lehman's example, once the subrogation was worked out and the carrier got the reimbursement they should then be reporting the correction report which would then trigger a revision at NCCI to revise the current mod and the prior year's mods.

Rep. Lehman asked who's obligation it is to report the subrogation and reimbursement. Mr. Ordoyne stated that once the carrier submits the correction report with the revised claim dollars that will automatically trigger it for that three year window. If it goes into the five year window there might be some communication needed by NCCI but the insured shouldn't have to do anything but if they are not seeing anything done they should raise it with their agent. Mr. Ordoyne stated that with regard to reserving, NCCI cannot respond to questions on carrier practices, especially when it comes to reserving.

Rep. Bart Rowland (KY) stated that with subrogation if NCCI adjusted the mod down for prior years would the carrier be obligated to adjust the premium and refund the customer based on the lower mod. Mr. Ordoyne replied yes as that is in NCCI's experiencing rating plan manual and rules. Because that mod was revised within the revision window as defined in the manual then the carrier would have to issue that refund.

Jeff Klein, Esq. at McIntyre & Lemon, PLLC, asked if occupational disease is treated the same way. Mr. Ordoyne stated that he did not get into occupational disease as there is a whole separate claim limitation for occupational disease that is a bit more complex and it is not really seen that much. Claims for occupational diseases would go into the mod calculation and there is a separate layer after that but it is not common.

DISCUSSION ON FLORIDA'S WORKERS' COMPENSATION INSURANCE MARKETPLACE RESPONSES TO COVID-19

Geoff Bichler, Esq., Founding Member & Managing Partner at Bichler & Longo, PLLC, stated that the starting point for these issues is always going to be the state work comp statute. The Florida statute relating to occupational disease and exposure is very stringent and prohibits claims for toxic exposure and injury or disease. The statute (440.02) states that "An injury or disease caused by exposure to a toxic substance, including, but not limited to, fungus or mold, is not an injury by accident arising out of the employment unless there is clear and convincing evidence establishing that exposure to the specific substance involved, at the levels to which the employee was exposed, can cause the injury or disease sustained by the employee."

That standard has been in place since 2003 reforms to the Florida work comp Act and have created a lot of problems for injured workers who have attempted to bring these types of claims so you don't see many of these cases brought. That may be why NCCI stated that this issue is not that common because most states have similar restrictive language relating to occupational disease and exposure claims. That is the starting point and has to inform any consideration of liability or immunity or additional legislation that may be looked at to try to limit claims related to COVID. Further, Florida law has a specific occupational provision which is in Florida statute 441.51 that has similar language to the statute just discussed. The bottom line is that there are very restrictive and difficult standards in Florida.

A recent Florida appellate case that was very anticipated as it related to COVID was released in November with re-hearing denied in January just before COVID cases began in Florida. The case involved an occupational exposure and a death claim. There was a concurring opinion from Judge Wolf who is a very prominent jurist in Florida and features regularly in constitutional decisions in Florida and said the case and *Gibson* "reject the use of overwhelming circumstantial evidence to prove the statutory requirements of clear and convincing evidence in toxic exposure cases. Direct proof of the level of exposure to the toxic substance is simply not available in a great number of toxic exposure cases. I am, therefore, not convinced that workers' compensation is a viable alternative to the tort system for workers that are injured by toxic exposure at the work place. Either the court system or the Legislature must deal with this problem."

Mr. Bichler stated that as an advocate that represents injured workers and primarily first responders, this was a reversal of the trial judge that had found in favor of the widow of the worker who died following a very clear exposure to a toxic substance in the workplace and the evidence was overwhelming. From Florida's perspective, there is a very thin edge as to what may be constitutional and not in these types of circumstances.

When this issue first began and was looked at with COVID, it was clear that statutory protections would be needed. A lot of states have implemented presumptive legislation which is quite controversial but in Florida there is a history of presumptive legislation being passed to protect first responders. There was work done early in the process to try and get a presumption passed either through a Governor Executive Order or by statute. The Governor did not issue an Order but the CFO did in late March and it essentially advised state agencies and employers in Florida that they should recognize these claims as presumptively work related. That was not binding but something that a lot of Florida employers recognized and agreed that it essentially was the right thing to do for first responders.

At the same time, federal legislation was moving related to public safety officer benefits which provide for health benefits and some limited disability benefits for first responders who were injured or killed on the job. Congress did pass the legislation and it went into effect in August and recognized COVID as presumptively work related at least with respect to death claims. The language there was something thought to be beneficial for Florida police officers and firefighters. Mr. Bichler stated that separate legislation in Florida was also proposed. Florida has special protections for first responders in Chapter 112 and separate legislation was proposed for some union leaders and a template was created that they can use to try and go find sponsorship to pass legislation that would provide basic coverage for COVID cases with the ability to rebut the presumption in certain circumstances where you could demonstrate that the disease was contracted somewhere else.

Because of the timing of Florida's limited legislative sessions, the session was during the middle of the pandemic and the session ended and there was no opportunity to pass the legislation but there is interest in potentially doing it again this year and with the way things are going in Florida with COVID cases rising it appears this may be a good approach to the issue to make sure that first responders are getting covered under work comp for these types of conditions.

At the same time, there is a Task Force in Florida that is pushing primarily to restrict liability which is similar to what is being seen at the federal level where they want to immunize employers from liability claims related to COVID. That is problematic from a civil liberties standpoint that you would not allow someone to bring a claim regardless of circumstances and that may be where the rub is at in Washington. There is a sense of the need to protect employers that may not be real. If you are looking at the legislation that exists in most states, it is restrictive and it is very difficult to prove these cases anyway. In speaking to others, once the previously discussed Florida appellate case was decided last year, most attorneys that represent injured workers pretty much gave up the idea that you could prove an occupational disease or exposure case as the standard is so difficult as the cases are essentially suicide missions as you are likely to lose the case and not meet the burden.

Mr. Bichler urged the Committee to look at the precise language in state statutes regarding exposure and occupational diseases and then make a determination as to how difficult the standard is and whether anything additional is needed to protect employers from liability. Mr. Bichler stated that he would suggest nothing further is needed as about half the claims in Florida are being accepted. That is shocking as given the legal standard, Mr. Bichler stated he doesn't think any employer would have to recognize COVID-19 as being work related. It is encouraging that roughly half of the cases are being acknowledged and it seems as though employers and carriers are attempting to do the right thing in various circumstances. Mr. Bichler stated that his sense is that this may not be the sort of pressing issue that it seems and individual states will have their own determinations as to the compensability of these types of conditions.

Ya'Sheaka Williams, Esq., Partner at Eraclides Gelman, stated that when she thinks about 2020 and COVID, this has definitely been a year of change and adaptability. We have been thrust into this new world of remote working and having to adapt to the change in the world. Work comp has adapted to the changes that COVID has presented as well. On March 9, 2020, Governor DeSantis issued a state of emergency and

Executive Order 20-52 which essentially limited personal interactions outside of the home. At that time, many businesses closed or worked from home. Ms. Williams stated that all of her insurance defense clients are remote still today with the expectation that they will return to their offices at some time in 2021 on a graduated basis in order to ensure that they are able to socially distance and keep everyone safe.

Another thing that was big with the Executive Order was that it prevented elective surgery. In most instances, that may not make a big difference but when you are thinking about work comp and injured workers who are scheduled for an elective knee or back surgery that was stopped because the Governor wanted to make sure that surgeries could be done safely while not exposing patients and doctors to COVID and at the same time ensuring that if there was an issue as a result of COVID those facilities could quickly respond.

Eventually, that caused a ripple effect in work comp. If you have a person scheduled for surgery on March 15 the expectation is that they would be out of work for two weeks and the expectation is that you are paying them lost wages for that period of time and then you are able to get them back to work. If elective surgeries are delayed, the employer's exposure continues because the injured worker can't return to work and their out of work status is prolonged and quite possible their ability to recover from the surgery, although it's elective, could have a ripple effective from having them recover long erm.

About two months later, some changes were made with another Executive Order being issued on May 4 (20-112). That Order stated that "Local jurisdictions shall ensure that groups of people greater than ten are not permitted to congregate in any public space that does not readily allow for appropriate physical distancing." Also, "Bars, pubs and nightclubs that derive more than 50 percent of gross revenue from the sale of alcoholic beverages shall continue to suspend the sale of alcoholic beverages for on-premises consumption." If you represent a district or an employer that is largely a business they are drastically impacted by that Order. Not only are they losing revenue but you also have a diminished workforce because if you have a business that more than 50% of revenue is from alcohol and that is stopped, and if they don't have sufficient menus to serve food then more than likely they are not going to be open or they are going to be open at such a reduced capacity that it's going to cause significant loss. At that time, capacity at restaurants was limited to 25%.

On June 5, Executive Order 20-139 was issued which took a look at long term care facilities. The Order stated that those people working at such facilities must undergo routine testing. That is excellent because that means the spread of the virus can be prevented and people with the virus can be treated. Also, retail stores and fitness facilities were allowed to reopen as long as they could ensure social distancing and able to sanitize the facilities. Then, restaurants and businesses moved to 50% capacity and businesses really started to reopen. Then, in September the state moved to the right to work phase and that phase is where the Governor really got aggressive in trying to re-open businesses and getting the economy re-started after roughly six months of businesses being somewhat stagnant because of the precautions needed to help cease the spread of COVID.

All of this relates to work comp. In work comp, if you are an employee that is primarily paid in cash or in tips, their IRS filing is heavily relied on to calculate what the average weekly wage is which is used by the carrier and the claimant's counsel to determine how

much weekly cash benefits the workers would be entitled to if they are out of work based on their work restrictions. The tax deadline was delayed from April to July so there was no obligation for the worker to file before July so in that regard there were issues with trying to calculate what a person could be entitled to on a week to week basis.

Regarding unemployment compensation, during the initial state of emergency in phase one, many businesses were closed and operating at a significant reduced capacity. Ms. Williams stated that many of the employers she represents were furloughing their employees at least for the short term. For those employees, they were not fired but were furloughed and allowed to collect unemployment compensation and so the question is how does unemployment compensation directly impact work comp. Under Florida statute 440.15, it addresses a person's entitlement to unemployment compensation benefits and the impact on work comp. First, if a person is on a no-work status but has been furloughed they would be entitled to unemployment compensation which would include the $600 per week additional benefit provided by the CARES Act. If a person receives unemployment compensation at any time during which they are on a temporary total disability work status where their doctor has said you are so injured that you are unable to work at all, you cannot receive unemployment compensation and compensatory total disability benefits at the same time. Temporary total disability benefits are paid at two thirds of the claimant's average earnings during he week. So, the claimant is unable to double dip. For the employer carrier, that reduced the exposure on that particular claim for as long as the person is receiving unemployment compensation.

For someone who is on duty or has work restrictions at the same time they were furloughed, they would also be entitled to unemployment compensation during that time but they would be able to receive the full 64% of their average weekly wage in conjunction with unemployment compensation. Unemployment compensation is primary so the employer carrier will receive a dollar for dollar offset of unemployment benefits received. As an example, if a person would normally receive a temporary partial disability benefit of $200 per week but with unemployment compensation in the CARES Act they were receiving $700 per week – during that week of temporary partial disability they were receiving no money from work comp because they were fully compensated by unemployment compensation and receiving a benefit of the CARES Act. Ms. Williams stated that for her practice, the positive of the unemployment compensation CARES Act was that for injured employees they weren't able to receive unemployment compensation and work comp or the amount of unemployment compensation that they received was so high that they were entitled to receive unemployment compensation throughout temporary partial disability benefits which in turn reduced the file exposure on the claim.

Ms. Williams stated that another thing that had to be dealt with in phase one were doctor's office closures. At the beginning, it was almost a sense of ants scrambling around figuring what was safe and not safe. Many doctor's offices had to close to make sure they could rest and operate in a way that was safe for them and patients. One medical practice in the Tampa area contracted COVID and as a result the office and multiple offices in that practice group closed down for 3 weeks to make sure it was safe and everything was cleaned. That was a big deal because a lot of injured workers were being sent to that practice group.

Then, there was a concern of injured worker fear. For instance, many did not want to leave the house or go to the doctor's office over fear of contracting COVID. That results in delayed care. However, what has been very positive for work comp practice in Florida is that many doctors have become more innovative and there has been an uprising of Teladoc. When Teladoc was first introduced, Ms. Williams stated that she was skeptical, but this year it has become so prevalent and successfully operated for injured workers being treated. It has also resulted in doctors being more efficient and being able to treat more injured worked which has been a silver lining of COVID. Not every doctor agrees, but for those that do, it is a great way to keep cases moving forward and getting injured workers back to pre-accident status. Physical therapists are also providing therapy via Teladoc which is very innovative and a great way to get injured workers back to work. Ms. Williams stated that the only hiccup she has seen with Teladoc has been technology as it almost presupposes that the injured worker has the necessary technology to get the benefit of Teladoc. There are some vendors out there who provide the technology to injured workers to assist them for appointments. It is very important that those issues are addressed and COVID has highlighted the need to work together and use a more collaborative model in treating injured workers.

Going forward, Ms. Williams stated that enhancing cleaning and treatment protocols will be a priority. You are seeing changes in the amount of people that are allowed to come into the examining room which can be an issue if the injured worker needs a translator. Many times, now the translator attends the visits by phone because the doctor is limiting the amount of people in the room. Nurse case examiners who typically would attend an appointment to get information to give the employer carriers are now attending telephonically. Also, doctor's offices are now conducting temperature checks and waivers and questionnaires or requiring the worker to stay in their car prior to the appointment. Ms. Williams stated that she has noticed providers really adapting to COVID at a great rate as she really hasn't seen a significant decline in the treatment injured workers are receiving.

Ms. Williams stated that she had a case that went to trial earlier this year where the injured worker felt uncomfortable seeing a physician in-person and they were offered to provide transportation services. The worker was concerned with whether they would be the only person in the vehicle or whether they had time to disinfect the vehicle. In that case, the judge ordered that accommodations be made to find a doctor closer to the claimant's home because of his concerns with transportation and COVID. Ms. Williams noted that treatment options have been very innovative and there has been a lot of flexibility in practice. Ms. Williams noted that since COVID, there has been less workers and less claims and that the cases she does have are more litigious because more focus is able to be on those cases. With a reduced workforce and businesses closing, there are less claims and the claims that are filed are related to people having pretty significant injuries and not your run-of-the-mill minor work comp claims and they are significant enough for the person to want to file a claim versus dealing with it and keep working.

Ms. Williams stated that one thing that has been key throughout this has been communication. COVID required these work comp cases to be handled on a more collaborative basis – more communication with claimant's counsel, doctor's offices, vendors who are helping move the cases to the system and getting the injured worker back to work. That is a positive, as has also been the case with the expanded use of telemedicine in the work comp system. Ms. Williams stated that this has been a year of

change and adaptability for everyone and if everyone remains collaborative going forward, the results should be positive in the end.

David Langham, Deputy Chief Judge of Compensation Claims at the Florida Office of Judges of Compensation Claims, stated that he has been in this industry for over 30 years and he has never seen anything like COVID. Judge Langham stated that his main advice for anyone legislating or regulating in this system would be that the ancillary and tangential affects are going to be far broader than the direct affects and that is where minds need to be moving forward. The big peak for work comp claims in Florida was in July and since that time even though the state has opened since then the curve has flattened. A lot of folks thought that once the state was re-opened there would be a lot more work comp claims but that has not happened.

There are 22 million people living in Florida and there have been 23,452 loss time claims reported – the people who have claimed they have suffered a work injury. That is exceedingly low in the grand scheme of things and is important to note. The vast majority of those claims fall into a cost that is less than $5,000 to the carrier; they have a mean average cost of $703 each. Some of the blame for that can be put on the federal government as they stepped in and provided a greater unemployment compensation and some of the blame can be attributed to Mr. Bichler's comments about how hard it is to prove an occupational disease in Florida so some folks looked at things and saw how high the hill they had to climb was or they could just take the unemployment compensation which was a good benefit and a lot of those cases probably steered that way. Judge Langham noted that the vast minority of cases did get very expensive and the mean average of the 6 highest cases was almost $800,000 each. Judge Langham stated that cost does not come from indemnity but rather medical care and the cost of medical care for COVID is very expensive and is something that needs to be monitored.

Miami-Dade is by far the most densely populated county in Florida and 31% of the claims are coming from there. Another 8% comes from Broward so almost 40% of the cases come from an area of the state that has almost 22% of the state's population. That supports the notion that population density is important but not critical as this meeting today is in Tampa that has 7% of the state's population and only 3% of the lost time claims which indicates that COVID can be controlled and better treated in urban areas. For some reasons it is not in some places.

Judge Langham stated that the 31% COVID lost time claim number compares to 8% of all lost time claims in Florida this year. That shows that COVID claims are really a big percentage but they are also only 8% of total expenditures, including the very expensive claims of about $800,000 each, so this is a very broad and very important segment of claims but the cost of them today is simply not where you would expect them to be. The word "today" is important because a lot of scientists are saying that there is such as thing as "long COVID" which refers to the fact that some people may have bad health outcomes years down the road due to exposure and we may be talking about some folks about lung transplants and cardiopulmonary disease of a variety of things. So, picking these things up as compensable today may create risks for insurance carriers 5-10 years down the road and that may be part of the cost not seen yet.

Of the almost 25,000 claims, only 45% have been denied. It turns out that a lot of those denials are based on negative test results – employees who have gone to their employer to report they have COVID at work and they say they have symptoms and then they get

a test result back 10 days later that says they tested negative. That is going to be denied and rightly so. Part of the flattening of the curve might be that employees are not so quick to report in today's environment because for the most part there is wide access to rapid test results.

There is a disparity in the way the money shakes out. Florida's Division of Work Comp chose to categorize all the claims into categories: airline; healthcare; office workers; protective services (first responders); and service industry. The numbers are not in parity everywhere. The office numbers are closely tied: 10.6% of the claims and 10.7% of the cost. But, the protective services category is 32.5% versus 44.2% and the service industry category is 29.2% versus 10.2%. Part of that may be due to optimism bias and Judge Langham warned against that as first responders and doctors are trained professionals and they have convinced themselves that they are invincible and that is a psychological occurrence that we know occurs.

Judge Langham stated that the denials are not totaling $0. For compensable claims the number is about $40 million spent and that number is expected to rise but the denial claims total about $500,000 spent. For cases that are denied and they are not moving forward in terms of expenditure it is important to remember that there are still costs associated with that and employers and carriers are paying those costs to get testing and quarantine time and those sorts of things. Judge Langham noted that of the total amount of lost time claims, Mr. Bichler believes that it is in large part to folks doing the right thing and Judge Langham stated that he does not doubt there is some of that but it also occurs to him that some employers are picking up the claims because by doing so they get a healthy dose of work comp immunity and that may be part of this. We do know that there are several cases pending in Circuit court where employees are trying to sue their employers and they are concurrently in the work comp system. So, all of that probably goes into an employer's decision making process in all of this.

Sen. Bob Hackett (OH) stated that he appreciated Ms. Williams' comments and hopes that the American Medical Association (AMA) was listening because with regard to telemedicine, providers are able to see more patients and it is cheaper most of the time to do telemedicine versus in person care.

ADJOURNMENT

Upon a Motion made by Rep. Lehman and seconded by Asm. Cooley, the Committee adjourned at 10:30 a.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
SPECIAL COMMITTEE ON RACE IN INSURANCE UNDERWRITING
INTERIM COMMITTEE MEETING
MARCH 5, 2021
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Special Committee on Race in insurance Underwriting held an interim meeting via Zoom on Friday, March 5, 2021 at 1:00 P.M. (EST)

Senator Neil Breslin of New York, Chair of the Committee, presided.

Other members of the Committee present were:

Asm. Ken Cooley (CA)
Sen. Travis Holdman (IN)
Rep. Matt Lehman (IN)
Rep. Joe Fischer (KY)
Rep. Bart Rowland (KY)
Rep. Edmond Jordan (LA)
Rep. Brenda Carter (MI)
Asm. Kevin Cahill (NY)
Asw. Pam Hunter (NY)
Sen. Bob Hackett (OH)

Other legislators present were:

Rep. Shawn McPherson (KY)
Sen. Jim Burgin (NC)
Rep. Carl Anderson (SC)

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Tess Badenhausen, Assistant Director of Administration, NCOIL Support Services, LLC

INTRODUCTORY REMARKS: CHAIR BRESLIN AND INDIANA REPRESENTATIVE MATT LEHMAN – NCOIL PRESIDENT

Senator Neil Breslin (NY), Chair of the Committee, thanked everyone for joining and then turned things over to NCOIL President, Representative Matt Lehman

Rep. Lehman thanked everyone for joining and stated that he is proud to sponsor the proposed definition of “proxy discrimination” alongside Chair Breslin and he believes the definition represents the best path forward for the organization. Rep. Lehman stated that the Committee had a very good discussion on this issue at its last meeting and he would like to thank everyone that participated. In his discussions with Chair Breslin, Rep. Lehman noted that they feel confident that the proposed definition before the Committee represents a solid work product and is something that should be adopted by the Committee so that NCOIL can fulfill its role in providing guidance to states when developing public policy on this first of the two committee charges.

Rep. Lehman stated that he knows Chair Breslin will touch upon this as well, but they both believe it’s vital that the definition of “proxy discrimination” recognize that there is an

intentional act associated with it. This is necessary because the legal term "proxy discrimination" has the word "proxy" right in it, and "proxy" already has a definition that involves volition. It's important that the definition in statute not be in contradiction with the definition as understood by general society. Such a contradiction would create havoc for essentially everyone involved in the underwriting portion of the insurance industry.

Rep. Lehman stated that he also wants to note that since proxy comes to us with an existing definition, that proxy discrimination needs to remain separate from disparate impact discrimination, which involves no intent. The second charge of this Special Committee is to review individual underwriting factors. The Committee will see that some of those factors have a disparate impact on protected classes, and the Committee may conclude that some of that disparate impact is unfair. That requires separate analysis from the fairly straightforward definition of proxy discrimination. Rep. Lehman then repeated something that he said in December but stated that he thinks it's important to reiterate: having conversations like these is not always easy, but NCOIL cannot sit idly while decisions that can have a huge impact on our constituents and the state-based system of insurance regulation in general are made without input from state insurance legislators. Indeed, state legislators are those that have been vested with the authority to make such decisions pursuant to the McCarran-Ferguson Act enacted 75 years ago. Rep. Lehman stated that he looks forward to the discussions today.

Chair Breslin stated that he is proud to sponsor the proposed definition of "proxy discrimination" as it deals with such an important and timely issue. The Committee had a very good discussion on this issue at its last meeting in December where it heard from several speakers with very different views on this issue. A number of people reached out to Chair Breslin afterwards saying it was great to see so many people come together on such important issues. The driving force behind crafting the definition in the manner in which it appears is the need to explicitly recognize that "proxy discrimination" involves some affirmative decision or volitional act by an individual or entity. This concept of intent is necessary both because the legal term "proxy discrimination" includes the word "proxy" which comes with an existing definition, and in order to separate it from being equated with disparate impact discrimination, which involves no intent.

Chair Breslin stated that while he doesn't want to go too far down a linguistics rabbit hole, he does want to spend a little time reviewing the actual, existing definition of "proxy". One dictionary defines it as: "[o]ne who is authorized to act as a substitute for another." Another definition reads: "[T]he authority that you give to somebody to do something for you, when you cannot do it yourself; a person who has been given the authority to represent somebody else; something that you use to represent something else that you are trying to measure or calculate." The words "authorized" and "authority" involve some level of affirmatively and/or intentionally granting permission to someone. The top Merriam-Webster definition of "authorize" reads: "to endorse, empower, justify, or permit by or as if by some recognized or proper authority (such as custom, evidence, personal right, or regulating power)."

Contrast this intentional discrimination which has always been prohibited, with disparate impact, which has, with certain exceptions, always been legal within the insurance industry and involves no intent. Accordingly, equating "proxy discrimination" and disparate impact would both contort the use of the word "proxy" in the phrase so as to render it inconsistent with its plain meaning, and completely revamp the insurance

ratemaking system. Adopting a prohibited disparate impact standard for insurance ratemaking analysis across-the-board would simply be incompatible with basic insurance principles.

Chair Breslin stated that he strongly believes that NCOIL adopting this definition of "proxy discrimination" will be beneficial to not only the organization by demonstrating leadership on such an important issue, but also to states as they begin to deal with these issues in their legislatures. For example, a bill was introduced earlier this week in Colorado containing the term "proxy discrimination" but the bill does not define the term. Everyone on this call today knows the importance of words being defined in legislation. Undefined terms create problems for the legislators that enacted the law, the regulators that enforce the law, courts that are called upon to interpret the law, and those governed by the law.

However, Chair Breslin noted that the Committee's work does not end with defining the term "proxy discrimination." More attention should be given by the Committee during its April meeting to the issues surrounding rating factors and disparate impact. As referenced earlier, as a general matter, disparate impact has always been legal within the insurance industry and by definition, there is no intent involved. However, based on the Committee's discussions during its December meeting, the Committee should further discuss instances where there is overwhelming evidence that disparate impact amounts to unfair discrimination because of, for example, a rating factor's negative impact on a protected class.

That process recognizes that in insurance, actuarial justification is the one core standard of risk-based pricing that applies to every rating factor. But, from time-to-time state legislators, after extensive debate during which all perspectives all heard, decide that even if certain factors can be actuarially justified, social considerations warrant that they be exempted from the core standard or risk-based pricing. This is what happens across the country in state legislatures when deciding whether or not to prohibit insurers from using certain rating factors in underwriting such credit score, zip code, or gender. That is the proper way to address any social unfairness in the insurance underwriting process rather than imposing a disparate impact standard.

That brings us to the format of today's meeting, the Committee will first hear any comments and questions from legislators regarding the definition of "proxy discrimination." Once all legislators are finished speaking, the Committee will then hear any comments and questions from interested persons. Once all comments and questions are heard, Chair Breslin stated that he would entertain a Motion to vote on the definition. Next, the Committee will follow the same format of hearing from legislators first and then interested persons regarding the next steps for the Committee's April meeting when discussing rating factors and disparate impact.

CONTINUED DISCUSSION AND CONSIDERATION OF "PROXY DISCRIMINATION" DEFINITION, AND AMENDMENTS TO NCOIL PROPERTY/CASUALTY INSURANCE MODERNIZATION MODEL ACT

Asm. Ken Cooley (CA), NCOIL Vice President, thanked Chair Breslin and Rep. Lehman for their work. It is worth noting a very important related concept to the whole point made by Chair Breslin concerning the importance of working within a universe of defined terms of known meaning. The business of insurance is one that if you enact statutes

which are vague in their expression then you can have a lot of liabilities arise during the period of time from when the onset of the statute is until they get clarified. Asm. Cooley stated that he feels that in the area of rating, to introduce uncertainty as to on what are the rates founded on really jeopardizes the capital base of insurers because until that all gets sorted out claims can come in and disputes can arise and it can be a very heavy load to deal with in litigation and claims payouts arising from things not being clear.

Asm. Cooley stated that he feels that there is a special responsibility which only insurance oriented lawmakers would grasp which is that to introduce vagueness into the rating statutes and then passing them in states trusting that its going to get worked out in time actually exposes the capital structure of insurance companies to a very significant legal issue. It runs in favor of being conservative, cautious, and thoughtful in how we pick apart something and examine the importance of language and the extent to which it affords clarity so that we are not opening up the potential for legal problems.

Rep. Brenda Carter (MI) stated that she would like to mention the fact that when she and her colleagues were discussing this in Michigan one of the questions was whether gender orientation could be considered as a rating factor by insurers. NCOIL General Counsel, Will Melofchik stated that question goes more towards the Committee's second charge in terms of discussing specific rating factors. NCOIL CEO, Cmsr. Tom Considine, stated that additionally, if an insurer were to use a neutral factor intentionally as a substitute for gender, that would be unfair discrimination by proxy and would be precluded by this definition. Rep. Carter replied thank you.

Rep. Edmond Jordan (LA) stated that he takes somewhat of a different sentiment to this. He does not see the definition as a move forward but rather backwards. Rep. Jordan stated that he listened to the remarks regarding the definition of certain words and a lot of time was spent on proxy, but not on discrimination. Definitions for discrimination include: bigotry, hatred, inequity, injustice, intolerance, prejudice, and unfairness. If the Committee is not dealing with the disparate impact aspect of these issues, then Rep. Jordan stated he is really not sure of what the purpose of the Committee is.

Definitions are fluid. Rep. Jordan stated that if he said someone was a "bad" man, there is context associated with that – it could mean that you are awful but it also could mean that you may be great. If someone said Patrick Ewing is a "bad" player it could mean that he is good. The truth of the matter is that we can define a word to mean what we want it to mean within an organization or an industry. Rep. Jordan stated that he has a disagreement with that. There is a famous quote which says that if you stick a knife in my back nine inches and pull it out six inches, there's no progress - you have to heal the wound that created the injury. Rep. Jordan stated that he believes folks have been discriminating - not this Committee and not individually, but as an industry there may be some fear on how it got there and how to make a profit without certain factors in place.

Rep. Jordan stated that he believes this Committee is well intended but this is only its second meeting and he does not believe you can fix this in one meeting and then vote the next but if that's the attempt then so be it. Rep. Jordan stated that he understands there are efforts to move forward and he believes everyone in good faith wants to move forward. Rep. Jordan stated that he doesn't think the proposed definition gets the Committee to the place where it needs to be - more work needs to be done. Difficult discussions need to be had and he doesn't think that one leads merely by not wanting to be left behind. Rep. Jordan stated that he understands there are other entities trying to

develop a definition but the fear of being left behind doesn't necessarily mean that you are the leader on the subject. Rep. Jordan stated that he believes that if we want to be leaders we need a more thoughtful approach. That is not to say that this approach is not thoughtful, but the Committee can do better. Rep. Jordan stated that he is willing to work on that and would ask for a commitment from everyone to get there.

Chair Breslin thanked Rep. Jordan for his comments and stated that hopefully that's what the Committee is trying to do - to arrive at a valid insurance industry that does now acknowledge or allow any racism to creep into its rating system. It is not a perfect process because it depends on a lot of people to make sure that it acts that way and along the way mistakes will be made but hopefully if we're all trying to climb the same mountain we'll get to the top together.

Asm. Kevin Cahill (NY), NCOIL Treasurer, stated that he agrees with some of Rep. Jordan's comments in that we have a proactive responsibility to root out discrimination wherever it is but in particular in the area of insurance where there has been a history unfortunately of discriminatory practices in the past. Asm. Cahill stated that while he wholeheartedly supports Chair Breslin and Rep. Lehman on their work and moving this issue forward, and for taking the initiative Cmsr. Considine deserves credit, he believes that even on this first charge the Committee could do more. Asm. Cahill stated that understands that there is a traditional sense of proxy discrimination of requiring an intentional act. However, there is also a belief that proxy discrimination can occur without an intentional act.

Asm. Cahill referred the Committee to a recent Iowa Law School law review article that discusses this very issue especially in age of artificial intelligence. Asm. Cahill stated that for those reasons he wont support the definition but noted again that is not meant to be a slight on the parties involved because he applauds them for their work.

Asw. Pam Hunter (NY) stated that she would like to add on to Rep. Jordan's comments. Foundationally, she feels that this is not the right direction if we're not talking about systemic longstanding discrimination in the industry. Asw. Hunter stated that if you look at long term decisions that have affected communities like redlining, and we're talking about today how we're not going to take into consideration a person's skin color but we're going to talk about someone's zip code, she knows that there are a couple of census tracts where she lives that are the highest poverty rates in the entire country of people of color so they are going to disproportionately have a negative advantage for loans and insurance.

Asw. Hunter stated that she feels strongly that the Committee can do much better in having a broader conversation. Asw. Hunter stated that she knows that the Committee is going to get more in depth in terms of disparate impact and rating factors but if we don't foundationally start in the right direction it wont go to where we need it to be. Asw. Hunter stated that she agrees that this can be more thought out and take more time. While there are other organizations involved, it's not a race to the finish line, but rather making sure we are taking the appropriate steps to right historic wrongs and make sure we have equity going forward. Asw. Hunter stated that she doesn't think the Committee is there yet and its no disrespect to the people involved or the organization but she believes the Committee can do better.

Chair Breslin stated that anyone who would tell him that there hasn't been racism in the industry is deceiving him and not telling the truth but hopefully everyone learns from mistakes. As the famous saying goes – he who forgets the past is doomed to repeat it. The Committee should continue to talk about the past but sometimes that can also be detrimental if you only focus on the past and Chair Breslin stated that he believes the Committee is looking forward and trying to figure out how to move on to make sure that all classes legally are protected and that the insurance industry is at the forefront of making those changes.

Rep. Lehman stated that the comments made by Rep. Jordan, Asm. Cahill and Asw. Hunter brought up some very good points but they focus more on the second part of the Committee's charges which is the rating factor discussion. The factors will be part of the second charge of the Committee but setting forth a definition is key to setting a bar out there that says "we don't want you playing games if you are moving pieces of the puzzle around." What pieces that are part of that puzzle will be part of the second half of the Committee's discussions. Rep. Lehman stated that he doesn't want to cut anyone off but it seems that the discussions thus far are focused on the second charge and we need to focus on the definition right now that we want to put out there that can go into law so that it cant be used improperly by departments and carriers.

Hearing no other questions or comments from any legislators, Frank O'Brien, VP of State Gov't Relations at the American Property Casualty Insurance Association (APCIA) first thanked Chair Breslin and the Committee for their work on this important issue. As the comments today show it hasn't been easy and APCIA doesn't think it will get any easier but few things that are important are never easy. Second, with regard to the definition, APCIA joins in urging its adoption. In proposing and debating and hopefully adopting the definition, NCOIL is laying out a marker as an initial statement of public policy. By acting in a space where others have not NCOIL fulfills its essential role in assisting lawmakers and others on issues of importance to the state based system of insurance regulation. That is what this Committee and this organization is doing today and will continue to do in the future. Finally, Mr. O'Brien noted that the definition is entirely consistent with the dominant body of case law – it is what the law is now as opposed to what others may want the law to be. The law is a dynamic force and a dynamic object and it is through debate and discussions such as this that change is achieved. But, change begins with a first step and this definition is the first step.

Erin Collins, VP of State Affairs at the National Association of Mutual Insurance Companies (NAMIC) stated that NAMIC is supportive of the NCOIL direction and concept of both identifying proxy discrimination as a space for action as well as the connection of the concept of intent as it is applied there. NAMIC absolutely agrees that unfair discrimination includes this definition and is absolutely prohibited and has no place in our industry. Ms. Collins stated that she would like to hit a couple of points to explain why in NAMIC's view connection to intentionality is the only viable path forward for a definition of proxy discrimination. First, there has been quite a lot said about applying a disparate impact analysis to insurance or just looking at outcomes of underwriting and rating and setting aside risk profiles and actuarial science - that's a challenge. That means that applying risk classification based upon scientific evidence would be disallowed if the outcome was disproportionate. Ms. Collins stated that she cant think of a single factor anywhere that can survive that test. It's not out of an aversion to examining and having an honest discussion about underwriting and rating, it's just that an outcome approach just does not work with risk based pricing. Even if individuals only

belong to one protected class instead of multiple there is very little feasibility that outcomes will directly align with demographics.

Ms. Collins stated that for example, take the factor of age of a vehicle which is a good one because it can work both ways – it it's new it has new tech and new safety features, and if it's old maybe it doesn't have safety features and is more susceptible to severity. Ms. Collins stated that she has a car that's two years old and according to a Pew research study, 5% of American women have one of her protected class characteristics and that's a little over 8 million people. Well, what if of those women a disproportionate number drive cars that are two years old compared to the rest of the population. My insurance carrier doesn't know, nor do they want to know, about my 5% characteristic but if you apply a typical disparate impact analysis to the factor of age to the vehicle, two things happen. One, its highly likely that age of the vehicle doesn't survive that test and is disallowed as a factor and now my neighbor driving the average age vehicle is going to have to subsidize my newer car.

The second thing that happens, and this is important to me as an individual, is that because my insurance carrier will have to test all of their underwriting variables and show that test and prove it out to regulators in this way, all of a sudden by carrier is going to have to ask me about my 5% characteristic and will have to track it and store it. Ms. Collins stated that some people are going to say that she is engaging in hyperbole or it's too blunt of an instrument that she is using or that she doesn't understand how a disparate impact standard would really be applied and maybe they're right because regulators probably wouldn't start with going after age of a vehicle as a factor. They would pick and choose where to apply the standard and issue declarations about certain factors or reject filings if they have time and resources to do that.

Ms. Collins stated that she doesn't consider that a fair system but she can certainly see the practicality of that outcome. But, that's not the whole story here. If we divorce intentionality when we're talking about this broad concept of proxy discrimination and use disparate impact as an underwriting standard as some have called for, the insurance companies will be universally pulled into bad faith litigation on very single factor that they use no matter what the regulators do and that is something no one wants. Accordingly, Ms. Collins stated that the proposed definition is a good path forward. We're all trying to engage and discuss what industry's role can be in combating systemic racism in America.

Ms. Collins stated that when she listens to people smarter than her talk about potential solutions what comes up over and over again is access: access to insurance; increased products and coverages due to competition; decreasing risk through mitigation and that resulting in more access; and how we can attract new and diverse talent in the industry. Ms. Collins stated that those are things we can and should focus on and she is looking forward to that conversation with this Committee. But upending decades of actuarial science and applying something that isn't risk based is not going to create access in the market but rather will constrict the market and make it hard to know what insurance to write and how much and for how many people – that's not the answer. Creating a highly competitive market with lots of companies to choose from with the ability to match rate to risk is the path forward and where we should start. For that reason, NAMIC supports the definition and encourages adoption.

Birny Birnbaum Director of the Center for Economic Justice (CEJ) stated that CEJ appreciates NCOIL's efforts to examine the impact of systemic racism on insurer practices and insurance companies. However, the proposed definition reflects a profound misunderstanding of how systemic racism affects insurance. By defining proxy discrimination only as the intentional use of a proxy characteristic for a protected class, the definition if adopted would memorialize insurer practices that discriminate indirectly on the basis of race, would discourage insurers from examining the racial impact of their practices and would restrict current regulatory efforts to address such unfair discrimination. It is fundamentally incorrect to say that proxy discrimination must involve intent. The argument misunderstands how bias affects insurance outcomes. The proposal basically takes the view that unless you intend to discriminate, there can be no discrimination and relieves insurers from any responsibility to test their practices for systemic bias.

The realistic view is that systemic racism and historic discrimination can be reflected and perpetuated in so called neutral factors. Literally everyone outside the insurance industry trade associations understands that big data algorithms can reflect and reproduce historic discrimination and that presence of systemic racism demands proactive examination of insurer practices for unnecessary racial discrimination. It is also factually incorrect that disparate impact analysis harms risk based pricing. Such analysis is completely consistent with actuarial practices.

Mr. Birnbaum stated that he would like to get to the type of disproportionate impact that is tied to the use of proxies for prohibited characteristics and not to the outcomes. In earlier conversations we described one situation where insurers were using age and value of a home for underwriting factors for homeowners insurance with the result that communities of color were systemically denied home insurance because these communities were characterized by older, lower value homes – results directly tied to historic discrimination in housing. When challenged, insurers discovered that the factors they were using, age and value, were more correlated with race than with insurance outcomes. As a result of the disparate impact challenge the insurer moved to more relevant risk factors such as the condition of the home and its systems with the result that insurance became more available in communities of color and there was a better correlation between risk classifications and outcomes.

This second type of impact involves unintentional, unnecessary discrimination on the basis of race. It's unnecessary because the facially neutral factor that is reportedly associated with the insurance income is in whole or in part a proxy for the protected class characteristic and predictive of that class characteristic and not the outcome. Stated differently, the facially neutral factor has a spurious correlation to the insurance outcome and is really correlated to the protected class characteristic. So, CEJ suggests that a better definition of proxy discrimination to really get at that unnecessary racial discrimination would be: "Proxy discrimination is the use of a non-prohibited factor that, due in whole or in part to a significant correlation with a prohibited class characteristic, causes unnecessary, disproportionate outcomes on the basis of prohibited class membership."

Mr. Birnbaum stated that he will finish by saying that that any efforts to address systemic racism and proxy discrimination have to apply to all aspects of insurer's operations, not just pricing and underwriting. For example, insurers could be marketing based on protected class factors directly or indirectly and that would not be prohibited by the

definition. Yet with big data analysis insurers can micro target customers, focusing on those they view as high value and excluding those they view as low value with the result that those who are low value that happen to be in communities of color would never see preferred offers. Similarly, for anti-fraud and claims settlement, companies are using big data algorithms and sources of data such as facial analytics that are known to have a strong bias.

The other two points are that industry admits that the proposed definition adds no new tools or resources to regulators. During the December meeting of this Committee Mr. Birnbaum stated that he asked The Honorable Nat Shapo, former Director of the Illinois Department of Insurance whether it's his position that if a regulator discovered an insurer using a perfect proxy for race could the regulator take action to stop that discriminatory practice. Mr. Birnbaum stated that Dir. Shapo offered the view that regulators have that authority. So, given that view the proposed definition not only fails to add any new tools but actually restricts activities that insurance regulators have long engaged in to stop the use of blank proxies. Now, they somehow have to prove intent where currently regulators work on things they know have an unnecessary and unfairly disproportionate impact.

Mr. Birnbaum stated that, in closing, CEJ urges NCOIL to reject the proposed definition of proxy discrimination and hopes that the Committee's intent is to address impacts of systemic racism in insurance. If that's the case, the proposed definition accomplishes just the opposite and would memorialize such unnecessary proxy discrimination.

Dir. Shapo stated that he would like to speak for a couple of minutes since his prior testimony was just cited. First, Dir. Shapo stated that the description of his testimony from December is inaccurate. Dir. Shapo stated that the idea that Mr. Birnbaum asked him a question about a perfect proxy and that he gave a particular response doesn't conform to his memory and is not reflected in the record of the hearing. Dir. Shapo stated that he doesn't believe he was asked a question by Mr. Birnbaum, nor does he believe he could have been as NCOIL to his knowledge only allows Committee members to question witnesses – not other witnesses to do so. Also, Dir. Shapo stated that he thinks that the testimony he gave about the subject is quite a bit more nuanced than described by Mr. Birnbaum. Dir. Shapo stated that he did offer a view on the general subject that he thought the language in the current prohibition in rating based upon a protected class like race should be understood to cover proxy discrimination. Dir. Shapo stated that he has a longstanding concern about regulators sometimes not using the tools they have before they seek more and that informed his position that he just recited.

Dir. Shapo stated that he was also particularly concerned about moving toward a definition that could have bought in the same kind of disparate impact outcome under the guise of proxy discrimination which is reflected in the CEJ submission. The submission talked about proxy discrimination but it's clearly about disparate impact and the distinctions between the two have been well covered in this meeting and prior meetings. The bottom line as he understands it is that NCOIL felt strongly it was necessary to define proxy discrimination particularly because of the idea that without a definition it could bleed over to disparate impact, and NCOIL has also mentioned that the NAIC has adopted a proxy discrimination standard without defining the term so as a practical matter that is the position that NCOIL has taken and makes perfect sense.

Dir. Shapo stated that another accuracy point is that he believes on this question about the age and value of a house there is a reference to insurers finding that there was a correlation to race and not a correlation to risk. There wasn't a citation to this assertion in the CEJ letter but the best he can guess is that it's probably a reference to some decision in the 1980s under a federal anti-discrimination statute. Dir. Shapo stated that he believes the statement is that when challenged insurers found that the factors they were using, age and value of home, were more correlated to race than with insurance outcomes. Dir. Shapo stated that he is not aware of anything in the record that says insurers found that and concluded that they were using factors that were more correlated with race than insurance outcomes. Dir. Shapo stated that he thinks what you had there was a very specific federal statute under which litigation was brought that only pertains to housing and thus in the insurance world homeowners insurance, and the defendant insurance companies as rational actors will do in litigation entered into settlement agreements that may have affected the types of factors they used. That doesn't mean that they concluded that they were correlating with race and insurance outcome.

Dir. Shapo stated that those factual quibbles sort of funnel into the basic disagreement he and Mr. Birnbaum have on these issues. When looking at this it's a question of do you think disparate impact on every factor is the way to analyze this or is it better to funnel into what Chair Breslin said before which is to conduct an examination of individual factors and a determination of whether there is social unfairness that outweighs the social fairness of their actuarial justification. There was a lot of discussion about that at the last hearing and its brought up again here. Dir. Shapo stated that his view is that he thinks the concerns raised by certain Committee members are very important concerns but charge two of the discussion and the legislator's application of their political judgment is the well-established way that legislators have addressed these problems in the past.

Mr. Birnbaum stated that the record is clear that in the last Committee meeting he did ask Dir. Shapo that question and he did respond as set out in CEJ's letter. The second point is that it was not the 1980s it was 1990s and it was a claim brought under Federal Fair Housing Act (FHA). The fact that it was brought under the FHA doesn't really import a problem with the issue of whether disparate impact analysis is relevant and useful for insurance and whether it promotes better risk-based pricing or whether it harms. The evidence is that disparate impact analysis improves risk-based pricing. Industry has never been able to provide a single example of how its harms risk-based pricing. The fundamental problem here is that the definition is conflating two issues – its conflating the types of historic discrimination that leads to embedded outcomes such as shorter life expectancy for black Americans or certain diseases that black Americans suffer – that type of outcome can't be separated from actuarial analysis. The type of issue that we're talking about here can be separated from the outcomes and that's where the problem lies.

Cmsr. Considine stated that while Mr. Birnbaum and Dir. Shapo disagree on the issue of whether a question was asked at a prior meeting, he does not believe Chair Breslin would have allowed another interested party to ask another interested party a question at an NCOIL hearing. That has never been done and the record does not reflect that happening. Perhaps Mr. Birnbaum is referring to an exchange that happened at an NAIC meeting.

Rep. Jordan stated that his immediate concern is he is not sure what exactly the Committee is accomplishing. It just seems the Committee is creating a definition of proxy discrimination seemingly in response to the NAIC. And then there is the question of whether the definition eliminates or mitigates discrimination. In his opinion, it does not so he goes back to his first question of what is the Committee accomplishing. The Hippocratic oath of "do no harm" applies here and Rep. Jordan stated that he believes that if the definition is adopted the Committee is probably doing more harm than good. Rep. Jordan stated that he will close by saying if we substitute gender for race and you're hearing complaints from the people who it immediately affects and you move forward then are they really being heard.

Hearing no further comments or questions from legislators or interested persons, upon a Motion made by Sen. Travis Holdman (IN), NCOIL Immediate Past President and seconded by Rep. Joe Fischer (KY), NCOIL Secretary, the Committee voted to adopt the definition by a vote of 7-3. Rep. Jordan, Asm. Cahill and Asw. Hunter were "no" votes. Rep. Carter did not record a vote as she left the meeting prior to the vote being taken.

Chair Breslin then mentioned that the Committee will be meeting again during the NCOIL Spring Meeting next month. The Committee will continue its second charge of discussing disparate impact and specific rating factors. Currently, Peter Kochenburger, Executive Director, Insurance Law LL.M. Program, Deputy Director, Insurance Law Center, Associate Clinical Professor of Law at the University of Connecticut School of Law will be delivering a presentation regarding insurer's use of criminal history in underwriting. Chair Breslin offered the opportunity for everyone to offer suggestions for other topics for the Committee to discuss.

ADJOURNMENT

Upon a Motion made by Asm. Cahill and seconded by Sen. Holdman, the Committee adjourned at 2:30 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
JOINT STATE-FEDERAL RELATIONS & INTERNATIONAL INSURANCE ISSUES COMMITTEE
CHARLESTON, SOUTH CAROLINA
APRIL 16, 2021
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Joint State-Federal Relations & International Insurance Issues Committee met at the Francis Marion Hotel on Friday, April 16, 2021 at 10:15 A.M. (EST)

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

Other members of the Committee present were (* indicates virtual attendance via Zoom):

Rep. Deborah Ferguson (AR)*
Sen. Jason Rapert (AR)
Asm. Ken Cooley (CA)*
Rep. Matt Lehman (IN)
Rep. Joe Fischer (KY)
Rep. Bart Rowland (KY)
Sen. Kirk Talbot (LA)
Rep. Brenda Carter (MI)
Sen. Neil Breslin (NY)*
Asm. Kevin Cahill (NY)*
Sen. Roger Picard (RI)
Del. Steve Westfall (WV)

Other legislators present were:

Sen. Mathew Pitsch (AR)
Rep. Matt Dollar (GA)
Rep. Terri Austin (MI)
Rep. Jim Gooch (KY)*
Sen. Stewart Cathey (LA)
Rep. Sarah Anthony (MI)
Rep. Kyra Bolden (MI)
Rep. Kevin Coleman (MI)
Sen. Lana Theis (MI)*
Sen. Paul Utke (MN)*
Rep. Justin Hill (MO)
Asm. Ken Blankenbush (NY)
Rep. Brian Lampton (OH)
Sen. Ronnie Cromer (SC)
Rep. Kevin Hardee (SC)
Rep. Jim Dunnigan (UT)

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Tess Badenhausen, Assistant Director of Administration, NCOIL Support Services, LLC

QUORUM

Upon a motion made by Sen. Roger Picard (RI), Vice Chair of the Committee, and seconded by Del. Steve Westfall (WV), the Committee waived the quorum requirement without objection by way of a voice vote.

MINUTES

Sen. Hackett stated that if there are no comments or questions regarding the minutes of the Committee's December 10, 2020 meeting, the minutes will stand as read. Hearing no comments or questions, the minutes stood as read.

DISCUSSION ON NEW FEDERAL BALANCE BILLING LAW – THE NO SURPRISES ACT

Before beginning the discussion, Sen. Hackett noted that Ohio is one of the states that has passed balance billing laws and since the enactment of the No Surprises Act (NSA), a lot of questions have been coming in as to how the state and federal laws will work together. Chris Garmon, PhD, Senior Consultant at Compass Lexecon and Assistant Professor of Health Administration at the University of Missouri, stated that the NSA protects patients from surprise, out of network (OON) medical bills and regulates the payment disputes between health plans and OON providers. So, what is a surprise medical bill? A surprise OON medical bill is when a patient receives treatment unexpectedly or involuntarily from an OON provider and then they are sent a bill requiring that they pay the difference between the insurer payment and the provider's full charges.

This can occur in a number of situations. The most common that you hear about in the press is say you break your leg and need to go to the ER for the nearest hospital in your network but it turns out that the physician treating you is not in your network and you end up getting a balance bill later on. One of the first examples from the past six years or so that got a lot of press was from the New York times – Elizabeth Rosenthal documented a case of an elective OON bill. The patient was very experienced with how our health system works and he needed an elective neck surgery. He made sure the hospital was in network and his surgeon was in network and even went so far to ensure that the anesthesiologist on call that day would be in network. He goes into the surgery, is put under general anesthesia and the surgeon calls in a secondary surgeon and it turns out that he was not in the patient's network and a few weeks later the patient got sent a bill for over $110,000. So, surprise OON medical bills can occur in elective situations and they can also occur with emergency transport with either ground or air ambulances.

So, how often does this occur? Dr. Garmon stated that his research found that with ambulance cases it can occur quite often and with air ambulance roughly 60% of the time there is the potential for an OON balance bill and for ground ambulances about 50% of the time so it's like flipping a coin if you need emergency transport with an ambulance. Emergency room cases are somewhere between one quarter and one fifth of the time but even with elective in-patient cases such as obstetrics cases roughly 9% of the time you can have a surprise OON medical bill. The financial burden for patients with these bills can be extensive. Research recently published last week shows that for emergency room cases they end up paying on average over 10 times more than other emergency room patients where all of the care was in network.

This has understandably led to a bipartisan push for recognition that we need a solution and many states have passed balance billing laws but of course they only cover a certain portion of the commercially insured population. The federal government finally responded by passing the NSA which is a federal prohibition on surprise OON bills and it was included in the omnibus COVID relief bill in December of 2020. It protects patients from balance bills in emergency situations, in elective procedures where there are for instance an OON physician in an in-network hospital even for a scheduled surgery when

there is not prior approval for that OON physician and even in that case there are exceptions where certain specialties like anesthesiologists and radiologists are prohibited from balance billing with or without prior approval. And it also prohibits balance billing in air ambulance cases as those balance bills can be quite extensive and extreme. Patients are not protected from ground ambulance balance bills so that is one area that is not covered by the NSA. The NSA establishes an independent dispute resolution (IDR) process subject to baseball style final offer arbitration. These protections wont start until January 1 of next year.

With regard to the IDR process, the first step of that after a patient is treated by an OON provider is that the insurer must send payment to that provider within 40 days. It's important to note that many of you may be aware of the greatest of three rule that was part of the Affordable Care Act (ACA) that regulated OON emergency payments from insurers to providers. That no longer applies. The NSA amends the portion of the Public Health Services Act that the greatest of three rule was a part of so this process supersedes the greatest of three rule so that will no longer apply. So, the insurer could send any payment, it could be very small or all of the charges – there is no regulation as to what the initial payment is. If the provider is dissatisfied with that initial payment the provider can initiate the IDR process. It starts with a 30-day negotiation period followed by the baseball style arbitration where the arbiter has to pick one of the two proposals – the arbiter cant select an amount in between them.

The claims can be bundled as long as they involve the same provider, the same insurer and the same service. The losing party pays the cost of the arbitration and then then arbitration cannot be used for another 90 days after an arbitration hearing for the same provider, insurer service combination. So, the IDR process in the NSA is really designed to get the parties to the table and settle before arbitration. The hope is that arbitration will be rarely used and that these disputes will be settled beforehand. So, what factors can the arbiter consider? First, the arbiter in the legislation is specifically prohibited from relying on charges including percentiles of the charges, the usual customary and reasonable rate (UCR), and Medicare and Medicaid rates. The arbiters can rely on the median in-network rate and there is a lot in the NSA that suggests this will be the benchmark that arbiters will often use. They can also rely on prior contracted rates between the insurer and provider that are the subject of the arbitration hearing; market shares of either or both parties; patient severity of that case; and the provider's training and experience quality (if a hospital), teaching status of the hospital, and case mix of a hospital. So, there are many things the arbiter can rely on but not the charges, or Medicare or Medicaid or the UCR rates.

There are a few other things that in air ambulance cases the arbiter can rely on such as the vehicle type and the population density of the pickup location. Air ambulance providers will be required to submit cost and charge data to the federal government and the NSA also establishes an advisory committee on air ambulance quality and safety. So, how does this relate to state laws? As many of you already know, state laws only apply to those health plans that are state regulated – the fully insured health plans. The NSA will apply to all health plans, fully insured and self-insured and it preempts state law with certain exceptions. The exceptions are the methods for determining OON payment. If a state has its own IDR process or it uses its own benchmark for OON payment the state can continue to do that and fully insured health plans in that state can continue to do that and use the state's process for determining that OON payment. If a state already regulates provider directories of the fully insured health plans then state can

continue to follow that regulation. And a state law is allowed to exceed the patient protections set forth in the NSA so for instance if a state law prohibits balance billing for ground ambulance cases, then the state can continue to do that. The NSA does not preempt state law when that state law exceeds the protections of the NSA.

Thera are still many remaining questions. The final rules have not been set for how this will work in practice. We are still waiting to hear from the Department of Labor (DOL), Treasury and Health and Human Services (HHS) how this will work and be implemented. One question centers around what about state law for insurance in Virginia that allows self funded plans to opt-in – could those self-funded plans choose the payment dispute resolution process that they find most favorable? The legal scholars that Dr. Garmon has read suggest that the regulations from HHS and DOL will probably come down and say no and they have to follow the federal IDR process but that is still an open question until we see the final regs. What about a state like Missouri where its arbitration process is optional or non-binding – would the NSA preempt state law in that case? What happens if a patient residing in one state sees an OON provider in another state? That seems like a perfect example of where federal law would apply but it's not clear from the statute itself whether the provider's state law, if it's a fully insured plan, would apply or whether the patient's state law would apply or whether the federal law would apply.

And then of course there are many parts in the IDR process that will have to be detailed by DOL, HHS and Treasury. For instance, how are the arbiters supposed to weigh market share? How will they weigh the different factors in picking a payment from the providers and insurers? Lastly, there has not been a lot of research on the effects of the NSA on state law yet. Probably the best research that Dr. Garmon knows of is the Zach Cooper paper last year looking at NY's surprise billing law which found that it led to a reduction in OON bills and a 15% reduction in in-network cases. That is the only paper so far that has looked at how a state law has affected the negotiations between providers and insurers in that in-network price because it can – it can affect the leverage of one side or another and the paper found that it did result in a 15% reduction. However, their data is only using one insurer and they only had ¾ of data after the implementation of the NY state law so there is still room for more research on the NY state law.

And in particular, Loren Adler looked at the arbitration awards from the NY state law and found that the mean arbitration award exceeded the 80th percentile of charges which suggests that NY's law should be inflationary and should lead to an increase in in-network prices which contradicts the prior paper and suggests more research needs to be done on the NY law. Loren Adler and others also looked at California's surprise billing law and found that it led to a drop in the number of OON claims and they have ongoing research on some of the other effects of CA's law. Ben Chartock looked at NJ's arbitration awards and found that they cluster around the 80th percentile which is no surprise because the arbiters in NJ are shown the 80th percentile of charges and that's one of the things that they can use in choosing which proposal to accept. Finally, in the past few weeks, Sabrina Corlette and others at Georgetown have looked at NJ, TX, CO and WA's IDR processes and found that NJ and TX handled thousands of arbitration cases whereas in CO and WA it was rarely used. The only difference in those two sets are that NJ and TX in those cases the arbiter can rely on the provider's charges which suggests that providers are using that more often to settle disputes.

Sen. Hackett stated that he was really involved in developing Ohio's balance billing law and one of the things that they like about their IDR process is that they wanted to make sure negotiations went on strongly and when it got to the arbitrator they had to submit their last offer. They didn't want it to go back to the parties because if you had wide differences when you start, in reality you are making winners and losers. Sen. Hackett believes that the Ohio system is successful because they didn't want to create an arbitration system where everybody is running to arbitration all the time. The Ohio Insurance Commissioner did a phenomenal job of bringing everyone together and the providers and plans got together and finally agreed on things. One thing that really helped with the emergency room was the ability to go back and look at previous network charges because one concern was that they would have a network phase and with the new network they didn't have any negotiations and the network charges were reduced so the arbitrator has the ability to look back over the last several years and see what was paid in network.

Sen. Hackett asked if, with baseball arbitration, the NSA takes the last offer? Dr. Garmon stated that it is final offer arbitration and they have to choose either the provider's offer or the insurers offer and they can't split the difference. Prior contracted rates are one of the things that arbitrators can consider. The hope is that the arbitration process will be rarely used and we'll have to wait and see as to how often it is used. I think its been designed with a 30 day cooling off period and a prohibition on going back in within 90 days so it has been setup to encourage a settlement beforehand so the arbitration will be rarely used.

Sen. Hackett stated that in Ohio its broken down as to who pays for it ¾ one side and ¼ on the other and asked Dr. Garmon how the NSA deals with that issue. Dr. Garmon stated that the losing party pays the cost of arbitration. Both parties will pay a fee to cover the costs of administrating the system but the losing party pays the arbiter's costs.

Rep. Jim Dunnigan (UT) asked if a state could enact protections that are less than what the NSA provides for. Dr. Garmon replied no – in those situations in which the federal law applies and the state's does not then the federal law would preempt. Rep. Dunnigan stated that so if one party is unhappy with the federal law they couldn't try to enact a law that would water down the federal law. Dr. Garmon stated that is his understanding. The only area of uncertainty is in the cases of where there is a self-funded law to opt-in and we'll have to wait and see as to whether its possible for the self funded health plan to basically pick and choose which system depending on which it sees as more favorable for payments. But in terms of patient protections, a state cannot pass a law that would protect patients less than the federal law. The federal law would preempt in that case.

Rep. Dunnigan asked if the NSA applies to non-network emergency room treatments. Dr. Garmon replied yes – it applies to OON ER providers, whether facilities or physicians, and elective OON providers for instance physicians it applies to them as well. All of that applies without prior approval but for certain specialties it applies in a blanket fashion such as for anesthesiologists. An anesthesiologist cannot get prior approval to bill OON so it applies to them regardless of prior approval. Rep. Dunnigan stated that with regard to air ambulance, he believes many air ambulance providers do not have contracts and are not in-network so how does that work if the majority of them are not contracted at all? Dr. Garmon stated that in an air ambulance case, the insurer would send a bill to the air ambulance company within 30 days and then if the air

ambulance provider is not satisfied with that payment they can initiate the IDR process. Since most air ambulances are OON it will be interesting to see how HHS and DOL determine that median in network rate that would be one of the things the arbiter can consider. I also forgot to mention that the median in network rate is what will determine how much the patient owes so their typical in-network cost sharing will be based on the median in-network rate so it will be interesting to see how the agencies determine that rate for air ambulances since so few of them are in-network – we will have to wait and see what rule they will use for that.

Asm. Kevin Cahill (NY), NCOIL Treasurer, asked with regard to the tools the arbiter has available to determine the appropriate amount, is he to understand that they cannot refer or use as guideline UCR or Medicare or Medicaid? Dr. Garmon replied yes. Asm. Cahill asked what the logic is behind that. Dr. Garmon stated that this was all politics from his understanding. The health plans obviously would like for Medicare and Medicaid rates to be considered since they tend to be lower than commercial rates; the providers would like to have their charges used as benchmarks because they tend to be higher. In order to get the bill passed the big compromise was to explicitly include in the bill that arbiters cannot rely on charges and cannot rely on Medicare and Medicaid and cannot rely on UCR.

Asm. Cahill asked if a state has a more comprehensive system, one that gets past federal preemption, could that state use Medicare and Medicaid and UCR and other things that could lead to a balanced determination by the arbiter to arrive at the appropriate conclusion. Dr. Garmon replied yes – the state can use its own method for determining the OON payment for those fully insured health plans that the state regulates. The NSA explicitly includes that exception to the blanket preemption of state law. Asm. Cahill asked if there are any other restraints upon state regulators and legislators to regulate state plans beyond the things that have been stated. Dr. Garmon stated no. The state can use its own method for determining the OON payment. If the state has its own regulation of provider directories for fully insured state regulated plans it can continue to do that. If the states protections go beyond the NSA it can continue to have those protections – the state could pass a law that is less protective of patients than the NSA but in those cases where they don't overlap the NSA would preempt state law.

Asm. Cahill stated that as a quick aside, he got a surprise bill a few months ago and he chose instead of just calling the provider he filed a claim just to see how it would work and it was like kryptonite. The provider and insurer worked to resolve it and it all worked out. These programs do actually work and are taken seriously by both providers and insurers and it behooves us to fill in any gaps to make sure the consumer is out of the middle. Dr. Garmon stated that one thing he failed to mention is that the NSA explicitly prohibits the provider from even sending a bill to the patient so a patient should not even be aware of what's going on. After Jan 1 of next year patients should be unaware of anything and should not get a bill in the first place.

Sen. Hackett stated that ground ambulances were not included in the NSA but they were included in Ohio's law and there was a major push at the end to try and get them to opt out. Sen. Hackett asked Dr. Garmon if he knew the thought behind why the ground ambulances were not included. Dr. Garmon stated he is not sure but what he's heard is that because in many jurisdictions ground ambulances are provided by local gov't entities that it was legally tricky to prohibit ground ambulances but again he is not fully

understanding that because some states have been able to do it so for whatever reason they are not included in the NSA but the bill does require a committee to be set up and study ground ambulance cases and calls on agencies to submit reports on ground ambulance balance billing but it doesn't protect patients.

Sen. Hackett stated that the biggest complainers were the private companies because of the ones that were tied to the local government and fire departments and many times they had levies and different negotiations and different deals so they didn't think it was a level field so they are actually talking about brining legislation back. Dr. Garmon stated that he hopes so as that is the big missing piece in the NSA – patients aren't protected from ground ambulance balance bills.

DISCUSSION ON U.K. SUPREME COURT'S DECISION ON BUSINESS INTERRUPTION COVERAGE TEST CASE

Matt Brewis, Director of General Insurance and Conduct Specialists at the Financial Conduct Authority (FCA), stated that when he last spoke to the Committee in September, the FCA had just received a judgment from its high court which then went to the UK Supreme Court so today it will be helpful so summarize what has happened to date and discuss the main issues that have come out of the case. To recap, in the early days of the pandemic a number of issues were brought to the FCA's attention about business interruption insurance policies and how insurers were handling claims. Many businesses were seeing closures and disruptions and were making claims under policies expecting to be covered. The handling of claims however resulted in insurers rejecting them out of hand and that raised serious concerns about the contracts when it wasn't explicitly clear in the coverage about covering pandemics. So, the FCA determined that the best and quickest course of action would be to ask a court and judge to interpret contracts with clauses in them which could be read different ways. Accordingly, the FCA took eight insurers wordings and chose those not necessarily because they were the most egregious cases but because their language was similar to language used by the 60 or 70 other firms that write business interruption coverage in the UK.

So, those wordings were used and delivered to a court to get clarity one way or the other as quickly as possible. The test case focused on non-damage business interruption clauses. Many policies in the UK are damage policies so if you have a fire or a car goes through the window of your shop. But non damage clauses typically refer to if your restaurant and chef get salmonella or there is a murder on the street that your shop is in and therefore you can't get access to the building – those are typical, local reasons why people might have such coverage but as stated it was not apparent that those policies did not allow coverage for a pandemic.

In September, the high court had just handed down its judgment in the test case and the high court decided that most of the clauses centered around diseases and prevention of access were and should have provided coverage. So, on the big elements of the case the FCA won and therefore an agreement was sought with the insurers but for a number of reasons six of the insurers decided that they would like to make an appeal. The UK has a process where if certain conditions are met you are able to leapfrog various layers of the court system and you can go straight to the UK Supreme Court which heard the case in December. In January they handed down the verdict which effectively upheld every element the FCA had won on at the high court and the elements the FCA had appealed were decided favorably for the FCA as well. To a very significant extent, for

those elements taken through the courts the Supreme Court decided in favor of the policyholders.

So, what does that mean? First, lets discuss the trends clause. In the UK, the prime minister went on the news and said don't go out anymore but the legislation that stopped business from opening didn't start for another fortnight so what insures were doing were saying if you take the two weeks prior to when your business was closed, i.e. when you were forced to close by the government, your restaurant was at 30% of normal volume and therefore we will payout at 30%. The Supreme Court said no, that's not right – our view is that COVID was the cause of the disruption and therefore you should take into account the full impact of COVID and that includes things such as the prime minister's announcing that people shouldn't go out so you should compare it to the same kind of period a year previously as opposed to two weeks prior to lockdown. The Supreme Court also decided a number of issues such as if you were a restaurant and you had been forced to close because of the government, if before you were forced to close you had a takeaway business then coverage wasn't provided whereas if you started up the takeaway business during the pandemic then you were covered. The Supreme Court threw that argument out and said partial closure of premises as well as full closure should be covered.

Probably the biggest impact on the insurance industry has been the Supreme Court overturning the Orient Express case which related to a hotel in downtown New Orleans which was damaged by Katrina back in 2005 but was repaired more quickly than the surrounding area and when it tried to open it didn't have any business because of the damage to the infrastructure around it. The insurers said you may be open but no one is going to be coming anyway therefore its not valid and that was upheld at the time by the courts. The Supreme Court found that such decision was incorrect so from a UK perspective now it relates not just to the immediate cause but the causation of why the business was forced to close. This will have an impact on clauses in insurance contracts written in the UK that relate to wide area damage like hurricane, flood and pandemics.

Insurers are now making payments and the FCA is publishing the number of claims on a monthly basis that insurers have received and the amount they have paid out. As a result of the Supreme Court judgment they have paid so far about $1 billion and over 50,000 policies have been accepted but the total number is yet to be decided so they will grow. More broadly one of the lessons learned is contract certainty is a big issue. In our minds whether it's a pandemic or cyber insurance which is still relatively new you can imagine a similar situation happening with a big cyber attack so how can we ensure contracts are written clearly to provide certainty without being 400 pages long with exclusions. That is an issue the global industry is focused on.

Sen. Hackett asked if the policy said clearly that pandemics were excluded then the court judgment could not affect that – it was only in cases where it wasn't mentioned, is that correct? Mr. Brewis said yes – some had explicit lists of coverage that for example said SARS but not COVID and there were arguments that SARS is similar to COVID but yes if pandemic was excluded that wasn't part of the case.

DISCUSSION ON ERISA-PREEMPTION IN LIGHT OF SCOTUS DECISION IN RUTLEDGE V. PCMA

Professor Elizabeth McCuskey of the University of Massachusetts School of Law stated that she is delighted to speak to the Committee about some good news for state healthcare regulation and the Employee Retirement Income Security Act of 1974 (ERISA) preemption puzzle from the Supreme Court in December of this year – the Rutledge case. For this case, we're basically starting with the old ERISA law, a federal statute passed in 1974 with extraordinarily broad preemption language that has been an obstacle to state health reforms of all different kinds since then because the statute preempts any and all state laws that relate to any employee benefit plan. The Supreme Court and federal and state courts try to apply that inscrutably broad phrase and have developed a very complex and opaque set of precedents that makes litigation against state health reforms or at least the threat of it inevitable and unpredictable. Even state laws that withstand ERISA preemption often face the headwind of litigation.

Enter a state law from Arkansas that regulates pharmacy benefit managers (PBM) reimbursement practices to pharmacies. This was a law that essentially requires PBMs to pay pharmacies no less than the pharmacies acquisition cost for the covered drug. In other words, it was an effort primarily to save independent and rural pharmacies from bankruptcy for underpayment of the PBM intermediaries on behalf of health plans. In retrospect the emphasis on how to prop up independent and rural pharmacies plays an even more important public health effect when we look at the success that particularly West Virginia had in rolling out its COVID vaccine strategy using independent and rural pharmacies. The question about this seemingly rather narrow state law was litigated all the way to the Supreme Court on an ERISA-preemption challenge - namely whether ERISA preempted Arkansas form enforcing the PBM reimbursement practice.

With that setup to the Supreme Court, NCOIL should be applauded as it participated with an amicus brief and had a very persuasive amicus brief explaining to the Supreme Court the ways in which ERISA frustrates health policy at the state level and the ways in which ERISA jurisprudence should not apply to the case. The Supreme Court agreed with NCOIL, at least in the holding of the case, in a unanimous opinion authored by Justice Sotomayor starting that the Arkansas state law was not preempted because it did not sufficiently relate to the employer sponsored insurance plans that were challenging its application. The holding at the Supreme Court indicates the Court's unanimous view on how much federal uniformity ERISA demands and the answer was not that much. The Supreme Court explained that ERISA preemptive effect creating federal uniformity is primarily targeted at plan structure, benefit choices and beneficiary status – core aspects or central features of plan administration. The Supreme Court said that ERISA does not preempt state regulations that merely increase costs or alter incentives for ERISA plans without actually forcing those plans to adopt a particular scheme of coverage.

This is an important clarification of a notoriously opaque area of Supreme Court precedent and it gives states some running room to enact all kinds of different healthcare regulations that are aimed at cost control and affordability for patients which are typically the primary aim of state healthcare regulations these days. In particular, the Court notes that crucially, not every state law that affects an ERISA plan or causes some dis-uniformity in plan administration has an impermissible connection with an ERISA plan and it particularly singles out state regulations that merely effect the cost of administering a particular plan. Ultimately, the logic of the decision and the way the Supreme Court approached it reanimates a 1995 case called Travelers which was about state regulation of hospital billing rates and said that was not preempted and it expands

the logic of Travelers and explicitly says the logic of Travelers dictates the outcome of this case and in doing so it really outlines a broader category of state regulation that is outside the bounds of ERISA preemption, namely healthcare cost regulation.

It provides a very good Supreme Court precedent and explanation of why healthcare cost regulation might not sufficiently relate to these core functions of plan administration and therefore might not be preempted. It also focuses on the role of the PBM as an intermediary or contractor with the plan itself and explains that state regulation of the intermediary of the PBM as opposed to the actual plan does not directly regulate health benefit plans at all. The opinion seems also to carve out space for state regulation of health plan intermediaries as opposed to direct regulation of the health plan itself. Perhaps most useful and maybe most important in the logic of the opinion is that it singles out issues that are not covered by ERISA regulations as a space in which states should feel more confident in filling in their own regulations. This is a slightly different approach to ERISA preemption than several of the most recent Supreme Court opinions.

ERISA does not fill in the entirety of the field of employer health plan regulations – it leaves a lot of gaps and many issues have no federal law at all outside of ERISA. The broad language of the ERISA statute seems to say that states can't regulate in that space either but this opinion and Justice Thomas' concurring opinion made clear that the thrust of ERISA preemption is to make sure that states are not conflicting with ERISA regulations and there should be additional space to fill in areas that ERISA doesn't actually cover. This is also important because it narrows the holding of the Gobeille opinion of the Supreme Court in 2017 which held that VT's effort to collect all payer claims data from an employer's self funded plans third party intermediary was preempted but the Supreme Court in Rutledge clarifies that's mostly because the claims data is a core feature of plan administration and most importantly the claims data collection is covered by some ERISA regulations and could be administered by the federal DOL so there is less space for a state to regulate there than on the PBM regulation.

Thinking more broadly about the implications for state healthcare regulation of this unanimous Supreme Court opinion, the categories of state efforts that would be well served to rely on the logic and language from the Rutledge case include PBM regulation writ large so there are all kinds of things that states may want to regulate about PBMs and there are 45 different state regulations on PBMs and they range from PBM gag clauses to transparency on rebates to limits on patient cost sharing and spread pricing. The language and logic of Rutledge arguably puts PBM regulation outside of the shape of ERISA preemption because its not directly regulating a health plan but rather a contract and a third party intermediary. In addition, by focusing on cost control regulation, or the mere impact of cost, the opinion suggests that there is a broad category now of healthcare rate regulation that would be outside of ERISA preemption and that broader category includes provider rate regulation from the 1995 Travelers case and the slightly broader category that would include also Supreme Court prescription drug rate regulation after the Rutledge case.

Other aspects of state healthcare regulation aimed at cost control that might have some indirect economic influence on the cost or administration of plans also would fit within the sphere of protection that the Rutledge case offers which includes all kinds of consumer financial protection laws in healthcare that states have passed including surprise billing legislation, air ambulance legislation, and as Dr. Garmon explained the NSA offers a

federal floor on what the protections for consumers would be against surprise bills but it leaves room for states to add protections. The adding of protections on top of the NSA would ordinarily be subject to ERISA preemption analysis and the NSA explicitly says it is not altering ERISA preemption but the language of Rutledge and its logic would suggest that even though the NSA forgoes any effect on ERISA preemption that there is space for states to add on top of that. More broadly, the state efforts of cost control and affordability that have become so urgent for state regulation in particular over the last decade are well served by the language and logic of Rutledge which takes cost control and puts it well within the state sphere of authority and also explains that some influence on the cost or administrability of an employer sponsored plan does not lead to ERISA preemption.

Of course, Justice Sotomayor reminds us that actual benefit requirements, beneficiary status and the core features of plan administration or the actual forced choice of a plan to adopt a particular coverage are still preempted by ERISA but there is a lot of important stuff that is even bigger than consumer financial protection that might fit within the language of Rutledge, particularly state regulation of third party administrators and possibly even the state establishment of public access plans and attempts to collect contribution from employers. This is good news and some running room for states and the case gives states more latitude by cutting the limit of ERISA preemption and leaves states more space to pursue healthcare cost control measures and improve affordability for consumers without facing the headwinds of ERISA that they used to. Overall, Rutledge is a pretty unbelievable win for state regulation but leaves the underlying obstacle of ERISA's underlying statutory language in place and it leaves in place four decades of maddeningly incoherent attempts to apply it so there is still a need for Congress to revisit ERISA by perhaps including a waiver or giving states some explicit statutory room to ask the DOL to give permission for particular state experiments and remove the remaining uncertainty of ERISA preemption litigation. ERISA preemption reform is a drum that I beat every time that I am on stage so that is why I am beating it again.

Sen. Jason Rapert (AR), NCOIL Immediate Past President, stated that NCOIL should be recognized because for the first time in many years NCOIL offered an amicus brief and weighed in on a national level which was a big decision. Sen. Rapert said we know the impact on PBMs but asked Prof. McCuskey how she sees this impacting other areas because this case has the potential to impact many different areas. Prof. McCuskey stated that NCOIL' brief was targeted at the really important core policy level of the need for states to regulate their own healthcare systems, particularly for cost control. Implications can include healthcare rate regulation which I think is on the table as states have Rutledge as a shield that should deter some litigation and in particular the broader effort of states to try and control costs including Supreme Court prescription drug reimbursement, prescription drug pricing and any other state public access plans have some additional ammunition from the Rutledge opinion and logic because it explains how those state efforts are not within the contemplated uniformity that the original statute was passed under and it explains the ways in which the relationship between those kinds of state rate regulation, surprise billing consumer protection laws is too much of a tangential relationship to the actual core features of a benefit plan to trigger ERISA preemption. Importantly, it takes those state efforts outside the ambit of ERISA preemption so you don't have to get into the secondary argument as to whether those things are pushing up against self funded plans as opposed to fully funded plans.

ANY OTHER BUSINESS

Roderick Scott of the Flood Mitigation Industry Association (FMIA) stated that he comes from a historic coastal Louisiana community with no levy protection as there were 14 floods in 15 years. He is the board chairman of the newly formed FMIA. This country is facing unprecedented threats from natural hazards and the dangers to our building is increasing and as a result insurance rates are increasing through the roof. We are headed for a massive asset devaluation according to the banks and two years ago I sat in the Treasury building where the banks estimated $1.5 trillion dollars are at risk of the rising threat of flooding and insurance rates. We told the baking industry and Treasury and FEMA that its about $600 billion of retrofit to elevate and flood-proof the buildings so that we can manage our way through this changing climate and not have flooded buildings. My town is 86% elevated – it takes a week to recover from a flood now and we are the most advanced mitigation community in the world as far as we can tell.

On January 1, the holy grail of financing for this adaptation was signed into law by former President Trump called the STORM Act which is a state revolving loan program and at that meeting at Treasury I watched the banking community commit to the government and our nation $600 billion in financing to fix these buildings. They cant loan it directly to the communities but can loan it to the federal government back down to the states and to the taxing authorities and attach it to the taxes to be repaid over 20/30 years. People cannot afford to do this but we can afford to finance it and then people can pay it off. We have to adapt to a changing environment to reduce our losses that are increasing every year. We were introduced to NCOIL and have come before you to ask for some help – you are the legislators and in order to pass this money through from FEMA there will have to be enabling legislation created in each state to create a state revolving loan program. Our industry is ready to expand 2,000% in the next 20 years and hire an additional 500,000 construction trade people to build our way through this adaptation which we call the next moon project. We have to do this. Millions of buildings are at risk. We're asking NCOIL to entertain healing our industry – we know how to fix the buildings but we don't know how to write the legislation and we need state enabling legislation for every state and territory to be able to create the pathway for financing to come to its citizens. I look forward to seeing you again in Boston and we're willing to make the investment to create this model legislation for each state.

Sen. Hackett stated that this topic will be on the Committee's agenda at its next meeting.

ADJOURNMENT

Heating no further business, the Committee adjourned at 11:30 a.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
NCOIL – NAIC DIALOGUE
CHARLESTON, SOUTH CAROLINA
APRIL 16, 2021
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) NCOIL – NAIC Dialogue met at the Francis Marion Hotel on Friday, April 16, 2021 at 2:15 P.M. (EST)

Assemblyman Ken Cooley of California, NCOIL Vice President and Chair of the Committee, presided.

Other members of the Committee present were (* indicates virtual attendance via Zoom):

Sen. Jason Rapert (AR)
Rep. Matt Lehman (IN)
Rep. Joe Fischer (KY)
Sen. Paul Utke (MN)*
Sen. Bob Hackett (OH)
Del. Steve Westfall (WV)

Other legislators present were:

Rep. Deborah Ferguson (AR)*
Sen. Paul Wieland (MO)

Sen. Mathew Pitsch (AR)
Rep. Matt Dollar (GA)
Rep. Terri Austin (IN)
Rep. Jim Gooch (KY)*
Rep. Daire Rendon (MI)
Sen. Lana Theis (MI)*
Rep. Justin Hill (MO)
Sen. Walter Michel (MS)
Asm. Kevin Cahill (NY)*
Rep. Forrest Bennett (OK)
Rep. Wendi Thomas (PA)*
Sen. Ronnie Cromer (SC)
Rep. Jim Dunnigan (UT)

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Tess Badenhausen, Assistant Director of Administration, NCOIL Support Services, LLC

QUORUM

Upon a motion made by Rep. Matt Lehman (IN), NCOIL President, and seconded by Rep. Joe Fischer (KY), NCOIL Secretary, the Committee waived the quorum requirement without objection by way of a voice vote.

MINUTES

Upon a Motion made by Rep. Fischer and seconded by Rep. Lehman, the Committee voted without objection by way of a voice vote to approve the minutes from the Committee's December 11, 2020 meeting.

DISCUSSION AND UPDATE ON STATE ADOPTION OF AMENDED CREDIT FOR REINSURANCE MODELS

Before beginning with the agenda, Asm. Cooley stated that as we participate here today in a hybrid format with people participating via Zoom while others are in Charleston, it illustrates that COVID-19 has forced everyone to adapt to these unprecedented times. In the insurance context, both insurance legislators and regulators had to adapt legislation and regulation in recognition of the reality that changes had to be made to allow for businesses to operate and ensure consumers are protected. NCOIL has been following the work that the NAIC has done in this area in terms of listening to feedback as to what regulations should be changed or temporarily altered such as in the areas of electronic testing for producers, and the NAIC should applauded for its work.

Asm. Cooley then recognized NAIC President and Florida Insurance Commissioner David Altmaier for introductory remarks. Cmsr. Altmaier thanked the Committee for the opportunity to have these discussions today and stated that the NAIC has long valued its partnership with NCOIL and the discussions that have taken place over the years. There are clearly a number of issues to discuss today that are going to impact insurance consumers in all states and the partnership between the legislative and executive branches is going to be crucial in addressing these issues.

Asm. Cooley then began with discussions on the agenda, beginning with an update on state adoption of the NAIC's amended credit for reinsurance model law and regulation. The topic has been on this agenda several times because of its importance to upholding the state-based system of insurance regulation. As a reminder, the amendments to the Models were adopted due to certain provisions of the Covered Agreements between the U.S. and European Union, and U.S. – and United Kingdom. States must adopt the amended Models to avoid federal preemption of state reinsurance laws within 60 months from September 2017 – the date the Covered Agreement with the EU was signed. Also, there was an assessment recently conducted by the federal government of the remaining non-compliant states. Asm. Cooley asked for update as to how the NAIC's efforts have been progressing in terms of working with state legislatures to introduce and adopt this legislation.

South Carolina Insurance Director and NAIC Immediate Past President Ray Farmer stated that this is an extremely important issue to the NAIC and NCOIL alike. The NAIC is making good progress. Last year was a little bit of setback due to COVID but some pressed on and passed the amended models so they didn't have to do that this year. The numbers are changing daily and we are up to 26 states that have had the model law signed into law and four states have such legislation currently pending on the Governor's desk, including Florida, as we expect some of those to be signed as early as next week. We have 18 or 19 others that have it under consideration so that number should be added to at the end of the year. Dir. Farmer stated that no one gets any credit for the delay caused by COVID so everyone is pressing on and as far as he knows there have been no discussions with the Federal Insurance Office (FIO) or anyone else about extending the deadline and we are aware that FIO has been starting to look over the states' shoulders to see how everyone is doing.

Asm. Cooley stated that this continues to be a priority for NCOIL to urge its member states to get this work done so that the requirements of the covered agreements are

established and it is incumbent upon state legislators to focus attention even during the time of disrupted operations in state legislatures to get this work done.

NAIC SPECIAL COMMITTEE ON RACE IN INSURANCE ISSUES

a.) *Update on Special Committee Activity*

Asm. Cooley stated that the third meeting of NCOIL Special Committee on Race in Insurance Underwriting concluded yesterday. The Committee has been busy defining "proxy discrimination" from the standpoint of state lawmakers and discussing insurer's use of certain rating factors in underwriting. NCOIL has been closely following the NAIC's Special Committee on Race in Insurance. Asm. Cooley asked for update as to Committee's progress and timeline.

Cmsr. Altmaier stated that the NAIC's Special Committee has indeed been very busy and as we all know, the Committee was formed last Summer under the leadership of Dir. Farmer and focused on five workstreams up to this point. There is one workstream each for diversity and inclusion in the insurance industry as well as in the insurance regulatory departments and at the NAIC and the other three workstreams are related to each of the three major areas of business – health, life and P&C. The full Committee has had three public meetings, the most recent one being last Tuesday in conjunction with the NAIC's spring national meeting. At that meeting the Committee heard status updates for each of the five workstreams and each workstream submitted a report that included recommended next steps or charges for the committee going forward. There was some really good discussion during that meeting with a broad spectrum of stakeholders and the NAIC appreciates the letter sent by NCOIL which will be discussed in a moment.

The NAIC currently has a draft set of charges that are exposed for a 30 day period that began this last Wednesday so that concludes on May 14 at which point Cmsr. Altmaier anticipates some additional discussions with respect to that. Just to underscore, the NAIC is certainly committed to having a very thoughtful and deliberative process with respect to these issues such as unfair discrimination, unfair bias, proxy discrimination, disparate impact – these are all very complex issues so while progress is important we need to make sure we are being deliberative in order to avoid having unintended consequences in our markets. State insurance regulators have been discussing these issues frequently. For example, last August the NAIC adopted a set of guiding principles on artificial intelligence (AI) and they included a non binding concept encouraging industry participation to take proactive steps to avoid proxy discrimination against protected classes when using AI platforms. The NAIC looks forward to more work of that nature continuing across its letter committees, executive level task forces and special committee.

The NAIC is aware that NCOIL is working to define proxy discrimination and several good discussions have taken place. Cmsr. Altmaier stated that he feels compelled to offer some initial perspectives from some of the NAIC's members who have raised some concerns with respect to the direction of that at this point as essentially re-stating current laws that already prohibit intentional discrimination and might not take into account the technological evolution that's taking place in the insurance sector and the concerns surrounding the affordability and availability of products to individuals of certain demographics. The NAIC looks forward to continuing engagement on that as it works through its own process and NCOIL works through it's as well. The NAIC intends to

continue working on these issues as it views this as a very long term project and we don't think there will be a lot of short term deliverables and there will be significant opportunities for engagement and collaboration.

b.) *Discussion on NAIC Closed Meeting Process*

Asm. Cooley stated that he thinks a big question is partly a process question and to use an analogy from the CA legislature – as COVID hit, it forced a change in its typical procedures and how hearings operated and how people participated and social distancing. This actually led to the legislature going back and examining the state constitution for the rules it laid out for how these bodies conducted itself. The legislature is a body subject to rules which it has to adhere to and it constrained its options in order to comply with the constitution. With respect to the process the NAIC has established there are some basic questions as to how this conversation relates to precedence in the organization as there is no language in NAIC bylaws for a special committee – it has working groups, task forces, and committees. Open and public record rules don't relate to the work of a special committee. The idea that a constructed special committee would be a coordinating body is unclear as to what exactly that means and where the authority comes from in NAIC organizational documents just as how the CA legislature had to ask itself how it conducts its business. Accordingly, the general question is tracing the authority and the foundation for discussions because that gets into what is the basis for calling a closed session. Asm. Cooley asked for comments on those issues.

Cmsr. Altmaier stated that the NAIC does have an official policy on open meetings and the special committee is subject to the terms of its open policy proceedings. Taking on the question of the title of the committee – special committee was just simply a title that the NAIC used to underscore the importance of the work – outside of that special committee has no special treatment with respect to how the NAIC governs its operations. The NAIC is treating the special committee for purposes of how its processes are governed essentially the same as it would treat any other executive level task force. Special committee was just simply a way of addressing that the issues are ones of critical mass importance to the NAIC. That being said, the NAIC and its workstreams have had a blend of public and open meetings as well as closed meetings. The NAIC felt very comfortable that the closed meetings met one or more of the criteria that are contained in the NAIC open meetings policy with respect to the ability to close into a regulator only session. It's important to note that at no point were any decisions made during a closed meeting – all of the things proposed have been discussed in open and transparent meetings and have bene exposed for additional comments forms stakeholders as the NAIC does for any number of regulatory items.

With respect to the coordinating aspect of the special committee, this work will cut across a broad spectrum of the insurance segment and therefore will cut across a broad spectrum of ongoing NAIC workstreams particularly with respect to the work that's ongoing at its letter committees. The NAIC has characterized this as a coordinating body in an effort to make more efficient and streamline the work that is already ongoing so that there are no redundancies in the process and hopefully make that process a little bit more efficient.

Asm. Cooley stated that typically the way organizations exist is that you have bodies which assign work to committees which is a delegation, and the delegation is what it is until its gets revised. Most typically it seems in his experience with the NAIC that the

assignment of duties comes through the executive committee process so it still doesn't really answer what differentiates a special committee that they have the authority to modify work delegated by the executive committee. It seems that the NAIC has a body that is poised to provide a great deal of direction across the NAIC that is differentiated from the executive committee where most matters of structure are decided. When you look at the definition of the NAIC executive committee, its role is to assign and set up the structure and assign the work so it seems that the NAIC has a special committee that is doing the work of the executive committee without an explanation as to how that is done. Asm. Cooley stated that he believes its analogous to how in CA they needed to reexamine how its meetings were conducted to determine how it aligned with law because that is the foundation of everything.

Cmsr. Altmaier stated that, to be clear, the special committee does have charges that have been assigned to it by the executive committee. The executive committee has approved and delegated to the special committee the charges that it is currently overseeing. The charges that have been exposed by the special committee, once they have been approved or adopted by the special committee following its normal process, those will also go to the executive committee to be approved by that body as well. That is a process the NAIC has followed with all of its other executive level task forces and so charges that are being delineated to other NAIC workstreams will go through that executive committee process like they have done historically. So, even though it is called a special committee it is being treated the same way as the NAIC would treat an executive level task force. The NAIC anticipates that once the charges have been approved by the executive committee, the letter committees that are assigned those will follow their normal process which has historically been very transparent and will continue to be so. Accordingly, Cmsr. Altmaier stated that he believes the special committee has been delegated charges in the same manner historically as other executive level task forces have in the past.

Asm. Cooley questioned whether historically, aren't discussions of charges in a public setting at various meetings? It's still unusual to call something internal matters and have a great deal of substantive work direction come out of it without public commentary. In CA the budget process is public and everything get exposed in conversation. Cmsr. Altmaier stated that each of the workstreams had public meetings with the exception of workstream two which is exploring diversity among the insurance departments so the NAIC did solicit public comments on the charges before it had the open discussion on Tuesday. The NAIC solicited public comments on those charges during that meeting and they are now engaged in a 30 day exposure period for the charges as they have been exposed. Cmsr. Altmaier stated that he believes that is very similar to what has been done in the past.

Sen. Jason Rapert (AR), NCOIL Immediate Past President, thanked all of the NAIC representatives for being here and used the opportunity of the open forum to ask what the status is at the NAIC of the model law they have been working on relating to pharmacy benefit managers (PBMs). Cmsr. Altmaier stated that his understanding is that at its last stop there was some discussions surrounding the PBM model and it went to the Regulatory affairs framework under its B committee and there were some pending items still to be discussed among regulators so a final vote was postponed. Sen. Rapert asked if the Model will encourage that PBMs be subject to insurance department regulation. Cmsr. Altmaier stated that he would have to check on that and then circle back. Dir. Farmer stated that it is open ended at this point but a number of states

including South Carolina have enacted legislation requiring PBMs to be regulated in the department of insurance. Sen. Rapert stated that is good to hear and offered any assistance NCOIL can offer because despite of all the good things that have been happening with regard to PBM regulation, such as the NCOIL PBM Model Act, those entities continue to morph and do their best to avoid regulation. Sen. Rapert stated that he has no problem with people doing business, but he just wants them to do so fairly. Sen. Rapert states he appreciates the time and attention the NAIC has put on this issue as well as all the work legislators have done as well.

Cmsr. Altmaier thanked Sen. Rapert and stated that he recalled Sen. Rapert speaking during an NAIC meeting on the issue of PBM regulation and he made very insightful remarks. Commissioner Glen Mulready, Oklahoma Insurance Commissioner, stated that he believes the hang-up over the progress of the NAIC PBM model thus far relates to the drafting notes contained therein.

Asm. Cooley stated that obviously issues dealing with race are highly sensitive topics and that in his experience years ago the NAIC did have a coordinating body in the area of climate but he does not recall it as providing direction to the other committees. Asm. Cooley stated that he believes that in organizational life units get delegation and following and running the traps as to how decisions get made and how responsibilities are allocated really vest in the executive committee and when direction starts coming from other bodies that anomalous in the organization and he certainly thinks that in the time of COVID it is incumbent to provide for opportunities for comments which are meaningful time wise. Some of the associated timelines for comment in the special committee have been very short and that makes it very difficult for people to reflect upon what is being called a deliberative process. Commenters need opportunity for deliberation and that invariably takes time for reflection. Asm. Cooley stated that he thinks it is well to go back and look at the specifics of the NAIC public record documents and try to line it up with the bylaws and the role of the executive committee. The NAIC has taken a highly sensitive document and conjured up something that doesn't align with what the NAIC has done in the past and doesn't align with the NAIC's bylaws and public records. It's a level of improvisation on a topic of vast importance to our country that seems less than judicious given the long established workings of the NAIC through committees, working groups and task forces.

c.) *Discussion on NYS DFS Circular Letter No. 5 (2021 Re: Diversity and Corporate Governance)*

Rep. Lehman stated that about a month ago the New York Department of Financial Services (NY DFS) issued a circular letter to all New York domestic and foreign insurance companies which was "intended to support the industry's existing diversity, equity and inclusion (DEI) efforts and to outline DFS's expectation that New York-regulated insurers make the diversity of their leadership a business priority and a key element of their corporate governance." Specifically, the letter stated DFS will collect data from insurers relating to the gender, racial and ethnic composition of their boards and management including information about board tenure and key board and senior management roles.

Rep. Lehman stated that while increased DEI efforts should be applauded, there is a concern as to whether such efforts should be mandated by prudential regulators rather than by legislators. For example, in Asm. Cooley's home state of California, the boards

of publicly traded companies based in the state are now required to have at least one racially, ethnically, or otherwise diverse director by 2021, but that requirement was imposed by the California legislature – not the California Department of Insurance. Accordingly, Rep. Lehman asked if the NAIC envisions more insurance departments following the lead of NY DFS and requiring certain information to be reported and made public. Rep. Lehman also asked since some of the work streams of the NAIC's Special Committee on Race in Insurance are focused on researching, analyzing, and making recommendations as to the level of diversity and inclusion within the insurance industry, does the NAIC plan to impose such reporting requirements on insurers and perhaps make it part of an accreditation standard?

Cmsr. Altmaier stated that this is an issue that is very similar to many other issues that the NAIC deals with in that while we certainly use the NAIC to strive for consistency across all states in terms of how we are regulating our market, certainly each state has jurisdiction over their state via their executive and legislative branches. While we will have these kinds of discussions with the special committee in its first workstream with respect to what are ways to explore increasing diversity and inclusion in the insurance space, there is nothing stopping a state like NY proceeding with its own efforts.

My Chi To, NY DFS Executive Deputy Superintendent, stated that she can provide an overview of the NY DFS recent guidance and explain its process that led to the issuance of the guidance. Supt. To acknowledged the open relationship that NY DFS has always had with Sen. Neil Breslin (NY), Chair of the NCOIL Special Committee on Race in Insurance Underwriting, with many insurance topics including diversity and inclusion. As was already mentioned, in mid-March a circular letter was issued that focused on diversity and corporate governance and was addressed to all NY domestic and foreign insurance companies operating in NY. The guidance was issued following extensive research and discussion with industry and that was intentional as it was very clear to NY DFS that it had to have a very collaborative approach and that's what they did. COVID did delay some discussions but by the end of the year the discussions were resumed. I would say that the result of all of the discussion with industry is that there are a lot of initiatives and significant commitment existing today in our industry in the companies we regulate on improving diversity in the industry and in these organizations. We framed our approach as what is the best way for us as regulators to support those existing efforts and existing commitments. The result of that inquiry is the circular letter that was issued.

To briefly sum the letter up, it really makes two points – it outlines an expectation that insurers make diversity a business and corporate governance priority. The letter doesn't say how insurers are supposed to do that and its deliberatively not prescriptive. NY DFS considered many other approaches taken by other regulators in other states and countries including CA and its quota approach. NY DFS deliberately did not go in that direction and its approach was based on the studies and what's happening in the world including investor pressure on insurance companies and other companies to hold companies and businesses accountable for increasing diversity. We felt that this should be treated as a business priority as companies know how to implement their business priorities so NY DFS is not in the business of telling companies how to do that so that is why its not prescriptive. Interestingly, in its informal outreach by bouncing the letter around before formally issuing it to make sure that it would be well received by industry, some of the feedback from industry was that they would actually like some help around best practices because a lot or companies want to make an effort but have obstacles

and don't really know how to do it. In response to that feedback nothing in the guidance was included on specific practices NY DFS expects companies to follow but it will host a webinar focused on best practices which we will invite industry to come to and share and learn from other people's experiences.

So number one outlines an expectation that insurers make diversity a business and corporate governance priority. Number two is an effort to collect and publish data relating to diversity of boards and management of companies, NY domestic and foreign companies. Why are we doing that – in our research we realize there is really no data that is specific to the insurance industry on diversity. Industry participants actually mentioned that to NY DFS as something that was lacking because the absence of data meant that companies didn't know where they stood compared to their peers. To remedy that and to increase transparency, NY DFS concluded that collecting the data and publishing it on a an aggregate basis would be helpful to the industry because it would allow companies to see where they stand compared to their peers and we hope transparency will be a powerful motivator for companies below the average to strive to improve diversity.

NY DFS was concerned to not impose an undue burden with the data and collection on smaller companies so there was a cutoff of $100 million in annual premiums to exclude some smaller companies that might find that collection overly burdensome. We're planning to collect data on the diversity composition of boards and senior mgmt. so not the entire workforce in order to focus on the top of the organization and to make the effort of not such a huge data collection effort. We are planning to collect the data over the summer with the expectation that it will be published in the fall on an aggregate basis and the collection survey is designed to gather information on the type and size of insurer and other relevant factors so that it can be sliced and diced in ways that it hopes are useful to the industry.

We did encourage companies to disclose publicly this data as part of their DEI efforts but we are not mandating it so that was just a strong encouragement. Regarding the authority, from a NY perspective, our authority we believe exists both in the broad mission of our agency to promote the financial stability of our industry. We believe issues of corporate governance clearly fall within that purview. In fact there is a model law at the NAIC that is an accreditation standard on corporate governance that includes a question dealing with diversity policies so we really believe this falls within that scope of authority.

Rep. Lehman thanked Supt. To and said something that causes concern from a legislative standpoint is terms like investment pressure and putting pressure on companies to change. Rep. Lehman stated that he is also concerned about what NY DFS would do with a mutual company that doesn't have that investment pressure – what do you with privately held companies where the board is more or less their family members and not a diverse group. Are there any parameters that NY DFS would take into consideration to say we are not mandating this? The bulletin does say "first steps" which implies that second and third steps may be taken. As a legislator, what should I expect in terms of things being brought to me to be put into statutory code?

Supt. To stated that the data collection has a $100 million cutoff but the guidance generally applies to all companies regardless of size and regardless of corporate form, either mutual or otherwise. I did mention investor pressure as just a data point that we

considered understanding as you pointed out that certain types of companies are not going to have public investors and the basis of the guidance is a vast body of data around diversity makes a compelling case that increased diversity at the top of organizations is good for business. There is a lot of detail in the letter and as financial regulators focused on strong financial performance of companies that is why we are focused on that – we want our businesses and companies to be competitive and to innovate and have access to the best talent. That is why we are focused on it as a financial regulator.

In terms of next steps, I think the idea there was that we believe there is a lot of effort already underway. It may be all we need to do is issue the letter and there will be no further steps. The reference to first steps is to say we will see what happens next and of course we will always be in dialogue with our own legislators to make sure that to the extent we need legal or statutory authority we will make sure to seek that which is why the dialogue with Senator Breslin and legislators is so critical.

Asm. Cooley thanked Supt. To and stated that companies need to operate in the American and global marketplace and that is important. Asm. Cooley stated that he is sitting in front of the flag of a city he helped found and in the 2000 census Rancho Cordova was identified as the most rapidly diversified place in CA during the decade that led up to that and #2 for all of CA in terms of diversity in individual neighborhoods. That has led to an unusual happening of more commercial office space in Rancho Cordova than in downtown Sacramento which is 12 miles away and in fact an awful lot of fortune 500 companies put their offices there which says that it is good business to have a business that are populated by people wo are reflective of all of America and global markets and it supports credibility of the marketplace and supports a sensitivity to the variation within these markets. Asm. Cooley thanked Supt. To for her remarks.

UPDATE ON PROPOSED CHANGES TO SSAP. NO 71

Asm. Cooley stated that the Committee has had two robust discussions on the issue of proposed change to Statement on Statutory Accounting Principle “Policy Acquisition Costs and Commissions” (SSAP 71). In Tampa most recently we discussed this and there are questions as to who maybe be disadvantaged by the changes. NCOIL is hoping that in this area of commission funding agreements in which some carriers enter into third parties that there are substantive changes being proposed that will have a significant impact on a number of insurers. NCOIL is looking for a phase in period to allow companies to adjust. Asm. Cooley asked if there was an update on the status of the proposed changes.

Cmsr. Altmaier stated that the update in SSAP 71 since Tampa is that we have a number of our working groups and task forces advance the revisions through its process and they landed on the desk of the E committee on March 15 where it adopted the proposed revisions. For those that might not be familiar with this back in 2017 a state insurance department through its examination process identified a carrier that was using this accounting process and the state DOI felt that it was not in compliance with SSAP 71. Subsequent to that in 2019, revisions began to clarify SSAP 17 to confirm that. Since that point of time, The NAIC has identified only four insurance companies that the revisions would impact. With respect to the substantive vs. non substantive nature of the changes, that is the basis of the fact that the NAIC felt that the changes did not represent a significant shift from the accounting policy so it wasn’t a factor of how many

dollars the impact may be to the four insurers it was because we felt that this was the accounting practice previously and we were just clarifying the intent of that because of the difficulty through that particular examination process.

That was recommended by the working group and task force and the E committee as recently as this past week on March 15th. They adopted an effect date of 12/31, 2021. At least two of the commentors requested that the effective date be no later than that date so we believe that was responsive to some of the comments received. The E committee had also discussed grandfathering and that concept was considered by the various working groups and task forces but we ultimately determined to not go down that path. Because of the small number of firms that are engaged in this practice, we felt as if our current framework for carries to get permission for a permitted accounting practice from their domestic state regulator would be the most appropriate way to handle that.

Typically, it terms of next steps when our E committee adopts things of this nature we would generally consider that at the following plenary meeting which was held a couple of days ago but because of the discussion on this issue we pulled this item off of that particular agenda so that our members and stakeholders could give it further consideration and we have another discussion on that at our next scheduled plenary meeting to take place within the next three months.

Rep. Lehman stated that with an implementation date of the end of the year and taking no action until September, if I am one of those four firms, should I consider this a done deal? Cmsr. Altmaier stated that it's not quite a done deal because it does have to be approved by the plenary body which is the entirety of our membership but I would say that given the discussions that have taken place at the working group and task force and committee levels I would be surprised if there was change at plenary in terms of the outcome of this. Because we have been working on this since 2019 I would expect that the four carriers would hopefully have been considering that the change might be happening and be making preparations for that.

Rep. Lehman stated that he has heard from others that it may be broader than four companies. Is there a reason this has to be put in so quickly – I'd rather have two years or three years for something like this as it could have a pretty serious impact on at least those four companies and I think it's a bigger impact than something that could be handled very easily. Has there been a discussion on a longer phase in/effective date. Cmsr. Altmaier stated that yes consideration was given to the phase in but ultimately the working group and task force and E committee determined not to do that primarily because as you are all well aware, our insurance industry is not shy and if there had been more than four companies affected I think we would have likely heard their commentary through this process by this point given how long we have been discussing this. Because of the fact that we feel comfortable that we are dealing with a small universe of carriers, should there be any necessary needs to have a more delayed implementation phase, the permitted practice with their domiciliary state insurance regulator would be the most appropriate venue to achieve that.

Asm. Cooley sated that this is obviously an issue of importance to legislators and it touches operations of carriers operating under state law. Asm. Cooley asked if any other Commissioners wished to make a comment as a multi jurisdiction perspective would be of interest.

Cmsr. Mulready stated that he has his concerns with this proposal but as he has dug more in to this he has became more comfortable with the number that has been impacted and the number of companies affected. At the public E committee meeting there was some robust discussion about possibly delaying the implementation so I think there is some chance of that possibly happening but outside of that I think I have settled into where it's going forward and the question remains as to whether there might be a delay.

Dir. Farmer stated that the NAIC is a diverse membership of 56 jurisdictions and as has been outlined today we have a committee process and this issue has been debated an awful lot. I sit on the E committee and the other day the vote for South Carolina was "no" and was one of two or three no votes but I respect the committee process and as Cmsr. Altmaier indicated this will be on the plenary agenda later as opposed to the one earlier this week so there is time for additional debate. This is an example of where the NAIC might have disagreement within the organization but the process is still being followed and I'm comfortable with that.

Mike Chaney, Mississippi Insurance Commissioner, stated that Mississippi has no policies that would be affected by this change to SSAP 71 but we did vote "no" in the committee process for a reason that we wanted more time to look and see just what the ramifications of what the changes would be on certain companies. The issue is are the companies able to put up the dollars that have been deferred up to five years. We do know of four companies that are affected and possibly three others. The dollar amount minimum is about $400 million that would have to be put up immediately and it could range up to $600/700 million that would have to be put in so this is essentially dollars that would be in surplus. If you grandfather the people in and let them go forward they will have all of the dollars in within five years. If you require that you make it effective at the end of December and you could argue we gave them 24 months to put that money back into surplus, that's a possible solution instead of five years. To Cmsr. Altmaier's comment, I agree that we need to go ahead and address it and get it out of the way and I think we will probably address this in September. Cmsr. Altmaier stated that it will probably be addressed before September.

Cmsr. Chaney stated that the NAIC has the same constraints of having virtual meetings and you can only do so many at one time and it's hard to schedule them where everyone can meet at the same time.

Asm. Cooley invited all other NAIC representatives to comment. Troy Downing, Montana Insurance Commissioner, thanked everyone for this process. A lot of comments were made in terms of SSAP 71 and Montana just like Mississippi doesn't have any domestics that are affected by that but we're still trying to understand what the issues are with delaying or not.

Dana Popish Severinghaus, Acting Illinois Insurance Director, thanked everyone the opportunity to participate and stated that she has attended NCOIL in the past when working on the company side and it's a pleasure to be on this side as a regulator.

Alan McClain, Arkansas Insurance Commissioner, stated that he has been involved with the NAIC when he was with other state agencies and he has always watched the collaboration with NCOIL and he always thought it was a very important collaboration to make sure that these discussions happen with legislators.

Cmsr. Mulready stated that he wanted to point out even though its held as a non-substantive matter as opposed to substantive which in general terms just means it's a clarification and not something new, due to feedback from NCOIL, Scott White, Virginia Insurance Commissioner, heard things loud and clear and based on that the NAIC officers and E committee chose to handle that process differently. It didn't change the substantive and non substantive issue buts it's been through an extensive process that it normally would not have due to NCOIL's concerns.

ADJOURNMENT

Heating no further business, the Committee adjourned at 3:30 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
LIFE INSURANCE & FINANCIAL PLANNING COMMITTEE
CHARLESTON, SOUTH CAROLINA
APRIL 16, 2021
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Life Insurance & Financial Planning Committee met at the Francis Marion Hotel on Friday, April 16, 2021 at 3:45 P.M. (EST)

Representative Wendi Thomas of Pennsylvania, Vice Chair of the Committee, presided.

Other members of the Committee present were (* indicates virtual attendance via Zoom):

Asm. Ken Cooley (CA)*
Rep. Joe Fischer (KY)
Rep. Jim Gooch (KY)*
Rep. Daire Rendon (MI)
Asm. Ken Blankenbush (NY)
Asw. Pam Hunter (NY)*
Sen. Bob Hackett (OH)
Rep. Carl Anderson (SC)
Rep. Jim Dunnigan (UT)

Other legislators present were:

Sen. Mathew Pitsch (AR)
Sen. Kirk Talbot (LA)
Rep. Kevin Coleman (MI)
Sen. Paul Utke (MN)*
Sen. Paul Wieland (MO)
Asm. Kevin Cahill (NY)*

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Tess Badenhausen, Assistant Director of Administration, NCOIL Support Services, LLC

QUORUM

Upon a motion made by Rep. Daire Rendon (MI) and seconded by Asw. Pam Hunter (NY), the Committee waived the quorum requirement without objection by way of a voice vote.

MINUTES

Upon a Motion made by Asm. Ken Cooley (CA), NCOIL Vice President, and seconded by Asw. Hunter, the Committee voted without objection by way of a voice vote to approve the minutes from the Committee's December 11, 2020 meeting.

DISCUSSION ON RETIREMENT SECURITY INITIATIVES IN THE BIDEN ADMINISTRATION

Monique Morrisey, Economist at the Economic Policy Institute (EPI), stated that the EPI has been around since 1986 and we're particularly concerned with policies that effect

low and moderate income households and families. Today I've been asked to talk about what the effect of COVID-19 has been on retirement and the policy response to it - both to the COVID-19 pandemic and the economic downturn and in general what the Biden administration and democratic Congress might have in store for us. The pandemic recession was very different from a typical recession. Usually, and this includes the great recession which was atypical in its severity, but not atypical in its cause, what we've seen in more recent recessions is that there was an asset bubble that burst and then there was a collapse in aggregate demand and the economy recovered only as we had fiscal and monetary policies that supported a recovery. The great recession was a big collapse and the recovery was very slow in particular for the public sector which you all probably remember not so fondly.

This was atypical because it wasn't so much that there was an unexpected collapse, it was that the economy shut down for precautionary reasons and basically a lot of leisure and hospitality and other industries were told to stay home. That affected the service sector in particular which is atypical as it wasn't the usual cyclical industries like construction and manufacturing especially durable goods manufacturing like auto – that's not what really got it, it was things like restaurants, hotels and also healthcare which was somewhat of a surprise since this was a healthcare crisis. The other things that were atypical was that women were disproportionately affected by the job declines and again because they are also overrepresented in the service sector and some other specific sectors that were impacted and also because they were probably more likely to stay out for caregiving reasons since schools shut down.

What was typical was that we always see in a recession that young workers and minority workers are disproportionately affected and this was absolutely true in this recession too but what was atypical was that we also saw there was across the board declines in jobs and that included older workers – workers over 65 but also workers in their late 50s for example who are usually relatively protected during recessions because they typically have more tenure on the job but when they lose their jobs its much harder to get their job back. This is atypical because we saw that their job losses were significant but we also saw them rebound reasonably well with the exception of the over 65s and minority older workers. Some of the most vulnerable groups are still in trouble but overall I was expecting even worse problems and maybe when the economy rebounded that older workers would be left on the sidelines but we're not seeing that as much but they were impacted more than usual. Also, as a labor economist I should say that when we look at job losses its been very difficult and there have been problems with surveys as people have not been answering surveys the way they used too and also making the distinction between being laid off, being temporarily laid off and quitting or taking yourself out of the workforce for health and safety reasons was harder to do than usual.

On the bright side, unlike the great recession, the policy response to the pandemic recession has been basically scaled to the task at hand. The great recession lingered for many years after especially in the public sector because the policy response was inadequate but this was not the case this time as we actually saw strong fiscal response both during the Trump and now the Biden administration. We think that other policies that the Biden administration is putting in place will have long term positive effects on the economy too. With the American jobs plan, people look at it and say its another multi-trillion dollar plan but its stretched out over a decade and its largely paid for so its not an obvious fiscal stimulus but we think it will support the recovery. I was recently listening to a panel with the chief economist for Moody's and he is optimistic that we are really

going to see a short, sharp recession as we've already seen about two thirds of the job losses bounce back and its looking good for the future. Assuming we get the pandemic under control and assuming we don't have another unexpected wave with the variants or more people reusing to get vaccines or something like that, its looking good for the economy overall.

That said, the pandemic itself and the expected recovery has had very different impacts on different groups of people. Some people have called it a k or v shaped recovery or something like that. Basically, upper income households were largely unscathed and a lot were able to work remotely and they had their spending power in some cases very high and we are seeing that in some cases a sustained or potentially a bubble in the stock market and housing values are really high. For people who own houses or have 401ks, unlike the great recession, especially as there are more likely to be older households who have accumulated assets they are not going to see the kind of decline among older workers approaching retirement after the great recession where upper income and older households who had accumulated savings and assets were mostly affected by the decline in hosing and stock prices. This is not happening this time and we are also not seeing despite rules about tapping into 401k savings, we haven't seeing a significant increase in tapping those savings early because people who have 401k savings of any significance are not the kinds of people who are hurting during this pandemic.

That's the good news for upper and middle income people while people at the bottom half of the income distribution chain are the people who bore the brunt of the job losses and I think though that the good news is that we have seen that the recession will be short and sharp. My worst fear is that the most vulnerable people including vulnerable older workers would have trouble getting back into the economy is not being borne out as it looks like that people are being re-hired and two thirds of the job losses have been recovered and I think that's going to continue assuming no additional COVID problems.

Regarding D.C., after years of mostly incremental reforms especially as it relates to retirement that didn't get major pushback from employers or financial industry, now we are seeing that things are moving fast and that the what we call Overton window has shifted to things that even for moderates and centrists that would have been unthinkable a decade ago. It's not only because the Biden administration is moving fast on a lot of things and Congress and not only because of the pandemic breaking things open but also because people in the retirement space have made things that were once unthinkable seem necessary now.

Simultaneously, even though I think there is potential for big moves on social security and possibly mandating employer contributions to retirement plans, we are also seeing at the same time that the people who had been working on incremental fixes, notably Chairman Neal of Ways and Means is teeing up a SECURE 2.0 plan and I'm sure NCOIL has been active on the impacts of SECURE 1.0. There is potential for incremental and bolder changes on the retirement area. When I say bold, I mean anything that would require employers to do anything including potentially contributions as opposed to the incremental reforms that focused on maintaining the retirement system that we have now which is largely voluntary and tax incentivized and focused on individual accounts and maintaining consumer choice. I think that increasingly retirement folks are focused on making things simple, automatic or mandatory and di-emphasizing choice and emphasizing affordability, and fairness, keeping costs low and

addressing risks. Those all wont happen this year but they are more on the agenda this year than they used to be.

There are a lot of reasons why the Overton window has shifted. First, there has been growing support for social security expansion among democrats – its not bipartisan yet - and I think that lit a fire among people who aren't interested in expanding social security but realized that the incremental reforms to 401k plans and similar plans were not going to cut it and they needed to do something more bold even if they wanted to preserve a system that relies heavily on individual accounts. Also, the states have taken the lead on things like auto IRAs and related plans and that made something like auto IRAs push Congress to do federal similar legislation. I think also there has been a heightened awareness of racial inequality and wealth gaps and also previous incremental reforms haven't had the impact that people hoped they would. Those are all reasons why we are seeing more bold plans. My evidence for this isn't recent but for example, Senators Coons and Klobuchar in 2019 introduced the Saving for the Future Act which mandated a 50 cent per hour employer contribution. They were not known for being on the fringes of policy so the fact that there was an employer contribution mandate was significant and it didn't get much pushback as you would have expected.

Also, one of the big players on this is AARP who for may years said we will not support anything that has an employer mandate and this is not an official AARP plan but an influential person at AARP co-authored with Jason Fichtner who is a Republican at the Bipartisan Policy Center and William Gale formerly of Brookings so these are very centrist people - they also had a plan that would require employers and others to contribute and this would be a modest amount basically to allow people to delay social security take up and get a higher monthly annuity. I think it's a great plan as its not huge but its great. These are some of the things that are in the background and may not happen anytime soon but this would not have happened even five years ago. I think that we should always remember and I think you are focused on is that the things that will really prevent the most vulnerable people from extreme situations in retirement are often things that have nothing directly to do with insurance or retirement but address problems that lead up to having a precarious retirement. That includes things related to disability and long term care (LTC) and in case I don't get the chance to talk about it, I know that Washington state is taking the lead on LTC as they are putting in place a plan Washington Cares that is a social insurance plan to support home care LTC services. I think that's really interesting so in addition to states taking the lead on retirement states are now starting to take the lead on LTC which I think is wonderful.

So, what do we have on the agenda. It hasn't surfaced yet but the social security subcommittee led by Chairman Larson has been actively pushing a popular measure among democrats, the Social Security 2100 act which is an expansion plan and we have got word that the democratic leadership in Congress may want to push this forward soon because its viewed as politically popular not necessarily among Republican legislators but definitely among both Republican and Democratic voters. On the employer side with employer based plans the big things that already happened is the multi employer pension crisis has been resolved so the impact it had on the rustbelt and Appalachian states that were most impacted because of the teamster and mine worker plants that were most affected this also frees up Senator Brown who has been very active on retirement to work on other things and he has also talked about wanting to have some kind of mandatory employer plan and we will see more action on that.

We have been seeing a lot of action on SECURE Act 2.0 which is the follow-up to the SECURE Act. Also, auto IRAs more generally is something that I think is going to be more short term coming up. Regarding the SS 2100 Act it was actually one of the more moderate expansion acts that the Democrats have supported. It will not appear in its current form in this Congress because the Democrats are being careful about keeping to the pledge to not raise taxes on people earning below $400,000 because also it included a gradual increase in the payroll tax and that got a lot of pushback so they are going to have to trim it down but Rep. Larson is very intent on pushing it forward and I think that House leadership is very interested in making it a priority so I think that something like this pared down that will still extend the solvency of the SS trust funds but maybe trim back some benefit improvements will be put in the works this Congress and I hope so.

Regarding SECURE 2.0, I was recently in another conference where Chair Neal's general counsel spoke about what would be in it. None of this is firm but it's a follow up to the SECURE Act and some of the interesting things that would be in it are more far reaching that what was in the original SECURE Act is it would allow employer match on student loans and would also potentially include auto enrollment requirement on employers and then there are sweeteners on employers to have matches which is something I don't support – I think relaxing that requirement minimum distribution is a solution waiting for a problem. I think its great that they are looking at the saver's credit but I don't think that there is any indication that they are going to make it refundable so I think that is going to have not as much of an impact as it ought to but otherwise that should be a priority. These things could change and I think Acts 1.0 and 2.0 are really sort of a hodgepodge of whatever they could get support for.

Also, as you know, legislative fixes aren't everything so I want to flag that social security folks are very concerned that with social security offices being closed, there has been a drop off in applications for disability and supplemental security income (SSI) and I think that's very worrisome and I want to plug states to try to help their constituents access these benefits because there is a big problem with people not being aware that they are eligible. Its not normal for there to be a big drop off in applications during a time when we know that there are major health problems happening so this is entirely due to information and access problems and until these offices open up and even after its going to be an issue. States have an incentive to get their citizens to access these benefits because its federal money so please if you can do something to advertise and encourage people to apply for these benefits that is necessary as this is not a good sign.

Also, I haven't had a chance to look at it but the Biden administration just released a draft of its revised fiduciary language and I cant speak to it but I know that the consumer advocates are happy about it so I think that's a good thing and I think you were involved in that issue. Also, President Biden had a joint Task Force with Senator Sanders after the election and there were other things on this agenda that have been raised that we might see – one is a caregiver credit which is very popular and a way to expand social security benefits and the other is to focus on how unequal tax incentives are for retirement saving and there are also issues related to peoples access to affordable banking services which I think indirectly affects people's financial security.

SIX MEGATRENDS DEFINING THE NEXT WAVE OF LIFE INSURANCE AND RETIREMENT

Martin Spit, Insurance Strategy & Transactions Leader at Ernst & Young (EY), stated that he is pleased to share EY's research of where it thinks the industry is headed. When we say that I recognize that when you ask consultants what's going to happen everything is in turmoil and everything is in disruption and everything will change overnight but I actually don't think that's the case. When you look at the life insurance industry today in the U.S. its in good health and companies are mostly very well capitalized and the total premium numbers are towards $700 billion per annum and we see that the industry continued to fulfill a key role in the savings and retirement plans of Americans. What we do see though is if you take a very long term view for instance in the late 1990s about 10% of all household assets in the U.S. was in life insurance products. Today that is less than 4% so on the really long terms scale you can say that the industry is losing some of its competitiveness against other asset classes such as retirement accounts and IRAs. So it's a shift form one to another but for many players in the industry this convergence and shift between traditional life insurance players and low asset management driven entities is of great importance.

Against that backdrop we now look at the industry we simply have broken what we think is going to happen into three things: what are the trends impacting the industry today; what do we think how that will play out in some future stories and response to trends; and in the aggregate what do we think future business models will look like. If you look at trends we see six things happening to the industry going forward. Some of the trends are a little more applicable outside the U.S. and vice versa. The first trend is financial health and wellness is a key theme and what we mean by that is increasingly consumers are treated less on a product by product basis and want to be treaded on a more holistic advice perspective. We've seen that in the technology side with things such as robo advice but we also see it in the way that companies are starting to deliver advice to clients and take a more holistic perspective to what people want and need.

The second trend is around long term value and that takes different shapes. It's definitely been a view of insurers for awhile but we see that consumers are starting to have different interests for instance in the assets that companies invest in and we see that there is both a need and drive for clarity around hoe environmental, social and governance (ESG) frameworks are measured and frankly that's an area where a lot of my clients today are struggling with because there really is no apples to apples comparison between the different frameworks. The third one that we think is of global importance as well as in the U.S. is importance of collaboration between government and regulators and trust me we didn't write this in because we knew we would be speaking with you today. We think that as a regulated industry this has always been very important but we also see that the tax environment and the encouragement that the SECURE Act has given to annuity products is very important in terms of getting these products into the right hands and giving people the right tradeoffs in making sure that they invest in products that are right for them. Personally I haven't seen much business pickup since the SECURE Act as we would have liked but we also think that the current economic environment for annuity writers is petty tough so it may take time to settle in.

Fourth, we also think that ecosystems and omnichannel engagements are going to become more important and what we mean is a blend of different products, different distribution strategies at relatively different times in consumers lives. We just heard about student loans and we see the direct research is that priorities have shifted as two decades ago student loans didn't really feature in priorities that much but today they are a key concern of people entering the workspace and we expect that companies have

positioned themselves well to try to understand what are needs of consumers throughout their pre and post retirement needs and how to respond to that. Fifth, and probably the trend I'm working on most, is around capital optimization and convergence. We've seen that in the COVID crisis interest rates have both gone up and down a bit but currently the capital environment for many of the clients I serve is pretty tough and it means a lot of them are looking at better ways to structure that differently for instance through reinsurance transactions. One of the big things we have seen over the last decade is really the rise of alternative capital and pre backed capital in the life and annuity industry and that is a trend we expect to continue and many of those companies have come to great maturity and are being seen as serious parties these days maybe more so than 10 years ago when just getting started.

Lastly, we see a level of commoditization as well as customization in the industry and that's maybe a little counterintuitive to see together but what we mean is that it becomes increasingly easy for consumers to understand how are my funds invested if I chose an annuity product with a carrier and can I do that on my own and certainly we see that more sophisticated consumers are applying that as a strategy. We think the answer to that is to both recognize that's the case and with commoditization comes usually a different price point and that's something the industry should think about in terms of its long term overall capital position and customization should come out most in being at the right time in the right place to meet consumers where the demand is and that could be in a traditional retirement planning session but it could also be in a five minute window at the airport when somebody knows they want to get term life insurance and wants to get it over with. Those are models that the life insurance industry today is not really geared up to.

When we think what will happen we've actually thought about six ways the industry responding to that. For instance, we do see that things like life and wellness concierges and subscription models where you talk about insurance as a service becoming more interesting to people and we think that companies need to find a right balance in serving customers in a different way. We recognize that the industry is complex today and will be complex tomorrow so it's a little arrogant to say these are the business models we think people should comply with and live up to in the future but we tried our best to articulate six that we believe will be relevant in industry going forward.

We think that there remains room for global and regional consolidation because there has definitely been benefits of scale in the industry both in terms of operations perspective and a capital perspective. We believe that ecosystems and meeting consumers where they want to transact business will lead to a market extension and we think that there are companies that will specialize in that. We believe there will be increased segment specialization for instance on high net worth individuals and also on individuals that would need equal protection for the remaining 10 or 20 years of a working life. We think that overlaps with solutions specialists: nimble firms innovating with advanced analytics and underwriting. We believe that digital challengers will grow in importance quite a bit maybe three or four years ago thinking about digital and direct to consumer distribution of life and annuity products was pretty unheard of such as Ladder on the low end of the market but also we have entities like PoliyGenius that try to broker policies up to a large amount for insurance so we think thats definitely maturing and will find its place. Lastly we think a group of companies will say we are not so good at originating but are really good at managing books of business and capital that is deployed in there and will become back-book aggregators.

Rep. Kevin Coleman (MI) stated that there something mentioned about unfunded liabilities and retirement programs and it mentioned collaboration with government and regulators. Can you expand on that and talk about what you see coming down the road? Mr. Spit stated that when we walk about unfunded liabilities its mostly in the pension risk transfer market where there are company pensions that are not as strong as they should be. That's a pretty mature market in the U.S. already and in places like the UK and Netherlands and we think that will continue to increase and we'll see the solutions that used to be available only for very large corporations to make a pension risk transfer happen in a meaningful way are now becoming more available to the lower end of the market – its not exactly low and mid-size entities yet but the industry is definitely growing and its actually quite attractive for a number of capital players in the market given the long term benefits and assets that come under management with it.

CONSIDERATION OF RESOLUTION IN SUPPORT OF THE LIVING DONOR PROTECTION ACT (LDPA) (S.377/H.R. 1255)

Rep. Thomas stated that she is very proud to sponsor the Resolution along with Assemblywoman Carlton (NV), Chair of the Committee, as it deals with a very important topic. The Resolution is very straightforward and supports a piece of federal legislation that has bipartisan support and is supported by the American Council of Life Insurers (ACLI) and consumer advocacy organizations such as the American Kidney Fund (AKF) – both organizations are here today to speak in support of the Resolution. I don't want to take too much time away from the speakers we have here today, but the Resolution essentially protects living organ donors and promotes organ donation by making it unlawful to decline or limit coverage of a person under any life insurance policy, disability insurance policy, or long-term care insurance policy, solely due to the status of such person as a living organ donor.

This is a bit personal for me as I have two legislators that I serve with that have been involved in this. One is Representative Tarah Toohil who actually donated a kidney to her mother and I didn't know this when I agreed to sponsor this but just last week we had another PA Representative who received a kidney and is recovering and doing well. So this is particularly important to those of us in the PA House. I support this Resolution and urge adoption as it strikes the right balance between the needs of living organ donors to protect their families' financial futures and the need for life insurers to underwrite fairly. I also think it's important to note that while NCOIL will always remain cautious regarding federal involvement in the proven state-based system of insurance regulation, such involvement is sometimes warranted and until federal legislation such as the "Living Donor Protection Act" is enacted that would give baseline protections to organ donors nationwide, states are operating under a patchwork of living organ donor protection laws.

Deborah Darcy, Director of Government Relations at the AKF stated that she is also an NAIC consumer representative and is here to support the Resolution and am hopeful that with NCOIL's support we'll get the bill over the finish line and get it enacted. As you know, the LDPA will help people obtain the transplants they need. The bill is great for patients and living donors and really good for society. As a patient advocacy organization the AKF works on behalf of the 37 million Americans living with kidney disease and the millions more at risk. We support people wherever they are in their fight against kidney disease for prevention through transplant. One out of every six kidney

failure patients cannot afford the cost of care and AKF is there for them providing treatment and financial assistance and last year we assisted 74,000 kidney patients with their health insurance and in fact one in every 14 transplant recipients in 2020 were able to get their transplant because we helped them with their health insurance. We are one of the nation's highest rated nonprofits and we invest 97 cents of every donated dollar into our programs and we hold the highest 4 star rating from Charity Navigator and the platinum sealed transparency rating from GuideStar.

The AKF has ben working on the LDPA on both the federal and state level to ensure that people who donate a kidney will have access to affordable life, LTC and disability insurance. We believe that it will increase the number of living donations because it will provide assurance to people who have concerns about the availability of these types of insurance. In order to provide more dialysis patients with transplants we need more living donors. The AKF appreciates your time and effort in creating the Resolution and we believe with your support the LDPA will help enactment of the legislation and ultimately will improve people's lives. From the patient perspective the statistics are clear and they are laid out in the Resolution. There are about 108,000 people on the transplant waiting list. 82% of those are in need of a kidney. Every nine minutes another person is added to the transplant list. Seventeen people die each day waiting for an organ. Only one in five people on the wait list will receive their organ.

On an individual level, the reality is even harder. The physical and emotional cost is high for those waiting for a kidney transplant. Patients with kidney failure must be on dialysis for three days a week for four hours per treatment or be on dialysis overnight on most days a week and they must do this until they get a transplant. 80% of dialysis patients are too sick to work. A kidney transplant would give them their health back and provide opportunities to be in the workforce. In order to increase the number of transplants performed we need to increase the number of kidneys available. Living donors can help fill that gap. Giving the gift of an organ is the ultimate altruistic act. It takes an incredibly special selfless person to donate an organ. Organ donors are the healthiest people. If they are not healthy they will not be accepted as an organ donor. If someone makes that decision to offer an organ so another can live more fully and freely they should be protected. Unfortunately, living donors can face some difficulty with life insurance. A patient on dialysis told me that a friend was willing to donate his kidney but then he heard rumors that the might not be able to get life insurance. He had children and needed life insurance and rescinded his offer.

We also know from two studies that some living donors have faced these difficulties. A 2014 Journal of American Society of Transplantation article reported on a survey of 186 living donors. 25% of respondents faced some kind of difficulty in getting life insurance. A 2000 study created a secret shopper who had the exact same profile except one was a living donor and one was not. He applied for life insurance at 10 companies using both profiles and he had difficulty getting life insurance at one company when he used the profile of living donor. Studies have shown that living donors are just as healthy and live just as long as non donors so the living donor should not have faced any issues. The prohibition on discrimination will ensure that people who make this decision to donate an organ will be protected.

Another aspect of the bill is that it will codify a 2018 Department of Labor (DOL) opinion letter which stated that living donors are covered under the Family and Medical Leave Act (FMLA). Prior to the opinion letter, an advocate of ours who needed to take time off

work to donate her kidney to her husband had been told by HR in her office to fill out the paperwork saying that she needed time off to care for her husband who was receiving a kidney transplant. At that point, she could take time off work to cart for her husband but they didn't know if she could take time off for herself for donating the organ. Now that the opinion letter has been issued living donors know that there eligible for the FMLA and know they will have a job when they come back. Recovery times are usually out of the hospital in a couple of days so two weeks is usually fine Some people need a little bit more time. We believe the opinion letter can also be rescinded so we would really like for it to have the force of law behind it.

Finally, the bill is really good for society. In addition to dialysis being really hard on the individual waiting for a transplant, the cost of the healthcare system is very high. Again, as correctly stated in the Resolution, Medicare spends about $89,000 per dialysis patient per year. Compare that to after transplant Medicare would spend about $35,000 on that same patient per year. Hence the bill would result in better outcomes for patients and lower healthcare spending. So, once again I want to thank you so much and we are in full support of this and we look forward to continue working with you on kidney issues in the future.

Karen Melchert, Regional VP of State Relations at ACLI thanked the Committee for the opportunity to speak in support of the Resolution. The ACLI and its 280 member companies are dedicated to protecting consumers' financial well being through life insurance, annuities, retirement plans, LTC insurance, disability income insurance, reinsurance, dental vision and other supplemental products. The LDPA, a bipartisan initiative in Congress, ensures living organ donors will not be denied life or disability income insurance solely on the basis on their decision to help someone in need of a vital organ. The bill strikes the right balance between the needs of living organ donors to protect their families financial futures and the need for life insurers to underwrite accurately and fairly. People need to be able to make a life changing decision without it negatively impacting their life insurance choices. We are honored to stand with the AKF in support of organ donation and the immeasurable value it provides to humankind and we greatly appreciate NCOIL for bringing this Resolution forward and we urge its adoption.

Rep. Daire Rendon (MI) thanked the sponsors for the Resolution and stated that she has a brother who received a kidney from her sister 31 years ago and he has been retired for years and her sister is now retired in Arizona and he is now waiting for his second kidney. This is a big deal and she understands the importance of it.

Rep. Jim Dunnigan (UT) asked Ms. Melchert if there has been any analysis as to whether this increases the mortality risk for insuring a donor. Ms. Melchert stated that she is not sure if that analysis had been done but the ACLI has worked on this Resolution and the bill in Congress with AKF and there is obviously some impact to a person's vitality but I think we came to the conclusion that it's is not as significant as perhaps we thought it might be so its something that we would consider but wouldn't be the sole basis for denying coverage or raising rates. Ms. Darcy stated that she can forward the study that shows the same longevity.

Rep. Dunnigan stated that he thinks its wonderful that people are donors. But in Ms. Darcy's presentation she was commingling different pots of money as you are saying its going to save money in the healthcare system and be productive but its going to maybe

cost someone over here. The ones that have the increase in cost aren't going to get the savings. Rep. Dunnigan asked Ms. Darcy if she understood that. Ms. Darcy stated that is why she talked about the healthcare system as a whole and didn't really say Medicare but in terms of dialysis patients, once somebody has their transplant they save money on Medicare. Rep. Dunnigan stated that's wonderful but saving money in Medicare doesn't do anything for those additional costs in the commercial market but this is certainly better for the donor and he supports that. Ms. Darcy stated that the number of living donors is a small group and she can forward that study that was done by a researcher in Baltimore or Maryland.

Upon a Motion made by Rep. Rendon and seconded by Asw. Pam Hunter (NY), the Committee voted without objection by way of a voice vote to adopt the Resolution.

RE-ADOPTION OF MODEL LAWS

Rep. Thomas stated that per NCOIL bylaws, all NCOIL Model laws must be considered for re-adoption every five years or else they sunset. The three Model laws scheduled for re-adoption are the Beneficiaries' Bill of Rights (regarding retained asset accounts), the Life Insurance Consumer Disclosure Model Act, and the Long Term Care Tax Credit Model Act.

Rep. Thomas asked if there were any questions or comments on the Models scheduled for re-adoption. Hearing none, upon a Motion made by Rep. Carl Anderson (SC) and seconded by Asw. Hunter, the Committee voted without objection by way of a voice vote to re-adopt the Models.

ADJOURNMENT

Hearing no further business, the Committee adjourned at 5:00 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
WORKERS' COMPENSATION INSURANCE COMMITTEE
CHARLESTON, SOUTH CAROLINA
APRIL 16, 2021
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Workers' Compensation Insurance Committee met at the Francis Marion Hotel on Friday, April 16, 2021 at 5:00 P.M. (EST)

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

Other members of the Committee present were (* indicates virtual attendance via Zoom):

Sen. Jason Rapert (AR)
Asm. Ken Cooley (CA)*
Rep. Matt Lehman (IN)
Rep. Daire Rendon (MI)
Rep. Tom Oliverson, M.D. (TX)*

Other legislators present were:

Sen. Mathew Pitsch (AR)
Sen. Travis Holdman (IN)
Rep. Jim Gooch (KY)*
Sen. Kirk Talbot (LA)
Rep. Kevin Coleman (MI)
Asm. Kevin Cahill (NY)*
Rep. Dennis Powers (TN)
Rep. Jim Dunnigan (UT)

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Tess Badenhausen, Assistant Director of Administration, NCOIL Support Services, LLC

DISCUSSION ON SOUTH CAROLINA WORKERS' COMPENSATION MARKETPLACE AND RESPONSES TO COVID-19

Gary Cannon, Executive Director of the South Carolina Workers' Compensation Commission (Commission), stated that he will discuss how the Commission is set up and some of the issues they have dealt with this past year. We have six commissioners that are appointed by the Governor and appointed by the Senate and they are staggered terms. There are seven districts in which the commissioners conduct hearings in across the state. They rotate their district every two months so there is some sense of rotation there. The chairman and two other commissioners are up for reappointment this year and we just learned they will be up before the Senate judiciary committee next week and then next year we have two more commissioners up in that six year rotation as they serve for six years.

The commissioners basically serve in a judicial capacity in the seven districts conducting administrative law hearings of the disputes between the individual claimants and their employers. They also participate in phone conferences and approve settlements. The public policy is a little different in SC as they also approve regulations and approve the medical fee schedule. Many states have medical fee schedules that service providers

have to abide by and must be approved by the general assembly but in SC the commissioners approve the fee schedule and it must be updated once per year per statute and its based on Medicare CMS values and SC is typically about 40% higher on its values in the fee schedule than Medicare.

The Commission's mission statement is of course very much like NCOIL's and we try to provide an equitable and timely system that benefits injured workers and one of the core values that we press into our employees every day is to apply the facts of the case to the law. It's a level playing field and there is no special interest groups out there and we also try to have continuous improvement and respond timely to our constituents. Stakeholders are very much like those at NCOIL – employers, employees, insurance carriers, medical service providers, attorneys, uninsured employers fund, guaranty fund, and members of the general assembly. As I mentioned, we have a very small agency but the systemic economic impact of work comp in SC is about $1.04 billion annually. This past fiscal year we paid out $451 million in medical and $587 million in indemnity payments so you can see the economic impact and that doesn't include the premiums that are paid.

The annual operating budget for the Commission is about $8.1 million per year and about $2.5 million is appropriated by the general fund and $5.6 million is approved as expenditures from fines and fees it collects from its stakeholders. We have 63 approved full time employees but for the past several years we've only been funding 53 of those, 18 in the general fund and 45 in the earmark fund. The Commissioner has several departments and divisions – commissioners; executive director; information technology because its the foundation of all services provided; insurance & medical services does the coverage and compliance requirements; claims makes sure all forms are filed every year on a periodic basis; and judicial is like the courts and takes disputed cases and gets them over to the commissioners.

As I mentioned earlier, the commissioners have two functional capacities – judicial and public policy. The commission has several intergovernmental partnerships – they do not have dedicated hearing sites in SC so they have to beg borrow and steal the sites for the commissioners to conduct hearings across the state so we use local government council chambers, court houses, and other state agencies hearing rooms. We have about 100 on a list that we use but that's a constant battle for us to continually obtain those sites for the commissioners to use. We use the department of employment workforce for employer wage and personnel data for coverage compliance. We have a regular contractual relationship with the SC Department of Vocational Rehabilitation where the research data base is and last year they referred 2,204 referrals to the claimants for potential service for vocational rehab. We have an ability to go to probation, pardon and parole partnership facilities so that the incarcerated persons who are filing work comp claims will go to the prison conference room and our commissioners do not have to attend that. And then certainly with our department of insurance (DOI) we have a great relationship with Director Ray Farmer and his staff and when we have to notify carriers of paying fines and we are looking at adjuster training and I'm not sure if this is a problem in other states but in SC we have a lot of out of state adjusters that are handling individual cases and many times they don't know SC law and as you can imagine the law in SC may be different than other states in handling and adjusting a claim so we are working with the DOI to look at getting some training requirements for the adjusters in SC.

Some of the challenges and opportunities we faced this past year was obviously COVID-19 and the pandemic. The commission is also in the process of updating its IT legacy system. Others include: venues which is always on the commissioner's list of challenges in terms of what it needs to do and how to get the hearings held; medical service provider manuals and adjuster training are other challenges. With regard to how the commission's COVID-19 cases have gone – since February of last year the commission has had 3,251 cases filed related to COVID; last month there were 175. As you can imagine the three largest counties were the three most populous counties in the state – Greenville, Charleston, and Richmond. We had 25 fatalities. The commission has 13 open cases denied and 1,829 closed denied cases. Most of those cases do not go to dispute as most settle and that's why they are closed denied and there was some settlement there.

Some more information on COVID cases includes: The commission had 101 attorney representation and the medical amount paid out on the closed cases was $444,372 and the total paid on the Non-Medical Paid indemnity Cases was $1,885,537. That's the total amount – not per case. As you can imagine the highest number of the occupation of cases filed happened to be registered nurses and the medical field. Last year, Governor McMaster issued an Executive Order where he closed the agency to the public and all state agencies. The commission continued by having 20% of its staff working on site and 80% work from home and the commissioners suspended in-person hearings from March until June 1st. When hearings started again the hearings were conducted by Zoom and CourtCall and pre-hearing conferences were conducted by telephone but it was decided by the jurisdiction commissioner whether they were going to have something in person as well as or if it was going to be electronic. So each of the seven commissioners managed the docket that way. We then cut off any paper documents being submitted to us and only accepted electronic versions by USPS.

On June 1, the Commission re-established in person hearings and established a lot of CDC safety protocols on in person hearings but meetings continued to be held via Zoom and CourtCall and we are having our first business meeting this month in person since March of last year because of COVID numbers going down. We established the advisory notices that would go out to notify stakeholders of what was going on with those hearings. The IT project that we have been working on that started in 2018 to replace a 30 year old claims mgmt. system and the new system plans to allow online form completion, electronic payments, electronic service or orders, allow people to view and download documents, enhance security and provide data collection analysis.

We worked on it for over a year and we had an initial release date of Oct. 31, 2019 and once released it was delayed in until December 4 and we had some problems. The vendor was unable to correct the problems and the product they delivered was unacceptable and the vendor of course needed additional funding to correct them and we denied the request and the vendor terminated the contract on February 14, 2020. We were able to get Microsoft to conduct a gap analysis of the system that they developed to find out exactly how much of the code they provided us we could use and basically Microsoft said the system would need to be started over and do a complete rebuild. We filed a dispute with the chief procurement officer against the contractor and the dispute hearing is pending and we initiated a tracking responsibility and we are now contacting other states who have recently initiated this upgrade of their legacy IT systems to determine how they went through this. MN is one state, KS is another and so we are determining exactly what needs we will have for the new system and we are

accepting advice from the chief procurement officer to accept those proposals. We are hoping that once the hearing is conducted that it will have no bearing on us going forward to conduct RFPs with soliciting proposals to get our system up and running.

The commission has the responsibility of ensuring medical care is available to claimants and controlling costs of the system. There is a balance there of adopting a fee schedule to put a maximum amount of an amount that a medical service provider can be paid but the balance of that is to make sure medical are is available to the claimants. As I mentioned we have medical service provider lists which is updated annually and is based on Medicare and we are currently updating it effective April 1 and it was based on the resource based relative values from CMS. There were several issues that came up when the medical service provider manual was being updated and it was deiced that some of them needed further study so they will be chartering an advisory committee to look at those issues to help ease the administrative burden that is placed on the medial service providers and that process will be staring next week. With regard to venues, there are seven districts across the state consisting of 54 sites. There are no dedicated hearing rooms so court rooms, city/county council chambers, state agency conference rooms, and technical colleges needed to be used.

DISCUSSION ON CALIFORNIA STAFFING AGENCY REFORM ASSOCIATION (CAL-SARA)

Mark Bertler, Executive Director of CAL-SARA, stated that he and his colleague, Pollie Pent, CAL-SARA Membership Chair and former CA DOI Insurance Detective, are pleased to be here to talk about their model on CA based on some frustrations with work comp insurance fraud in CA and perhaps across the country. We formed this trade association in 2020 so we are really new and we formed it to be an association of businesses to promote legal and regulatory compliance in the sale of workers' compensation insurance and to promote the common business interest of members in recognizing and eliminating workers compensation' fraud in the temporary staffing/staffing/recruiting industries.

Ms. Pent sated that she is going to talk a little bit about the current situation in CA and to do that she is going to use a metaphor with one of the last patrol calls she took when she worked patrol prior to going to work for the city and county of San Francisco. I got a call for a domestic violence in progress and I showed up to the call and I heard screaming and I increase my backup to code three and I made entry and from the back of the hallway a woman jetted out of a room and she was obviously injured and behind her was a man and he started coming towards me and I ordered him to get down and he started crawling towards me. I finally got him to stop and I started cuffing him while he was on his belly and I got one hand cuffed and when I started to get the other he started actively fighting me. I'm basically sitting on him controlling one of his hands and he is just moving and what I noticed was there are five blue accordion style lid bins in a half circle and he is crawling toward those and I am of course telling him to stop and I can hear the siren of my backup coming. The wife yells at me from the corner of the hallway where I told her to stay that there are six rattlesnakes in every box because he is dealing illegal reptiles and I can hear as he is starting to hit the boxes to turn them upside down so that they will slither out on me I can hear their tails starting.

At that moment at the door comes my backup who is a younger guy and a surrogate son and he is almost laughing at the sight of me sitting on him and I told him about the

rattlesnakes. The backup pulls out his gun and starts waving his gun at the boxes and I told him that if you don't have snake shot in that gun its not going to be helpful. We took the guy to jail and the wife was ok and it turns out he was dealing illegal reptiles. The reasons why I use this as a metaphor is because that's how work comp fraud felt to me when I got involved at the city of San Fran then I lateraled to the CA DOI. When I got involved with Professional Employer Organization (PEO) and staffing fraud, what I learned was there were boxes all around me and snakes of different colors in each box because the fraud is horrific. In the PEO and staffing agencies in CA its actually an underground economy as there are billions of dollars a year that are being diverted out of the state regulated system into the fraudulent system and that system undermines business practices because it creates unrealistic and fake pricing because cheaters actually do it cheaper.

I remember when I was a campfire girl we would sing that song over and over – cheaters never prosper and that is not true in CA work comp especially in the staffing and PEO industry. The fraud in CA is not addressed by any specific rules and laws as far as regulation of PEOs and staffing. There is zero regulation. All we have in CA are CA penal codes that have to do with grand theft, forgeries for fake certificates of insurance (COIs) and two insurance codes in the penal code and then we have our insurance code - that is the only way to regulate the problem – criminal prosecution. For four years I did nothing but work staffing and PEO fraud in PEO and in that time I had three cases filed and my 4th case was filed immediately after me leaving in August 2020 and the reasons why they are difficult to file is only the CA DOI has the expertise to file these cases as they are extremely complicated and multifaceted and because of that they take a lot of time. The crimes ranges from simple grand theft from simply stealing money for monetary instruments to forgeries for passing COIs which are monetary instruments but the investigations require specialized units such as computer forensics so when we serve a search warrant we are going to get all of their data and payroll records and all internal and external communications from e-mail which is all vital to criminal prosecution but they also require forensic audits especially if you are going to theft or premium fraud issues and those are very difficult to find in CA. In fact the entire northern part of CA which is Bakersfield North and if you are familiar with CA that's a lot of territory there is one forensic auditor at CA DOI.

These cases don't offer a lot of bank for buck in terms of stats. The dollar amounts are huge but I had one case where I actually got it filed and in CA it was a $64 billion case and they were based out of GA and operating in several other states including SC and we figured it was about $120-220 million the best we could track via audit. The IRS had four people for that. So, from a timeframe it took three years to investigate and the state flew me to GA several times and there wasn't a lot of bang for buck because I only got four arrests for that and the idea that we would get money back was very low because many of the fraudsters are very clever and their assets are offshore or they spent it all.

CA DOI is drastically understaffed like many law enforcement agencies right now and they most often deny cases even good cases for lack of resources. Injured workers in CA in these cases are most often vulnerable populations that have low skill levels and don't for the most part speak English and the percentage I had at one time was 68% of the workers in one case I was working didn't speak English and they were 95% Hispanic. They have limited employment options and because if that they are easily intimidated and silenced. An important part of PEO and staffing fraud is making sure that claims go away and this is a perfect workforce to do that with because they don't

understand their rights under work comp laws and they often need the job which is why they came to the U.S. and so they are easily intimidated and silenced into not pursuing claims. For all of these reasons this type of work comp fraud involving PEO and staffing fraud is rampant and unchecked and that a polite way of saying it because its out of control.

Mr. Bertler stated lets talk a little bit about our approach. One of the reasons we came together as a trade association is to address the challenges Ms. Pent talked about. We want to encourage stakeholders to join CAL SARA and commit to combating fraudulent practices. We want to develop educational materials and presentations to inform about fraud and empower stakeholders to fight fraud in their businesses. We want to participate in coalitions and joint efforts to address and expose fraud. We want to identify and assist whistleblowers in exposing and addressing fraudulent practices and activities which can be hard with limited English proficiency and we want to act as that safe haven. We also want to pursue litigation to hold fraudulent actors accountable. One portion of our association is our litigation arm and one of the reasons that we are here is because one of the first things we did in November was that we sued one of the largest work comp fraud companies in the country.

Ms. Pent stated that when we file litigation we receive a fraud referral. We sometimes receive them on the CAL-SARA portal and sometimes people call me directly or sometimes insurance brokers will actually send us information. We use the Unfair Business Practices Act as an available remedy through litigation under California Business and Professions Code 17200 as our basis. We do this because CA case law has allowed for any sort of business practice that offends public policy, is oppressive, that causes injury to business or markets, that is unscrupulous unethical or immoral so it gives us a pretty wide breadth of ability to go after people. The other thing we have done is looked at aiding and abetting which is a criminal statue. Obviously we are not going to file a criminal case so what we have done is looked at civil conspiracies in CA which requires CAL-SARA to provide evidence that "the defendant had knowledge of and agreed to both the objective and the course of action that resulted in the injury, that there was a wrongful act committed pursuant to that agreement, and that there was resulting damage." I can tell you in the number of cases we have taken into CAL-SARA to date which I will say is we are litigating three right now and there are six others that I have done the initial investigation on this is not hard to prove and in fact its easy and as Mark mentioned we also like to work with other partners and we also package them and notify CA DOI of them to let them have a chance of taking the case but ultimately I have been taking them straight to the county DA which has been very helpful and successful and almost all of them have been accepted for prosecution in a criminal sense.

Mr. Bertler stated that our membership includes staffing agencies, brokers, PEOs and others and we ask that they support our association with dues and also we have a litigation arm so we ask for contributions to our litigation fund to pay the lawyers. One of the things that we understand is that work comp fraud is multidirectional so not just insurance companies reporting fraud on staffing agencies, its staffing agencies trying to get by and either going around or violating the rule so we ask that our members sign a code of conduct that says they will not be involved in these sorts of activities and since this is the 21st century we provide them a digital badge and we allow them to use that on their materials and the reason we like digital badges is because if we find out someone has violated our code of conduct we can take away the digital badge electronically and they cant use it anywhere as it won't show up on any of their material and if it does our

agreement says we can prosecute them for it. This is to work with stakeholders and maintain a fair and compliant CA staffing agency marketplace. We are focused on staffing agencies and our core functions are education, assistance, and as mentioned taking action.

We reach out to like minded individuals and organizations to join forces to identify and eliminate fraud in the work comp insurance marketplace. As Ms. Pent mentioned, one of the large organizations that we are in court with right now, we are adding to the plaintiffs in the federal district court in CA and we are also interested in developing and borrowing educational tools to help individuals and organizations identify and avoid workers' compensation insurance fraud. We believe education is a really important part of us as I think sometimes people believe what a fraudulent insurer tells them and they have no other way to determine if that's real or what kind of trouble they get into.

Ms. Pent stated that CAL-SARA is going to continually pursue its current ligation and I should add that we have to have standing in any kind of litigation so that is why we ask people if they have a complaint and they want us to file that they join as a member. We are going to continue litigation and investigating and looking into the practitioners of all different kinds of fraudulent work comp activities. Right now we have a multiple employer welfare arrangement (MEWA) that is illegal that we are looking at and a staffing company that was dissuading their injured people and we have illegal collateral agreements in another managing general agent (MGA) we sued that was a big company doing most of the staffing in CA as their collateral agreement was not actually approved by the state.

Mr. Bertler stated that CAL-SARA is developing and producing educational materials including webinars to explore the various aspects of workers' compensation fraud and its impact on the
staffing industry and workers. That includes partnering with our gov't agencies and regulators but by the same token one of the things that Ms. Pent told me that I thought was very interesting was that she was an insurance investigator and a sworn officer taking these things down and one of the thigs we are able to do as CAL-SARA and of the reasons why we function better as a trade association is that it allows us and Ms. Pent and other fraud investigators to take any pathway that works so if we get stalled going up the chain of command in the DOI we can go to the county DA and if we get stalled there we can go to federal court so that is one of the benefits of building an association like this.

Sen. Utke stated that you mentioned you are a trade association so are you separate from the state as far as funding goes or do they help fund you? Also, this sounds like a massive job and you have plenty of work in front of you – how big is your organization and how many members do you have at this point? Mr. Bertler stated that we are an independent 501(c)6 trade association so we are a non-profit and domiciled in CA and we have about three of us who are working on it right now and we are building a dues base. We started in October of 2020 and we filed a massive lawsuit in November of 2020 and hit the ground running but trying not to get too far ahead of our supply chain.

Sen. Mathew Pitsch (AR) stated that he is fascinated by this and stated that he is an engineer so he wants numbers and percentages and asked if this is happening in a lot of states and if we as legislators should be finding numbers and dealing with this problem. Ms. Pent stated that's exactly why we are here as part of what we are doing is to get

awareness out and the cases we are working are all multistate and I might have done the prosecution in CA for victims and losses in CA but every single one of them was working in almost every state in the nation and I would say that I could name out of four large PEOS that were committing fraud I could say we are way above $20 billion just in terms of what I could quantify in terms of CA losses and that does not cover all the premium loss to the insurance companies, I'm talking about losses to businesses and losses to the uninsured fund in CA and losses to everybody down the chain. With regard to COIs, everyone listed on the COI in CA under the work comp appeals board rules all of those are named in any lawsuits including employment practices liability insurance (EPLI) providers for those companies so its just a shotgun approach to try and fix it but its not fixing it but just band aiding the problem.

Sen. Pitsch asked if legislators should stay involved and if this is occurring across the country. Mr. Bertler stated that its just not surfacing and Ms. Pent was very kind to her former employer as sometime things just get stalled and with one of the recent cases CAL-SARA was pursuing the CA DOI said it didn't have adequate resources and as a former lobbyist my response was show me your budget proposal where you asked for additional resources to prosecute this sort of thing and we want to partner with them as we don't want to demonize state regulators we want to have them take more seriously the fraud that is going on and frankly its hard to quantify because there are a lot of people involved and a lot of people don't know they are being taken advantage of and when we filed that one big lawsuit people from around the country, staffing agencies and insurance brokers said we know those people and we have lots of problems with them so thank you for doing that but that's kind of the big splash that we started with and hopefully it picks up steam that gets rid of at least some of the largest fraudsters and one of things we talk about is what if we are successful. If we are successful there will be fewer work comp insurance providers because of the amount of fraudulent ones that go out of business so how do we handle that challenge. And one of the things we are going to talk about is market remediation – rather than getting big cash settlements that goes to who knows who lets use to it to rebuild the insurance infrastructure in the state just like if you did if someone environmentally polluted land or water.

Ms. Pent stated that what she found in the cases she was working was that she noticed that a lot of the middle level brokers that were involved with the fraudsters were located in a state in the Midwest and when I would get my prosecution packages ready I would send it to them thinking that ok I've done the job and I just have to do my job and go arrest these people but what I found was that this is in Illinois they only have five detectives in the entire state. I talked to another broker who moved from GA to TN because TN and TN DOI was not robust either but in GA they had a robust DOI and they don't have a lot of special agents but they are very aggressive in their actions and have a separate work comp department so a lot of it depends on what the state have going as well.

THE EARLY IMPACT OF COVID-19 ON WORKERS' COMPENSATION CLAIM COMPOSITION

John Ruser, President & CEO of the Workers' Compensation Research Institute (WCRI), thanked the Committee for the opportunity to speak about the early effect of COVID on work comp claims. I want to stress that this is an early look at the data through the second quarter of 2020 but I also want to argue and ill show some data at the end that the findings that we present in this study tend to generalize that the same findings would

be found if you were looking at more recent data. The WCRI is an independent non-profit founded in 1983. We have a diverse membership and funding support from insurance companies, large employers, labor unions, state agencies and independent rating bureaus. We focus on the delivery of work comp benefits, we don't focus on pricing as there are other organizations that do that. Importantly, we don't make policy recommendations nor do we take positions on issues – we just present the facts so that all stakeholders can make informed decisions about the work comp system so we are a resource for elected officials such as yourselves but also for all stakeholders.

So, I'm going to answer a few questions in this presentation. I'm going to talk about how COVID-19 claims have varied across states in the first two quarters of 2020 and what are some of the factors behind the variation that we see. I'll talk about non COVID claims and to what extent the pandemic has affected the number of non-COVID claims in 2020 and the previous year. Finally, a little bit about how time to injury to medical treatment was impacted by COVID and then I'm gong to supplement with a little bit of state data to show the continuing relationships that we see in the data.

We are looking at 27 states here and using a database that WCRI has built over the years of work comp clams which is a large database and highly representative of states including the states on the list and in the study we are going to look at claims with medical or indemnity payments that arose in the first two quarters of 2019 and 2020. For 2020 you may ask if the claims were all accepted and interestingly the answer is not necessarily as they are claims that had a payment in some states and a payer can make a payment to a claimant but not actually accept liability for the claim.

First, we'll talk a little bit about COVID claims and what you see is the percentage of all paid claims that were COVID-19 claims in the 2nd quarter of 2020 and obviously what jumps out is the remarkable percentage of variation in the number of COVID claims across the different states. SC had only 1% of all claims being COVID claims as of the 2nd quarter of 2020 and the number rose all the way up to 43% in MA. So what are the reasons behind the numbers in the variations we see. Well, the severity of the pandemic at the time of the data is crucial and compensability rules play a big factor here and I know you've talked about presumption rules and polices in previous meetings and such rules and polices and laws do have an impact on the fraction of all claims that are COVID claims as ill show you in a minute. However, there are other compensability factors that come into play. MA has a pay without prejudice rule so the insurance company doesn't have to accept the claim to be making payments and it's a common practice in MA and then NJ has a special law in place before COVID hit – the Thomas P. Canzanella Twenty First Century First Responders Protection Act that allowed for first responders to receive work comp in the event of an illness due to a pandemic. So, these are rules that went into effect as to whether or not a claim receives payment for COVID. We're calculating our numbers as the number of COVID claims relative to all claims so if there is a big drop in the volume of no COVID work comp claims that also affects the numbers as a bigger drop in the number of non COVID claims means a bigger increase in the ratio of COVID to all claims.

One thing we found that did not seem to matter was the variation of industry across the different states so for instance the fact that there is a lot of healthcare in MA really was not a factor behind MA's high number. So, ill show you a couple graphs to show how some of these factors impact the variation in work comp claims. The colored bars represent the number of COVID deaths per million in the genera population, not the work

comp population. There are three states, CT, NJ, and MA that at the time had over 1000 deaths per million due to COVID and so those are the states that not surprisingly have the most COVID claims at the time. At the other end of the spectrum those with the green had fewer than 100 deaths per million in the population at the time and not surprisingly those are states that tended to have fewer COVID claims at the time.

Another issue is presumption laws in the states so in gold we've indicated the eight states that had presumption laws or regs in place at the time of the study through June 4th and some folks know there were other laws passed after that time period including NJ in September but these are the eight that had them in place at the time and what you could see was that COVID claims tended to be higher in states where there was a presumption law in effect so I guess that's not really a surprise. However, again, there are other factors that come into play – MA not having a presumption law didn't affect the fact that it was the highest CVOID claims. The other thing to note is that there were many states that did not have presumption laws in effect but still had COVID claims up to 5% and even PA and DE over 10%. So, where did we see COVID cases amongst all of the industries and occupations at the time of this study. We saw them in two categories of industries – high risk and low risk service industries. The risk was being measured here in terms of the risk of a non CVOID related injury so principally those industries had most of the COVID claims. So what we did was more drilling into those broad industry categories and what we saw was, and we know this more and more, is that most of the COVID claims arose in assisted living facilities in hospitals and physician offices.

Lets talk briefly about what happened to non COVID claims at the beginning of the pandemic. We saw a big drop in the number of non COVID claims during the 2nd quarter of 2020 as compared to the same quarter of 2019. In MA, the number of non COVID claims dropped as much as 50% and in a typical state the number of non COVID claims dropped by at least 30%. The red line shows the percentage drop in employment between 2020 Q2 and 2019 Q2 and it shows that indeed there was of course a drop in employment as the result of the pandemic during those quarters but it doesn't account for the drop in the claims as some of the claims dropped because of the slow down in economic activity without necessarily a drop in employment but also things related to working from home and social distancing and the like. One thing that's really fascinating is that even though the number of non COVID claims dopped substantially during this time period, if you look across the different types of injures, they didn't look that different as compared to 2019 so for example the most frequent kind of injury both in 2019 q2 and 2020 q2 was sprains and strains followed by lacerations an contusions so while there tended to be fewer work comp claims for injuries the distribution looked very similar during the pandemic as compared to before it.

Lets talk about time from injury to treatment. We all heard a lot about the potential for delays during the pandemic in terms of getting medical care so what we did here was look at non COVID claims with paid medical services during the first couple of quarters of 2020 and compared to the same quarters in 2019 and of this particular setting we looked at more severe claims such as those as more than seven days away form work. What we saw was relatively small drops in the proportion of claims that received various medical service in 2020 as compared to 2019. So on the left those are the q1 injuries that arose in ether 2019 or 2020 and on the right those are q2 injuries and what you see is some modest drops in the provision of medical services. For q1 injuries 64% of 2019 received physical therapy and only 61% received physical therapy in 2020 or a very

modest 3% drop in claims receiving medical services. What we see here is when an injured worker filed a work comp claim they tended to get medical service during the pandemic as they had before.

When it comes to time to medical treatment, the number of days before an injured worker received medical services here you see that perhaps in 2020 the medical services were delivered a little fast but essentially what you see is that they were delivered about as fast during the pandemic as they were before the pandemic and again there weren't as many non COVID claims but when they occurred they tended to get the same medical treatment. This is the number of services provided both for evaluation and mgmt. and for physical therapy and you can see that injured workers got the same number of services during the pandemic as they did beforehand.

I've been showing you some evidence from the first couple of quarters in the pandemic so does it hold up to more recent data? What we saw was that no COVID claims were lower in 2020 than 2019 and I'm going to show you some other consistent evidence that shows that continues to be the case. I showed you the COVID claims were mostly seen in healthcare and social assistance industries as well as in public administration including first responders ill show you that remains the same too. I'll show you some excellent data from MN provided by the MN Dept of Labor and Industry and it shows the monthly claims count for COVID and non COVID claims and there are three things to draw from the graph. The red line shows the number of COVID claims that arose in a month of the year and you can see that the number of COVID claims spiked in December of 2020 and sort of surged around the same time the pandemic surged in MN and many other states during the winter this past year and into this year.

The blue line is non COVID claims in the previous year before the pandemic while the yellow line is non COVID claims during the pandemic and consistent with what I showed you before you can see that the non COVID claims in 2020 have been consistently below the non COVID claims in 2019 - the yellow line is consistently below the blue line and particularly low in the April/May time when we did the study and again in the window of time when the pandemic hit MN. Another piece of data from the MN dept. of labor is which kinds of workers are filing COVID claims and you can see consistent with our data its healthcare and social assistance workers and docs and nurses and people like first responders who are covered by the MN presumption law but what you can also see is that there are some COVID claims arising in other industries where the presumption doesn't apply including manufacturing and transportation and warehousing. So the takeaway is that while most of the COVID claims in MN have occurred in healthcare and social assistance and public administration where there was a presumption there were other cases as well.

Lets quickly flip over to WA and some data I extracted form a WA state publication showing that 80% of all of the COVID claims in WA through Feb. 8 2020 were in healthcare, social assistance, and public administration so again its very consistent with the data that we show.

Rep. Matt Lehman (IN), NCOIL President, stated that you are looking at claims data and with as much as we went to work from home were there injures within the home that became compensable? When you talk of being in the course of employment, could I be covered if I fall in my home while working? Dr. Ruser stated that's a great question and we are not yet able to answer that with our data and we are trying to tease out in the

data where the location of the injury was as it is not as obvious in the claims data that we received so I think its something that we definitely need to be mindful of as there are clearly ambiguities that arise in injuries while working for home as to whether you were on work status. Another issue that will probably arise is neuromuscular skeletal disorders and if you look at U.S. data over the past quarter century there was a big drop in such injuries like carpal tunnel syndrome as employers put more ergonomics in place but that's not necessarily the case in the work from home environment so we'll be looking into whether we see a rise in those kinds of cases.

Rep. Lehman stated that the MN slide stated that if that stretched for the U.S. when you look at social assistance and healthcare and public administration being the three biggest, those folks were not working from home so I always wonder if it played a part but I'm not sure if it really did. To your point of more long term are we going to see long term injuries as a result of not having my same office chair that will be interesting to see the data. Dr. Ruser said we will continue to follow the data in subsequent years.

ADJOURNMENT

Hearing no further business, the Committee adjourned at 6:15 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
FINANCIAL SERVICES & MULTI-LINES ISSUES COMMITTEE
CHARLESTON, SOUTH CAROLINA
APRIL 17, 2021
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Financial Services & Multi-Lines Issues Committee met at the Francis Marion Hotel on Saturday, April 17, 2021 at 9:00 A.M. (EST)

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

Other members of the Committee present were (* indicates virtual attendance via Zoom):

Sen. Jason Rapert (AR)
Asm. Ken Cooley (CA)*
Rep. Matt Lehman (IN)
Sen. Tom Buford (KY)
Rep. Joe Fischer (KY)
Asm. Ken Blankenbush (NY)
Asw. Pam Hunter (NY)*
Sen. Bob Hackett (OH)
Del. Steve Westfall (WV)

Other legislators present were:

Sen. Mathew Pitsch (AR)
Rep. Terri Austin (IN)
Sen. Brandon Smith (KY)
Rep. Kyra Bolden (MI)
Rep. Brenda Carter (MI)
Rep. Daire Rendon (MI)
Sen. Lana Theis (MI)*
Sen. Paul Utke (MN)
Sen. Dean Kirby (MS)
Sen. Walter Michel (MS)
Asm. Kevin Cahill (NY)*
Rep. Forrest Bennett (OK)
Sen. Roger Picard (RI)
Sen. Ronnie Cromer (SC)
Rep. Jim Dunnigan (UT)
Rep. Warren Kitzmiller (VT)

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Tess Badenhausen, Assistant Director of Administration, NCOIL Support Services, LLC

QUORUM

Upon a motion made by Asm. Ken Cooley (CA), NCOIL Vice President, and seconded by Rep. Matt Lehman (IN), NCOIL President, the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a motion made by Sen. Jason Rapert (AR), NCOIL Immediate Past President, and seconded by Rep. Joe Fischer (KY), NCOIL Secretary, the Committee voted without

objection by way of a voice vote to adopt the minutes of the Committee's December 11, 2020 meeting.

DISCUSSION/CONSIDERATION OF NCOIL INSURER DIVISION MODEL ACT
Rep. Jordan stated that the first topic on the agenda is the consideration of the NCOIL Insurer Division Model Act. The original version of the Model was sponsored by Connecticut Senator Matt Lesser, but Asm. Cooley has since introduced an amendment by way of a Committee substitute which is in the binders on page 259. We will be voting on the Model today, but I'll first turn it over to Assemblyman Cooley.

Asm. Cooley stated that he is very proud to sponsor this Model. What's presented before you today is an amendment by way of a Committee substitute to the original version introduced by Sen. Lesser. The backdrop to this is that in March of 2020, NCOIL adopted an Insurance Business Transfer (IBT) Model Act. Like the IBT Model Act, insurer division statutes address the significant limitations in the current methods available to insurers to transfer or assume blocks of insurance business in an efficient and cost-effective manner that provides needed legal finality. While IBTs and insurer divisions are similar in some respects, they are nonetheless distinct restructuring mechanisms with different functions. Accordingly, following NCOIL's adoption of its IBT Model Act, it made sense that there should not be one Model without the other for states to consider adopting.

Sen. Lesser then stepped forward with an initial draft of the Model and an issue that arose in the process related to whether to require or permit the Insurance Commissioner to utilize an independent expert and hold a public hearing during the course of reviewing an insurer division transaction. The first draft of the Model permits such action while the Colorado bill and the Committee substitute in your binders makes such action mandatory. That is the biggest distinction between the two proposals. I relate this back to the 1980s when I was chief counsel to the Assembly Committee on finance and insurance and we did a lot of oversight looking into the administration of certain facets of the DOI because they had one unit where very technical issues were being settled by one individual exercising their own judgment and they were so technical they weren't really exposed to consideration and controversy arose to that fact so in my view adding a requirement for a public hearing when these types of transactions are being reviewed kind of aligns with what we said about sunshine is the best antiseptic and it requires that deliberations about restructuring of the business, albeit a technical issue, have the benefit of a public hearing and public input. I think it supports transparency in gov't and accountability and in that sense it's a very important change.

That said, I have also included drafting notes on those two issues which are on pages 264 and 267 of your binders. Those drafting notes explain that while the Model requires the commissioner to select and retain an independent expert and hold a public hearing in especially large or complex divisions, some state insurer division statutes provide the commissioner discretion to do so regardless of the size or complexity of the transaction. And then the Model sets out factors states should consider when considering whether or not to require the retention of an independent expert and require a public hearing.

So, the principal change aligns with the idea of sunshine is the best antiseptic and in these types of restructurings the basic rule in the NCOIL Model is that there should be a hearing with an outside expert to inform the discretion exercised by the regulator although we do provide a path via drafting notes for something else. Before closing I

would like to point out a couple of changes to the Model that have been made since it was released in the 30 day materials. The changes are on page 266 and 267 of your binders and deal with the very important issue of guaranty fund protection and basically ensuring that guaranty coverage is as expected and that the funds act as expected. I feel very strongly about guaranty fund protection as I am also sponsoring similar amendments to the NCOIL Guaranty Fund Model Act currently pending in our P&C Committee.

I present this as an alternative to the original version of the Model and I think it's a good place for NCOIL to land in making clear that we support sunshine being the best antiseptic as sound policy that is well established in our business and the drafting notes are designed to be the result of different local positions. Thank you, Mr. Chairman. I request the support of the body for this proposal and I'll turn it back over to you.

Paul Martin, VP of State Relations at the Reinsurance Association of America (RAA), stated that RAA supports the committee substitute and would like to thank Asm. Cooley for his leadership on this and as he indicated this is essentially the CO bill that all stakeholders worked on in 2020 to get to a place where everybody felt comfortable to balance the needs of companies that wanted to do divisions and the other stakeholders who wanted transparency and accountability that hearings and expert witnesses can provide. In fact, this substitute is so good, if it is adopted, we would urge the Committee to consider reopening the IBT model that you adopted last year and make it congruent with the division model. I know Sen. Rapert is running the NCOIL IBT model in his state and assuming the amendment we proposed gets into that we are hoping that the Sen. Jason Rapert AR IBT Model will become the Model for NOCIL. We think that this strikes a really good balance between the interests of all the parties and provides everyone the necessary confidence that when we do these transactions going forward that they have been vetted.

Upon a Motion made by Rep. Lehman and seconded by Asw. Pam Hunter (NY), the Committee voted without objection by way of a voice vote to adopt Asm. Cooley's committee substitute with the changes he discussed.

DISCUSSION ON DEVELOPMENT OF NCOIL REMOTE NOTARIZATION MODEL

Rep. Jordan stated that we discussed this issue at our last meeting in December and now we have the first draft of a Model for discussion which is in your binders on page 274. The Model is still in the early stages of drafting and is meant to generate discussions as there is no sponsor attached yet.

Bill Anderson, VP of Gov't Affairs at the National Notary Association (NAA), thanked the Committee for the opportunity to present and stated that he wants to talk a little bit about remote online notarization (RON). Let me take a minute to clarify what we mean by RON because there is not just one but there are five different types of notarization in our world today and it would be great to make sure we are all on the same page. The first type of notarization is paper notarization and is what we all have come to know very well where the documents signer and notary are physically present and in the same room. Paper documents are used and the signer uses a paper full of identification to verify their identity to the notary and the documents are signed using ink pens and physical notary seals. The second kind of notarization came around about 20 years called electronic notarization. In this, the document signer and notary are in each other's physical

presence like a paper notarization but electronic records instead of paper documents are used and the signer passes a physical form of ID to the notary just like they do in a paper notarization to verify identity and since electronic documents are used the documents are signed with electronic signatures and electronic notary seals.

Then in 2012, RON came about and here the document signer and the notary appear before each other using communication tech jus like I am appearing before you today via Zoom. Electronic records are used to transact the notarizations but with the identification the signer is identified to the notary by using multiple factors of identification because its inherently insecure for a signer to simply display on camera a physical form of ID to the notary like they would in each other's physical presence. Then the documents are signed using electronic signatures and electronic notary slips. The fourth type of notarization is a variation of RON called paper RON. Here, the document signer and notary appear before each other using comm technology like a RON but paper documents are used not electronic records and they are signed and sent back and forth between the signer and notary through the mail. The signer is identified through the notary using multiple factors of identification and ill describe that a little bit more in a moment and then the documents are signed using ink seals and physical ink signatures. The final type of notarization came about due to COVID in the last year and that's what we call remote ink notarization. Like RON, the document signer and the notary appear before each other using comm technology. Like paper RON, paper documents are used and sent back and forth to the parties through the mail. Here, the signer is identified by flashing ID through the camera to the notary while they are in Zoom or comm tech session and not by using multiple factors of identification and then the documents are signed by ink pens and seals.

With that in mind I want to give everyone an explanation that I am going to be talking mostly about #three here today – RON. With that, lets look at the lay of the land. As of 2021, we have 32 states that have enacted RON permanently in statutes. The states in blue had enacted permanent RON through 2020 and the states in green have introduced it this year and we already have three states that have enacted it - WY, UT, and WV. The WV bill also included remote ink notarization and that's the first state that has chosen to enact a permanent statute like that. Now all of these statues that have been enacted are based upon one or more uniform model acts and they are the NAA Model Electronic Notarization Act published in 2017, the Revised Uniform Law on Notarial Acts Uniform Law Commission in 2018, the Model Legislation for Remote Online Notarization by the Mortgage Bankers Association and American Land Title Association. All of the 32 enactments reflect one or more of these acts and these acts all have many things in common. Once the laws are enacted and all of the statutes give the notary commissioner the ability and authority to promulgate a set of rules there is another set of standards that comes in – the Remote Online Notarization Standards Mortgage Industry Standards Maintenance Organization. Many of the administrative rules across the country reflect those standards.

Turning to the COVID temporary actions, in the last year there has been a whole slew of activity giving notaries temporary authorization during the pandemic to perform remote notarization – either RON or, more commonly, remote ink notarization. There's been 26 Governors that have issued Executive Orders allowing them to do so. Eleven states chose to enact temporary legislation to allow notaries to do this. Six states published emergency regulations and 16 state notary commission officials issued formal guidance to notaries on how to do this. I note there that the states in red used one or more so you

might have had a state where the Governor issued an executive order and then there were emergency regulations adopted as well as guidance so there has been a lot of activity. Only two states during the pandemic have done nothing with remote ink notarization or RON – CA and SC.

With the 13 or so states we basically have 2/3 of the country that have enacted permanent RON. For the remaining third, there are really four key policies that you really want to make sure that you clarify for your Model. The first is ID. I mentioned earlier that multiple factors of ID are used in RON. Here, the body of literature suggests that you should identify a remote individual based on something they know, something they have or something they are. Something they know would be knowledge based authentication questions that only that individual could possibly be able to answer. Something you have would be an identification credential that during the RON session is captured on camera and then sent off to a 3rd party service to determine whether the ID appears to be genuine. Something you are would be like a biometric like a face scan or thumbprint. You should use multiple factors, two or more of those things to identify the remotely located individual. Secondly, electronic records should be used and I say this for two reasons – because in an electronic notarization over the internet you have potential chain of custody issue. When you go before a notary for a paper notarization you take for granted that the notary knows that the same document that they are notarizing is the same one that the document signer signs because it just is handed cross the table to one another but with a remote notarization how do you know? And with a remote ink notarization where a paper document is mailed how do you know if after the person signs the document they changed something before the document gets sent to the notary in the mail.

So, in these electronic platforms that allow for RON, they have the ability to present the electronic record being notarized simultaneously both with the notary and the signer and they can see what each other is doing with the document in real time so when they sign the notary can see it and when the notary notarizes it the signer can see it. The second policy is electronic records because it allows us to use cryptographic technology to apply to what we call a taper evidence seal to the document. Once the documents are signed this cryptographic solution is applied and then after its applied if any changes are made to the document everyone will be able to know that and there will be a complete audit trail of the changes and then people will be able to decide whether or not to trust the document. The third policy you should consider is an audio visual recording of the RON. All of the states that have enacted permanent RON require this and it provides important evidence of the remotely located individuals willingness to sign the document and their mental competence in doing so and it also provides evidence of what the notary did. Should a document be contested after you will have the recording there to see what everyone did. The final policy to consider is recognition. Notarial actors cross borders with documents every day and every state has a statute that recognizes the notarial acts of sister states. We recommend that you leverage the existing inter-state recognition laws that the states already have on the books to recognize RON. There has been some discussion with the notary community as to whether the interstate recognition laws explicitly will allow RON. While they don't explicitly say so my recommendation is that you fall back on them because they all say as long as the notarial act is performed by a notary public of the sister jurisdiction it will be recognized.

Frank O'Brien, VP of State Gov't Relations at the American Property Casualty Insurance Association (APCIA), stated that we put this issue forward and we're pleased and

thankful that NCOIL has put it on the agenda so as to begin the discussion and from our point of view and the industry point of view this is part of a larger group of issues out of the COVID pandemic. One of the things that COVID caused everyone in the business community and frankly pretty much everywhere is to take a look at things in terms of what we were doing, why we were doing them and how we were doing them. This is part of a number of issues including various electronic communication type things including e-signature and e-deliveries and e-posting and on the auto side of things various registering of motor vehicles as in MA we have the registry of motor vehicles as opposed to the department of motor vehicles (DMV) but DMV related issues particularly in the area of total loss valuations salvage titling issues and e-titling issues in general. In that regard I note that a number of states are currently looking at various digitalization practices when it comes to electronic vehicle titling and we are getting into areas like blockchain which I'm sure that Mr. Anderson on the notarial side of things is aware of as well.

We are also looking at remote issues. One of the success stories coming out of this as my colleagues in the agent community will know is that we've had a flood of states that have moved toward online and remote licensing applications and that has proven to be successful and is something hat bears looking into in terms of other remote applications in particular on the examination side of things both in terms of licensing, using financial examinations in a remote setting - things like that. In terms of this particular thing, I want to note that Mr. Anderson has probably forgotten more about notaries and notarization than I will ever know and I appreciate his expertise as well as the expertise of his trade association. In terms of looking at this from our point of view in the insurance community one of the things that happened is that when we all went remote like everyone else all of a sudden people didn't want to be in the same room with other people so that pretty much grounded the traditional in person notarization practice to a halt the traditional paper approach that Mr. Anderson noted.

That required a number of states to pivot to various forms of electronic notarization. Some states pivoted more successfully than others. The 30 plus states that were noted on Mr. Anderson's slides dare I say that they may not have been 30 different approaches but at least 15 different approaches depending on what state and what box was being gored during the process. For example, we ran into situations in some states where they allowed online remote notarizations but the remote notary literally had to be in the same state or some other location requirement and that caused some issues. The other thing that took place is over the years it was one of those things we used notary requirements on a lot of procedures because that's what we've always done and it was easy to add a notary requirement and over the course of the years notary upon notary upon notary requirement was added to various processes. Particularly in the insurance context where we are moving more and more to the electronic side of things, it caused us to question whether there was value associated with the notary process. We do believe there is value associated with the notary process in a number of different transactions however in some cases there may not be as much value as perhaps there once was.

For example, in situations where an insurance company has a significant number of vehicle titles, a total loss situation or salvage title situation, where we have to track down the owner who was our customer and get the persons signature notarized there is not a lot of value there. We know the customer, we know what we need to do and its an extra step. On the other hand, the formal process of putting a notary signature and appearing

before a notary does add a level of formality and level of gravitas if you will to various transactions. So, there are two ways to go through this. One is to take a look at moving toward more of a remote notary process and basically making it easier. The other is to go through the statutes and on a case by case basis kind of decide where a notary adds value and where it does not. We think that its more of an efficient way to do this and frankly a situation that would not engender as much opposition from the notary community to move forward with a remote notary situation. That's one of the reasons why we put this particular piece of legislation forward. It's a question of moving forward in an increasingly electronic environment, moving forward in a way to try to encourage efficiency to lower costs and of course if we are able to lower costs then that has a direct impact on the bottom line of our consumers.

Rep. Jim Dunnigan (UT) asked Mr. Anderson if he is familiar with the NCOIL draft. Mr. Anderson said yes. Rep. Dunnigan said he wants to talk a little bit about identification - you said there is know, have and are types of ID – is have an ID a biometric and know a specific knowledge by the person? Mr. Anderson stated that under the draft, there is a definition of identity proofing. I think that would be a knowledge based authentication point where an identity service provider like lexis aggregates challenge response questions from your transactional and life history and you are presented with those five questions and you have to answer four out of five correct in two minutes or less in order to pass. That is something you know. Something you have would be an ID card which under stat statutes they have a provision called credential analysis where the signer takes a photo of an ID and transmits it through the system and then there is a third party service that looks at the ID and the placement of the elements of the ID on the front and back to determine whether or not its valid. Something you are would be a biometric.

Rep. Dunnigan stated that the proposed Model talks about identify proofing and satisfactory evidence is a passport or some other form of gov't ID so that would be have or if you have personal knowledge of the individual or then you can go to what you are calling a know, well actually that wouldn't be the know, that would probably be part of the have if you have somebody with a lexis Nexis or some other type of public identify proofing that they can do. Mr. Anderson stated that the draft Model basically says if the parties know each other so if you are doing remote notarizations in your company and there are lots of notarizations going back and forth every day like in our business I'm a PC agent here in CA and in the 50 states and we do a lot of notary bonds and in CA they have to be notarized. You could identify that person based on personal knowledge because of the relationship of working with each other so you wouldn't have to use the two forms of identity proofing in that regard because you can use personal knowledge. You can also use what we call a credible witness so that's a person that's known both to the notary and to the signer who takes an oath to identify the signer. But if not then you fall back on two forms of identity proofing which would be the knowledge based questions and probably the credential analysis as it is implemented in current laws.

Rep. Dunnigan asked if knowledge based questions are currently being used. Mr. Anderson stated that it is being used in virtually all states with enactments. In fact, if you were to get on a plane and you forgot your ID to give to the TSA agent they would put you through with a knowledge based authorization quiz in order to verify your identity to let you get you plane so that's a form of ID that you would continually use in many contexts today. Rep. Dunnigan asked if that means TSA would let someone through airport screening with knowledge based questions. Mr. Anderson replied yes.

Rep. Jordan stated that in the draft Model there is a 10 year retention requirement but in LA there is a seven year retention on records for attorneys so after you complete and a case is closed you have to retain those records for seven years but I am wondering why there would be a longer retention period on remote acts as opposed to what we have for physical paper for attorneys. Mr. Anderson stated that there has been a lot of discussion on this and the statutes range from five years to 10 years which is most common and I think the reason is because the mortgage industry likes records to be actually kept for the life of a mortgage which could be 30 years so they're probably going to keep them for 30 years if they can but 10 years was seen something as compromise.

Rep. Jordan stated that the Model will be discussed further in July and to please submit any comment to NCOIL staff.

DISCUSSION ON CAPTIVE INSURANCE LEGISLATIVE LANDSCAPE AND POTENTIAL MODEL ACT

Sen. Jason Rapert (AR), NCOIL Immediate Past President, stated that he would like to express his support for this discussion and for the concept of captive insurers. Several states have worked on this issue as you know. Arkansas has a very strong captive insurer statutory and regulatory framework and I think that having NCOIL discuss this topic and develop a model law to provide states guidance when they are looking to develop a captive insurer statute would be extremely beneficial. We hope this will lead to a strong model law. The language you have before you is still in the early stages of being ready to serve as a model law, but I would be very interested in using the language as a starting point to sponsor an NCOIL captive insurer model act. I don't see Sen. Tavis Holdman (IN), NCOIL Immediate Past President, but he's very well experienced in this arena and I hope todays discussion will be educational and informative and I hope by I think by our next meeting in July we can have a version of such a Model ready for discussion and debate by the committee. Its important for us as we have done with other issues to develop a strong model for other states to use as a framework for captive insurers.

Rep. Dunnigan stated that I'm going to give a brief overview of Utah's history as a captive domicile. In 2003 the state insurance commissioner approached me and said we would like to attract captives as it's a good industry and each captive typically brings well paying jobs so I sponsored legislation in Utah and created the statute to allow captives. A couple key competitive features included no state premium tax, a very simple $10,000 license fee and it started to grow and in 2011 I sponsored legislation to amend it to allow for sponsored cell captives sometimes referred to as rent a captive and from 2007-2016 we had a significant boom during those years with UT becoming an attractive place for what are called micro captives. In 2016 we reached a peak of 535 actively licensed captives and for about the last decade UT has been the second largest captive domiciliary in the nation and the 4th largest in the world.

Currently, UT is one of the largest and most respect domiciles in the country and world for captives and the total annual reported economic benefit including local payroll, hotel nights, professional services, and other expenditures has exceeded $11 million per year since 2011, with a high of $18.2 million in 2019. Total cash and other invested assets held in Utah financial institutions reached a record high of $1.633 billion in 2020. Total gross written premium was also reported at a recorded high in 2020 of $1.51 billion. This past session which we concluded in March the state risk manager came to me and

said UT had an earthquake a year ago and we had some significant wind storms and the state has billions of dollars in assets in property and he said will you change the law so that the state risk department or manager can create a captive to manage the risk and get more access to her reinsurance market. We carefully created that and we are very cognizant that we didn't want the captive competing with the private commercial market and that passed this session.

Anne Marie Towle, Global Captive Solutions Leader at Hylant, stated that I lead the global captive solutions tam at Hylant and I've been involved in the industry for nearly 30 years and overall with a lot of different captive insurance associations. I currently am a board member of the VT captive insurance association and VT is the largest U.S. domicile for captives and third largest globally, very similar to UT as just mentioned. I think its important as we're looking at model legislation and involving the different domiciles here in the U.S. and sharing information and getting everyone involved.

I first wanted to discuss some concepts with you as I'm not sure how much of an understanding that everyone has with captive insurance companies but as we're working with operations and individual companies whether for profit or non profit we really look at and evaluate their risk tolerance and appetite and there are a number of different types of captives that we'll touch on in a moment. On the risk appetite spectrum, financial control and program control are the big drivers for organizations when you look at from a U.S. perspective and some of the IRS laws that are available and what you can avail yourself of, making sure you adhere from a risk mgmt. perspective and really what is the driving motivation of why people want to establish a captive and really its to take on some of the risk and manage that risk and control their losses because as you look at the spectrum and moving up to a guaranteed cost program to eventually a deductible program and even up to a group captive program or a single parent it becomes very instrumental as people are looking to control their costs form an insurance perspective.

Part of its going to be different for every single organization on how they measure their risk and what their appropriate risk tolerance will be. So thinking about what does that mean if I'm a non profit community hospital versus a for profit organization that's a global organization – how they measure their risk tolerance is going to be very customized for each individual company and that's important as they are evaluating taking on a risk program. It becomes extremely important when you think about the plethora of risks that are out there today for many different types of organizations. We are dealing with a lot of different things today that we weren't 10 or 20 years ago when we think about cyber threats, active shooters and I'm here in IN and we had a horrific event a couple of days ago at a FedEx facility and you think about these exposures to risk and what can we do to help mitigate some of these areas and a captive can be a solution for many organizations out there.

So when we think about how do you identify these different risk and design a program, today what we are seeing in terms of trends within the captive insurance organizations is the different types of policies that we have listed here on the right hand side so we are seeing a lot of active use in the P&C market and I probably don't need to explain to all of you that it's a hard market today and with the pandemic going on its been a challenge for may orgs so managing their property risk and some liability risks and healthcare costs as you can imagine are continuing to increase so how do you manage it and finance some of it. The way I view a captive essentially is it's a risk financing vehicle so how can you

set money aside, be able to protect yourself and control the claims you have in a variety of different coverages.

So when you think about some of those captive basics, its looking at in true form the way I describe it is a licensed, regulated form of self insurance. So thinking about very similar to any traditional insurance company the primary use for a captive around the world with the 7,000 plus captives out there is really what we call a single parent captive and that is where you are going to insure the risks of your own org and potentially any affiliated companies with you and then you have the opportunity to take on a layer of risk. None of the captives out there that's been established in the U.S. and globally in various domiciles take on unlimited risk – its very structured and tailored to an org so managing that risk is important. For instance, I work with compensation and taking on a primary layer and funding it through a captive is something that has been tried and true for quite a long time since the beginning of captives. There are other types of captives and I know the gentleman from Utah mentioned sponsored cell legislation that was passed and he was sponsor of that type of legislation which is important. We have cell captives, sponsored cell captives, or segregated cells and they have become very poplar over the last 10-15 years because instead of setting up your own established captive you can go down the path of renting it and we mean instead of setting up and owning your own single family home you could rent an apt basically is what I compare it to. With renting there is lower cost of entry and lower annual operating costs due to the timelines of being able to utilize and rent a facility is fairly quick compared to some other structures so its become much more popular and there are quite a few cell structures available in a variety of sates and countries for orgs to utilize that type of facility.

The other types of captives ill touch on quickly relate to group/association or a risk retention group (RRG). The RRG is a little bit more traditional similar to a traditional insurance company and follows the NAIC guidelines of course. There has been a lot of discussion and thought as to how we can make changes to any types of these captives whether its one of them or all of them and I think when looking at model legislation and accepting and understanding the ability to do business in the various states is an important aspect and that's something to consider when we look at the continued growth of captives particularly in this hard market and coming out of the pandemic and how people are looking to finance their risk and control their own destiny.

A couple of more points as to why captives continue to be very popular and a good strategy in a risk managers toolbox. Its going back to what I mentioned earlier on having control and the other additional aspect that's really important for many orgs is access to capacity. There are orgs out there for instance right now child welfare agencies are having an enormously difficult time carrying cost effective insurance for their sexual molestation coverage and so opening up a captive potentially is one solution where they can access additional reinsurance carriers that they might not be able to access from a traditional commercial placement. So looking at manuscript and coverage forms, that could be a broader coverage form and then support on reinsurance capacity is an important driver I think today and we're seeing this more and more. The other area that I think is truly important is the pandemic risk opened a lot of peoples eyes of business interruption and covering costs and insurance for that pandemic whether its event cancellation or even coverage for interruption related to a virus or communicable disease so I think there are going to be a lot of changes coming forth for captives seeking to insure a layer and I think there is going to be additional capacity with the

insurers who may want to entertain and take on some level of risk in these areas so we're looking at continued growth in the next few years in this capacity.

Wrapping up on some concepts, there are a variety of reason companies go down this path and then they think about having a little more control over their own destiny and the flexibility with designing their own programs yet still partnering with a lot of carriers out there it becomes instrumental when looking at soothing out that cost of risk for the long term and not being subject to the peaks and valleys of the overall industry because that can be extremely frustrating when trying to budget and plan for insurance on a year to year basis so when you have good loss history and have the ability to manage and finance some of those costs within an insurance company you own and control and partner with some traditional insurance companies it can be a win-win all the way around. I think some of these reasons really help drive home the message and thought process when talking to risk managers and C-suites across the country in orgs that have been involved in captives for 10-20 years – the stakeholders that are going down the path right now to explore the opportunity.

Gary Osborne, Chair of the South Carolina Captive Insurance Association (SCCIA), stated that he is a Scottish chartered accountant that's had the pleasure of living in SC for nine years and served as Chair of SSCIA. I've been involved in the captive industry since 1985 and lived in Bermuda, VT, Hawaii and SC and so I've had a great deal of experience with jurisdictions that are working this and very familiar with laws in other states and I believe there are laws in 35 states that have captive laws now. I'm here to present on behalf of SSCIA and I also am involved with the VT captive insurance Assn so I bring their comments as well. We're very open to hearing NCOIL's main driver for this because I've been involved in creating laws in VT, SC and other states and there almost is a model act and Rep. Kitzmiller (VT) being involved in VT and almost every other state has started with VT's law and adapted it so we would like to see the model act if its coming out as being a model and it's a great starting point and then you've got all the other states that have made a couple of variations and I think the draft is an initial job of putting together a sort of best of all that that's out there and one of the best things about the U.S. is that we have 50 jurisdictions and there is a small amount of variation so one of the biggest things we want to make sure of is if any model act comes out of here that its not going to limit the ability to have some variation.

We understand that one of the drivers of the model might be that there may be a fear of somewhat of a race to the bottom that we're getting too competitive in our industry and we're here to talk with you as its important that yes maybe there is some need for a common standard to make sure we're meeting some form of minimum standard but we really do look forward to having the ability for variation between the domiciles. The vast majority are very similar but for instance NY and TX have come up with laws that were very much designed for their own in state companies so there are some variations in their laws that are very much stating that a TX business should do a captive in TX and its not really designed as a market for a SC company to form a captive in TX so that kind of variability is quite important. We are very confused to see this sort of initial approach – we like the first model but we'd just like to be an involved partner to make sure that our orgs can see that variability and flexibility and its not lost. Its important to note that captive insurance and alternative insurance is now almost 50% of the market and growing. As Ms. Towle stated we are seeing vast amounts of companies being formed right now in a variety of states and some sort of model that might allow for a little more clarity on where we are going to face self procurement tax, facing different types of how

do we operate cross states is one of the biggest issues facing our industry and there has been multiple approaches so we hope working with you as a group might come up with some answers that might allow for some sort of better reciprocity among states on how captives are treated.

Jeff Silver, Exec VP and General Counsel for Applied Underwriters (AU), thanked the Committee for the opportunity to speak and thanked Rep. Dunnigan for his remarks as UT is a vibrant captive jurisdiction. Mr. Silver stated that AU has been in the captive business for a very long time. Captives are proliferating as Ms. Towle has indicated. I was reading yesterday that there are now more captives in the world than regular insurance companies and the amount of captives is increasing dramatically as a very valuable tool in a number of different instances in terms of captive insurance companies. Its also important to one that there is a vacuum at the NAIC with respect to captives. They've discussed captives in various discussion groups and things of that nature but they really haven't addressed the issue of captives directly which I think this model legislation will do. What the model legislation is intended to do and Mr. Osborne's point is well taken – every state is going to have some variation in terms of capital and surplus requirements and things of that nature but what the model is supposed to do is to try to uniform it. We have 38 states that have captive laws – the model would attempt to uniform that and most importantly as Ms. Osborne also pointed out there is the a question of reciprocity. You have with the proliferation of these captives that are involved in multistate jurisdictions and an issue that has come up and that we've tried to address is you have a state domicile captive for example in UT – what is it going to do when it does business in another state – is it going to be recognized as a captive? So the model tries to 1.) talk about some kind of uniformity in the application process to streamline that across the states; 2.) attempts to leave the capital and surplus requirements to each particular state so that they can set their own requirements.

Section 15 talks about recognition in other states and I think that's great and really needs to be looked at and examined on a going forward basis so that the continued proliferation of captives can address he multijurisdictional issue that has arisen in the captive industry.

Sen. Rapert stated that NCOIL has had a great history in trying to pick some of the best ideas from across the states and try to produce a model that improves the issue and helps to improve the environment for different aspects of insurance. You mentioned some of the best things, could you leave with us one or two points that you want to leave us with as we continue discussion. Mr. Osborne stated that its important to note that this is a regulated entity and should subject to we try to use the term light but appropriate regulation because we are really insuring our own risk but its important to note that we have what I consider the best domiciles all require state examination on every 3-5 years or so and they also require things like audits. So its important that state departments rely on independent auditors heavily. The ability to perhaps waive that for very small captives is a possibility and I've seen that and don't mind it but its important that we have a kind of light regulation but its regulated and won't just become a free for all. There is definitely a need for oversight to make sure that companies are following their business plans so audits and even examinations are an important part of the process as we are regulated insurance companies and those sorts of things are in the major domiciles and while there can be some flexibility around that, that's the kind of thing we are looking for to make sure we are acting appropriately and responsive to the state regulators that are overseeing us.

Mr. Silver stated that the other point that is important is the reciprocity issue as that is critical in terms of as these captives continue to grow and each state continues to go out and get more captives the jurisdictional issues that are going to arise between a state having a captive in x state and that state's captive doing business in another state we need to address that issue because its becoming more of an issue on a going forward basis. Mr. Osborne stated that reminded me of an interesting example – OH is as state that has actually specifically excluded captives from self procurement taxes so that's a clear example of a state saying captives are a very useful tool whether you form it in OH or somewhere else we are not going to impose a self procurement tax so OH is one of the leaders in that reciprocity recognition for captives and is an example of a state that has provided an answer and made it much easier to do business in OH.

Sen. Bob Hackett (OH) stated that you mentioned NY and TX and OH is very similar and I carried the legislation and I appreciate the work SC and VT has done. In hindsight do you think that those states are too conservative? We just wanted the business of corporations in our state because business was going out of the state so we wanted our own corporations that have captives to move the captives to OH. But at the same time our DOI is saying that we didn't want to create a scenario of liability and liberal captives creating a problem and major corporations using captives to actually move some of the risk outside their bottom line. I know most states don't allow that but now that we've had a lot of years of captives do you think OH, TX and NY should get more liberal?

Mr. Osborne stated that he would hope to see NY and TX be a little more liberal but I'm not going to tell the legislators how to do business but I think those state have been successful and they were very focused to start with and I think they can expand. I'm working with a company now in NY to form a captive and they are a NY company and it makes sense if its NY and if it has operations in other states and becomes a little trickier. Especially in TX which is a little more restrictive than NY. I would like to see them become a little more open but that's for us to convince legislators. VT, SC, HI, and UT have done a great job of showing that they are not open for everything and they are definitely taking responsibility seriously as the failure rates for captives, as there are failures and we are never going to deny that, are in line or lower than the traditional insurance industry. So I would like to see TX and NY and other states be more open but I don't see that happening but I would have no problem with all 50 states having a captive law and then that would probably be the situation of most of the time a company would form in its own state because it does take care of many issues if you can do it in your own state and there has definitely been a movement recently that if your company is trying to form a captive and you are one of the 38 states quite often it makes sense to do it in the home state. This model act if it were adopted across the country could allow that and hopefully as other sates get more comfortable working on this perhaps they would become a little more liberal in their rules.

Sen. Hackett stated that when we create model legislation we try to create the framework but give states the ability to develop their own policy. OH and CA don't agree on a lot even though we work on some things together and so it allows that and that's why I think with this legislation I don't want to see the conservatism of some captive laws in some states go away because I think that's what they wanted so I want the model to have the ability to protect everybody but also to work for everybody so each state can come in and take the framework and make it more liberal or conservative. Mr. Silver stated that point is well taken but just recently WA passed legislation which taxes any

captive that has a risk in WA at 2% or will not let you form a captive in WA to operate so that is a state that is going in just the opposite direction that we think the states should go in.

Rep. Jordan stated that we will discuss this in the summer and it seems it generated lots of interest so we all look forward to hearing more on it.

ANY OTHER BUSINESS

Asm. Cooley stated that he would like to introduce a topic that he is very interested in and one which he thinks would be great for further discussion at NCOIL as its very relevant to its mission – legislative oversight. In many states, lawmakers are getting more assertive (and seeking a path and tools to use to give vent to those feelings) as a response to too much perceived unilateralism in how their Governors and executive branch officials chose to respond to the COVID crisis of the last 12 months very often without any communication with the legislative branch which actually adorned quite often because of COVID and the fear of becoming a super spreader event. There is a concern in legislatures I think about the role of the legislature as an independent branch of gov't and the mutual accountability that should exist.

Accordingly, with us here today is Ben Eikey from the Levin Center at Wayne State Law who will provide some brief remarks encouraging lawmakers to be informed on this growing topic and to incorporate the fundamental idea of legislative oversight into all Executive Branch interactions and asserting accountability. It is actually a very important evolution in western law in the magna carta which asserted powers on the king and said the king's powers were not unlimited – this is a very important idea and influenced our national and state constitutions. The levin center honors Carl Levin a 36 year U.S. Senator from Michigan who among other things Chaired the U.S. Senate Committee on U.S. investigations. Mr. Eikey is a resource for legislators. Here in CA we've worked with the Levin Center in some of our training for state lawmakers and they've also had a role for Council of State Governments (CSG) West and nationally as well. The ideas he will discuss are very bipartisan and important.

Ben Eikey, Manager of State Training and Communications at the Levin Center at Wayne State Law, stated that the LC is a bipartisan org dedicated to the enhancement of legislative oversight. Thinking about oversight and thinking about these three propositions for state legislative oversight, good gov't really does require oversight. We have to be able to gather the facts to be able to handle the foundation upon which we can then go forth to be able to a have policy disagreements. We believe that state legislatures of any size of any makeup can conduct good oversight. We have research in the LC and developed a 50 state study looking at the state of state legislative oversight in legislatures across the country and next week we are actually releasing new research looking at contract oversight specifically and we are going to be looking at AL, HI, ID, LA MD and TN. We have found that all sorts of different states can develop all sorts of unique and innovative ways to conduct effective oversight to be able to make sure that the laws and rules are actually being followed.

We also think that the public should demand good oversight from state legislatures. We have seen a little bit of a lapse in the attention on oversight and we think part of that is due to a lot of investigations that we might have seen from media that are still happening but just a little differently today with the rise of social media and as a result we think that

the more the public looks at this and understands that this is a priority we think that will result in better gov't overall.

When thinking about who runs an investigation, you of course have your different committees with their different legislative priorities but then you can have select committees and there are several different legislatures across the country that formed joint legislative committees in response to the pandemic to try to enforce effective oversight on how their state will respond either through oversight on a state's unemployment system or oversight on the distribution of personal protective equipment (PPE). And then also individual members are key. An interesting story is that yesterday we had a meeting with the WA DC office of the European parliament and they lamented their difficulties in the European parliament with getting members to participate in hearings or investigations and we actually responded back and said some of the best investigations that have ever happened are investigations with just even two individual members, one Democrat and one Republican and they hold each other accountable and together and don't operate in an echo chamber. Those are some of the best investigations we've seen all across the country as there is a lot of influence in just the offices we see state legislators holding and their ability to be able to conduct good effective investigations.

Over the course of an investigation, you have to go through certain stages: fact finding to be able to get the information from the dep't/agency whatever it is that you are conducting oversight over, and the write it up because if you don't write it up then it disappears and its forgotten if you are in a term limited legislature or something where it can be mixed up on facts its very important to have that paper trail; during the hearing there is all sorts of strategy and play in terms of who you invite to the hearing and how you ask questions and the order in which questions are asked – there is a lot of strategy involved in that to be able to get the info you need to be able to fulfill legislative purposes. Asm. Cooley stated that here in CA we have had the interesting experience with our heavily Democrat legislature but the minority leader has actually in training said she recognizes that part of the role in bipartisanship is that sometimes the members of one party may be the one you want to set up to ask a certain question so it's the opposing party to say the Governor or Governor's people so there is a way in which the fact that we are of two different viewpoints and two different parties actually becomes a tool in the legislators toolkit to think how some things are choreographed as hearings unfold which gets to the issue of bipartisanship and who asks what questions becomes a legislative skill and tactic.

Mr. Eikey stated that LC has lots of training and info available on its website if you a e interested in looking at as an intro to this sort of topic. We have videos and various info as to how to form a hearing and ask questions and write docs to the agency or entity requesting information. If you do follow this how do you know if its good oversight thinking about the credibility and quality of the investigation. You have various ways to be able to do this in DC but at the state level its sort of a new area. There is a relatively decent amount of research that has looked at congressional oversight over the course of many years but state legislative oversight we're kind of looking into that in terms of how to measure what is and is not good oversight. We certainly have seen trends across the country in certain areas where legislatures at large do excellent oversight and other areas that can be improved which is the reason why next week we are publishing research looking at contract oversight because we have seen that as a particular area really across the country that could be enhanced. We think measuring good oversight is

going to become more clear as we see different workshops conducted across the country.

The LC provides oversight training for state legislators and other information that can be found on their website. We have a very good hour long presentation with the CA general assembly which Asm. Cooley helped with. We have a 2019 study of legislative oversight across the states at www.stateoversightmap.org which is a state of state legislative oversight study to say where are we now. We recently just launched a state oversight list serve which is new. We also have other information on legislative oversight across the country and various updates and events. And we have a panel focused on legislative oversight in light of the pandemic on May 4. We have three panels in which a NE senator, ID senator and CA assemblyman will join. We hope you can join.

Rep. Jordan stated that this will be discussed further at the summer meeting and we have some people in LA interested in talking to you and our woman's caucus in particular. Mr. Eikey stated that the LC was recently contacted by a LA Representative so there is a little interest established and I look forward to gaining traction and continuing discussions.

ADJOURNMENT

Hearing no further business, upon a motion made by Asm. Cooley and seconded by Rep. Fischer, the Committee adjourned at 10:30 a.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
PROPERTY & CASUALTY INSURANCE COMMITTEE
CHARLESTON, SOUTH CAROLINA
APRIL 18, 2021
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Property & Casualty Insurance Committee met at the Francis Marion Hotel on Sunday, April 18, 2021 at 9:00 A.M. (EST)

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

Other members of the Committee present were (* indicates virtual attendance via Zoom):

Sen. Jason Rapert (AR)
Asm. Ken Cooley (CA)*
Rep. Matt Lehman (IN)
Rep. Joe Fischer (KY)
Rep. Brenda Carter (MI)
Rep. Daire Rendon (MI)
Sen. Paul Utke (MN)*
Sen. Paul Wieland (MO)
Sen. Shawn Vedaa (ND)*
Asm. Ken Blankenbush (NY)
Asm. Kevin Cahill (NY)*
Asw. Pam Hunter (NY)*
Sen. Bob Hackett (OH)
Rep. Carl Anderson (SC)
Del. Steve Westfall (WV)

Other legislators present were:

Sen. Mathew Pitsch (AR)
Rep. Terri Austin (IN)
Rep. Jim Gooch (KY)*
Sen. Brandon Smith (KY)
Rep. Edmond Jordan (LA)*
Sen. Lana Theis (MI)*
Rep. Brian Lampton (OH)
Rep. Forrest Bennett (OK)
Sen. Ronnie Cromer (SC)

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Tess Badenhausen, Assistant Director of Administration, NCOIL Support Services, LLC

QUORUM

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

MINUTES

Upon a motion made by Asm. Ken Cooley (CA), NCOIL Vice President and seconded by Rep. Carl Anderson (SC), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's December 12, 2020 and February 19, 2021 meetings.

CONSIDERATION OF NCOIL DISTRACTED DRIVING MODEL ACT

Rep. Rowland thanked everyone for their work thus far on the Model as we have been discussing this issue for several months. We will be voting on the Model today but I'll first turn it over to the sponsors of the Model, Sen. Bob Hackett (OH) and Asm. Cooley, for some brief remarks

Sen. Hackett stated I won't take up much time – I just want to say a few words before we begin and note the changes that me and my colleague and co-sponsor of the Model, Asm. Cooley, have made to the Model since we last met in Tampa in December. The Model is in the legislative binders on page 353. The changes made to the Model are on page 358 in the form of a new Section 6 titled Enforcement and Reporting. That language was included in direct response to some concerns that were raised during our December meeting about the potential negative impact that distracted driving laws that allow for primary enforcement could have on minorities. The new language is taken from the existing Florida distracted driving statute and it requires the enforcement officer when issuing a citation for a violation of the Act to record the race and ethnicity of the violator. That information must then be compiled and reported annually to the Governor, the President of the Senate, and the Speaker of the House of Representatives. We have also included new language relating to unauthorized searches and seizures of a driver's mobile communications device. I think these are very good changes and they strengthen the Model. I look forward to a positive vote on the Model. I'll now turn it over to my fellow sponsor, Asm. Cooley.

Asm. Cooley stated Sen. Hackett did a great job in describing the changes to the Model and I'll just stress the importance of the changes in that they reflect the strength and bipartisan nature of NCOIL. At our last meeting, very valid concerns were raised regarding primary enforcement and I think the changes you have before you reflect a very strong compromise in that the Model still allows for primary enforcement, but it properly recognizes that attention must be paid to how laws like these may have a negative impact on minorities. By requiring the recording and reporting of this information, steps can be taken to address any wrongs at the appropriate time. Thank you to everyone who has worked on the Model and I look forward to shepherding it across the finish line today.

Hearing no questions or comments, the Model was adopted on unanimous consent.

CONSIDERATION OF AMENDMENTS TO NCOIL POST ASSESSMENT PROPERTY AND LIABILITY INSURANCE GUARANTY ASSOCIATION MODEL ACT

Rep. Rowland stated that this is another issue that we have been discussing for several months and we will be taking a vote today. I'll turn it over to the sponsor of the amendments, Asm. Cooley, for remarks. Asm. Cooley stated that this Model was actually readopted by this Committee during its September meeting but during the buildup to that meeting the National Conference of Insurance Guaranty Funds (NCIGF) had brought forth some proposed amendments to the Model to make the guaranty fund business dovetail better with the Model. The Model is in your binders on page 359. The first proposed amendment is on page 364 and would adjust the Model to address insurance business that has been "restructured" under recently enacted laws which permit insurance business transfers (IBTs) or divisions.

This amendment aligns with the guaranty fund consumer protections included in the insurer division Model that was adopted by the Financial Services & Multi-Lines Issues Committee yesterday. The second amendment is on page 368 and would expressly permit assessments to insurance company guaranty association members to fund various expenses that maintain the guaranty funds in an "always ready" posture even when claims activity is low. This is meant to plan in advance for insurance liquidations. It should be noted that the administrative assessment authority sought with this language, combined with any other assessments made to member insurers, would not exceed the two percent threshold already in place in most states. Overall, these amendments are important to recognize the important role that guaranty funds serve in protecting consumers. The amendments also reflect the reality that marketplaces change over time and adjustments to laws and regulations are often necessary.

Rep. Lehman asked as an overarching general question have we ever received a report on what the status of the guaranty funds are from jurisdictions. It seems to me that are talking about making sure they stay ready and we put parameters in place but I'm just curious have we seen any ticks up and down based on COVID or other issues and what's the overall status by state. Asm. Cooley stated that we can readily get one and it can be an outstanding program. You have the NCIGF as they are the crossroads for that type of info and in particular I know when they meet they are looking at national trends whether COVID related or not so I don't know when we last had a program overview from NCIGF but I'm sure they would be delighted to provide background and I think it would be good for us. My view is that the first line of consumer protection in insurance are the rating laws to keep company's solvent to pay claims and meet the expectations of the consumer but the second line of defense are the guaranty funds. They spend a lot of time making sure there are no gaps in coverage so I would think they would be delighted to put together an update on their work and recent trends of note. I see we are joined by Barbara Cox who is counsel for NCIGF who perhaps would like to comment.

Ms. Cox stated that we would be happy to deliver a presentation to NCOIL. I can work with NCOIL staff to make sure we are covering the topics that you are most interested in whether it's the levels of protection in and status of laws and assessments and solvency history, but any kind if info you would like we would be happy to make a presentation. Rep. Lehman said to add to that we've been having conversations about captives and a lot of times they don't fall within guaranty funds so as we move in that direction as well would you have data saying whether they are trusts or self-insured pools and things like that that are operating outside guaranty funds as that would be a good conversation as well. Ms. Cox stated we don't collect info on those entities and self-insured funds but we could probably do some research and put something together but I'm not sure we are the best organization to speak to those issues. I will say off the top of my head that I believe one state's guaranty fund protection is specifically excluded from captive laws. Asm. Cooley stated he will work with staff to work that out.

Hearing no further comments or questions, upon a Motion made by Sen. Hackett and seconded by Rep. Daire Rendon, the Committed voted without objection to adopt the amendments by way of a voice vote.

INTRODUCTION OF NCOIL FAIRNESS FOR RESPONSIBLE DRIVERS MODEL ACT

Rep. Rowland stated that we had a great discussion on this issue at our last meeting in December. Since that time, Senator Shawn Vedaa of North Dakota has stepped forward with a model act on this issue that he would like to sponsor.

Sen. Vedaa stated that I'm proud to sponsor this Model and I look forward to receiving feedback on it from a wide array of interested parties. The Model is in your binders on page 379 and is very straightforward. In 2014, NCOIL adopted a Resolution in support of "No Pay, No Play" laws – this Model can be viewed as the next step in support of those laws in the form of a Model law. I note that the Model is titled "fairness for responsible drivers" because I think that is the better way to frame this issue – it may seem like semantics but at the end of the day this issue is centered around fairness. The Model, and the laws in the approximately 10 states that have similar laws, including my home state of North Dakota, prohibits uninsured drivers from collecting the benefits of a system in which they do not participate. Specifically, the Model prohibits a person, or personal representative of a person, who was an uninsured motorist and who sustained bodily injury or property damage as the result of a motor vehicle accident from recovering non-economic damages for the person's bodily injury or property damage or death. It's important to note that such prohibition does not apply to economic damages, and there are exceptions as set forth in Section 5. Also, the prohibition does not apply to an uninsured motorist who at the time of the automobile accident has failed to maintain coverage for a period of 45 days or less and who had maintained continuous coverage for at least one year immediately prior to such failure to maintain coverage. I look forward to working with everyone on the Model.

Asm. Cooley noted that CA has a similar law that was adopted by the voters in the 1990s and it was certainly seen as fairness when presented to voters and they took it up.

Sen. Rapert asked if there was information as to how many states have adopted this type of law in addition to ND and CA. Sen. Vedaa stated approximately 10 states have already adopted this type of law.

Rep. Jim Gooch (KY) stated that regarding non-economic damages, I understand that the driver/owner of the vehicle may not be insured and they could be excluded from recovery but you may also have some who are passengers in the vehicle who may not be insured – is there a distinction there? Sen. Vedaa stated that I believe but am not certain that those individuals in the vehicle would be held harmless and would have some sort of recovery from the driver at fault.

Ken Klein, Professor of Law at California Western School of Law stated that I appreciate the opportunity to speak to NCOIL and it has made me think deeply about this interesting issue. I grew up in TX where one of the greatest country songs written said "the road to hell is paved with the good intentions" and I think that may be a preview of where I come out here. I've spent most of my career defending companies in business litigation and basically what my varied background has taught me is that I should test intuition with data because as I've become older I've concluded that most things that are intuitively true to me turn out to be unsupported by data. Regarding the big picture of the Model I note that the title has changed from no pay-no play to focusing on fairness and I take it the point being made is that primarily this is about uninsured motorists making insurance too expensive for the rest of us. So this is now framed as a proposal to reduce the cost of insurance by decreasing the percentage of uninsured motorist by

passing a law that penalizes uninsured motorists should they be in an accident and in response to the question asked as currently framed the model is talking about uninsured motorists and that probably does mean it doesn't act to exclude recovery by a passenger.

Intuitively this seems like a perfectly good idea but there is another side of the question which is depending on whether your state is a comparative negligence or contributing negligence state as a general matter you cannot recover any form of damages as a driver unless you are not at fault or someone is more at fault and you don't pay any damages unless you are at fault and the structure of this law is to create a penalty to an innocent or relatively innocent driver and to give relief to a driver who is actually at fault and give them a windfall of sort so if you think about it that way its intuitively troublesome. So I've tried to go to the data and see where it breaks on these two conflicting intuitions.

The starting point is to look at the goals of the proposal which are set out in NCOIL's 2014 resolution starting all of this it calls out three goals: to increase the percentage of folks who have insurance; lower insurance premiums; and reduce fraud. I will note by the way that except as expressions of fairness, fairness isn't on that list. Here is what the data tells me on these things and we'll get into the details of this after this slide. You're going to reduce the percentage of uninsured motorists if you pass this but only by a trivial amount; your premiums are going to down but again only by a trivial matter; you're probably not going to touch fraud at all and all of this will be with some fairness cots all of which are largely innocent drivers will actually not get full compensation of their actual damages; there will be windfalls to at fault drivers and you're facing a real likelihood of disparate impact by race so lets go through that.

Twice the insurance research council (IRC) in recent years has looked at these issues and provided us a good database once in 2012 and the second time in what is styled a 2020 report but came out last month. I contacted the people at IRC and they have confirmed that I am reading their reports accurately as I derived these numbers: The combined findings of the 2012 and 2020 IRC reports is that the percentage of motorists who are uninsured will reduce from 12.6% to 12.4%; in other words, you should see an increase of insured motorists of two-tenths of one percent. The bottom line is that the percentage of reduction in uninsured motorist rates that you should expect from the model is two tenths of one percent and that could still work out to be big numbers so you might be asking yourself well what about dollars and cents. Well, this is what you will get – if adopted the proposal will result in an average premium reduction of auto insurance per car per year of 16 cents.

So, what about fraud – fraud is a real concern. NCOIL is a member of the Coalition Against Insurance Fraud and I asked their Executive Director Matthew Smith about fraud and he noted that there is a concern as there always is of staged accidents and medical fraud rings and vehicle jump ins but he also confirmed for me what I believed to be the case which is that there is actually no data at all that a law such as this will reduce fraud and why is that? That's because the model assumes there are fraudulent claims – either accidents that didn't happen or non-economic damages that didn't happen and they aren't getting sniffed out by insurance professionals or ligation issues and they are getting paid and I'm sure that happens but I'm also sure there are legitimately uninsured motorists who get hurt who have true pain and suffering and this is a baby with a bathwater problem. You can't quantify as there is no data to quantify how much of this is

one and how much of this is the other but if you adopt the model what you end up doing is actually trying to disincentivize fraudulent actors by punishing non fraudulent actors and that at least should give you some pause.

So now let's turn to the newly titled concern of fairness because fairness is really the core of what is underlying this question. The next speaker will be Andrew Kirkner, Regional VP, Ohio/Mid-Atlantic Region at the National Association of Mutual Insurance Companies (NAMIC), who just a few months ago described in your last NCOIL meeting fairness this way – individuals who do not participate in the system should not be able to have the benefit of that system. But if you press on that its mixing apples and oranges because the proposal doesn't block an uninsured motorist from recovering any damages, it simply blocks them from a class of damages – non-economic damages. Back when I played cards in college, we would call this a tell because the concern here really is with a category of damages, not a category of victims and its just missing two things. I understand the concern but there are real fairness costs here: you will have some degree of punishing innocent victims; you will have some reward for the guilty; you're actually creating a moral hazard problem which in the world of insurance is not a trivial phrase because you as the IRC says will relieve at fault divers from having to compensate uninsured drivers which is a moral hazard inventive for at fault drivers to drive a little more recklessly. I'm not personally a big fan of moral hazard as I don't think the theory holds but it either holds or it doesn't and if you think moral hazard is a real thing that's how it plays out here but most importantly this does play out probably disparately by race and that ties into a great deal of what you heard among other things this past Thursday.

Here is the bottom line – for a 16 cent reduction in premiums at a two-tenths of a percentage decrease of the percentage of uninsured you're going to give some real windfalls to at fault drivers, largely innocent drivers are going to be punished and some disproportionate harm falls on minority communities. I welcome any questions. I acknowledge some may disagree with me but I'm here to simply provide the numbers and that is what they are -16 cents.

Mr. Kirkner stated that on behalf of NAMIC I am here today in support of NCOIL's effort to address affordability and fairness in auto insurance via the model before the committee. As mentioned when I testified before the committee in Tampa our support for the concept of the Model comes form a simple maxim and that is illegally uninsured drivers should not receive a windfall as a result of their unwillingness to participate in a system of pooled risk. The model before the committee largely accomplishes this goal by prohibiting the collection of non-economic damages for illegally uninsured derivers. In addition, the model also provides safeguards even for those same illegally uninsured drivers where they are injured through another party's bad act for lack of a better description whether that be DWI, fleeing from the police or intentional conduct so there are exceptions for those scenarios. I will just briefly respond to Prof. Klein saying I agree with those points that he said very clearly which was that the model will lower costs and it will decrease the amount of uninsured motorists – I think whether that's 16 cents or $16 dollars or $1,600 this group knows very well there are a number of downward pressures on premiums and a number of reasons for uninsured motorist populations and what we should be doing in everything we look at is trying to decrease those numbers. What the NV study for 2012 that I outlined at the last meeting tells us is that there will be some drop in these two metrics and I think anything we can do to put downward pressure on premium and the uninsured motorist population is a good thing.

The other quick point id like to address is Prof. Klein indicated that it would be intuitively troublesome to punish not at fault drivers. This is not about assigning fault this is about insurance as a pooled risk system – we pay into a system and that system pays us out when we have a covered accident. That is about as fair as it can get and folks that decide to not participate in that system should not be paid out. Finally, I would simply say that Prof. Klein went into great detail about how we should use data to support our assumptions and he then concluded his testimony by saying that this probably has a disparate impact and I think that's irresponsible and we need to look at the model with the data that is in place and absent some showing that its not the case the model will in fact align the concepts of fairness for those drivers who decide to participate in the pooled risk system.

Rep. Lehman stated that one word that stuck out to him in Prof. Klein's presentation was "the innocent driver" and I want to focus on "innocent" because I look at this and these are all people who you can make an argument are violating the law because every state has a financial responsibility law so if I'm choosing to drive with no insurance am I not choosing to violate the law and if so then I'm not really in my opinion an innocent victim. How do I marry those terms of an innocent victim and someone who is violating the law because everybody knows insurance is required by law because the minute they get caught they admit they knew they should have had insurance they just didn't want to pay the premium or they don't have the money to and there are issues there but help me bridge that gap I mentioned. Prof. Klein stated that I appreciate that question and the time constraints prohibited me from getting into nuance. Of course no one is wholly innocent so for example in this situation we're talking about two actors who are not wholly innocent – one is the person who doesn't have insurance and the other is the one who has violated the law by driving in such a way typically negligently that has caused an accident because you have to have a lack of innocence on both sides of the equation for the model to be triggered and what I would say to you is you have passed legislation in each of your jurisdictions saying that people must have insurance and therefore all uninsured motorists have violated those laws and you have set penalties for that and that's fine but now you ae changing the laws by taking away a class of damages. You are not saying that they can't recover damages because they are not paying – you're letting them play with some damages but not as to another set of damages so my question is what is the basis for that decision. What's the basis for saying you can recover for these damages but not for these others. You're not simply saying you are barred from the system. What's happening is you are focusing on non-economic damages because you suspect those aren't real damages and the reality is some of them aren't but some of them are.

Rep. Lehman stated that we put in exceptions for the person driving have violated the law but I don't think negligence is a statutory violation – if I slide on the ice and hit you I'm negligent; if I'm going 100 mph and I'm intoxicated now I'm violating the law as well as being negligent and we carve those exceptions out of if I'm truly a lawbreaker on my side then you can still get those damages but if I'm just negligent then you would not be entitled to those. Prof. Klein stated that I reach law and in my view of the world whether a law comes from a court decision or a statute its still a law in other words that's not a distinction of whether one is breaking the law if the source of the law is a court decision or a statute.

Asm. Cooley stated that I think this is a good discussion and I would grant that you can't really talk about insurance and an impact on rates without talking about other things as it's a multi variant conversation. With respect to no-pay no-play it's an interesting issue in so much as the voters adopted this policy in 1996 and the interesting fact in that is that in the 1980s CA saw average auto insurance rates increase that decade by 150% - very dramatic increases in rates across a decade. By the time we got into the 1990s it started to fall and after 1996 there were significant impacts in terms of the volume of uninsured motorist claims, bodily injury claims and auto insurance rates so I just want to say I do understand there is reality to Prof. Klein acknowledging that its hard to pin down the exact cost associated with improvement but when I stand back and look at what happened to auto insurance rates in CA over the 80s and 90s and specifically looking at what happened after the voters approved this doctrine in 1996 you do see rates falling and that's quite striking. I just feel that there is an aspect of you sort of just what do you find compelling – ensuring that people who are in their marketplace play by the same rules does support our system and this rule is designed to reinforce that and there is definitely a record of declining auto insurance rates and many other factors associated in the 80s and 90s in CA.

Rep. Edmond Jordan (LA) stated that LA passed a no-pay no-play in 1996 as well and I think there is a difference between correlation and causation because I can tell you we still have the second highest rates in the country right now so we have seen no reduction because of that. I will say our law is a little different in that we initially excluded the first $10,000 of damages and now it's the first $15,000 of damages but I heard Mr. Kirkner say this is not about fault this is about risk pool but I totally disagree with that as our tort system is based on fault so when you talk about relieving an at fault driver the uninsured motorist may not be innocent but innocent and guilty to me applies to the criminal code but we are talking about civil law and talking about fault or not at fault so now you are taking someone who is not at fault and punishing them for the acts of someone who is at fault and so maybe there should be some penalty and I think our provision is a little fairer when we say we are going to take a certain amount off the top that you will get a reduction in what you can recover but to say no recovery at all I don't think that's fair and to me its totally unfair and I think if we look at some of the things that Doug Heller of the Consumer Federation of America and some other people spoke about I think there are other ways to reduce insurance rather than this. If we're talking about doing this for 16 cents then is it really worth it but my bigger point is that LA is a comparative fault state and somebody who is at fault should not get a free pass as that's not fair at all. I do agree with some of the things that Prof. Klein talked about as it related to race and insurance and some of the costs as we get to the point of why people are uninsured I think we have more at play than meets the eye here. I disagree with the title of the model and somewhat disagree with the premise and I'm not sure exactly what we are trying to accomplish.

Asm. Kevin Cahill (NY), NCOIL Treasurer, stated that first I respectfully disagree with Asm. Cooley as I don't believe Prof. Klein stated that the economic impact was not easy to determine – he specifically said that the economic impact was a savings of 16 cents on an average premium and he also said that the impact on the number of uninsured motorists was negligible and that is truly negligible as two tenths of a percent is a rounding error. There is no real way of telling whether that would actually be the impact of it. I would like to ask the two panelists about innocent parties here because innocent parties are not always the people who are in the accident as sometimes they are the families of the people who are in the accident and how would this impact the rights of the

families to seek recovery from the negligent driver in an accident that perhaps cost the life of the uninsured motorist. Prof. Klein stated that's a tricky question and a lot of it turns on how much you read into the word motorist in the model because the model seems to only apply to the driver who was uninsured by the use of the word motorist – I take it that's the case but the kinds of damages you are discussing are often what we call derivative or dependent in other words the family's damages are dependent on the driver the primary injured to recovery and so to the extent the tort system in your state has a structure of recovery law that makes the families members harms flow from the ability of the primary driver to recover the moment you block the primary driver you block everybody else and of course the winner in that equation is the at fault driver who doesn't have to pay for the damages they caused however large they are and their insurance company who doesn't have to pay for the damages that were caused by their insured.

Mr. Kirkner stated that I don't disagree with anything Prof. Klein just said except for the focus on at fault and not at fault driers. Again, it seems to me that Prof. Klein is completely disregarding the fact that this is a scenario where a person has refused to pay into a system that is deigned to cover their losses for covered claims. Another thing I would like to touch on very briefly is something Rep. Jordan mentioned about the model barring recovery and that's not true. As Prof. Klein noted the model does not bar recovery what it bars is the recovery of non-economic damages. I think what the intent there is to strike some balance between damages that would make someone continue to live their life without having non-economic damages, the windfall aspect of this, from a system that they don't pay into. Again, this is a system that you pay into to ensure the benefits and this is scenario where those folks have not paid into that system. Asm. Cahill stated that my question was about the families of accident victims, can you answer that question. Mr. Kirkner stated that I think Prof. Klein did as I think it depends on the tort system in a given state but the maxim would remain the same – if the individual has not paid into the system the non-economic damages would not be accessible.

Rep. Brenda Carter (MI) stated that I have two questions, the first to Prof. Klein. You mentioned that disparate impact would definitely affect races but what about those who are in poverty as we are going through a pandemic where many people have lost their jobs and lost their ability to feed themselves let alone purchase auto insurance and to Mr. Kirkner you mentioned that those who initially decide to circumvent the system I agree with that 100% but what about those who cannot afford to participate in the system? Why it this legislation punitive to people who for economic reasons are unable to participate even if they want to – this seems to be punitive for those who cannot afford to participate in the system. Mr. Kirkner stated that I think it's a good question and it's a catch-22 of what we try to do when we talk about insurance laws. Part of the impetus for efforts like this is to lower insurance costs and drive costs down and I would push back a little bit at the earlier comments saying that the reduction in uninsured motorist population is a rounding error. I don't think it's a rounding error and depending on the population of your state it could be a very substantial number even if we accept Prof. Klein's numbers at face value which I don't have a reason to dispute. Then you start talking about the corollary benefits that come with reducing the uninsured motorist population the potential for some real positives here.

I think though to your question about folks who are not making a decision but rather circumstances have placed them in a position where they cannot participate I think the

states have remedies there so whether we're talking about residual markets or state run low cost auto insurance programs there are remedies available in the states even if you went so far as to subsidize insurance in some way for those who cant afford it there are remedies available to the states. I think those remedies would exist in a world where the model was passed or where it wasn't passed as those questions exist regardless of this model passing in a given state or not passing. Prof. Klein stated that I'm really glad you asked this question because there is an underlying assumption in this whole conversation which is that most people who are uninsured have the money to do it and they are just choosing not to pay and look I have very little sympathy for such people I truly do but I suspect that, and I don't have data to support it, that most people who don't have auto insurance or at least a significant chunk of them are because they can't afford it because the base level of auto insurance is not to insure me for my harm what I'm required to do is to insure for harm I cause and what the model is doing is its saying I didn't cause harm in other words the insurance I should be getting I didn't get but that's not the accident that happened. I didn't cause harm but I'm still going to suffer a penalty and it's just frankly I suspect everyone here can afford auto insurance and has it and we have a deep lack of appreciation and empathy for what most of this country actually looks like and how close to the edge most of us are living and I hope the pandemic has taught us a little something about that as to just how on the edge most of this country is and those are the people who are going to actually be hurt by this law.

Asw. Pam Hunter (NY) stated that after listening to this presentation and knowing we spent several hours on Thursday talking about disparate impact I would like to offer that the models we present are purposeful and I'm looking forward to ensuring that we're not on one hand working towards policies that are not discriminatory and then putting forth models in some ways that may impact as our last speaker made reference to whether its minorities, people of color, impoverished communities I think we always need to be looking at the steps further not just the language in the model but the impacts on the communities that this can affect. I have a very diverse population of folks that I represent from the very wealthy to native Americans and very poor and I believe Prof. Klein's comments speak to that in the state of our current situation in the pandemic. If we were to vote on this today I would not be supportive but going forward models that we present I think definitely need to take a look at some of the impacts that obviously we are spending hours talking about at NCOIL.

Rep. Rowland stated no vote will be taken today and I think this is a topic that will create considerable conversations at future meetings.

CONSIDERATION OF AMENDMENTS TO NCOIL PEER-TO-PEER (P2P) CAR SHARING PROGRAM MODEL ACT

Rep. Rowland stated that In December of 2019, NCOIL adopted the P2P Sharing Program Model Act which he was proud to sponsor. The Model has been very successful and has been introduced and adopted in several states across the country. Since the Model has been adopted, some amendments to the Model have been agreed upon by both the insurers and P2P car sharing companies which I am sponsoring and are included in the version of the Model you see in your binders on page. 382. Overall, the amendments aim to provide clarity and standardization of insurance coverage during the peer-to-peer car sharing transaction and deal with amending certain definitions in the Model; clarifying state insurance limits, primary liability, and underwriting issues; and providing additional recordkeeping requirements on the car sharing program. The

amendments are very simple and I look forward to the Committee's support today. I'll turn it over to Mr. Kirkner now who would like to say a few words.

Mr. Kirkner stated that I will be very brief as Rep. Rowland just outlined the amendments which came as result of negotiations between insurers and P2P programs and other stakeholders over a number of months and we think the amendments make a lot of sense at the state level. We had the opportunity to go into states and have these discussions and see what worked and what didn't work and I think these amendments specifically relating to underwriting freedom, definition tweaks and more clearly defining the lines of liability where termination time is in dispute really hep clarify the insurance coverage that is in place so I want to thank Rep. Rowland for this work and NCOIL more broadly. We support the amendments and hope the committee will approve.

On behalf of Enterprise Holdings, Enterprise Rent-a-Car, Alamo Rent-a-Car, and National Car Rental, Brad Nail stated that we are fine with these changes and will support them. I just want to take the opportunity as a reminder to the members here that this model is limited in scope to the insurance provisions of any bill that you might see in your state and if you look at chapter 2 of the model it addresses the scope issues and spells that out. Int the case of this particular issue, the insurance provisions are relatively non-controversial in the broader scope of this issue. You should also expect to see and hear language addressing equitable taxation of these transactions, airport issues, consumer protection issues and we're working hard to find compromise language on all of those issues as well but that's a discussion that's continuing. We support the NCOIL language and we expect all the parties involved to promote the language within your states but the debate is not going to be limited to that language.

Sen. Rapert asked if this Model now replaces the NCOIL Transportation Network Company (TNC) Model or if they remain separate. Mr. Nail stated that they remain separate Models.

Del. Steve Westfall (WV) stated that I support the amendments as they make the Model better and in 2020 WV passed P2P car sharing legislation and most of the amendments offered today are in the WV law. Rep. Rowland stated that he looks forward to enacting the P2P law in Kentucky in 2022.

Hearing no further questions or comments, upon a Motion made by Del. Westfall and seconded by Sen. Rapert, the Committee voted without opposition to adopt the amendments by way of a voice vote.

PRESENTATION ON COMMUNITY-BASED CATASTROPHE INSURANCE: A MODEL FOR CLOSING THE DISASTER PROTECTION GAP

Dan Kaniewski, Ph.D., Managing Director at Marsh & McLennan, stated that it feels like just yesterday I was addressing you in a different capacity when I was deputy administrator of Federal Emergency Management Agency (FEMA) until about a year ago. Back when I was at FEMA when I spoke to this Committee I said we were looking to the insurance industry for innovation and I hope what you'll see is an example of that kind of innovation in the industry and its largely due to experts like my former FEMA colleague Andy Read who is with me here today. We'll talk about community-based catastrophe insurance (CBCI) which we believe can help to fill the protection gap.

As we all know the protection gap exists and its growing for two big reasons – reduced funding and rising costs. Reduced funding because of all the challenges that I'm sure you are more aware of then I am which is funding shortfalls in state and local governments and on the rising costs its increased intensity and damage of disasters both of which are making the protection gap grow all the time. The financial impacts of catastrophic events are something that is hard to overcome or overlook. We know that from an insurance standpoint that take-up rates are low. We know that homeowners in CA have far too little insurance and we know that those in the central part of the U.S. have far too little insurance. We know that the National Flood Insurance Program (NFIP) is struggling to increase it's take-up rates. The fact that only 30% of homeowners in high risk flood areas have flood insurance is a problem. Overall nationwide it's in the single digits of homeowners having flood insurance. So what can we do – well CBCI is insurance arranged by a local governmental or quasi-governmental body to cover a group of designated properties or individuals within the community's jurisdiction. To talk about this in a little more detail is Mr. Read.

Mr. Read stated that to also elaborate a little bit about what CBCI is when we say community what do we mean. It could be any special purpose district, neighborhood association, there is flexibility around which type of entity could actually implement a program like this. If the entity has a financial relationship through tax or other means or other regulatory authority it certainly makes things easier so there is a broad definition of community as we talk through the specifics. Lets talk about where CBCI fits in the protection gap and comes channels which communities can buy down their protection gaps or increase their resilience. Looking at the waterfall graphic here, the first way by which communities can reduce their risk of course is through physical resilience enhancements so investments in risk reduction or mitigation or other preparedness investment to be better equipped to respond. The second way is through broader risk financing so enchanting the insurance market pursuing risk transfer or other financial resilience means to help buy down the economic losses and really shrink that protection gap component which is the third slide on the graphic. I would say in many case the protection gap is actually quite large and communities in many instances are facing a lack of insurance uptake and so proportionally this would probably be bigger for a lot of communities but we do see opportunity for CBCI to paly a role in both physical risk reduction and investments in mitigation and also obviously in disaster risk financing and enhancing the insurance market.

So what are the benefits of a CBCI program. As I mentioned, naturally there are incentives for risk reduction built in. When you are investing in disaster risk financing premium reductions or investment in physical resilience are naturally incentivized so you can better monetize those mitigation investments through those premium reductions rather than just relying on losses avoided which we find is kind of uneven in longer term return on investment so this provides a more near term return for communities who are actually investing in disaster risk financing through CBCI. Of course through the process of developing and implementing a CBCI program the community also would receive enhanced risk info and be better equipped to communicate that risk to the community and it would help them prioritize those mitigation investments and we believe very strongly in prioritizing community scale mitigation projects.

Additionally another benefit of CBCI programs is that they can allow the community to deliver targeted assistance so there could be affordability programs that could be implemented for low income high risk individuals within the community that could help

them incentivize or support the purchase of insurance and that can be effectively done through these types of programs. Additionally a community could help sustain and maintain the availability of insurance throughout loss volatility so somewhere between a market of last resort and an existing robust insurance market within the community the community could be in the middle helping to offer coverage and sustain that coverage through losses and of course intuitively more insurance in a community or risk transfer protection at the community level enhances the financial resilience of the community so it improves their credit risk profile and access to capital and can also speed up recovery significantly and allow for fast time to return to economic vitalization after a catastrophic event.

So what types of models are there and how do these CBCI programs get implemented so lets talk about the specific mechanics. Through our research we outlined four broad models by which communities could engage in a CBCI program. Across the models they allow for great flexibility for the community to tailor their program to the specific risk the community is facing and there are varying degrees of community control and varying degrees of expertise and resources required to implement so if you look at the graphic the four models we've outline from left to right increase in level of community control but also in expertise and potentially resources to implement. Notably the two programs on the left require a partnership with insurance carriers within the community whereas the models on the right allow the community to more directly engage capacity providers so lets talk about the specifics of each model.

The first is the facilitator model which is where the community essentially establishes a financial arrangement with an insurance carrier or carriers within the community to either partner on communities and marketing or to potentially go as far as to incentivize coverage through a tax credit or reimbursement or something of that nature or potentially even mandate coverage for a portion of the community so there is a lot of flexibility here and this is the least intense type of arrangement as the community is playing a facilitative role and the insureds community members are engaging directly with an insurer for both premiums and claims payment. There is a notable example of this type of structure in upstate NY with a community that offered a tax credit to incentivize high risk individuals who are low income to purchase flood insurance so that's kind of a means by which this can be affected at the community level a reimbursement backwards making incentives to purchase and partnering with an insurer to communicate and help distribute that within the community.

The group policy model is kind of think of an employee benefits type structure where the premium is paid into the employer or the community in this instance and then the community would work with a carrier to essentially acquire a group policy. Claims would then be administered and engaged with directly with the insurance carrier by community members. This allows for a little bit more control and certainly more leverage in terms of negotiating premium discounts for mitigation investments so there is a little more control for the community perhaps in that dialogue and conversation. They also probably get access to some better risk information at the community level with this type of model that they could use to communicate risk more broadly to the community so a little more engagement here. There is a notable example of this or pilot project that is pursuing something aligned with this model in NC where the state is looking at a potential means by which they could purchase insurance on behalf of low income individuals who are affected by recent flood disasters to purchase flood insurance on their behalf and they would be listed as informed so they would know if the policy is maintained by the

individual or cancelled or non renewed but the insured is the low income resident who has experienced flood damages and so they would work directly with the carrier on the claims. We certainly see opportunity for private insurance carriers or other private interest to engage in a similar manner with communities in this type of model.

The next model is the aggregator model which is where a community would buy a bulk parametric policy so you can think of this as potentially a parameter structure backed assistance program or insurance program or grant program so that community is engaging likely more directly with capacity providers in this case to acquire an innovative parametric insurance policy in bulk and this allows for flexibility for them to target how they would structure the payouts as they could determine it would be most appropriate to fund an emergency relief grant program and we are actually working with a community actually a large metropolitan area to help frame out and design a parametric structure that would allow for them to fund emergency relief grants for low income individuals at an event so there is real flexibility here. Parametric structures are unique there is what we call basis risk so the potential for a triggering event to occur and the structure not allowing for a payout or vice versa where a payout is triggered and you have experienced a loss event so these types of things need to be managed and the community would certainly need to work with some sort of broker in this instance to manage that risk.

The payout structure by which any payouts would be made after a disaster certainly need to be well defined and clearly communicated so there are clear expectations and the community would collect the premium through their tax relationship or other financial means surcharge within the community and I'll just say parametric structures have been implemented globally for these types of mechanisms in other countries and regions perhaps most notably nearby with Mexico's disaster relief program they leveraged parametric structures and we have seen in the U.S. a number of entities pursue parametric type structures as UT had an earthquake parametric that augmented their property insurance program and paid out after the spring earthquake last year and helped paid for deductibles and other expenses related to that and they ended up having coverage for a large amount of the damages there. The metro transit authority has also leveraged parametric structures to support their protection for their assets in the NY region so there is kind of precedence for those being applied. A community could leverage this to help cover individuals within the community but they also could bolt on and augment their existing property coverage to cover deductibles or the gaps that there might be with a parametric structure like this.

The last model is the community captive model and in this instance the community would establish its own risk bearing entity and potentially work with a fronting carrier or pursue outright licensure to offer some coverage within the community. We are working with a metropolitan area that has taken an innovative approach to their captives in the past where they have actually offered a subsidy for non profit healthcare providers when malpractice insurance was challenging and they are looking at expanding their authorities to help cover low income at risk individuals for flood so many communities and cities do have captive infrastructure already and we are using pilots down this line to see how a community could offer coverage. This is certainly the most intensive in terms of resource and expertise commitments at the community level and that's something obviously there is capitalization requirements and captive mgmt. but it certainly allows a lot of flexibility for the community to access reinsurance capital markets so there are benefits to accessing different forms of capacity but this is certainly the most intense of

the four models but allows for a greater degree of control over the coverages offered and there is potential for the community to deliver assistance through a captive as well so that is something else that could be beneficial. I'll turn it back to Dr. Kaniewski to talk through the five part framework we have for implementation.

Dr. Kaniewski stated that this is the how slide – how can we collectively or as a firm go through this effort. The importance is resilience as we are trying to have a more resilient community with more resilient community members so that when a disaster happens there aren't the financial and physical losses and to do that you need two things. You need insurance but also hazard mitigation and that's how we see this coming together with CBCI is bring both the investments in physical infrastructure called hazard mitigation with both the risk transfer mechanisms of insurance like products. In general, there is a five-part framework for implementation and the steps are not necessarily sequential, and it may be necessary to go back and forth among them. First you need to define the need and to do this it's a bespoke offering there's no one size fits all approach for all communities; you have to sit down with community members and define the need; then you need to determine what authorities they have as every local jurisdiction is going to have something different. Then you engage a diverse set of stakeholders who need to provide input for it to be successful. Then you need to analyze the risk and understand what you're looking to transfer and then finally transfer the risk either through a radiational carrier model or an alternative model.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Lehman and seconded by Asm. Cooley, the Committee adjourned at 10:30 a.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
CHARLESTON, SOUTH CAROLINA
APRIL 17, 2021
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee met at the Francis Marion Hotel on Saturday, April 17, 2021 at 1:30 P.M. (EST)

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

Other members of the Committee present were (* indicates virtual attendance via Zoom):

Rep. Deborah Ferguson (AR)*
Sen. Jason Rapert (AR)
Asm. Ken Cooley (CA)*
Rep. Matt Lehman (IN)
Rep. Deanna Frazier (KY)*
Rep. Jim Gooch (KY)*
Rep. Bart Rowland (KY)
Sen. Paul Utke (MN)*
Sen. Paul Wieland (MO)
Asm. Kevin Cahill (NY)*
Sen. Bob Hackett (OH)
Rep. Carl Anderson (SC)
Rep. Tom Oliverson, M.D. (TX)*
Rep. Jim Dunnigan (UT)
Del. Steve Westfall (WV)

Other legislators present were:

Sen. Mathew Pitsch (AR)
Rep. Matt Dollar (GA)
Sen. Bandon Smith (KY)
Rep. Edmond Jordan (LA)*
Rep. Justin Hill (MO)
Sen. Dean Kirby (MS)
Sen. Walter Michel (MS)
Rep. Kevin Hardee (SC)

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Tess Badenhausen, Assistant Director of Administration, NCOIL Support Services, LLC

QUORUM

Upon a motion made by Del. Steve Westfall (WV) and seconded by Asm. Kevin Cahill, 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. Westfall and seconded by Rep. Deborah Ferguson (AR), Vice Chair of the Committee, the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's December 10, 2020 meeting.

CONTINUED DISCUSSION ON NCOIL TELEMEDICINE AUTHORIZATION AND REIMBURSEMENT MODEL ACT (MODEL)

Asw. Hunter, sponsor of the Model, thanked everyone for their work thus far on the Model. The Model still remains a work in progress but I am confident that we will get it to a place where everyone can support it. There will be no vote today - hopefully the Model will be ready by either our July meeting or our November meeting. I do want to make one point before going any further. A lot of the discussion on the Model thus far has centered around the issue of payment parity and I'm sure many here have discussed that issue in their states as well as we had a lengthy discussion in NY during budget discussions dealing with telehealth coverage expansion. The Model is in your binders on page 302 and the reimbursement language is in Section 4(D) on page 304. By using the words "on the same basis" we're not calling for payment parity, but rather payment equity. For example, there is reimbursement language in a pending Iowa telemedicine bill which says "a health carrier shall reimburse a health care professional and a facility for health care services provided by telehealth on the same basis and at the same rate as the health carrier would apply to the same health care services provided in person." Such language is a great example of strict payment parity, which differs from the language you see in the Model. I just wanted to make that clear before we proceed further.

Brendan Peppard, Regional Director of State Affairs at America's Health Insurance Plans (AHIP), stated that he has spoken on this issue three times now before NCOIL so he is not going to go through everything he said before. I commend you as I think there are a lot of good thigs in the Model and I know you have been working hard on it and giving deep consideration. With respect, we do not read that language about payment parity the same way that you are reading it and we have significant concerns with that language. We do believe it requires payment parity. One thing I want to point out is that we've had a lot of discussion about the value of telehealth as an additional method of accessing medical services and we think that is absolutely correct and one of things we've discussed with you as this is seen as a potentially lower cost option and it has been priced accordingly in benefit design. We want to make sure that we keep the consumer in mind when moving forward with this and that's why we think its important to leave it to negotiation between carriers and providers on the payment rates and we don't believe that the model should be speaking to payment rates at all so we would request that that language be removed. I will leave it there and say I appreciate comments that legislators have made and if you are not comfortable removing the parity language we would ask for specific language saying that this does not require payment parity.

Rep. Jim Dunnigan (UT) asked Mr. Peppard if he had suggested language or example language. Mr. Peppard stated that they do not but they would be happy to work on some with the sponsor if she is amenable to that. My recommendation is that section be removed but we are happy to work with the sponsor however she would like. Asw. Hunter asked Mr. Peppard if he knows if there are any AHIP members who are in agreement with the Model language. Mr. Peppard stated that he has not heard from any AHIP members who are ok with the language. Rep. Dunnigan stated that payment equity implies equitable payment for similar services so if we are going to reimburse a provider if I'm seeing him in person in an office is that the same equity as if I'm getting a telemedicine visit from him – I don't think so. I think it's important to recognize the cost savings and lower price point for telemedicine to make it more cost productive and cost effective for consumers so hopefully we can take a look at that.

Rep. Tom Oliverson, M.D. (TX) stated that he thinks the way the language is structured essentially makes it clear is what we're talking about here is equal pay for equal work. It is about value but telemedicine is not about just making things cheaper, its about primarily in state's like mine leveraging the existing provider pool we have to be able to provide the same level of services at places that are distant and difficult to access or communities that are small that would not necessarily support specialty providers in those communities. I think for those of us that represent states that have a lot of rural communities I think its important we recognize its not just about saving money, its about expanding access and the degree to which we can entice more providers to embrace the technological advances of telehealth in order to expand access to underserved communities should be the most important thing we look at there. This isn't about making healthcare cheaper per se. That doesn't meant that there aren't circumstances where services provided over telehealth are not of equal quality or level of service in other words if I have someone coming in and I'm just doing a medication follow up to their diabetes mgmt. I would argue that the same level of services could be provided electronically as provided in person however if someone is coming in for a new diagnosis of heart failure or something that would require me to physically examine the patient in order to accurately assess what is going on that is not the same level of service. So I think the model that you have before you does strike that balance and so I think its important we recognize that this is really about whether or not the same conditions and level of service is provided which is what I think that language does.

Asm. Kevin Cahill (NY) stated that he disagrees with Mr. Peppard that it's a good idea to leave to contract as that will just perpetuate the uneven relationships that exist between health plans and providers. There are places where there are few providers who could extract a premium for telemedicine and in fact force a patient into telemedicine where that might be the appropriate venue for their care. Just as likely there are places where health plans are dominant in a marketplace and they can force if a provider wishes to participate a circumstance where they would have to accept a significantly reduced telehealth rate even if it was not warranted. The one thing I have said in the past when we discussed this is that to do this bill alone and I hope between now and July and November we can do this – to do it alone without a companion of network adequacy would be a large mistake. We have to put the check in there to make sure its the patient that comes first in every instance and this is not about making healthcare necessarily cheaper its always about making sure healthcare is accessible and quality in every instance and yes of course affordability is also a consideration. I would urge against what Mr. Peppard said in terms of leaving it to contract and I would also suggest that it should not be done at all without a companion bill for network adequacy.

Sen. Bob Hackett (OH) stated that we have been working on this for a long time in Ohio and one of things we've done is postponed getting the final bill passed because we are still in the pandemic and there was no expert that forecasted how much telehealth was going to be used that was close to being right. The amount of telehealth used in OH is phenomenal compared to what it was so a lot of it depends on the quality of the healthcare and its still too early to tell how well telehealth has done. One of the reasons I support the AHIP model is because when you talk to some of the providers they talk about the initial cost of setting up the telehealth system and sometimes you will see examples of cases where the providers will be ok with payment parity in a situation otherwise it wouldn't get done and I agree with Rep. Oliverson's points the way he said that. But by the same token we still have to look at the type of system because I think

the providers can work it the other way also. You give the ability to the provider to make the final decision and that's dangerous in itself because many times they're going to look at to say we want paid equal dollars for what we're doing. That's why OH has delayed making a decision on telehealth because all of the rules that we were going to pass in the bill had been passed administratively – our Medicaid rules and commercial rules so all we're doing really is codifying administrative rules that have been passed since last fall. That's the only question I say is I'm a proponent to let providers and plans negotiate to work it out because I can show you examples of cases where the provider will have it equal and I can show you examples of cases where it doesn't make sense. We just have to be really careful how we set the model up.

Rep. Ferguson stated that Arkansas already has a telemedicine bill that requires parity for in person and telemedicine visits. There is already a framework for paying this – it's called CPT codes. The CPT codes define exactly what payment is prescribed for a 15 minute visit and what goes on in that visit so there are already prescribed elements to doing a CPT code for whatever visit it is so there really is no reason to penalize someone for doing that visit telemedicine instead of in person.

Asw. Hunter thanked everyone for their comments and stated that the Committee has work to do and it will continue to work towards completing the Model.

CONTINUED DISCUSSION ON NCOIL MODEL ACT REGARDING AIR AMBULANCE PATIENT PROTECTIONS

Asw. Hunter stated that we had a great discussion on this Model at our last meeting in December. Since then, there is much to talk about as the Model has been introduced in several states, and it also may be impacted by the new federal balance billing law, the No Surprises Act, as well as a recent Eight Circuit Court of Appeals opinion. The Model is in your binders on page 307, and the Eighth Circuit opinion is on page 310. Asw. Hunter stated that you may have received an e-mail in the past hour from NCOIL staff containing some proposed amendments to the Model which will be discussed today but nothing will be finalized today and nothing will be voted on. I'll now turn it over to the sponsors of the Model for some introductory remarks before going to our speakers.

Del. Westfall stated there certainly has been a lot of action surrounding this issue since we last met. As Chair Hunter noted, in addition to the enactment of the federal balance billing law, the Eight Circuit Court of Appeals did in fact issue an opinion which ruled that a North Dakota statute seeking to regulate air ambulance membership products as insurance was preempted by the federal Airline Deregulation Act (ADA). However, and I'll let the speakers we have here today address this specifically, I believe that in its opinion, the Eighth Circuit laid out how a statute such as this Model could survive federal preemption. Accordingly, I have introduced amendments to the Model which you have before you today that I believe align with the Eighth Circuit's opinion. I've introduced this Model in my home state of West Virginia with language similar to these amendments and it passed with overwhelming bipartisan support and is currently pending on the Governor's desk.

Rep. Oliverson stated that I have also introduced the Model in Texas and we are still working on it in good faith with all the stakeholders. I think at the end of the day what we will probably pass in TX may differ somewhat from the Model in that it will primarily focus on disclosure language or what we're sort of referring to as the cigarette warning label

for lack of a better term although I don't mean that in any derogatory way that's just what it reminds me of. I've heard from folks in my large rural state here of TX on both sides of this issue and I think the general feeling my colleagues in TX have is we want to be clear that this Model is designed or legislation in TX would be designed to just inform consumers that they can make decisions and let them know about their options but at the same to acknowledge that these are two competing business models and that the state is essentially very neutral on that issue and we're not here to pick winders and losers but we just want to make sure consumers know what they're getting into ahead of time. I think that's the direction we're heading and my only ask of the Committee today would just be to ask that we postpone the adoption of the Model as a whole until after the legislative work in TX has had a chance to play out because I think that will give us a good perspective as a committee having legislation passing in two different states addressing the issue and I think that would be very informative to the model when it gets to its final form.

Asw. Hunter stated that based on your comments and the Eighth Circuit opinion I want to reiterate that there is not going to be a vote on the Model today and based on our bylaws and some of the comments put forth I'm not going to be putting forth a vote on the amendments as well as I think it will give everyone an opportunity to take a look at the amendments and see what happens in TX as WV has already had their vote and we want to be purposeful and doing our due diligence on the model going forward.

Chris Myers, Executive Vice President, Reimbursement and Strategic Initiatives at Air Methods Corporation (AMC), stated that he appreciates the opportunity to appear before you again to continue discussion on this important topic. Sine we last met there has been a key development that directly affects the Model and how consumers interact with membership products. The NSA was voted into law and will become effective on 1/1/22. This law significantly changes the landscape of the U.S. healthcare system and dramatically decreases the financial risk for patients as it prohibits the practice of balance billing. To be clear at the outset I am not here today to argue against the prohibition of memberships but instead for the appropriate regulation of them so that consumers are not deceived with what they are purchasing. AMC continues to believe that the best way for the patient to solve patient financial burden is to go in network with payers. We have led the industry in doing just that and have led the industry with in network agreements with almost every payer in every major state and we continue to work very hard to bring the thee big payers, United, Aetna and Cigna, in network as well.

The implications of the NSA make this Model even more important because of the following: memberships are largely obsolete starting 1/1/22 as they have been marketed to cover patient's financial exposure to balance bills which again will be prohibited in less than 9 months. These products are now marketed to cover only copays and deductibles so one must ask how does this factor into the federal govt's prohibition on routine waiving of copays and deductibles under the false claims act, anti kickback statute and the civil monetary penalty law. Given emergency air medical transport is also bookended by a continuum of care and value to consumers in covering copays and deductibles is actually determined by the insurer its subject to when an air ambulance claim is submitted and what amount of financial responsibility remains on a consumer's policy. Memberships offer far less financial value to customers previously since they now only cover copays ad deductibles. Companies that sell memberships believe these products operate above state law however states can and do regulate air ambulance subscriptions. Good examples of this are FL, NY and most recently in WV.

Importantly, there are several areas of consumer protection for state regulators to consider: payment to cost ratio decreasing - will consumers be charged fair premiums of memberships with patients main health insurance policies – how will regulators ensure that these products add financial value to the policyholder and are not merely duplicative coverage; sales of memberships to consumers who have no real need to purchase them – we already know that 35% or more of consumers who purchase these re Medicare beneficiaries. When comparing the data that was provided to NCOIL with the data from NAIC and AHIP on the U.S. medigap market, the largest membership project in the U.S., air med care network is the 2nd largest medigap product sold in the U.S., 2nd only to united healthcare. But without any regulatory oversight at the state or federal level whatsoever what about the additional consumers who truly will not have any out of pocket financial risk starting in January because of the NSA.

Because membership policies are completely unregulated there is no state or federal oversight to prevent consumers from being taken advantage of by being sold membership products by fraudulent companies. The last time I spoke to the committee we discussed Helimedic which masquerades as an air ambulance provider and air carrier but doesn't seem to actually exist yet you can google their website right now buy a membership from them that claims to cover you and your family from anywhere in the U.S. Confusing and deceptive practices vary within the fine print of memberships should be reviewed to determine if they are in the best interest of the policyholders. For example, disclosures for Medicare beneficiaries shift the burden from the consumer to certify they are Medicaid beneficiaries – what about adding disclosures for the NSA? Membership contracts sign away the consumer's first lien rights so that any settlement received form an auto or homeowners policy for example must first go to pay the full billed charges of the air medical bill. Terms and conditions also allow for auto renewals in perpetuity without consent or refunds. How will consumers that realize that they no longer can be balanced billed next year be able to get a refund after the NSA is enacted and to which state agency do they go for recourse if they cannot get a refund.

Some of the policyholders have been so scared to the potential financial burden of the balance bill that they have actually delayed care to be transported by their membership provider in a medical emergency based on the most closest and most appropriate provider. Memberships are indemnity products. Copays and deductibles are set by a third party – the payer, not the provider. In fact, a January 6 handout entitled "HR133 membership matters talking points – global medical response (GMR) states no air ambulance company can predict individual out of pocket costs as those are determined by insurance companies." Indemnifying the policyholder against costs determined and set by a third party entity is dispositive of the insurance question – air ambulance memberships engaging in this activity clearly fall within the business of insurance. The data filed in Air Evac vs. Dodrill in February of 2021 shows that these products are pooling risk like an insurance product, not pre paying for services. The patient cannot call for an air ambulance and has no choice in the matter. For a membership to be considered pre -payment the consumer has to have a reasonable expectation that they will utilize the product yet you and I have a higher likelihood of dying from heart disease than we do by being transported by an air ambulance.

Air Evac vs. Dodrill showed similar utilization among consumers who had purchased an air ambulance membership. In this case, 0.2% of these individuals in WV used their membership. There has bene a lot of confusion about the recent appeals court decision

in the Eighth circuit. State legislators and regulators have been told that this decision prohibits them from taking any action on regulating memberships because of the ADA. However this is not completely accurate. The Eighth circuit opinion found that a state law enacted "for the purpose of regulating the business of insurance" falls under the reverse preemption under McCarran-Ferguson Act. Hence, legislation like the proposed Model including the amendment before you today are permissible and appropriate ensuring meaningful consumer protections for air ambulance membership products. The proposed Model and the amendment takes a targeted narrow approach to appropriately regulate the business of insurance and protect consumers from predatory marketing and sales tactics. If membership products are simply pre-paid services then they should be just that and the economics should support it however, after 1/1/22, the only possible pre payment is for the copay and deductible. It's important to remember that based on the timing of service, when the claim is filed that there may be no copay or deductible. Additionally, when the provider seeks reimbursement for these services from a third party then they become a medigap product.

One final point to make is that there are much better ways to solve the financial burden that a patient may face. At AMC the average out of pocket expense for all is less than $165 and in the case where an individual cannot afford to pay that amount we use specific financial info from the patient to qualify them for appropriate discounts. We continue to support the model and the amendment is a way to give states a tool to help consumers to ensure that the coverage they are buying is not duplicative or deceptive. The proposed model takes a targeted and non prohibitive approach to a appropriately regulating the business of insurance and to protect consumers from predatory marketing and sales tactics.

On behalf of GMR, Eleanor Kitzman, former South Carolina and Texas Insurance Commissioner, stated that GMR opposes the Model as originally filed and as amended that has been discussed today. This is simply not insurance and its not an insurance contract and the Eighth circuit has said expressly that. GMR operates the air medical care network (AMCN) as the largest membership program in the U.S. with 3.5 million members in 38 states with 320 locations. A copy of the application and terms and conditions has been provided to you. Many of you have seen it before but I wanted you to be able to see the fine print referred to by Mr. Myers for yourself. I particularly want to draw your attention to a few things. The first is in section 2 that asks for the names of all names of the household because a single membership covers all members of the household for the same price. The 2nd is in section 3 the membership and payment options. Monthly members cost is only $9 and annual membership is $85 or $65 for applicants over 60 years of age. In addition to the terms and conditions that are printed on the application I've given you a large copy because there are some important aspects of that that I want to highlight as well

The membership ensures the patient will have no out of pocket expense if flown by a company providing pre paid protection against a company's air ambulance costs that are not covered by a members insurance or other benefits or 3rd party responsibility. The patients medical condition, not membership status, will dictate whether air ambulance transport is appropriate and required. An AMCN provider air ambulance service may not be available when requested. In return for payment of the membership fee, the AMCN provider will consider its costs that are not covered by any insurance or other 3rd party payer to have been fully pre paid. Memberships are not an insurance policy and neither the company nor the AMCN will be responsible for payment of services provided by

another air ambulance service. By applying for a membership the applicant certifies that they are not Medicaid beneficiaries.

I want to also point out what is not in the application and terms and conditions. Any restrictions on the number of transports; any questions regarding health condition of applicant; any question on health insurance that could provide a source of payment to the air ambulance provider. In summary this means that everyone in the memberships household is a member that could receive unlimited life or limb saving air ambulance transports for as little as $9 per month whether or not the patient is more likely to require transport based on the medical condition or has insurance. The NSA has ben mentioned as an important development and it is and GMR was involved in discussions on that legislation and that is a good thing for consumers. But it only eliminates one component of healthcare cost sharing features. That is any balance bill of any amount that the air ambulance provider has billed to the insurance company that is not paid by the insurance company. It does not eliminate or reduce the deductibles copays or coinsurance and it provides no protection to consumers who are injured or whose transports are deemed not medically necessary.

AMC has argued that going in network is the better way to reduce out of pocket expenses but being in network and having a membership is not mutually exclusive and membership still provides valuable benefits. We are in network with 139 insurers and negotiate with companies on a regular basis to go in network even more but that only affects the amount paid by the insurer to the air ambulance provider, it does nothing to reduce deductibles and copays which will continue to apply. AMC has also argued that deductibles and copays exist as a means to discourage overutilization and should not be routinely waived or forgiven. I'm not exactly sure how life or limb saving services that are dispatched by a 3rd party could be overutilized by a consumer but I also disagree with the premise that disallows a consumer to voluntarily purchase a product that could protect his or her family from the potentially high cost from the deductibles and copays over which they have no control. This seems a much better option for consumers than relying on charitable funds for patients to assist with out of pocket medical expense as promoted by air methods on its website.

Speaking of deductibles and copays there is another cost sharing feature contained in many heath insurance policies that has not been mentioned and that is called coinsurance. Coinsurance is an amount, usually a percentage of the covered amount of the claim, that is coinsured or required to be paid by the patient in addition to any deductible or copay. According to the Kaiser Family Foundation (KFF) the average coinsurance requirement in 2019 was 18%. Also according to KFF, 81% of health plans have a deductible and 24% of those are high deductible plans. The average out of pocket expense for high deductible plans for each air ambulance medical transport is $4,332. Again, deductibles, copays and coinsurance apply regardless of how successful an air ambulances negotiations with an insurer may be. AMC has also argued that a Medicare enrollee does not need a membership plan because Medicare fully covers air ambulance services. This is only true if the patient has purchased Medicare part b which is optional and there is still a 20% copay which based on Medicare's average payment for air ambulance service averages $1,160 which is over 17times the $65 membership fee for seniors – Cmsr. Kitzman acknowledged that math may not be correct.

It is possible that a Medicare supplement policy could cover the copay and we include a FAQ on our website encouraging consumers to check their coverage. Again, according to KFF 6.1 million Medicare beneficiaries had no source of supplemental coverage. Our programs provide enormous benefits with little to no downside to consumers. If a member is transported by a 3rd party his or her membership does not apply and they are not disadvantaged by their membership agreement. If they are transported by a network provider and insured we pursue payment for reasonable cost of transport from the member's insurer only. The member will never receive a balance bill and payment of the deductible, copay and coinsurance which would be far more than the cost of memberships are cancelled or waived. If a member is uninsured the entire transport is covered by the membership agreement.

I also want to address what has been said about the need for consumer protections. Supporters of the Model will claim that is needed to protect consumers form purchasing a product that they do not need or understand. We believe that our 3.5 million members who have made a decision to purchase the piece of mind provided by memberships are capable of assessing their needs. The overwhelming majority of new memberships are not purchased face to face through a pushy salesman rather they are purchased through direct mail or digital or other channels in which the consumer has ample opportunity to make a decision without any sales pressure. Over 45% of our members have had their memberships for over 5 years. In fact 800 of air evac's original 5,000 members still have their memberships today. It would be insulting to imply that our members have been duped all these years.

Supporters of the Model have also made a lot of allegations about unscrupulous and misleading sales tactics and confusion among consumers and delays on transport using the arsonist firefighter analogy. These allegations are always couched as this is something that could be happening and might have occurred and consumer may think and the like. They have not cited a single specific example of any of these things actually occurring. I've listened to testimony in some of the states where similar bills are pending most recently in WV where there was a physician who testified and I listened to his testimony a couple of times because I thought if anyone would be able to cite a specific example he would be the one but again it was couched as this could happen. As a former regulator one of my biggest concerns is complaints and when I took on representation of GMR and AMCN that was one of the first things I made sure of both internally and externally. I'm not saying there has never been a complaint anywhere but I haven't found the evidence and apparently neither has anyone else.

We believe the more appropriate way to address consumer protection especially with respect to a product that has been around since 1985 and that does not endanger a consumers life or health is through robust disclosures which we support in the model and we have been working with Rep. Oliverson's office in TX. Some of these disclosures are already in our terms and conditions and we support making them more prominent. Insurance is not the only way to provide disclosures. Finally, there has been mention of the Eighth circuit opinion and there is the WV amendment that has been offered by Del. Westfall – that has been interpreted in such a way as to involve this reverse preemption under the McCarran Ferguson Act and to achieve the result that they would like as represented by Mr. Myers. But what's being ignored is the courts express language that "subscription agreements are not insurance contracts." The Eighth Circuit reversed the lower court holding that there was reverse preemption under McCarran-Ferguson. An insurance contract is the starting point for reverse preemption

under McCarran Ferguson but its only the starting point. The statue must be enacted for the purpose of regulating the business of insurance. The purpose of this bill is not the regulation of the business of insurance its for the purpose of regulating a business model that some do not like or agree with. We believe that is wholly impropriate and we support all of the consumer protection disclosures and the like and are happy to work with the states and with this committee to fully protect consumers but we believe that consumers should have the option and we should not be going about taking choices away from consumers when we are talking about very high expense so we again we would very much like to see the version of the model as along the lines that Rep. Oliverson outlined.

Rep. Jim Gooch (KY) stated that my question is for Chris Myers and its you're in favor of the model and advocates believe that passing the Model will help your organization with some financial value so I'm just wondering is that based on your belief that it might help with competition as competing with other air ambulance providers or is it your ability to negotiate with providers to some contractual arrangement – does it have to do with reimbursement rates-? What do you see as the benefit of the Model as far as AMC is concerned. Mr. Myers stated that we see this as an issue that is been permeative for the industry like a lot of the historical practices in the industry whether that was aggressive billing practices, balance billing, or this because it fans the flames of the financial uncertainty for patients so our interest is around the financial impact for the patients. And that is why 5 years ago we started a patient advocacy program and why we stopped balance billing well before there was any discussion about the NSA and its why we continue to go aggressively in network and its why our numbers speak for themselves – you don't have to buy a membership in order to have a low out of pocket which for us is $165. We believe it's a bad practice for the industry regardless of what that may mean for AMC specifically – it creates fear for patients around a situation that probably wont occur given the 0.2% utilization rate which is unnecessary and unproductive and we think capitalizing on that fear of individuals is not good.

Del. Westfall stated that the proposed model is not a prohibition on air ambulance membership products and does not aim to restrict the ability to sell them to consumers but is it your opinion/position that states cannot regulate air ambulance membership products in any way. If yes, based on what and if no based on what kind of state consumer protection regulations are appropriate for these products. Cmsr. Kitzman stated that I think we're oppose to regulation as insurance because we believe that its not insurance. We also believe as courts have held many times that the ADA preempts any state regulation of anything related to rates routes or service and beyond that there aren't cases dealing precisely with this issue but we have and are supportive of the consumer protections and disclosures in the model. There are laws in other states that have provided some disclosure requirements and consumer protections. WY recently amended their statute which a few years ago had classified membership products as disability insurance but they have amended that statute and no longer deem it is an insurance product and there are quite a few disclosure requirements and consumer protections in there and GMR was involved in the discussions and negotiations on that bill in WY.

Del. Westfall asked if air ambulance membership subscriptions cover a patient's copay and deductible associated with air ambulance transports. If yes, are copays and deductibles determined and set by a 3rd party such as an insurance provider. Cmsr. Kitzman stated that we don't set them and what GMR does is if it's a membership

whatever the insurance company pays for that transport that's the end of the transaction there is no negotiated with the member and no further action that is taken. Any charges that might otherwise have applied are cancelled or waived.

Rep. Bart Rowland (KY) stated that I appreciate Dell. Westfall pointing out that nothing in the model says that these products could not continue to be sold in the future all it does is attempt to increase transparency which I'm glad to hear Cmsr. Kitzman is in favor of and it adds regulatory authority to our state regulators which I don't understand why we wouldn't be for that. Its good that we don't have bad actors today but what if we had future bad actors entering into this product and we should give our state regulators the ability to get a handle on them. My question is we're all familiar with products sold by Aflac, colonial life, and Transamerica and we've all seen them and they're sold to take care of very particular incidences – you buy an accident plan to take care of an accident; you buy a cancer policy and it pays you in the event you come down with cancer; you buy an intensive care rider or gap policy and you get paid should you have a heart attack or stay in the hospital – how would you describe an air ambulance membership which is bought for the very specific event of a ride on an air ambulance – how do you draw the distinction between one of those supplemental policies and a membership. Cmsr. Kitzman stated that those policies provide indemnification of expenses incurred by the policyholder to a 3rd party and AMCN does not provide indemnification of a third party and does not provide indemnification of the member in any way – it provides a service – period. Yes, we support the consumer protection disclosures and increased transparency – it doesn't have to be an insurance product to do that there are other ways to provide some oversight onto that which we believe is a better less onerous way to do it especially since in my opinion it just doesn't not meet the definition of insurance and the Eighth circuit agrees with us.

Mr. Myers stated that regarding potential bad actors, they exists today. The Helimedic example I raised I would encourage you to go on their website as it's a company that has no real air ambulance operations selling memberships to individuals today without any real ability to provide the service so we are living already with bad actors in this space. Cmsr. Kitzman stated that after hearing about Helimedic we also have tried to find out more about them and we have been able to find out very little however we already have laws on the books as there is already a remedy for what they appear to be doing and it its through Attorneys General and fraud statutes and unfair trade practices (UTPA) laws that are already on the books and if what they are doing is as is being alleged or implied there are already laws against that and they are in violation of them - calling this an insurance product is not going to deter an operation like that.

Rep. Deanna Frazier (KY) stated that some states like FL regulate these products as prepaid limited health service programs. Does GMR view FL's regulation of air ambulance membership products appropriate or do you plan to pursue legal action against FL. Cmsr. Kitzman stated I have no idea of what legal actions anyone may or may not be considering. I believe NE also regulates it as a discount medical product. GMR operates membership programs in both of those state I believe so the extent of the regulation is such that we have been happy to comply with it and are able to operate there under our usual business model.

Sen. Paul Wieland (MO) stated that a follow up is would you be comfortable with other states adopting what FL has done. Cmsr. Kitzman stated I have not studied the FL statute specifically so all I'm saying is that GMR is operating in FL and I think there are

probably a number of state laws if we were targeting reforms from scratch that's not the way we would do it but our business model works under a number of different approaches states have taken.

Rep. Jim Dunnigan (UT) asked what the loss ratio is on the product. Cmsr. Kitzman stated that because it is not an insurance product I don't believe that loss ratio is something that is calculated in the way that you would for an insurance product but I actually don't have knowledge of that so I cant answer it but I would note that's an insurance concept and this is not an insurance product. Rep. Duningan stated let me ask it another way – if you took your subscription fees and subtracted your claims what's the ratio. Cmsr. Kitzman stated I don't have that information. Rep. Dunnigan asked if that information could be provided. Cmsr. Kitzman said I certainly will look into it. Rep. Dunnigan asked if you think the legislators are precluded form perhaps expanding some of the pieces of regulation on this so it could be considered insurance under McCarran-Ferguson. I'm just reading the Eighth circuit case which is interesting – some of the things they are talking about like balance billing they are all integral parts of insurance so I guess my question is do you think the legislators are precluded from fleshing this out so it looks more like insurance and calling it insurance would that qualify under the Eighth circuit rational Instead of just going after balance billing could we regulate different pieces of it.

Cmsr. Kitzman stated that I don't think so because just calling it an insurance product doesn't make it an insurance product but even if it would meet a definition for an insurance product or insurance contract that's not enough for McCarran-Ferguson. The statute has to be enacted for the purpose of regulating the business of insurance and this is not. We are not in the business of insurance. The membership product is incidental to our business its a part of our business but its not an insurance product and we are not in the insurance business so I don't think that further attempts to shoehorn this into some definition of an insurance contract really gets supporters of this model where they want to get to.

Rep. Carl Anderson (SC) stated that it appears that you are afraid of something could you tell us what we you are afraid of. Cmsr. Kitzman stated that is not a matter of being afraid of something its that we just don't believe that its an insurance contact I don't think anyone is going around asking to be regulated as something that they are not. It would also create a situation where some air ambulance providers are regulated as insurance and others are not and we believe having been in this business for a very long time having a very good track record with it having lots of happy customers seeing no evidence of companies or anyone actually delaying transport or medical care that this is worse than a solution in search of a problem it's a competitor in search of an advantage. We have a business model that they do not and that some do not agree with and that's their prerogative but going back to what I said earlier it would be highly unusual to prohibit a product that has been around as long as this with the track record it has and that when we have what's being called by supporters of the model, not any consumer that we're aware of, can be handled in a less onerous way and certainly we want our members to be informed. We want them to buy this product because they believe it adds value and I think the fact that 45% of our members have been with us for 5 years or more speaks volumes. I think anyone that deals with consumers would be very happy with that.

Asw. Hunter stated I am asking NCOIL staff to put together some sort of legal panel relative to the impact of this Eighth circuit decision and perhaps the likelihood of a U.S. Supreme Court action. We could do an interim zoom meeting or hold to July.

Mr. Myers stated that he would like to respond to Rep. Anderson – this is not about competition. We can sell memberships if we wanted to today. Historically AMC did have some memberships but we choose not to sell them so this is not about us not wanting to compete we are happy to compete on service every day this is about not promoting a bad practice and taking advantage of peoples fear of a potentially devastating financial issue and that's why we don't do it.

Sen. Jason Rapert (AR), NCOIL Immediate Past President, asked if there are there any current actions right now in this space being handled right now by the Attorney General under deceptive trade practices or are there even any active cases? Cmsr. Kitzman stated we are not aware of any. Sen. Rapert stated we always need to be careful of picking winners and losers in states and this venue. This body has the absolute ability and willingness to get out there and make sure there is a fair and level playing field but I've never seen the body getting into picking winners and losers and deciding what is good or not on the free market. I look forward to more information on this and I appreciate all the work done thus far.

Rep. Oliverson stated we've heard this three times and I want to let committee members know that in our testimony in Texas when we heard this bill the issue of Helimedic was brought up and within a very short amount of time we reviewed a letter from their CEO identifying them as a European company with a long track record that is seeking to do business. I have been to their website and I don't know how to buy a membership on their website, I've tried but I cant. Cmsr. Tom Considine, NCOIL CEO, has a copy of the letter I received and I want to be clear that if we are going to use a company as a specific example like that they should have the opportunity to defend themselves. They have attempted to do that by reaching out to my office and I think its fair for committee members to hear from them as well. It's regretful that we keep on bringing them up as an example – they have reached out to me in TX and have been very upset with the things that have bene said about them.

I think this model boils down to a couple of things. I think we're all in agreement that at the end of the day we don't want to pick one side over the other we simply want consumers to know what they are getting into. If a consumer thinks there is value in a membership so be it but the consumer should also be aware that they may be signing up for something that they don't actually need and that should be made clear to them. And I think the second point related to the Eighth circuit decision which by the way TX is not bound by nor is the majority of the U.S. is whether or not something has to be classified as insurance in order for state law governing disclosures to have any real teeth behind it. I think that's the question and I fully support a decision to get some legal advice and counsel because I can tell in TX we are trying to work through I think we know what we want to do and I think both sides don't really object to the idea of disclosure the question is really whether or not disclosure is meaningful without conversations about insurance and that's what we need to focus on the next couple of months. I appreciate all of the work thus far and the stakeholders have been respectful of me and my office and tried to be constructive. I think if we continue to work on this we will have something we will be proud of.

DISCUSSION ON ALL COPAYS COUNT COALITION ACCUMULATOR ADJUSTMENT PROGRAM STATE MODEL LANGAUGE

Asw. Hunter stated that before we begin, I want to note that this model language is not before you for consideration today as an NCOIL model law. Rather, this is model law language developed by the All Copays Count Coalition (Coalition). This discussion is meant to be educational only.

Steven Schultz, Director of State Legislative Affairs at The Arthritis Foundation, stated that he is representing the Arthritis Foundation and also the Coalition which is a group of patient provider organizations that's working on a solution to accumulator adjustment programs across the country on both the state and federal level. Likely a lot of you have heard about accumulator adjustment programs but they are not necessarily like they sound so I am happy to review them. Many chronic disease patients use copays systems such as copay cards or manufacturer assistance to be able to afford their life saving medications. Very recently in the last several years copay accumulators have become kind of common in insurance plans that really prevent any such assistance from 3rd party payments from counting towards cost sharing such as a a patients deductible or annual out of pocket maximum. The example that we often share is that a patient will continue to utilize their assistance and pay at the pharmacy counter and eventually that assistance is going to run out and at that point they are going to find out at the pharmacy counter or wherever they are getting their medication that they still owe all of that cost sharing usually in the middle of the plan so usually it's a surprise to them because its usually not in bold language in terms of disclosure to the patient so then the patient has to figure out how they will afford likely some of the time very expensive medications like in our field they tend to be biologic medications which are thousands of dollars.

So likely because of that issue of affordability patients will have to make a decision of going in debt themselves to find another way to pay trying likely another high price medication or just not being adherent on their medications. All situations are not extremely good. Just going through some of the trends we are seeing – these have become increasingly utilized. The AIDS Institute partners with the Coalition and has been tracking these types of protocols and programs very recently and they have shown that all the states that don't have a prescription on the program there is at least one plan that has a copay accumulator in their policy. Fourteen states have them in every single policy so there is not even a case where a patient who is educated about these types of programs can shop around and see and purchase a plan that doesn't have one. Thirty two states have at least two thirds of plans that have accumulator adjustment programs and lastly only three states have fewer than half of their plans that have accumulator adjustment programs so its extremely prevalent and growing. There is also a study that shows a trend where even when discussing with the health insurers as far as their medical and pharmacy directors they in addition to the patient provider groups there is a sense that this is being put in place to shift the cost on the patients as posed to the other folks in the supply chain.

The solution that we've adopted at the Coalition is model language and is probably the simplest bills that you are going to see out there and it tends to be the shortest bill introduced in the states and they are just as simple as no matter who is paying for these funds whether its pharmaceutical manufacturers, copay systems, a go fund me page, aunt or uncle, those funds and 3rd party payments should be counting towards a patient's cost-sharing requirements. This language has been endorsed by our partners like the

American Medical Association, American Cancer Society Cancer Action Network, AIDS Institute, National Hemophilia Foundation, Cancer Support Community, American Kidney Fund and many others.

Regarding the landscape of where they have been introduced we've seen a great deal of success over the last couple of years having it enacted in VA, WV, IL, AZ and GA and this patt year KY took action just last month and there are a few months that are closing in on enaction as it is currently on the Governors' desk in OK and close to the Governor's desk in AR and just has one last procedural hoop and a shout out to Sen. Rapert who was the Senate lead on the bill. Its also passed a chamber in the house of MI and in OR and closing in on floor votes in NY OH and TN. Also, Rep. Oliverson heard this bill in committee this past week so its becoming one of the most introduced bills and talked about throughout the country. Because of that, what we hear in the discussion at hearings in opposition is that it tends to focus on assistance and the merits of assistance rather than the merit of introducing and implementing these types of programs that shift the cost to patients and more about a discussion about just the assistance. We also hear about the notice of payment parameters from U.S. Health and Human Services (HHS) which does allow states to put these programs into place but usually not mentioned is the fact that in the same payment parameters they give the power to the states to enact legislation like the states that have enacted it and have really pointed to the states saying if you don't want to have these types of programs then pass legislation accordingly. We also often hear about plan design and how this type of assistance could circumvent plan design which is not true in the sense that to get on these types of plans that need assistance you need approval from your insurance and need to go through things like prior authorization and step type therapy that step your way through lower cost alternatives including generics to be able to use assistance towards your insurance which is the point of this type of bill that we want to see this type of assistance applied to insurance so of course it has to be a medication that's approved by the insurance plan.

We also often hear about generics that this is gearing patients off of generics not brand name drugs and we often state that 99.6% of the drugs that have this type of assistance are for medications that don't have a generic and are just brand names that don't have a generic yet and likely can't have a generic because they are biologics that can only have a biosimilar. Also, there is the element of plan design that plans have plan design elements like utilization design tools to walk patients through lower cost alternatives before getting onto these type of medications that would have this type of assistance that is the real heart of the problem that we are trying to solve. There are also discussions about issues that block this type of assistance like Medicare and Medicaid which are gov't entities likely not able to be like for like comparison with private insurance and then other state that have done this in this space as far as copay assistance. I'll mention MA which has had some discussion about restricting assistance and often its pointed to it as a state that bans assistance which is not true as the state each year or every other year allows assistance to take place and sunsets just because of identifying that assistance is crucial for patients to stay adherent and even 7 of 9 plans in MA have an accumulator adjustment program. CA is my state and I'm a constituent of Asm. Cooley and there a couple of years ago enacted legislation that restricted assistance for patients having gone through step therapy and prior authorization or generic equivalents as a way of that argument of steering patients onto brand name drugs. The result of that you would think is no accumulators in CA but that is incorrect as a majority of health plans in CA have such programs and so that dismisses the

argument that this is more about accumulator adjustment programs or more about steering patients onto generics rather than brand name drugs because if that was the case CA would have no accumulators in their state regulated plans.

Lastly, we often hear that this will somehow drive up premiums if we ban accumulator adjustment programs but since these are new programs that were just recently implemented in the last 5 years or so you can look at where the status quo was before assistance was being utilized without these programs and nothing is demonstrably shown that premiums have gone down as a result of these programs and even analyzing the states that have enacted legislation like VA or AZ we have not seen premiums go up as a result of enacting legislation.

Mr. Peppard stated that since this is not going to be developed into an NCOIL model and since there is another agenda item I'm not going to get into a detailed discussion about this ill just simply say that right now as Mr. Schultz alluded to, Medicare and Medicaid consider copay coupons to be an illegal kickback and their position is that copay coupons induce a patient to use a specific drug with the rest of the cost picked up by the taxpayer and our thought is that we should not be tying the hand of the commercial market because that would disallow them from being able to similarly be responsible with those consumer dollars which they pay.

Sen. Rapert stated that we just passed this bill in AR and AHIP sent lobbyists to AR to oppose the bill so I want to ask why is that you want to disallow consumers and individuals some of which are paying outrageous prices for drugs for insurance someone with hemophilia. Why is it your concern that you want to disallow them the opportunity to be able to reduce their own expenses for the benefit of their family when there are rebates that are given directly from drug manufacturers to help people and often it is their physician to provide them the ability or at least a connection to get a rebate. Why is it that you are going around the country and fighting people when we know the cost of insurance and medications are so high – why would AHIP take this position.

Mr. Peppard stated that you are correct in saying the cost of mediation is tremendously high and we are not opposed to reducing the cost of medicine. Sen. Rapert said my question is why would you want to disallow individuals and families to get the benefit of the rebate which is what it was intended for. Mr. Peppard stated that the rebate is coming from the drug pharmaceutical company and as I mentioned in the gov't programs these are considered an illegal kickback and considered inappropriate. We don't believe that commercial plans should be treated any differently. Sen. Rapert stated that I ran into this language in AR and I take great exception to you saying that a mom and a dad that have a child with hemophilia that are forced to be on a high deductible plan that you are saying that they get an illegal kickback because they use a rebate coupon. I know that's been stated with Medicare and Medicaid but it so happens that this is not even the issue and focus of this particular proposal. It's not dealing with Medicare or Medicaid it is only dealing with commercial plans so would you please stay off of trying to make them sound like criminals because they are trying to save money for their family. Why is it that you need to intervene and stop individuals from getting the benefit of those rebate coupons. Mr. Peppard stated that I was not suggesting that those individuals are engaged in an illegal kickback – it is the pharmaceutical manufacturers who are inducing them to purchase a more expensive drug and it is being considered an illegal kick back in those federal programs and so that's why I'm referring to that because you're right that

this proposal does not deal with those, this deals with the commercial market and I'm making the argument that the commercial market should be treated similarly.

Mr. Schultz stated that the like to like comparison between Medicare and Medicaid with this is that Medicare and Medicaid ban this type of assistance and accumulator adjustment programs are not banned on this type of assistance. The patient is still allowed to use that type of assistance and the other members of the supply chain are still able to take in the funds but they are just not crediting the funds so its not necessarily a like to like comparison even if we were getting down the road of Medicare and Medicaid.

Sen. Rapert stated that I appreciate the Chair making this a discussion item and after dealing with this issue and some of the information I've learned in the past few weeks if you don't have anyone that is in a position to sponsor this language for an NCOIL model I would be happy to get it started and also happy to partner with anyone that would want to do that because this is an issue that is very familiar and I think we need to take a stand on it.

Asw. Hunter stated that we probably will need that sponsorship and discussion after what we heard today.

Rep. Ferguson stated that I want to reiterate what Sen. Rapert said – my understanding from my discussion in AR is that the coupons were given primarily for drugs that doctors already had the patients on they weren't encouraging the use of higher cost dugs and they are not required to get the drug if its not already on the dug formulary. I think this is worth looking at for model legislation and AR had a pretty good bill.

Asw. Hunter stated that we will continue this discussion in some fashion in July and Sen. Rapert will reach out to Committee members about potential sponsorship as well.

CONSIDERATION OF RE-ADOPTION OF MODEL LAW

Asw. Hunter stated that per NCOIL bylaws, all NCOIL Model laws must be considered for re-adoption every 5 years or else they sunset. The Model law scheduled for re-adoption starts on page 322 in your binders - the Employer Sponsored Group Disability Income Protection Model Act (Originally Adopted November 2016). Some amendments may be made to the Model after this meeting so the Motion to re-adopt, if agreed to by the Committee, will be to readopt until the Summer Meeting, not the full five years. Upon a Motion made by Rep. Anderson and seconded by Asm. Cooley, the Committee voted without objection by way of a voice vote to re-adopt the Model until the Summer meeting in July.

ADJOURNMENT

Hearing no further business, upon a motion made by Asm. Cooley and seconded by Rep. Anderson, the Committee adjourned at 3:00 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
BUSINESS PLANNING COMMITTEE AND EXECUTIVE COMMITTEE
NCOIL SPRING MEETING – CHARLESTON, SC
APRIL 18, 2021
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Business Planning Committee and Executive Committee met at the Francis Marion Hotel on Sunday April 18, 2021 at 10:30AM (EST)

NCOIL President, Rep. Matt Lehman, IN, Chair of the Committees, presided.

Other members of the Committees present (* indicates virtual attendance via Zoom)

Rep. Deborah Ferguson (AR)*
Sen. Jason Rapert (AR)
Asm. Ken Cooley (CA)*
Rep. Joe Fischer (KY)*
Rep. Edmond Jordan (LA)*
Sen. Paul Utke (MN)*
Asm. Kevin Cahill (NY)*
Sen. Bob Hackett (OH)
Sen. Ronnie Cromer (SC)
Rep. Jim Dunnigan (UT)
Del. Steve Westfall (WV)

Other Legislators Present were:

Sen. Mathew Pitsch (AR)
Rep. Brenda Carter (MI)
Sen. Paul Weiland (MO)
Rep. Forrest Bennett (OK)
Rep. Carl Anderson (SC)

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, General Counsel, NCOIL
Tess Badenhausen, Assistant Director of Administration, NCOIL Support Services

QUORUM

Upon a motion made by Sen. Jason Rapert (AR), NCOIL Immediate Past President, and seconded by Rep. Joe Fischer (KY), NCOIL Secretary, the Committee waived the quorum requirement without objection by way of a voice vote.

MINUTES

Upon a motion made by Asm. Ken Cooley (CA), NCOIL Vice President, and seconded by Asm. Kevin Cahill (NY), NCOIL Treasurer, the Committee voted without objection by way of a voice vote to approve the minutes of the December 12, 2020 Committee Meeting minutes.

FUTURE MEETING LOCATIONS

The Hon. Tom Considine, NCOIL CEO, stated that the 2021 Summer Meeting as it currently stands is scheduled for July in Boston, MA, but with current COVID rules and restrictions, Boston may not be able to hold the meeting. NCOIL staff told Boston that they need to let NCOIL know by May 1 ideally, but certainly no later than May 15 if it is possible to hold the meeting there. NCOIL is currently in discussion with Newport, RI as a fallback location, the reasoning being that it is close enough to Boston if anyone made travel arrangements in advance.

For the remainder of 2021 meetings, the Annual Meeting is in Scottsdale, AZ in November. Since the last meeting in December, NCOIL has signed a contract with the Westin in San Diego, CA for the 2023 Spring Meeting. Also, in 2025, the NAIC has taken the traditional week of the NCOIL Annual Meeting, which usually ends the Saturday before Thanksgiving. During a meeting Rep. Lehman had with NAIC leadership, he said that NCOIL cannot meet in December because too many people miss the pre-filing deadlines in their state, so NCOIL will meet the week prior to the typical week with the 2025 Annual Meeting falling on November 12-15, 2025. Also, based on that the NCOIL Annual 2026 and 2027 meetings will be booked during the traditional dates so we can lock those down.

ADMINISTRATION

Cmsr. Considine noted that there were 281 registrants for the Spring Meeting: 145 in-person and 134 virtual. Cmsr. Considine noted that it has crossed the point where there are more people attending in-person than over Zoom. There were 51 legislators from 23 states: 39 in-person and 12 virtual. There were 12 first-time legislators. There were eight commissioners (or equivalent): six in-person and two virtual. Fourteen insurance departments were represented. The turnout for the Spring Meeting for total number of attendees and legislators is the highest NCOIL has recorded since the start of electronic registration (January 2016).

Rep. Lehman remarked that it was great to see 51 legislators from 23 states. To see 23 states involved is really an attribute to where NCOIL is heading.

Cmsr. Considine gave the 2021 unaudited financial report through March 31, 2021, showing a revenue of $368,681.23 and expenses of $242,722.13 for an excess of $125,959.10 heading into this meeting. Cmsr. Considine did remark that NCOIL will receive revenue from the spring meeting soon after it concludes, and that NCOIL still needs to pay expenses from the meeting but all things considered the year thus far has been financially strong for NCOIL.

Cmsr. Considine continued that invoices for dues have been sent out and that collection is similar to where we were last year at this time. Cmsr. Considine thanked all states that have paid dues so far, and noted NCOIL is optimistic that it will have a solid year of dues collection. The budget committee, Chaired by NY Asm. Kevin Cahill, NCOIL Treasurer, has advised NCOIL to be a little less lenient with states who claim that they do not have room in the budget for dues since we had conversations with officials last year about that. Accordingly, NCOIL may need to reach out to legislators to ask for help with dues payments.

Rep. Lehman remarked that based on the new dues system and stipend program, there has been an increase in first time legislators. Seeing the amount of first time and returning legislators illustrates that the revised dues system and stipend program was the right step to take.

CONSENT CALENDAR

Rep. Lehman noted that the consent calendar includes committee reports including resolutions and model laws adopted and re-adopted therein, as well as ratification of decisions made and actions taken by the NCOIL Officers in the time between Executive Committee meetings.

The consent calendar included:

The Life Insurance & Financial Planning Committee re-adopted the Beneficiaries' Bill of Rights, the Life Insurance Consumer Disclosure Model Act and the Long Term Care Tax Credit Model Act. The Committee also adopted a Resolution in Support of the Living Donor Protection Act.

The Health Insurance & Long Term Care Issues Committee re-adopted (until the Summer Meeting) the Employer Sponsored Group Disability Income Protection Model Act.

The Financial Services & Multi Lines Issues Committee adopted the Insurer Division Model Act.

The Property & Casualty Insurance Committee: adopted the Distracted Driving Model Act; adopted amendments to the NCOIL Post Assessment Property & Liability Insurance Guaranty Assessment Model Act; and adopted amendments to the NCOIL Peer-to-Peer Car Sharing Program Model Act. Additionally, the NCOIL COVID-19 Limited Immunity Model Act was also adopted during an interim Zoom meeting of the Committee on 2/19/21.

The Special Committee on Race in Insurance Underwriting adopted amendments to the P&C Insurance Modernization Model Act defining "proxy discrimination" during an interim Zoom meeting of the Committee on 3/5/21.

Rep. Lehman asked if any Committee member wanted anything removed from the consent calendar. Hearing no such requests, upon a Motion made by Asm. Cooley and seconded by Rep. Fischer, the Committee voted to adopt the consent calendar without objection by way of a voice vote.

OTHER SESSIONS

Rep. Lehman began by thanking South Carolina Lieutenant Governor Pamela Evette for delivering the Keynote Address.

Rep. Lehman also thanked Robert P. Hartwig, Ph.D., CPCU – Clinical Associate Professor in the Finance Department and Director of the Center for Risk and Uncertainty Management at the University of South Carolina's Darla Moore School of Business, who

during the legislator luncheon, delivered a presentation titled “COVID-19: One Year Later.”

There were two interesting and timely General Sessions – “The Future of Long Term Care Industry in Light of COVID-19” and “Mandatory Police Liability and its Impact on Safety.”

On Thursday, the Special Committee on Race in Insurance Underwriting met for the third time. Rep. Lehman thanked Sen. Breslin for continuing to do a great job in Chairing the Committee.

Rep. Lehman also noted that he saw a lot of people conversing with everyone during networking breaks, particularly with regulators from so many different states. and it was great to see that.

Cmsr. Considine added that since the Keynote Address needed to be moved to accommodate the Lieutenant Governor’s schedule, many people who signed up for the lunch instead went out for lunch downtown which left a lot of lunches unaccounted for. Cmsr. Considine thanked SC Rep. Carl Anderson, who arranged to take the leftover lunches to the Baker Family Donation Center so that the lunches did not go to waste and were instead given to people who needed it.

OTHER BUSINESS

Pursuant to NCOIL 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 member of the Executive Committee at his or her first meeting – such person must attend the meeting of the Executive Committee to qualify for such membership status. Accordingly, Rep. Lehman welcomed AR Sen. Mathew Pitsch, who Chairs the Senate Insurance and Commerce Committee in Arkansas, as an NCOIL Executive Committee member.

Rep. Lehman then turned it over to Sen. Rapert. Sen. Rapert began by stating that one of the proudest traditions of NCOIL is bipartisanship. Sen. Rapert nominated MI Rep. Brenda Carter as an NCOIL Executive Committee member. Sen. Rapert noted that Rep. Carter is the Minority Party Vice-Chair of the House Insurance Committee in Michigan. Rep. Carter is the first woman elected to represent House District 29 in Michigan. She has a long legislative history before entering the state legislature and her husband is actually a city council pro tem. One of the strongest features of NCOIL is that most time you don’t even know the political party of people that are at the meetings since people are so focused on the policy and the legislation. The motion was seconded by Sen. Ronnie Cromer (SC), and passed without objection by way of a voice vote. Rep. Lehman stated to Rep. Carter that it has been great to see her consistently attend NCOIL meetings and that he looks forward to seeing her at meetings going forward.

Rep. Lehman then introduced Teresa Casey, who on behalf of the Industry Education Council (IEC) offered a suggested topic from for discussion at upcoming NCOIL meetings. Ms. Casey introduced a topic from Scott Zajic of SafeLite. It is a consumer protection topic relating to upward pressures on premiums resulting from safety features advancing in auto glass and other automobile safety elements. Ms. Casey noted that the IEC has submitted the topic more in detail in writing to NCOIL. The IEC is finding

some bad behavior resulting from lack of understanding on the part of consumers for what needs to happen with particular kinds of recalibrations and other aspects on what had traditionally been simple repairs that have gotten more complicated. The IEC thinks that the time is right for NCOIL to take a look and get some education on this subject.

Rep. Lehman added for those that were at the breakfast on Friday morning, it was his honor to give the Regulatory Leadership award to South Carolina Director and NAIC Immediate Past President Ray Farmer. Director Farmer has done a great job leading the NAIC, and NCOIL is looking forward to continuing to work with the NAIC and Dir. Farmer.

ADJOURNMENT

There being no further business, upon a motion made by Sen. Bob Hackett (OH) and seconded by Sen. Cromer, the Committee adjourned at 11:30AM.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
SPECIAL COMMITTEE ON RACE IN INSURANCE UNDERWRITING
CHARLESTON, SOUTH CAROLINA
APRIL 15, 2021
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Special Committee on Race in Insurance Underwriting met at the Francis Marion Hotel on Thursday, April 15, 2021 at 2:30 P.M. (EST)

Senator Neil Breslin of New York, Chair of the Committee, presided*.

Other members of the Committee present were (* indicates virtual attendance via Zoom):

Rep. Joe Fischer (KY)
Rep. Bart Rowland (KY)
Rep. Edmond Jordan (LA)*
Asm. Kevin Cahill (NY)*
Asw. Pam Hunter *NY)*
Sen. Bob Hackett (OH)

Other legislators present were:

Rep. Terri Austin (IN)
Rep. Jim Gooch (KY)*
Sen. Stewart Cathey (LA)
Sen. Kirk Talbot (LA)
Sen. Lana Theis (MI)*
Rep. Wendi Thomas (PA)*
Sen. Roger Picard (RI)
Rep. Carl Anderson (SC)
Rep. Kevin Hardee SC)

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Tess Badenhausen, Assistant Director of Administration, NCOIL Support Services, LLC

INTRODUCTORY REMARKS

Sen. Breslin stated that he wished he was there in Charleston but given the very stressful budget process in New York along with several other issues he just could not make it. Sen. Breslin then stated that he would just like to say a few words about the Committee, the agenda, and the format for today's meeting. First, Representative Matt Lehman (IN), NCOIL President, is unfortunately unable to join us today, but he should be commended for his work in deciding to form this Committee. We go way back in NCOIL history. We disagree in some politics but I recognize him as a bright and capable legislator and committee charr at NCOIL and I am happy to see him as president and I would be remiss if I didn't mention Asm. Kevin Cahill (NY), NCOIL Treasurer, who has been a terrific NY legislator and is on his way to becoming NCOIL president.

I think we had a great session in December but its incomplete and hopefully with the number of distinguished speakers today we shouldn't have a problem with competing our task after which hopefully the committee can later quickly arrive at some conclusions and recommendations. I'd be remiss if didn't mention that there is now federal legislation trying to I think improperly intrude on our responsibilities as a sate based operation and

as you know over the years it generally pops up that of federal government saying they are going to stick their head in here. Relative to toady we'll hear from speakers, then open up for questions, then break, than hear from more speakers followed by a committee discussion. As many of you know when I am a Chair of a committee I tend to not be involved in discussion as it moves it along quicker and we can finish on time.

David Eckles, Ph.D. Risk Management and Insurance Program Professor at the University of Georgia's Terry College of Business, stated that this is a very important issue and I appreciate the opportunity to lend a voice in a table setting role. When I was asked to set the table I came at it from two perspectives – one from your perspective of what is the usual ratemaking concern of legislators and regulators and these are all things you've seen before that premiums should not be excessive and they should be adequate to cover losses and most importantly for this discussion they should not be unfairly discriminatory. From an economist perspective which is where I come from we think about the same things but we think about covering speculative losses and the costs associated with them and buffering what we might need for rainy days and of course for stock companies with a profit motive, profit. And in theory if we have a really competitive market that should drive out discrimination as it should take care of itself but of course that's a bit naive and that's why we have you guys and discussions about this.

Where does discrimination come into ratemaking. In broad strokes, ratemaking in some ways is inherently discriminatory. Insurers go out and try to figure out what are the factors that are related to either the frequency of a loss or severity of loss and try to identify them and they can be your age, the kind of car you drive, where you live and those sort of things. Some of these factors may indeed create what's called a disparate impact and I think a really good example is for older individuals. It's pretty clear that the older you get the more likely it is that you are going to die, unfortunately, so you have to pay more for life insurance if you want a life insurance product but of course that creates a disparate impact for the elderly or for how you want to define old age. So while this is unfortunate it is not discriminatory in a malicious way it's just sort of a necessary outcome of the product that life insurers are selling. From a regulatory perspective, you have to sort of balance these real factors with those that are discriminatory so that's sort of the rub when you try to sperate disparate impact versus discrimination or proxy discrimination.

I think its important to point out that these are not synonymous at least in my mind. Disparate impact is a situation that results in a disproportionate effect, a negative effect, against a protected class while proxy discrimination might start off the same as there still might be a disproportionate negative impact but there also is a very important second part to this which is that the factor that is identified in the case of an insurer is intentionally used as a substitute for the protected class so it's not being used to appropriately price insurance but rather to specifically and intentionally discriminate against a protected class. As you can imagine one of these is easy to figure out while the other is not so it's pretty easy to see the result of disparate impact and the first half of proxy discrimination as is there an impact on a protected class and if we go back to the life insurance example yes older people are going to pay higher premiums. The question then is the rating factor being used to intentionally discriminate against in this case the elderly. This is very difficult to prove and in that way its an unenviable task.

When it comes to your role or the role of legislators and regulators working together, its important to remember a couple of things. One is that while disparate impact may exist

you can solve that through legislation saying you can or cannot use certain rating factors which is a relatively easy solution. Proxy discrimination is something you can consider already under your purview and when we started this discussion one of the things and goals of regulators working in tandem is to work on unfair discrimination and that would be proxy discrimination so in some ways this is something that is already done or at least is intended to be done but is often time consuming and until recently the idea of proxy discrimination was undefined. That's what the NCOIL recent definition is intended to do is to provide a definition of proxy discrimination. That concludes my comments but I'll leave you with a reminder that proxy discrimination and disparate impact are not the same thing and its important not to equate the two and disparate impact is an unfortunate consequence but it can be solved through the legislative and regulatory process and proxy discrimination is unfortunate and not good but is harder to figure out and is already sort of under the purview of legislation and regulators.

Peter Kochenburger, Executive Director, Insurance Law LL.M. Program; Deputy Director, Insurance Law Center; Associate Clinical Law Professor at the University of Connecticut Law School, stated that the topic I have is one aspect in part of disparate impact analysis and unfair discrimination and what that might mean but it's also discrete from that as well and we know a few things. One is that it's been used for a long time. Two is that this info is increasingly available as jurisdictions, local and state, making the information public in a legal sense. Third is related to what we've been talking about for years with big data and predictive analytics is that it can be used and is used in more sophisticated ways that many of us are not sure how. These are some of the examples of companies, such as LexisNexis and Transunion which are very familiar to us and I don't pretend to have an exhaustive list in my field or here as its somewhat surprisingly difficult to get a sense of how criminal history is being used. Professors don't have subpoena powers which is probably a blessing for the rest of the world but is frustrating for us.

There are two issues to focus on. One is whether the information is being used accurately in other words at a fundamental level is the criminal record accurate – is it a mistake or is it someone else. But more important for our purposes is that criminal history is not static and it changes and how are those changes captured in an underwriting or claim model if at all. And then the second major issue is should criminal history records be used at all, with some narrow exceptions, given some of the problems we'll talk about but also given the rise in other risk factors we hear about all the time in the increasing number of risk classifications and the use of non claims data and non-underwriting data and social media and shopping habits to create a predictive risk model and given this would there be any measurable loss if we stopped using criminal history.

For the first it's a discreet issue to consider before going to the larger issue and that is arrest and conviction records are not static. With an arrest record charges could be dropped or the defendant could be acquitted or even if there is a conviction while it varies by state as states have a variety of ways in which a record could be sealed, a juvenile record for example if its ever even open but also for accelerated rehabilitation often for minor crimes and drug offenses in which that record is considered by law no longer to exist except for some limited purposes which do not include as far as I know insurance underwiring. Here is a diagram that hopefully illustrates this and that is the search engine finds a criminal record and it doesn't have to be a conviction it can be an arrest. Then the person pleads guilty but the nature of the offense is such that the person is given a fresh start and the record is sealed or expunged depending on the

state and cannot be used. It was an accurate record in the beginning but became unusable in theory and law but perhaps not in practice once there's a fresh start or substitute for fresh start once the fact that if the person is acquitted or the charges are dropped. But what happens then when there is a fresh start or the record is sealed – will the protocol in the search engine detect the absence of a criminal record and modify my profile so in the beginning I have many negative things going on and presumably I would be charged higher for insurance but now the record is sealed and the idea of a fresh start is that it doesn't affect me anymore. Does the initial criminal arrest simply exist for the rest of my life to be used in model after model? If in fact the model that captured it or models because there's more than one changed and does it make a difference and of course it does because increasingly we know the effects of a criminal record on employment and education and income and other areas so it matters how a record is used and do we know how they are being used and by we it's not so important that I know its important the individual knows but its really important that insurance state regulators and legislators know how this information is being used because otherwise the use of the information operates out of not an evil intent but in darkness and that's increasingly a problem.

The bigger issue is should the criminal history be used at all and we know a couple of things. One is that the criminal justice system in the U.S. from the police all the way through the prosecutors and defense and prison system and parole system – we have a very harsh system compared to many other areas in the world in terms of the numbers of people incarcerated. So we have the fact that criminal history data may be being used more often and may be being used in perpetuity that our system overall generates a significant amount of arrests and convictions and imprisonment along with the fact that we also know that there is a disproportionate effect on different groups particularly by race but not exclusively. Quickly some background information, over 10 million people were arrested in 2019 according to the FBI however some people were arrested more than once so the number could be lower but this is one year and each year the numbers have been roughly similar and have been as low as 7-8 million up to 11-12 million but the point is that and this is an estimate which I think is extraordinary one third of adult Americans overall in the U.S. have a criminal record which can be an arrest or conviction. The point there does includes infractions, traffic offenses and other violations normally it would be who cares and typically we don't care that much after we pay the fine but these things are also being caught in search engines and being utilized presumably not as serious as a felony but being utilized in risk classification and the disparities are not only in arrest but also in these minor infractions.

The U.S. is far above any other country in terms of prison population including China, Brazil, Russia and India and with due respect to those countries they are not countries I don't think we would want to model our criminal justice system off of and yet we imprison more and there are problems with all of these numbers in terms of reporting but nevertheless they are stark. As of last week, the federal prison population has African Americans more than double or triple any other race. To think about this again, this is a problem not simply because there is disproportionate police or a criminal justice system that disproportionally arrests and incarcerates African Americans – that is a significant problem but its also a problem for all of us with the fact so many Americans are estimated to have a criminal record. We also know points about the disparate nature of criminal record history. Nothing can be neutral police record and court actions and judicial actions can and often are even if not intentionally are biased and disproportionately affect the poor and African Americans and other people of color and

this is something that is not new to our country and more importantly has become more apparent. In 2020, systemic racism issues became clear as shown by the death of George Floyd and the trial continues. The following quote from the CDC illustrates that the effects are beyond periods of incarceration and beyond insurance and employment to reach significant health effects – “Unfortunately, discrimination exists in systems meant to protect wellbeing or health. Examples of such systems include health care, housing, education, criminal justice, and finance. Discrimination, which includes racism, can lead to chronic and toxic stress and shapes social and economic factors that put some people from racial and ethnic minority groups at increased risk for COVID-19.”

There is also a question of what the insurance sector which includes legislators, regulators, brokers, agents, 3rd party administrators academics, what is the responsibility. We cant solvethe underlying problems and nor should we be paralyzed as some from industry have suggested recently that we should study everything so we understand it. But we can do something to first of all understand exactly how criminal history information is being used and then restrict the use to only those areas where its absolutely necessary or where the nature of the criminal conviction is specific to the type of risk being underwritten such as convictions for insurance fraud as nothing is absolute and I don’t suggest this should be. One area can be legislators evaluate and then limit or eliminate specific instances of how criminal record history can be used. In other words a prescriptive approach and that may be necessary or appropriate but I have a more limited goal and that is to work with the industry and given these facts we’ve talked about to see if industry would voluntarily suspend use of criminal history data for several years in personal lines both so that the issue could be studied without potentially further harm occurring and also to see what effect on markets doe it have. I suspect and I’m not an actuary that it would have very little given the other risk factors we have but the value of doing so is significant.

Julia Angwin, Editor-in-Chief of The Markup, stated that I will mostly be talking about the coverage I have done of race and insurance underwiring. I’m at a nonprofit called The Markup but the work I’m going to be talking about was something I did when I was at ProPublica a few years back and it was a study of insurance pricing and the fact that it varies by zip code and there have been a lot of anecdotal concerns for years that minority zip codes were charged more so the same safe driver in a minority zip code would have a higher insurance premium and the question was that justified by risk and that had not been answered as far as I knew. It had long been observed that there were these differences and that it had impacted primarily communities of color so I decided to see if we could figure out whether these price differences were truly justified by risk. We went and got quotes by zip code for multiple insurance companies by zip code and bought them from a company quadrant along with partners at Consumers Reports and we used those quotes and compared them to the risk data that we could find. We filed public record requests in all 50 states for liability payouts per zip code. Only four states gave us that data while all the other states said they didn’t keep that data and so we were able to do the analysis for CA, MO, IL, and TX. And then we compared what the payouts were per zip code and what the premiums were per zip code to see whether there were disparities and we did this for one specific profile to make sure it was consistent so it was a 30 year old female teacher with a bachelor’s degree. We looked at those policies from various insurers in all of these different jurisdictions and we came up with charts that showed the ratio of the prediction in minority neighborhoods versus non minority neighborhoods so when you see something that’s over 1.2 we consider that

basically a 20% difference between minority and non minority neighborhoods and those are what we thought was worth looking at.

We charted them for each and every company per state so it was a lot of charts but what you can see is that most looked like the payouts on the x axis so that's how much insurers were paying out per zip code and the premiums were on the y axis and what you see is a pretty straight comparison of the minority neighborhoods in red of a pretty linear progression of whereas payouts go up premiums go up so that's something you would expect to see but what you don't expect to see is what we saw in the whiter neighborhoods which is the premiums declined in the higher payout areas so even though payouts were higher for some reason premiums went down toward that far end of the range and that was pretty consistent throughout all of the places where we saw disparities that there was this strange decline in the whiter neighborhoods. We published all of our data and you can see all of that on the ProPublica link.

This isn't just a theoretical issue so I went to Chicago and did some reporting about how this affects a regular person. Otis was paying $190 per month for Geico and had no accidents completely safe driver but he lived on the west side of Chicago which is a heavily black neighborhood and his rates were much higher than Ryan who lives across town who lived near Wrigley park and had an accident and he was paying $55 which was surprising and also Geico. When I looked deeper into their rates you could actually see that the property damage base rate was the difference and for Otis' zip code the base rate was $753 a year for the premiums and in Ryan's neighborhood the base rate was $376 so that was a huge disparity but actually the difference in payouts was completely minimal a $12 difference over three years in those two areas so that's sort of the difference in risk that was unexaminable with consistently penalizing minority neighborhoods so those are the findings we had in that story which I think raised the question of whether the use of zip code really was justified because it seems like its actually pricing in something other than true risk and it seems like its being used to identify minority neighborhoods and penalize them in many cases.

As you may or may not know CA did require insurers to adjust rates after that story came out. I'm not sure if there has been other action in the other states. After leaving ProPublica I started The Markup and we cover the impact of tech on society and the first story we launched was also an analysis of insurance. We looked at Allstate's algorithm which is called a retention model which attempts to price in whether people are more likely to switch to another insurer so they add a retention factor at the end of their analysis and we found a filing in MD where they actually described how the retention model would impact every single rate payer in the state and we were able to reverse engineer the algorithm and we showed via decision tree that it was a very interesting algorithm and it actually looked at how much you were paying so if you were paying $1,900 or more they assumed that you were indifferent to price and gave you a much higher increase and if you were paying less they assumed you were price conscious and didn't give you as much and the reason I bring this up in this meeting is because there was a race impact as basically the higher rate increases primarily impacted middle aged people, men and communities that were non white so there are times when there are disparate impacts of other than race I thought it was worth noting that race is one of the factors that was affected when you put together these complex models that basically are not related to peoples actual driving.

Daniel Strigberger, Esq. of Strigberger, Brown, Armstrong, LLP, stated that I am going to talk about interesting developments in Canada with respect to underwriting for auto insurance specifically in using issues such as age and marital status and sex to determine underwriting premiums. Just to give you a little bit of an overview in Canada the human rights law at a federal national level is contained within a document called the charter of rights and freedoms which is a constitutional amendment federally and it went into force in 1982 and basically that charter guarantees human rights and freedoms and the like to all Canadians it doesn't matter what province you are in and the only catch is that its only with respect to involvement or incidents with federal or private agencies and govt's and so on including police departments anything where a federal or provincial law infringes on one's rights then that is dealt with in the charter. At the provincial level and in Ontario specifically human rights is contained in a piece of legislation that is known as the Ontario human rights code and it provides protection to all residents of Ontario and all people in Ontario the right to not be discriminated against based on various protected grounds which include age, ancestry, race, citizenship, family status, marital status, sex and sexual orientation and there are others as well.

Like most pieces of legislation both the charter and Ontario human rights code have exceptions and the one that is contained in the Ontario human rights code deals with reasonable and bona fide grounds for acts of discrimination. To give a quick overview of auto insurance in Canada, some provinces in Canada have a government insurance so there is basically one auto insurance company that provides all the 3rd party liability and any first party benefits of property damage and anybody who has a drivers license or registered vehicle in that province is automatically enrolled into those policies with the one insurer. Those aren't as interesting as the other provinces including Ontario, Alberta and some others basically its private insurers like Allstate and Travelers who are responsible for insurance and when I say responsible I mean those are the companies that sell auto insurance in the provinces. Auto insurance is highly regulated at the provincial level and next to life insurance is probably the most regulated kind of insurance and every company it doesn't matter which company sells in Ontario but it has to sell a standard auto policy basically a one size fits all that's standard across the province and its written by the superintendent of insurance and it has mandatory first party benefits and 3rd party liability limits of a minimum $200,000 and a couple other coverages.

Insurers who are selling these products have their underwriting rating and classification systems approved by their respective regulators and they have to file these underwriting guidelines periodically and insurers usually determine risk classification based on various factors including obviously the type of vehicle being insured, the location of the vehicle and the drivers of vehicles and I'll be focusing on the drivers of vehicles. In Ontario legislation says that no element of a risk classification can use several factors for example an insurer that is classifying its risk and writing a policy cannot determine premiums based on the insureds income, employment history, credit rating and physical or mental health however there is no prohibition against using factors such as age and sex. This takes us to a Supreme Court of Canada decision form 1992 known as Bates and Zurich insurance and what happened was that the insured Mr. Bates was under 25 and a male driver and he was single and he brought a discrimination matter under the Ontario human rights tribunal against Zurich saying he was being discriminated on because he had to pay a higher premium for essentially being under 25, male and not married. He made a comparison to young, single, female drivers, young married male drivers or any driver that was above the age of 25 who was not charged any different

premium just based on those criteria so he alleged that there was a violation of his right to contract with an insurer on equal terms without any discrimination and of the right to equal treatment in the kinds of services that he was trying to obtain.

Interestingly the insurer at all levels of the dispute conceded that their practices were most definitely discriminatory so there was no issue that they weren't discriminating based on age and sex and marital status but they argued that this was one of the exceptions and the code says that there is an exception and that you are allowed to discriminate if its based on reasonable and bona fide grounds so a rate classification system for example which discriminates on the basis of prohibited group characteristics is reasonably necessary to ensure the efficient operation of the insurance system and this is what the insurer was arguing. It went to the tribunal and it held that it was discriminatory and made its way up to two appeal levels and at the Supreme Court of Canada level the court was split as there were seven judges hearing and five agreed with the insurer that it was discriminatory but it was within the exception provided meaning that they were doing what they were doing because there was no other way to basically collect that kind of info and assess risk for the group that they were assessing. A considerable portion of the analysis was devoted to availability of having a practical alternative so for example the court concluded that at the time the claim was brought there were no practical alternatives to rating drivers on these protected ground such as age sex and marital status and recall that the case came up in 1992 but the actual complaint was brought earlier in the mid 1980s. The court said that this did not meant that there would never be practical alternatives and it said that the insurance industry must strive to avoid setting premiums based on these grounds that they are not allowed to and left the door open for some day determining premiums for example male drivers who are under 25 and single.

This was met with a dissent by two judges and those judges held that there was an alternative to using the discriminatory classification system and basically the way they looked at it was that the premiums of drivers over 25 were set according to completely non discriminatory classifications so they held that given that there was this alternative to decide these premiums for over 25 and there was no evidence according to the judges that they could not adopt a similar rating system for people younger than 25 so they held that they didn't agree that there wasn't a practical alternative. So where this takes us now is to 2021 and if there are any kinds of practical alternatives to determine these rate classifications and what we're seeing more and more here is the use of telematics and usage based insurance (UBI) products and so a lot of insurance companies here are starting to offer drivers the ability to take this little black box device that you plug into your car and it measures things like speed, braking response time and other things about driving that they probably don't tell you however its offered to and sold to people as a way to pay lower premiums and basically if you drive better then your premiums will reduce and there is a problem with those little boxes in that they are plugged directly into the car so they don't know who is driving so you could have several drivers in a household and if one driver is a lousy driver while the others are good drivers the insurer wont necessarily know who is driving so it comes with its limits there.

Other insurers are starting to sell applications for smartphones where basically its not tapped into the car per se but it does measure things like speed, location and things like that as well and some of them talk via Bluetooth to other devices you can plug into your car as well so they do talk to each other that way so I think the question is this something insurers can use as a practical alternative to determine premiums for certain

groups who otherwise would have been discriminated by previously. I wrote an article about the Bates case and this issue in 2016 and at the time there were no cases that had revisited that with respect to insurance and now in 2021 that is still the case with respect to insurance however I anticipate that this issue is going to come up again soon because of the fact of with the existence of telematics and technology specifically that there must be ways to really focus on in on drivers for rate classifications as opposed to just collecting everybody into groups.

Asm. Kevin Cahill (NY), NCOIL Treasurer, thanked Sen. Breslin for his effort in leading this charge as these are important issues but I would suggest to the entire body that this is likely not the conclusion of this issue and its something that is ongoing and that was a point that came home to me even more so when Ms. Angwin spoke and it appears that everything that we've experienced to date when actuaries were pencil pushers will be exacerbated and magnified and multiplied in the information age when there is so much more data so that brings me to my question to her - do you believe based upon your analysis that technological innovations of the last several years and the growth of the amount of information available in the past several years will serve to make the premise of discrimination in insurance worse or will it have no effect or will it give us tools to ameliorate it. Ms. Angwin stated that I am really not a policy person so as a journalist who is observing this industry what I would say is that the thing that was so surprising to me is that the if you're trying to measure risk of an accident and whether you're going to have to pay out for an accident a lot of the variables just don't seem like they should be relevant like zip code or if you are likely to shop around for another rate so the inclusion of additional data like that shows discriminatory effects in my reporting and the explosion of big data means that more things like that are going to be included but I would say that algorithms are adjustable and you can adjust them however you want and one things that's really nice about the world of algorithms is that if you want to tune it and remove racial bias you can so it gives you an opportunity to do that. I'm not the person to tell you how that can happen but it can go either way and I do think that its troubling when you see variables in ways that it seems unintentionally discriminatory.

Asm. Cahill stated that brings me to my question to Mr. Strigberger regarding the exclusions written into law – I didn't hear you talk about race did you mention that? Mr. Strigberger stated that with respect to auto insurance regulation in Ontario with respect to risk classification there are no prohibitions against using factors such as age and sex and race as well. However, insurers don't at least I'm not aware of any situation where they have gone that far to use race as a condition. I know that there are some potential allegations that's being done because there are some neighborhoods outside the Toronto area where there are a lot of claims coming in and they are looking at it not from an underwriting perspective but from a claims perspective asking why are we getting so many claims form this town outside of Ontario and it just so happens to be a township with a lot of southeast Asian residents so there have been some rumblings in the news about how to deal with that but no there is no restriction about race.

Asm. Cahill stated that I would probably reach the same conclusion you did that there are no or very few companies that say here is our rate for black people and here is our rate for people of Asian descent and for white people. I think that they might not put that in their rate filing unless the Sackler family decides to lave pharmaceuticals and get into insurance in which case there would be some internal memos that would say that and they wouldn't necessarily put into the rates but what we're talking about here is proxy discrimination and that brings me to your presentation on the categories that were

excluded - were they excluded because they weren't actuarially sound or were they excluded because even though they had an actuarial value or could be perceived as having such public policy mitigates against – is it the latter because my sense is that it is. Mr. Strigberger stated that the overall piece of legislation is the human rights code of Ontario so much of these acts even though they are not excluded form the auto legislation most of these would be discriminatory anyway so the issue in the Supreme Court case was the court saying there were no practical alternatives but also that it fit within this bona fide reasonable exception so the criteria that the auto insurance legislation is explicitly targeting to me it looks a ;lot like its level of income, employment history, education and occupation and credit rating and credit rating was dominating the news recently because the allegation was that if people had a poor credit history then they are more likely to default on premiums and also be more high risk drivers. There seems to be a lot of moving targets here in terms of where this is all going. Asm. Cahill asked if the Canadian law or Ontario law specifically mention intent or is it just a blanket prohibition on discrimination using the factors. Mr. Strigberger stated that there is subjective competent so in the Zurich case they held that the insurer was being discriminatory but it was being done in good faith – they weren't being discriminatory for any malice or anything like that. It was intentionally discriminatory but there was a good faith element to it. If there is evidence that the insurer was doing it because of systemic racism or whatever the case is then they wouldn't get to use the exception. The objective component in the Supreme Court case was based on the use of practical alternatives. So intent plays into it but its not so much if its intentional or not it has more to do with why you were doing it.

Asm. Cahill asked Dr. Eckles in your demonstration in the difference between disparate treatment and proxy discrimination you made the point that was widely discussed at our last meeting about intentionally leaving out willful or negligent or known non willfulness that is things that might be known or things that might be perceived or things that might be of grave risk and some have opined that might equate to proxy discrimination – do you believe there is a need for an affirmative demonstration of intent before a demonstration of proxy discrimination is obtained? Dr. Eckles stated that I think if you are thinking of proxy discrimination as I thank of it as something that in the insurance context that a factor is being used to discriminate I think there is intent so it would be instead of just explicitly having a race you use zip code as an intentional way to get around that race not being allowed and using that as a sort of proxy for race so I think in my mind there would be intent needed. The Committee then took a 10 minute break.

Jim Lynch, Chief Actuary and Senior VP of Research and Education at the Insurance Information Institute (III), thanked NCOIL CEO Cmsr. Tom Considine, Rep. Lehman and the staff at the NCOIL for giving us the opportunity to speak on this important topic. The III commends the efforts at NCOIL to try to understand and address today's topic. Like NCOIL, the entire property/casualty insurance industry – companies, academic researchers, regulators, trade associations – has been focusing on this important issue. It seems clear that all parties sincerely want a more equitable society, and working cooperatively we can find solutions that address the issue of systemic racism while preserving the competitive environment that allows the insurance industry to keep its promises and protect its customers. At the same time it is important that the discussion be based on thorough, fact-based research. There are quite a few of these going on, as I will discuss later. III has been asked today to comment specifically on research conducted under the auspices of Consumer Reports magazine. Consumer Reports has

a well-deserved reputation for rigorous, independent product testing. Unfortunately, in this particular case, its research fell short.

The study, conducted in conjunction with ProPublica in 2017, attempted to be rigorous. It purported to find “substantial disparities in auto insurance prices between majority white and majority nonwhite neighborhoods. These disparities [it continued] were larger than risk levels could explain.” The study, unfortunately, made elemental errors that, once corrected, showed the exact opposite of what ProPublica asserted: auto insurers charge prices that properly reflect the actual risk in majority white and majority nonwhite neighborhoods. There are certain things it is important to know about rating variables: First: They work. They are effective at gauging the likelihood that a customer will be in an accident. Second: Every rating variable has been proved effective through actuarial analysis of actual data. Third: They are filed in advance with state regulators, along with statistical proof of their effectiveness. And they can’t be changed without similar statistical analysis. Fourth: Companies constantly review how effective these factors are. If they don’t work in the real world, they are adjusted or abandoned.

Last but certainly not least: The setting of private-passenger auto insurance rates is a colorblind process. Insurers do not gather information based on race or income, nor do they discriminate against anyone on the basis of race or income. The ProPublica study, published in 2017, alleges that auto insurers systematically price-gouged minority communities and areas with predominantly low-income households. In their words, “some major insurers charge minority neighborhoods as much as 30 percent more than other areas with similar accident costs.” That charge is simply inaccurate. Researchers, regulators and policymakers took the allegations seriously, examined them from different perspectives and in each case concluded that ProPublica got the analysis entirely wrong. ProPublica looked at ZIP code level auto insurance losses in four states where that information is publicly available. Their researchers fit a complicated mathematical model to those losses and compared the model’s predictions of losses to the premium that a hypothetical driver would pay in those ZIP codes. They found “many of the disparities in auto insurance prices between minority and white neighborhoods are wider than differences in risk can explain.” III, like many insurance organizations, were concerned about the charges. If true, they would paint a damning portrait of the entire property/casualty industry.

III hired a highly respected actuarial firm, Pinnacle Actuarial Solutions. Their overview of the ProPublica study found “multiple concerns with the analysis and resulting conclusions.” The most prominent: ProPublica didn’t properly handle ZIP codes in which there wasn’t a lot of data. The branch of mathematics that deals with thin data in insurance is called credibility, and it is part of the standard actuarial curriculum. As far as we can tell, ProPublica did not make this standard actuarial adjustment. It is actually not too hard to determine whether pricing models charge exorbitant amounts in minority neighborhoods. You just need to look at the losses incurred and the premiums earned in those neighborhoods and compare them with the losses incurred and the premiums earned elsewhere. The metric to do this – and I think many of you will recognize it – is the loss ratio, which is losses divided by premiums. If ProPublica were correct, minority neighborhoods would have loss ratios substantially lower than other neighborhoods. People buying insurance there would receive less back in loss payments per dollar spent than would those in other areas. Lower loss ratios in minority neighborhoods would be evidence of unfair discrimination. Let’s see what that simple, powerful analysis shows.

Here, an insurance trade group used the same loss data ProPublica got, and the actual premium data that corresponded with those losses, which it got from state regulators.

This shows Chicago and the rest of Illinois separately because ProPublica focused on the state this way, and the two areas are quite different, in both demographics and traffic patterns. In both cases, the loss ratios are quite close. On the left, minority neighborhoods posted a loss ratio of 55 percent, meaning that for every dollar of premium policyholders paid, 55 cents was used to cover claims. That's slightly more than happened in other neighborhoods, where 53.8 cents of every premium dollar was used to pay claims. So in Chicago, people in minority neighborhoods actually got a slightly better deal since they received slightly more of their premium back to handle claims, though the difference is pretty small and likely due to chance. In the rest of Illinois, the situation is similar. Minority neighborhoods posted a loss ratio of 57.2 percent, just a little less than other neighborhoods. Again, the results are close. There is nothing approaching the level of overcharging that ProPublica's analysis implies. In fact there is no evidence of overcharging. Slide three shows results in two other states where ProPublica found discrepancies, and again you can see that when you look at real data, there is no evidence suggesting any accusations of rate disparities that ProPublica alleged. ProPublica got the analysis entirely wrong.

The state of Missouri did its own, more comprehensive analysis and concluded that "No evidence was found that would indicate that higher rated territories are charged more relative to risk than lower-rated territories," adding in a footnote, "ProPublica got the analysis entirely wrong." Remember a few moments ago, I pointed out that the biggest mistake ProPublica made was failing to make standard actuarial adjustments to the data. What would happen if you used ProPublica's methods, but adjusted them appropriately? California regulators actually did this. They used ProPublica's modeling to look for discrimination in individual rate filings, but they made the appropriate actuarial adjustments. California classifies neighborhoods as underserved and non-underserved, but those terms align closely with minority and other neighborhoods. Slide 5 shows the result of that. These are two examples from actual filings from actual insurance companies and I took our the name of the companies but in the first, the underserved are charged 25% more than the non underserved they also experienced losses 40% more than the non-underserved and in the other example all of the underserved are charged 25% more than the no underserved the underserved experienced losses 27% more than the non underserved. In both cases, using actual data from actual filings, the Department of Insurance found that the areas in question paid considerably more for insurance – but that they also had considerably more expensive claim costs. This was consistent with the loss ratio analysis in Illinois, Missouri and Texas that we just looked at. It was consistent with what Missouri regulators found. The groups that pay higher insurance bills are higher risks to the insurance company. That's the way insurance is supposed to be. And it's another way of saying that ProPublica got the analysis entirely wrong.

The growing awareness of historical injustices make these unprecedented times. As the insurance industry, along with the rest of America's business and governmental institutions, examines past injustices and appropriate remedies, it makes sense to incorporate high quality, relevant research. Committees of both the Casualty Actuarial Society and the American Academy of Actuaries that are examining the matter. The NAIC is conducting research. The Insurance Research Council, which recently began a closer relationship with III, is looking into the impact of insurance credit scores and race.

I'm sure that we all welcome such sober efforts in our united quest to create a more just society. At III, we would strongly recommend any insurance policymakers or regulators look to research from organizations that have a credible, long-term commitment to understanding and improving the insurance industry. We would recommend you avoid overemphasizing the work of those who, though well-meaning, lack the grounding in property/casualty actuarial techniques, and therefore can reach incorrect conclusions that could have far-reaching, detrimental impacts. Thank you again for allowing me the opportunity to speak today. I welcome any questions you might have.

Tom Karol, General Counsel – Federal at the National Association of Mutual Insurance Companies (NAMIC), stated that I've been asked to speak about the standards for disparate impact that have been set up by Supreme Court and how they may impact state laws. Ill attempted to be neutral and educate and not and advocate but in fairness I must disclose that I have been NAMIC's lead lawyer in challenging some federal gov't disparate impact rules for several years. The lead case to talk about is community affairs Texas Dept. of Housing and Community Affairs v. Inclusive Communities Project, Inc., 576 U.S. 519 (2015). There were earlier cases and several Supreme Court challenges regarding disparate impact but Communities was the one case that finally made it to the Supreme Court to deal with some of the clear issues. I must make clear that Communities didn't involve insurance directly but did provide specific legal standards and performed a legal analysis of disparate impact and it would be prudent for state legislators and regulators to understand and appreciate the Supreme Court analysis and reasoning prior to adopting any disparate impact legislation or regulation.

There was some discussion earlier about disparate impact and disparate treatment. Both have legal definitions for illegal discriminatory practices. In contrast to a disparate treatment case where the plaintiff has to establish that there was a discriminatory intent or motive – the memo that was referred to earlier as well the writing things down – a plaintiff bringing a disparate impact claim must show that there is a disproportionately adverse effect on minorities that is not otherwise justified by a rational basis so disparate impact does not require intent at all and there are other terms that have been used like differential impact and disproportionate impact and others but these are not legal definitions and not a actionable so the import thing to do is focus on disparate impact which does not require intent and disparate treatment which does. The Court in Communities recognized that there was disparate impact that would not subject the practitioner to liability and the Court basically said that disparate impact liability must be limited so that other employers and regulated entities are able to make practical business decisions and choices. It did not go so far as to say there was good disparate impact but it did recognize permissible disparate impact.

The Court reasoned that there were proper limitations on disparate impact liability. It said that its properly limited to avoid serious conditional questions. It cannot be based solely on a basis of statistical disparity. If a population of a protected class is x the fact that the impact has been different than that number doesn't necessarily by itself show disparate impact and the Court warned that without adequate safeguards disparate impact might actually lead to cause race and other protected classes to be considered in a pervasive way and lead to numerical quotas and serious constitutional questions. So its not just the numbers – the numbers are a starting point but numbers alone don't get you to the point of liability. The Court articulated cautionary standards concerning disparate impact and these were specific to the Fair Housing Act (FHA) and Title 7 and presumably other laws that would mandate only the "'removal of artificial, arbitrary, and unnecessary barriers,'"

and not the displacement of valid policies so that basically in order to prevail with a disparate impact case you have to show the practice is artificial and made up and arbitrary and has no basis and is totally unnecessary – fairly high standards to show that basically variations from a numerical equilibrium is not itself a violation as there has to be some disparate impact that is caused by a policy that it is not all rational or necessary. The showing of racial imbalance would not without more establish a prima facie case of disparate impact. The plaintiff must prove a robust causal relationship between a practice, not just one action but existing practice, in any statistical disparity so it's a causal connection you have to tie the action that's being alleged to causing the disparate impact to the disparity and then show that it's not just a one time action but in fact a practice.

Even if these elements are shown a defendant can still prevail by showing that the challenged policy is necessary to achieve a valid interest - kind of an accidental discrimination if you will as a gov't entity or business is doing this and didn't mean to cause the disparity in statistical variations but basically is doing it for a good reason. Once they establish that all of the above is a finding of disparate impact. If the court applying these standards determines its improper disparate impact the next step which is very complex is the remedy. How do you change the policy. You can find the liability but to get rid of the underlying discrimination following the finding that there is disparate impact you have to basically say that there has to be a less discriminatory alternative. Basically either the court or plaintiff has to come up with that and say rather than do what the company or gov't entity is doing they have to do it a different way and indicate how the burden would be less so they have to come up with a replacement less discriminatory policy that could provide the necessary business or gov't functions and still have a less disparate impact. It's very difficult to do and show particularly on the plaintiff side where they may not fully understand the purpose and policy and operations of the existing policy being challenged.

Here is a very brief overview of the requirements that would be required by the Supreme Court – Communities does not explicitly require any state insurance disparate impact law to comply with any provisions stated however its a virtual certainty that if state insurance disparate impact law is enacted and it doesn't comply with Communities it will be subject to litigation challenges and will be challenged in courts so states that ignore Communities in enacting disparate impact laws do so at their own peril.

Mallika Bender, FCAS, MAAA, Co-Chair of the Casualty Actuarial Society (CAS)/Society of Actuaries (SOA) Joint Committee on Inclusion, Equity and Diversion, stated that I was asked to come here today to give a brief overview of CAS' approach to race in insurance pricing and our goal in CAS is to equip actuaries to be able to address some of the issues around race as it relates in particular to insurance pricing. To that end, we've laid out activities in four different areas including leadership, collaboration, education, and research and these areas are internets to the extent that one allows us to do the other and I was going to talk a little more about some of the areas of research we are doing. The efforts that we're looking at in terms of research I would put into two general categories one being a foundational knowledge to equip actuaries for discussions like today around systemic racism really understanding and defining these different terms like bias and fair and unfair discrimination and disparate impact and the implications on insurance because as you've seen there are many different ways and ideas to use those terms in the general public so we want actuaries to have a good understanding of the technical terminology. It's also important to look at the actual historical influence of

systemic bias and racism on the underlying insurance data so how we end up with unbalanced distributions in credit score by race or highly separate zip codes allowing actuaries to understand what's caused those underlying distributions to be unbalanced will help us to understand and develop solutions potentially.

We're also looking into actions taken by other industries including banking and financial services to address the presence of disparate impact or other systemic racism issues and we're looking at analysis of outcomes from actual historical regulations and legislation around the use of specific rating factors in other jurisdictions so for example if a state or province has limited the use of credit or gender like in the EU we'd like to understand what the market outcomes are of those to better understand what might happen in the future. That brings me to some of the forward looking research that we have planned one of those is stress testing rating models for the outcomes if different rating factors were limited or prohibited under legislation or regulation and what changes in positive or negative ways as we might expect that if a rating factor is removed from a plan that other rating factors might pick up that signal so its not going to be cut and dry positive or negative influence there may be a grey area.

We also like to proactively deliver actuarial methods for measuring and quantifying disparate impact with the next step being to understand what potential solutions are out there and could be developed to address this concern. As mentioned earlier there is quite a bit of new technology being used in actual practice and insurance in general like artificial intelligence (AI), telematics and UBI and we are starting to reach what are the positive or negative or neutral impacts in rating that could arise from the uses of those new technologies or shift toward those new technologies. We are looking for collaborators for a lot of the project because as one of the themes discussed today the use of data and the availability of data to conduct these analysis its so important getting the right data and being able to apply actuarial techniques so we're looking for collaborators and different sources of data to conduct this research in the coming months and years and we're looking forward to having more to report and share as we delve into this further. I should also say that the CAS is also not a public policy organization so we're not producing this to necessarily influence public policy but more to educate our members so they can be active participants in the work ongoing in the industry.

On behalf of the American Council of Life Insurers (ACLI), Andy Kramer, VP and Chief Underwriter at M Financial, sated that I'll be talking today about a basic overview of the life insurance industry and the evolution that has accelerated in the last year because of the pandemic. The objective here is to discuss the different types of insurance for life underwriting and the trends we can expect and when I say life underwriting I'm referring to not just life insurance but also disability and long term care (LTC) so the agenda today will discuss the differences between life insurance and P&C as the typical consumer puts all insurance in the same bucket but there are significant differences between life and P&C but I just want to point some are pretty obvious but they have a big impact about the life underwriting process and then we'll talk about the different types of life insurance underwriting - Guaranteed/simplified issue; Traditional full underwriting; and the late entrance to the game newcomer Accelerated underwriting which has made great strides in the last year because of the pandemic.

For the difference between P&C and life, on the P&C side generally the coverage is required whether it be auto liability required to license the vehicle or homeowners as a

condition of the loan agreement and because of that we have a much lower risk of adverse selection and when I use that term I'm talking about when an insurance company extends coverage to an applicant who's actual risk is far greater than they had expected based on the info that they had or put another way people of a higher risk generally want to purchase more coverage because they can get it at a cost lower than what they think is equitable. On the life insurance side, coverage is optional and that's where you get that potential for increased adverse selection. On the P&C side you can price the risk on a periodic basis whether its 6 or 12 months depending on the risk but with life insurance you only get one chance and there's no change to that rate or price to match the increased risk profile so if you underwrite someone today and they develop cancer or a heart condition you can't change the price as it's a unilateral contract. On the P&C side the loss amount is unknown but the loss event horizon is fixed it's the 12 moth policy period but on the life insurance side the loss amount is known its fixed on the face amount but the loss event horizon is unknown as there are changes in interest rates and all other environmental changes that can occur between now and when the eventual event occurs.

In the P&C world the profitability can be determined pretty quickly as at the end of the year you add up the premiums and subtract losses and expenses and incurred but not reported claims and you have a pretty good estimate of losses or profits but in the life insurance space you've got to estimate all of the future premiums and take the present value of that and estimate all the future losses and take the present value of that so there are a lot of moving parts and its difficult and it takes years to measure the profitability of a book of business to understand if you made the right underwriting decision on the book or not so understandably a lot of the life insurance world there is a lot of hesitancy to move forward and drive change as its probably one of the most least changing industries in the marketplace. Also, investment return is a key driver of profitability because of the long term nature of the business and a key component of the pricing calculation is the interest rates that you are assuming on the investment portfolio that you've taken out to cover all future losses.

As mentioned, underwriting at the time of the application is critical and it's that process of classifying all of the risks by the risk of that person either dying prematurely or becoming disabled or needing LTC. By law we must be able to demonstrate that similar risks are treated in a similar way and its actuarially sound and reasonably anticipates experience. The goal is to have similar risks priced with similar premiums and the key benefit of full underwriting is that it enables insurers to make products widely available and affordable at the lowest possible cost as if it wasn't for underwriting you wouldn't be able to have people protect 10 or 20 years of future income for income protection coverage. For example, in the final expense market sometimes known as burial insurance you have two different types of coverage you have guaranteed which is basically you take all comers if they sign the application you insure them and the only way that the insurance carrier protects their bottom line and risk for mortality is they exclude claims that occur in the first two years where if you die within the first two years it's a refund of premium plus interest. There are generally small face amounts of $1,000 to $50,000 generally there a lot of times used to cover funeral costs and you might see them sold on TV ads as you cannot be turned down and sold in mail flyers in direct to mail campaigns and I did some online shopping using my profile and generally it was about two times more expensive than simplified issue and that's because they don't underwrite they have to take all comers. On the simplified issue its generally accept and reject it's a little bit larger of $5,000 to $200,000 and a small number of health questions

generally two to seven questions identifying and weeding out leading causes of death and they may perform a prescription drug check to try and sniff out any adverse selection or non disclosure and the product is priced with a five year mortality load because that very simplified underwriting cant weed out all the risk but it weeds out quite a bit and generally they cost three times more than full underwriting best class and about two times more than full underwriting standard class.

These are a very important niche in the marketplace and the two product types serve the underinsured population where they just need coverage to cover the final expense so they are not a burden to the loved one when they pass. Finally there is traditional or full underwriting. With full underwriting it uses traditional underwriting data sources and it's a very lengthy process. Generally when you get over a face amount of $500,000 or $1 million it requires a paramedical exam and a lab result and they do a blood and urine analysis and when needed access to medical records and they go to your physician to obtain. They generally underwrite to multiple preferred and standard and maybe 10 substandard classes so it gives you a spectrum to ensure to maximize the best rate for their particular risk attributes. Generally full underwriting can take 30-60 days in the COVID world it's taken longer because it's taken longer to get medical records and exams primarily records because doctor offices have had all hands-on deck in their clinics to serve patients and they didn't have access to people to photocopy records. That brings us to accelerated underwriting and that started about 5/6 years ago where carriers were using alternative data sources and predictive models to identify low risk and clean cases and accelerate through the process so waiving paramedical exams and lab results and not requiring medical records and that reduces the process from weeks to days and it was a huge advantage throughout COVID because applicants were reluctant to have an examiner come to their home as they might have already been in other homes that day and they did want to take a chance or the couldn't get medical records. The accelerated programs with some of the data that I have seen saw a four times increase in volume form March through June and now they have really taken hold and virtually every carrier put resources into developing and improving accelerated underwriting programs.

The source for accelerated underwriting includes electronic sources that you can largely get in a short time as opposed to medical records which takes weeks and you can do a prescription drug check pretty quick in a minute or two and you can get electronic health records as a benefit from the Affordable Care Act as they digitized medical records and they are available quickly and their accurate and its been a huge time saver to have applicants to get coverage quickly. There are medical claims data sources and clinical lab tests that we can access quickly. Some of the industry trends as I see them going forward are that the pandemic has accelerated the change in the industry as I mentioned life insurance has historically been a slow moving industry because you have to be cautious but the pandemic accelerated that change as you had the producers willing to make the change and forced home offices to drive change and force new ways of doing business so it was truly a benefit to the industry. Accelerated programs enabled companies to issue policies when they otherwise couldn't have because customers were leery of medical exams and companies have invested heavily and will continue to do so in accelerated programs as we are seeing changes announced almost monthly now. And we have seen a dramatic increase in customer experience as I mentioned cases are getting placed faster and they can get coverage faster and carriers now with the pandemic they are being really challenged by the low interest rate environment as a lot of investment portfolios are invested in long horizon asset so every carrier is looking for

ways to cut costs so they can maintain the credit and interest rates and keep their policies attractive to consumers so accelerated programs are enabling them to underwrite through low cost channels so its been a big win for carriers. I expect additional evolution in this area with the digital move like this moving away from paper moving toward digital fulfillment and digital policies and digital signatures and it may require some regulatory changes in some areas as some regs are 30 years old and predicated on a paper policy and wet signature so we need to look at that. Finally, historically life insurance unwriting has been focused on the effect on your organs from your lifestyle looking at evidence of end organ damage from the decisions you made over the prior 20 years but what we're realizing is that these lifestyle choices which take years to affect us can be identified fairly early particularly with wearables and cell phones and wellness apps that we use we track diet, exercise, sleep and stress I think we'll see a trend where carriers offer the applicant the option of sharing that info for potentially higher price discount upfront. That gets me excited because I think it will make insurance more affordable to people who take care of themselves and concerned about a healthy lifestyle.

Rick Swedloff, Vice Dean and Professor of Law, Co-Director, Rutgers Center for Risk and Responsibility – Rutgers Law School, stated that I want to start by saying that I very much admire the work that everyone is doing at the committee level as its certainly the case that by defining proxy discrimination it will be highly significant because I understand that legislature are starting to use that term without defining it so that is useful and I think that to the extent that you are trying to identify processes that will certainly help at least in the short tern and prevent the kinds of invidious discrimination that insurance regulators have long sought to eliminate. Let me give my two basic concerns – first is that the definition says that proxy discrimination is the "intentional substitution of a neutral factor for a factor based on race, color, creed, national origin, or sexual orientation for the purpose of discriminating against a consumer to prevent that consumer from obtaining insurance or obtaining a preferred or more advantageous rate due to that consumer's race, color, creed, national origin, or sexual orientation." That is, it's not permissible by the definition to intentionally substitute the neutral factor for one of the prohibited factors I think it's a laudable goal and it may make sense to stamp out that kind of invidious discrimination intentionally discriminating but I have some fear that the definition is too focused in intent as others have said and I have another fear that the definition is wed to a traditional method of underwriting that may be heading to the sunset although others are more qualified as to how long that time horizon may be.

I'll start with a hypothetical or story and we'll talk about what traditional underwriters have historically done. When traditional underwriters are thinking about how to determine what price to give a particular category or group they have to select a factor or group of factors that will correlate with loss. For example an insurer might ask does the age of a house correlate at all with the likelihood that the house will burn down or that the house will suffer greater loss if there is a fire. The insurer can then run some fairly standard regressions that is some statistical techniques and can determine whether its true that the age of housing is related to loss or to higher loss in the case of a fire. If its true then those with older houses may be asked to pay more for insurance than those who are similarly situated but live in newer homes. Imagine that insurers don't have access to info about the age of houses or for some reason the state legislatures have prohibited them from using age of housing in their pricing. In that case insures might look for obvious proxies of the age of a house such as zip code or census track data which one might imagine would correlate to the age of a home. This hypothetical raises the first

concern I have with the new definition – the same data that might be useful for identifying the age of a house could also be highly correlated with a prohibited category. It's not hard to imagine, as Ms. Angwin suggested earlier, that zip code data which can be used to identify the age of a home could also be used to figuring out the racial characteristics of some areas. So if companies are facially using zip code data as a proxy for the age of housings stock can they avoid rate regulation under this definition because they are not using zip code to intentionally substitute for race. This is the difference between prohibiting intentional discrimination and disparate impact. The statute seems solely focused on the former although it's using some confusing language I think and I appreciate what others have done to try and make the difference clear.

I wont belabor this point as others have made some discussion on what is and isn't the value of disparate impact at this moment and I assume that this concern has been more vetted in earlier meeting but its something for the committee to keep an eye one because it may be that simply identifying obvious proxies that have been discussed today by Prof. Kochenburger and Ms. Angwin is less useful because the definition specifically says that companies cannot use those obvious proxies as a substitute for a prohibited category but implies that they could use those obvious proxies for other purposes so that's my first set of concerns. My larger concern deals with how the definition will work in the long run. Insurers are increasingly incorporating AI and machine learning into their underwriting processes. AI in short and again I hope I'm not repeating things that everyone knows but AI in short don't be afraid it's not like the movies and a machine out to kill us it's just a set of techniques employed by computers scientists to help computers solve problems. The most commonly used technique in AI is machine learning which is quite simply an automation of sophisticated statistical techniques. Other AI techniques are less based on traditional statistics and instead based on complicated matching or pattern recognition. Regardless of the particular technique that is used the computers use algorithms to get through data in an iterative and unsupervised fashion. What that means is what they are trying to do is sort through the data to try and find a particular output. To put it in the context of risk classification we've been talking about, an algorithm could search through training data such as all the lessons of particular homeowners insurers to find which bundle of characteristics best correlate with loss. That process is unsupervised and unstructured and what the means is that in contrast to traditional statistical techniques where humans have to have some intuition about a set of characteristics that might correlate with loss the algorithm has no such prior judgments and is simply trying to find the best set of characteristics that match with that loss it is sifting through the data time over time until it can best match a particular set of characteristics to loss.

That set of characteristics can be radically larger than any tridiagonal underwriting set of statistics. Traditional regression analyses are limited to 10-20 characteristics and AI is not so limited it can have hundreds. To be sure, machine data scientists can insist that algorithms don't use a particular characteristic such as race, creed, national origin if that's what the legislature says they cant use. And of course the data scientists could also prohibit the algorithm from using obvious proxies for those characteristics so if you all say you shouldn't use zip code or credit sore or criminal history, all totally viable things that the data scientists could go in and program in and it would not use those. But because AI can use many more factors in its underwriting than traditional statistical underwriting there are new risks that aren't being addressed by the current statute. Specifically, I want to talk about that AI could come up with a bundle of characteristics that are not an obvious proxy but taken together perfectly correlate with a prohibited

characteristic. So its not the kind of obvious proxy discrimination that you are all worried about regarding intent but rather will nonetheless burden the groups that the state statutes have sought to protect form higher prices.

What to do about that problem is really complicated and as Mr. Karol added it is difficult in part because whether we care about those things in part might depend on the line of insurance and the rationale for the burden on those groups so for instance no one is probably particularly concerned that the elderly are going to pay more for life insurance even if we wanted to protect elderly from paying more in homeowners - those are questions that are deep and difficult to answer. But it is the case that I think we are going to have to move away from focusing on intentional discrimination and move more towards thinking about disparate impact. To do that we need to several things and the first is collect more data. Ms. Angwin mentioned along with Ms. Bender that we need to have more data that's more available to more people so that independent third parties can be doing analysis of what the kinds of burdens that are befalling certain groups. Insurers can't be prohibited from collecting this information so some of the restraints on insurers that prevent them from asking questions above race, creed and national origin might need to be loosened so that we get more of that data but in exchange what we need is more sunlight about what kinds of losses different folks are suffering.

Once we have the info we can then have these deep conversations about when we care that people of color might be paying more and I take the III comment at face value that he doesn't believe that they are but let's assume that they might be paying more for different lines of insurance – why? Do we care and is it problematic or not. We could certainly tune algorithms once we have this data to prevent some of this or we could structure regs in a different way so that we limit the spread of different rates. Lastly, I'd like to clarify one thing Mr. Karol said – its course true that disparate impact under the Supreme Court analysis has been limited in a number of ways so that there are lots of defenses for disparate impact and its very difficult for plaintiffs to prove disparate impact but I'm not convinced that states couldn't do more under their own statutes and constitutions to prevent disparate impact for insurance if they so chose so this is a situation where federalism has to come to the fore – how that interacts with Supreme Court doctrine on disparate impact is a very complicated question and is one that has not really been answered. I think that as this committee looks toward future it should look beyond intentional discrimination to look at disparate impact of different rates on different communities.

Asm. Cahill noted to Mr. Lynch that while he demonstrated that as a scientific aspect of actuarial science that there were correlations that could be explained how do you explain something that reflects about a 10% difference in the distinction of the individual versus 100% interest in the premium – if it were 10% versus 20% or 15% versus 18% that might be a different story but what the individual was able to demonstrate was that the study revealed vast differences in premiums. Mr. Lynch stated that the ProPublica study's findings were incorrect. Asm. Cahill stated that he understands that is his impression but the analysis from the study demonstrated a disparity between characteristics and premium of almost 100% so even if there are aspects of it that do not meet the highest actuarial standards how do you explain that vast difference or do you assert that it doesn't exist. Mr. Lynch stated that the premiums are being charged as asserted in my discussion they are rates that insurance companies spend literally thousands and millions of dollars coming up with and making sure they obey the laws in every state and making sure the rating factors have a statistical basis so there are cases where one

person pays a low rate and another individual pays a high rate and without a thorough examination of the individual circumstances of each person and where they live does make a difference because the number of cars per square mile is perhaps the greatest predictor of the probability of being in an accident that exists but there are others that also do a very good job of predicting and when you put them together you can have people who pay vastly different amounts in insurance but those rates are justified and you know that they are because companies through things like adverse selection have a stake in charging the right rate form a marketplace point of view and for a legal and regulatory point of view have to. The individual cases there you would have to look deeply into what the circumstances were and what the rating factors were for them.

Asm. Cahill stated that I understand that in an industry based upon averages its difficult looking at individual cases but Mr. Chairman I want to point out that this really does point to the need to go beyond the current model that's being considered – systemic discrimination means that if everything works discrimination occurs and inappropriate unlawful discrimination is something that clearly I think needs to be further examined and if we limit it to the text of the model we will never get there. Asm. Cahill asked Mr. Karol regarding the application of Communities - this was a gov't agency that was I'll speculate being sued by a private group? Mr. Karol stated it was a FHA case that considered how tax credits for developers who built low income housing units were administered by designated agencies. Asm. Cahill asserted that it should not in any way be construed as something that would limit a state legislatures ability to define what's illegal or inappropriate discrimination and asked if Mr. Karol agreed. Mr. Karol stated that I said from the beginning that it's not an insurance case but it cites other cases that are not directly applicable to the facts and circumstance of that case and basically provides a rule of law that would be looked at by many courts dealing with this complex legal question.

Asm. Cahill noted that Ms. Bender that she stated she had concerns with statements about the flood of data available and someone pointed out the potential inability for a legislative body or gov't body to stay ahead of that data – is that a concern and if so how would you propose that it be viewed or considered? What tools could we use to overcome that massive amount of data that may be beyond our ability to inspect? Ms. Bender stated that we are posed with this challenge as well to understand first all of what data is out there and available and what data we haven't even yet to being collecting as an industry and that is a big challenge which insurers have noted as well that as Mr. Lynch mentioned we don't use race in our rating plans right now which means being able to collect that info to understand what is the true disparate impact or discrimination happening is the first step as we don't have that info to test the theories and its problematic to use other proxies like zip code or credit score to try and predict racial impacts within our data and models as well. There is a big gap there we are trying to understand how to fill.

Asm. Cahill asked Ms. Bender if she would agree with Prof. Swedloff that perhaps we have to revisit our restrictions or maybe even industry practices on data collection in view of the fact that such a significant amount of new data would be available and that it would become more difficult to ascertain what is actually a proxy perhaps more data should be collected, that's part one of the question and the other part is just an assertion that if data is collected I'll suggest that it may be reasonable to have a blind repository for that data that does not abridge proprietary info or put at risk competitive info where it could be examined for future policy. Ms. Bender stated that I won't say what I think the

public policymakers should do but I would say actuaries always welcome the ability to look at more data.

Asm. Cahill stated he was intrigued with Prof. Swedloff's presentation because it really enunciated many of the points that he was concerned with since the beginning but I'd like to focus on the collection of more data and how we do so in a responsible way that doesn't infringe upon ability of companies to continue to compete in an increasingly competitive environment. Prof. Swedloff stated that to be fair I don't have an answer to that question – I'm sure there are ways to provide loss data that then gets aggregated together by commissioners and then is aggregated across multiple insurers so third parties can use in a blind repository more than that I don't have any novel suggestions. Asm. Cahill stated regarding the avalanche of data that is now available someone had talked about the voluntary submission about the way you drive – that's the microanalysis of data that we've addressed in other meetings. If we cannot stay ahead of the factors leading into a determination that might be perceived as a proxy for illegal discrimination might it be appropriate for us to start to simply blanket or prohibit a discriminatory impact and require our insurers to look at that end of the equation instead. I'm asking not as a suggestion for a model law just for your thoughts.

Prof. Swedloff stated that there a lot of issues that you raised for instance if people have telematics devices in their car there are all sorts of questions about who owns that data and privacy issues but that's not what we're here for but what I was asked to talk about today and I'm happy come back and talk about other issue is the risk classification questions. I've written and I think that states individually or collectively are going to have to amp up their ability to understand what's going on with new models with AI models. It's very difficult to peek under the hood of some of the models – it's possible with machine learning models to understand what are the top 5-7 factors that are really driving the price. It's not always possible to understand what's driving the price when there are hundreds of factors. If that's true then the kinds of ratethat have gone on in the past might undermine in ways that would require us to think a little more carefully of using disparate impact as a regulatory tool and to do that would require some very hard thinking about what do we care about and when and that's the work the legislatures will have to engage with.

Asm. Cahill stated regarding the process today we had a member of one panel make a presentation and then we had a person on another panel refute it – in the future I think it would be beneficial for them to be on the same panel so there could be rebuttals. Thank you Mr. Chairman for all of your work and thank you to all speakers for their insights and expertise that we simply cannot possess as legislators.

Sen. Breslin stated that I think all of us have learned something today and we have to now apply it and it's a difficult process and during the past several months we've had a lot of people thinking we were moving in the wrong direction one way or another and I can assure that's not our intention its rather to collect as much information as we can and make recommendations that will positively affect the people who are buying policies. I think we've done a great job to collect a lot of information that will be useful to the committee to come up with some recommendations and we'll hopefully end up with something we all respect. I'm afraid that might be Tantalus reaching for the grapes as its very difficult. I don't think our job is done but I think we've collected a lot of information that can be very useful. I commend the speakers for helping the legislators achieve some degree of knowledge to make the right decisions and that will be done at the same

time that there is so much more information available each day that might have the ability to change our minds and rotate our point of view on an ongoing basis.

Sen. Bob Hackett (OH) stated that some of the frustrations we have as legislators as Prof. Kochenburger talked about the unfairness of looking at criminal records and if you look in republican states we have pressed hard to try and get records erased because we want people to get back to work and even some of the strongest republicans have changed their position because they realize that's important. I believe strongly that insurers use factors very strongly and regarding getting rid of criminal record in underwriting my question is if we are moving toward getting the less serious records moved out or erased and what's left are more serious don't the loss ratios from that underwriting of criminal records pretty much speak for itself that the loss ratio is there and its important to keep that factor in underwriting? But we have moved for example in OH we do things now that we would never have when I first started such as sealing records for people even with first degree felonies because we want to get people back to work and we realize they won't get hired if they have a certain type of criminal record.

What are the insurance companies finding out because it's in the news media all the time but if you talk to judges and law enforcement I still think it's an incredible underwriting principle and we are moving away from the records in trying to people back to work. Mr. Lynch stated that I haven't seen a lot of research about the particular variable that Prof. Kochenburger was talking about and I don't have all the info to what degree it used but as a general question I think tis an interesting and important one to ask – as the analysis of MO and what we saw in IL and TX and CA regulators looked that says that the rates that are being charged are appropriate given the risk profiles of the individuals being charged those rates if you alter that mix depending on which variables you prohibit it could well have an impact and I think that is on rating and that's one of the things that does need to be studied and I think if you think a bit about what makes some of the research Ms. Bender was discussing actually starts to look at that-what is the impact of a variable that's been excised. I've been in the insurance game long enough to know that there has been efforts 30 years ago to place restrictions on the use of territory rating variables and that didn't work out particularly well for the insurance industry or their customers as you had severe availability and affordability problems and I happen to live in NJ which was virtually ground zero for that problem so that can be the extreme impact and it needs to be taken into account when you contemplate these thing and is why you need research and we would recommend its done by organizations that have longstanding ties in the industry like CAS and others.

Prof. Kochenburger stated that I sort of agree with both sides – the efforts to decriminalize both in the sense of erasing criminal records when appropriate as well as making less minor offense criminal those are very important and of course go well beyond the value to insurance underwriting and I also agree that understanding more the effect of criminal records on underwriting and how predictive they are is also pretty important but it gets back to the earlier discussion from Canada in which the Supreme Court said there doesn't seem to be other practical substitutes for the use of gender there – well now we're years later in terms of progress and we're using dozens or hundreds of risk factors and the fact that we might lose one in which we assume its predictive – 1out of 200 what does that mean? It certainly doesn't mean insurer solvency and it may not even effect the risk pool and we make those decisions all the time. Pre-existing conditions are of course highly predictive of cost but we don't allow them for higher principles and say race is predictable for some aspect of insurance we don't allow

that either so there are two points – one is that given the nature of the criminal justice system both in the number of people penalized and how and the fact that there are some many other factors that are increasingly predictive it argues we should study it and even if its actuarially justified is it necessary to get accurate rates.

Sen. Breslin stated that it now appears that the panel discussions are over and asked if there is any further discussion to be had. Hearing none, Sen. Breslin adjourned the meeting.

ADJOURNMENT

Hearing no further business, the Committee adjourned at 5:30 p.m

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National Council of Insurance Legislators (NCOIL)

Trucking and Messenger Courier Industries Workers' Compensation Model Act

Adopted by the NCOIL Executive Committee on March 6, 2011, and the Workers' Compensation Insurance Committee on March 4, 2011. Readopted by NCOIL Executive Committee on July 17, 2016.

To be considered for re-adoption by the Workers' Compensation Insurance Committee on July 15, 2021

Sponsored for discussion by Rep. George Keiser (ND)

Section 1. Purpose

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

Section 2. Definitions

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

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

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

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

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

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

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

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

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

Section 4. Penalties

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

Section 5. Enforcement

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

Section 6. Effective Date

This Act shall take effect immediately.

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International Association of Industrial Accident Boards and Commissions Model Agreement Between Jurisdictions to Govern Coordination of Claims and Coverage[1]
July 29, 2005

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

To be considered for re-adoption during the Workers' Compensation Insurance Committee on July 15, 2021.

Background and Uses

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

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

- For employers, they reduce requirements to purchase insurance coverage in multiple or numerous jurisdictions when an employer sends employees to work for short periods outside the state of hire and normal employment
- For workers, they eliminate any possible questions with regard to the employee's right to obtain workers' compensation benefits from the state of hire and normal employment, usually the home state of the worker with medical providers close to home.

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[1] The special ad hoc committee of the IAIABC that contributed to this draft includes Richard Thomas (Chair of special committee and Kansas WC Division), Pamela Cohen, (WorksafeBC), Reg Gregory (Oregon Dept. of Labor and Industry), Robert Aurbach (Principal, Uncommon Approach), Brandon Miller (consultant). We would also like to thank Tammy Turner (Washington Industrial Commission) and Alan Wickman (Nebraska Insurance Commission) for their insightful comments

- For state WC agencies, they ease the enforcement investigations and sanctions required to maintain the scope of workers' compensation coverage desired.
- For insurers/payers they reduce ambiguity in claims handling by insurance adjusters and minimize the need to deal with duplicate claims and offsets.
- For all parties, they reduce the costs of litigation for benefits when the applicable coverage by two states is ambiguous.

By way of background, it should be understood that most states do allow claims that occur in the course of temporary employment outside of the "home" state of operations to be processed under the laws of the home state where the worker regularly works. However, employers are often exposed to the need to purchase multiple policies (especially when state-specific assigned risk plans are involved), which may result in them paying twice for the same workers' payroll. Disputes and litigation are most likely to arise when the claim is serious (major permanent injury or death) and the indemnity benefits are greatly different between states.

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

- If benefit levels are greatly different between the states, the state with the lower benefit level is constraining access to higher benefits for its workers that may be injured outside the state
- If one state has a much lower workers' compensation insurance rate (especially for mobile employment like construction trades), employers in the low rate state may have a competitive advantage in winning bids as compared to employers in the other party to the agreement (hence the common use of construction exceptions, given below).

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

Model Reciprocal Agreement

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

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

Who Is Affected By This Agreement

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

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

Basic Rule

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

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

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

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

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

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

[Option 1 for determining Temporary employment]

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

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

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

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

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

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

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

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

8. The residence of the worker;

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

10. Other information relevant to the determination.

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

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

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

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

[Additional optional conditions on application of this agreement]

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

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

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

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

Exclusion From The Basic Rule

This Agreement does not apply to any “A” worker of a “B” employer while working in the State of “A” nor to any “B” worker of a “A” employer while working in the State of “B.” It is understood that an employer from either “B” or “A” may have work in the other state where they may have both “B” and “A” workers not on temporary assignment. This circumstance would require the employer to obtain coverage in both states to cover the subject workers of their respective states.

Certificates Of Coverage

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

Effective Date

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

Termination

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

Notice

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

Drafting option:

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

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National Council of Insurance Legislators (NCOIL)

Model State Structured Settlement Protection Act

Supported by the NCOIL Executive Committee on February 27, 2004, July 22, 2006, July 17, 2011 and November 20, 2016.

Sponsored by Sen. Carroll Leavell (NM)

To be considered for re-adoption during the NCOIL Workers' Compensation Insurance Committee on July 15, 2021.

SECTION 1. TITLE.

This Act shall be known and referred to as the "Structured Settlement Protection Act."

SECTION 2. DEFINITIONS.

For purposes of this Act--

(a) "annuity issuer" means an insurer that has issued a contract to fund periodic payments under a structured settlement;

(b) "assignee" means a party acquiring or proposing to acquire structured settlement payment rights from a transferee of such rights.

(c) "dependents" include a payee's spouse and minor children and all other persons for whom the payee is legally obligated to provide support, including alimony;

(d) "discounted present value" means the present value of future payments determined by discounting such payments to the present using the most recently published Applicable Federal Rate for determining the present value of an annuity, as issued by the United States Internal Revenue Service;

(e) "gross advance amount" means the sum payable to the payee or for the payee's account as consideration for a transfer of structured settlement payment rights before any reductions for transfer expenses or other deductions to be made from such consideration;

(f) "independent professional advice" means advice of an attorney, certified public accountant, actuary or other licensed professional adviser;

(g) “interested parties” means, with respect to any structured settlement, the payee, any beneficiary irrevocably designated under the annuity contract to receive payments following the payee’s death, the annuity issuer, the structured settlement obligor, and any other party to such structured settlement that has continuing rights or obligations to receive or make payments under such structured settlement;

(h) “net advance amount” means the gross advance amount less the aggregate amount of the actual and estimated transfer expenses required to be disclosed under Section 3(e) of this Act;

(i) “payee” means an individual who is receiving tax free payments under a structured settlement and proposes to make a transfer of payment rights thereunder;

(j) “periodic payments” includes both recurring payments and scheduled future lump sum payments;

(k) “qualified assignment agreement” means an agreement providing for a qualified assignment within the meaning of section 130 of the United States Internal Revenue Code, United States Code Title 26, as amended from time to time;

[(l) “responsible administrative authority” means, with respect to a structured settlement, any government authority vested by law with exclusive jurisdiction over the settled claim resolved by such structured settlement;]

Drafting Note 1: this Model recognizes that in some states a structured settlement may have been approved by an administrative body, i.e., a “responsible administrative authority,” rather than a court. The definition of “responsible administrative authority” and subsequent references to that term are bracketed, because they can appropriately be omitted in a State whose laws do not provide for administrative approval of structured settlements (or in which the only settlements that receive administrative approval are workers’ compensation settlements and such settlements are excluded from the definition of “structured settlement” as discussed in note 2 below).

(m) “settled claim” means the original tort claim [or workers’ compensation claim] resolved by a structured settlement;

Drafting Note 2: References to workers’ compensation are bracketed, because in some States transfers of payment rights under workers’ compensation settlements are incompatible with workers’ compensation laws.

(n) “structured settlement” means an arrangement for periodic payment of damages for personal injuries or sickness established by settlement or judgment in resolution of a tort claim [or for periodic payments in settlement of a workers’ compensation claim];

(o) “structured settlement agreement” means the agreement, judgment, stipulation, or release embodying the terms of a structured settlement;

(p) “structured settlement obligor” means, with respect to any structured settlement, the party that has the continuing obligation to make periodic payments to the payee under a structured settlement agreement or a qualified assignment agreement;

(q) “structured settlement payment rights” means rights to receive periodic payments under a structured settlement, whether from the structured settlement obligor or the annuity issuer, where –

(i) the payee [resides] [is domiciled] in this State; or

Drafting Note 3: This definition, which determines the applicability of a statute based on this Model, refers to the place where a structured settlement payee has his or her primary, continuing residence, e.g., where he or she pays State taxes, is registered to vote, is licensed to drive, etc. In some States that place may commonly be referred to as the payee’s “domicile,” in other States it may be referred to as the payee’s “residence.”

(ii) the structured settlement agreement was approved by a court [or responsible administrative authority] in this State

(r) “terms of the structured settlement” include, with respect to any structured settlement, the terms of the structured settlement agreement, the annuity contract, any qualified assignment agreement and any order or other approval of any court [or responsible administrative authority] or other government authority that authorized or approved such structured settlement;

(s) “transfer” means any sale, assignment, pledge, hypothecation or other alienation or encumbrance of structured settlement payment rights made by a payee for consideration; provided that the term “transfer” does not include the creation or perfection of a security interest in structured settlement payment rights under a blanket security agreement entered into with an insured depository institution, in the absence of any action to redirect the structured settlement payments to such insured depository institution, or an agent or successor in interest thereof, or otherwise to enforce such blanket security interest against the structured settlement payment rights;

(t) “transfer agreement” means the agreement providing for a transfer of structured settlement payment rights.

(u) “transfer expenses” means all expenses of a transfer that are required under the transfer agreement to be paid by the payee or deducted from the gross advance amount, including, without limitation, court filing fees, attorneys fees, escrow fees, lien recordation fees, judgment and lien search fees, finders’ fees, commissions, and other payments to a broker or other intermediary; “transfer expenses” do not include preexisting obligations of the payee payable for the payee’s account from the proceeds of a transfer;

(v) “transferee” means a party acquiring or proposing to acquire structured settlement payment rights through a transfer;

SECTION 3. REQUIRED DISCLOSURES TO PAYEE.

Not less than three (3) days prior to the date on which a payee signs a transfer agreement, the transferee shall provide to the payee a separate disclosure statement, in bold type no smaller than 14 points, setting forth —

(a) the amounts and due dates of the structured settlement payments to be transferred;

(b) the aggregate amount of such payments;

(c) the discounted present value of the payments to be transferred, which shall be identified as the "calculation of current value of the transferred structured settlement payments under federal standards for valuing annuities", and the amount of the Applicable Federal Rate used in calculating such discounted present value;

(d) the gross advance amount;

(e) an itemized listing of all applicable transfer expenses, other than attorneys’ fees and related disbursements payable in connection with the transferee’s application for approval of the transfer, and the transferee’s best estimate of the amount of any such fees and disbursements;

(f) the effective annual interest rate, which must be disclosed in a statement in the following form: “On the basis of the net amount that you will receive from us and the amounts and timing of the structured settlement payments that you are transferring to us, you will, in effect be paying interest to us at a rate of _____ percent per year”;

(g) the net advance amount;

(h) the amount of any penalties or liquidated damages payable by the payee in the event of any breach of the transfer agreement by the payee;

(i) that the payee has the right to cancel the transfer agreement, without penalty or further obligation, not later than the third business day after the date the agreement is signed by the payee; and

(j) that the payee has the right to seek and receive independent professional advice regarding the proposed transfer and should consider doing so before agreeing to transfer any structured settlement payment rights.

SECTION 4. APPROVAL OF TRANSFERS OF STRUCTURED SETTLEMENT PAYMENT RIGHTS.

(a) No direct or indirect transfer of structured settlement payment rights shall be effective and no structured settlement obligor or annuity issuer shall be required to make any payment directly or indirectly to any transferee or assignee of structured settlement payment rights unless the transfer has been approved in advance in a final court order [or order of a responsible administrative authority] based on express findings by such court [or responsible administrative authority] that —

(i) the transfer is in the best interest of the payee, taking into account the welfare and support of the payee's dependents;

(ii) the payee has been advised in writing by the transferee to seek independent professional advice regarding the transfer and has either received such advice or knowingly waived in writing the opportunity to seek and receive such advice; and

(iii) the transfer does not contravene any applicable statute or the order of any court or other government authority;

SECTION 5. EFFECTS OF TRANSFER OF STRUCTURED SETTLEMENT PAYMENT RIGHTS.

Following a transfer of structured settlement payment rights under this Act:

(a) The structured settlement obligor and the annuity issuer may rely on the court [or responsible administrative authority] order approving the transfer in redirecting periodic payments to an assignee or transferee in accordance with the order approving the transfer and shall, as to all parties except the transferee or an assignee designated by the transferee, be discharged and released from any and all liability for the redirected payments; and such discharge and release shall not be affected by the failure of any party to the transfer to comply with this chapter or with the court [or responsible administrative authority] order approving the transfer.

(b) The transferee shall be liable to the structured settlement obligor and the annuity issuer:

(i) if the transfer contravenes the terms of the structured settlement, for any taxes incurred by the structured settlement obligor or annuity issuer as a consequence of the transfer; and

(ii) for any other liabilities or costs, including reasonable costs and attorneys' fees, arising from compliance by the structured settlement obligor or annuity issuer with the court [or responsible administrative

authority] order approving the transfer or from the failure of any party to the transfer to comply with this Act;

(c) Neither the annuity issuer nor the structured settlement obligor may be required to divide any periodic payment between the payee and any transferee or assignee or between two (or more) transferees or assignees; and

(d) Any further transfer of structured settlement payment rights by the payee may be made only after compliance with all of the requirements of this Act.

SECTION 6. PROCEDURE FOR APPROVAL OF TRANSFERS.

(a) An application under this Act for approval of a transfer of structured settlement payment rights shall be made by the transferee and shall be brought in the [court of general jurisdiction or other designated court] in the [county][other political subdivision] in which the payee [resides][is domiciled], except that if the payee [does not reside][or is not domiciled] in this state, the application may be brought in the court [or before the responsible administrative authority] in this state that approved the structured settlement agreement.

(b) A timely hearing shall be held on an application for approval of a transfer of structured settlement payment rights. The payee shall appear in person at the hearing unless the court [or responsible administrative authority] determines that good cause exists to excuse the payee from appearing in person.

(c) Not less than twenty (20) days prior to the scheduled hearing on any application for approval of a transfer of structured settlement payment rights under Section 4 of this Act, the transferee shall file with the court [or responsible administrative authority] and serve on all interested parties (including a parent or other guardian or authorized legal representative of any interested party who is not legally competent) a notice of the proposed transfer and the application for its authorization, including with such notice:

(i) a copy of the transferee's application;

(ii) a copy of the transfer agreement;

(iii) a copy of the disclosure statement required under Section 3 of this Act;

(iv) the payee's name, age, and county of [residence][domicile] and the number and ages of each of the payee's dependents;

(v) A summary of:

(A) any prior transfers by the payee to the transferee or an affiliate, or through the transferee or an affiliate to an assignee, within the four years preceding the date of the transfer agreement and any proposed transfers by

the payee to the transferee or an affiliate, or through the transferee or an affiliate, applications for approval of which were denied within the two years preceding the date of the transfer agreement; and

(B) any prior transfers by the payee to any person or entity other than the transferee or an affiliate or an assignee of the transferee or an affiliate within the three years preceding the date of the transfer agreement and any prior proposed transfers by the payee to any person or entity other than the transferee or an affiliate or an assignee of a transferee or affiliate, applications for approval of which were denied within the one year preceding the date of the current transfer agreement, to the extent that the transfers or proposed transfers have been disclosed to the transferee by the payee in writing or otherwise are actually known to the transferee.

(vi) notification that any interested party is entitled to support, oppose or otherwise respond to the transferee's application, either in person or by counsel, by submitting written comments to the court [or responsible administrative authority] or by participating in the hearing; and

(vii) notification of the time and place of the hearing and notification of the manner in which and the date by which written responses to the application must be filed, which date shall be not less than five (5) days prior to the hearing, in order to be considered by the court [or responsible administrative authority].

SECTION 7. GENERAL PROVISIONS; CONSTRUCTION.

(a) The provisions of this Act may not be waived by any payee.

(b) Any transfer agreement entered into on or after the effective date of this Act by a payee who resides in this state shall provide that disputes under such transfer agreement, including any claim that the payee has breached the agreement, shall be determined in and under the laws of this State. No such transfer agreement shall authorize the transferee or any other party to confess judgment or consent to entry of judgment against the payee.

(c) No transfer of structured settlement payment rights shall extend to any payments that are life-contingent unless, prior to the date on which the payee signs the transfer agreement, the transferee has established and has agreed to maintain procedures reasonably satisfactory to the annuity issuer and the structured settlement obligor for (i) periodically confirming the payee's survival, and (ii) giving the annuity issuer and the structured settlement obligor prompt written notice in the event of the payee's death.

(d) If the payee cancels a transfer agreement, or if the transfer agreement otherwise terminates, after an application for approval of a transfer of structured settlement payment rights has been filed and before it has been granted or denied, the transferee shall promptly request dismissal of the application.

(e) No payee who proposes to make a transfer of structured settlement payment rights shall incur any penalty, forfeit any application fee or other payment, or otherwise incur any liability to the proposed transferee or any assignee based on any failure of such transfer to satisfy the conditions of this Act.

(f) Nothing contained in this Act shall be construed to authorize any transfer of structured settlement payment rights in contravention of any applicable law or to imply that any transfer under a transfer agreement entered into prior to the effective date of this Act is valid or invalid.

(g) Compliance with the requirements set forth in Section 3 of this Act and fulfillment of the conditions set forth in Section 4 of this Act shall be solely the responsibility of the transferee in any transfer of structured settlement payment rights, and neither the structured settlement obligor nor the annuity issuer shall bear any responsibility for, or any liability arising from, non-compliance with such requirements or failure to fulfill such conditions.

EFFECTIVE DATE. This Act shall apply to any transfer of structured settlement payment rights under a transfer agreement entered into on or after the [thirtieth (30th)] day after the date of enactment of this Act.

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National Council of Insurance Legislators (NCOIL)

Property/Casualty Flex-Rating Regulatory Improvement Model Act

Adopted by the Executive Committee on February 27, 2004, and readopted on November 20, 2011 and July 17, 2016.

To be considered for re-adoption during the Property & Casualty Insurance Committee on July 16, 2021.

Drafting Note: This model is intended for consideration in jurisdictions with a more restrictive rate-filing and review system than outlined in this bill. The model is intended to serve as an interim approach to enactment of an open competition–based system, as endorsed by the National Conference of Insurance Legislators (NCOIL) Property/Casualty Insurance Modernization Act.

Section 1. Short Title

This Act shall be known as the Property/Casualty Flex-Rating Regulatory Improvement Model Act.

Section 2. Scope

This Act applies to personal lines insurance written on risks in this state by any insurer authorized to do business in this state.

Section 3. Flex-Rating Provisions

A. Notwithstanding the requirements of [insert citations of state laws providing for the filing, review, approval, and/or disapproval of rates for property and casualty insurance], a filing made by an insurer under this section that provides for an overall statewide rate increase or decrease of no more than twelve (12) percent in the aggregate for all coverages that are subject to the filing may take effect the date it is filed. The twelve (12) percent limitation does not apply on an individual insured basis. No more than one rate filing may be made by an insurer pursuant to the expedited process provided in this subsection during any twelvemonth period, unless a rate filing, when combined with any other rate filing or filings made by an insurer within the preceding twelve (12) months,

does not result in an overall statewide increase or decrease of more than twelve (12) percent in the aggregate for all coverages that are subject to the filing.

B. Rate filings falling outside of the limitation provided for in subsection (A) of this section shall be subject to [insert citations to the appropriate filing and review provisions of the insurance code], unless those filings are otherwise exempt from those provisions pursuant to another section of the insurance code.

C. A filing submitted pursuant to subsection (A) of this section is considered to comply with state law. However, if the Commissioner of Insurance determines that the filing is inadequate or unfairly discriminatory, he/she shall issue a written order specifying in detail the provisions of the insurance code the insurer has violated and the reasons the filing is inadequate or unfairly discriminatory and stating a reasonable future date on which the filing is to be considered no longer effective. An order by the Commissioner pursuant to this subsection that is issued more than thirty (30) days from the date on which the Commissioner received the rate filing is prospective only and does not affect any contract issued or made before the effective date of the order. For purposes of this Act, "unfairly discriminatory" means a rate for a risk that is classified in whole or in part on the basis of race, color, creed, or national origin.

D. No rate increase within the limitation specified in subsection (A) of this section may be implemented with regard to an individual existing policy, unless the increase is applied at the time of a renewal or conditional renewal of an existing policy and the insurer, at least thirty (30) days in advance of the end of the insured's policy period, mails or delivers to the named insured, at the address shown in the policy, a written notice that clearly and conspicuously discloses its intention to change the rate. A notice of renewal or conditional renewal that clearly and conspicuously discloses the renewal premium applicable to the policy shall be deemed to be in compliance with this subsection.

Section 4. Effective Date

This Act shall take effect thirty (30) days after its approval by the Governor.

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National Council of Insurance Legislators (NCOIL)

Draft Language for Resilient [State] Revolving Loan Fund Model Act

**** Draft as of June 15, 2021. This document is intended only as a discussion and conceptual draft as there is no sponsor attached.***
****To be discussed during the Joint State-Federal Relations & International Insurance Issues Committee on July 15, 2021.***

Since 1980, the United States has experienced 265 weather and climate related events that have each cost $1 billion dollars or more in damages. Further, recent data shows that natural disasters are increasing in both frequency and strength. This puts increased burden on insurance markets, can make certain risks increasingly difficult to insure, and can increase the cost of insurance for consumers. According to the Natural Institute of Building Sciences, every dollar spent on natural disaster mitigation saves $6. It is therefore in the best interest of states to support resilience and mitigation projects to reduce this burden, reduce the cost of natural disasters, and to save lives and property. Recent federal law, the "Safeguarding Tomorrow through Ongoing Risk Management Act" or the "STORM Act" authorizes the Federal Emergency Management Agency (FEMA) to enter into agreements with certain state agencies to provide capitalization grants for hazard mitigation revolving loan funds to provide low interest loans to fund local mitigation projects. This model legislation aims to provide states with a framework to be able to access this funding and fund local disaster mitigation projects.

Table of Contents

Section 1. Title

This Act shall be known and cited as the "Resilient [State] Revolving Loan Fund Act."

Section 2. Definitions

For the purpose of this Act:

(a) “Fund” refers to the Resilient [State] Revolving Loan Fund.

(b) “Emergency Management Department” refers to the state agency responsible for emergency management in the state passing the “ Resilient [State] Revolving Loan Fund Act.”

(c) “STORM Act” refers to the “Safeguarding Tomorrow through Ongoing Risk Management Act” (Public Law 116-284).

Section 3. Purpose

For the purpose of establishing a special, non-lapsing loan fund, the Resilient [State] Revolving Loan Fund, to provide loans for local resilience projects that address mitigation of all hazards, including natural disasters.

Section 4. Intent

(a) It is the intent of the [state’s legislative body] that the Emergency Management Department apply to the Federal Emergency Management Agency under the provisions of the STORM Act, when funding is available, to enter into an agreement to capitalize the revolving loan fund established under this Act with money appropriated to the Fund.

(b) The Emergency Management Department may grant loans under this Act to local jurisdictions, at least in part, to meet federal matching requirements for federal resilience grants, including Building Resilient Infrastructures and Communities (BRIC).

Section 4. Revolving Loan Fund

(a) This Act establishes the Resilient [State] Revolving Loan Fund.

1. The Fund is a special, non-lapsing fund that shall be available in perpetuity for the purpose of providing loans in accordance with the provisions of this section.

2. The Fund is not subject to [any article of state code which dictates that at the end of a fiscal year, the unspent balance of an appropriation to special funds or accounts reverts to the general fund of the state].

3. The State Treasurer shall hold the Fund separately, and the Comptroller [or state equivalent] shall account for the Fund.

4. The Fund consists of:

i. Money appropriated in the state budget to the Fund;

ii. Investment and interest earnings of the Fund;

iii. Repayments of principal and interest loans made from the Fund; and

iv. Any other money from any other source accepted for the benefit of the Fund.

5. The Fund is administered by the Emergency Management Department.

6. The Fund may be used only to provide low – or no – interest loans to local governments and non-profit organizations for local hazard mitigation and resilience projects.

7. The loans provided under the Fund shall be for a fixed loan period.

8. Any interest earnings of the Fund shall be credited to the Fund.

9. Money expended from the Fund is supplemental to and is not intended to take the place of funding that otherwise would be appropriated to local governments for resilience projects.

10. Loans from the Fund may be used to satisfy the nonfederal match for federal mitigation grants.

(b) The Emergency Management Department shall, taking into consideration requirements from the STORM Act, establish application procedures and eligibility criteria for loans from the Fund. The eligibility criteria shall require that a local government or non-profit organization demonstrate:

1. Need for a loan to address hazard mitigation; and

2. The ability to repay the loan, if required, at a later date.

Section 5. Effective Date

And be it further enacted that this Act shall take effect _____.

81st OREGON LEGISLATIVE ASSEMBLY--2021 Regular Session

Enrolled

House Bill 3272

Sponsored by Representative MARSH; Representatives CAMPOS, DEXTER, FAHEY, GOMBERG, GRAYBER, HAYDEN, HUDSON, KOTEK, KROPF, LIVELY, MEEK, MORGAN, PHAM, POWER, REYNOLDS, SCHOUTEN, SMITH DB, VALDERRAMA, WILLIAMS, WITT, Senators JAMA, KENNEMER, RILEY

CHAPTER .....

Oregon HB 3272 Signed into Law on June 11, 2021. This will serve as the basis for the presentation from Amy Bach and Rep. Pam Marsh (OR) during the Property & Casualty Insurance Committee on July 16, 2021.

AN ACT

Relating to insurance; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. Sections 2, 3 and 4 of this 2021 Act are added to and made a part of ORS chapter 742.

SECTION 2. (1) As used in this section:

(a) "Homeowner insurance" has the meaning given that term in ORS 746.600.

(b) "Property" means structures and dwellings, and the contents of structures and dwellings, that are covered by a policy of homeowner insurance.

(2) If a policy of homeowner insurance requires an insured to repair, rebuild or replace damaged or lost property in order to collect the full replacement cost for the property, the insurer shall, subject to the policy limits:

(a) Allow an insured to repair, rebuild or replace damaged or lost property:

(A) In not fewer than 12 months after the date of the insurer's initial payment toward the cash value of the property that was damaged or lost; or

(B) In not fewer than 24 months after the date of the insurer's initial payment toward the cash value of the primary dwelling of the insured that was damaged or lost, if the damage or loss occurred in a location that was subject to a declaration of a state of

emergency under ORS 401.165 and the damage or loss is directly related to the emergency that was the subject of the declaration.

(b) Provide additional living expenses to an insured, subject to the policy limits for additional living expenses, for a period of 24 months after the date of the damage or loss to the insured's primary dwelling if the damage or loss occurred in a location that was subject to a declaration of a state of emergency under ORS 401.165 and the damage or loss is directly related to the emergency that was the subject of the declaration.

(c) Add time to each of the periods described in paragraphs (a) and (b) of this subsection in increments of six months for a total period of not more than 24 months under paragraph (a)(A) of this subsection and a total period of not more than 36 months under paragraphs (a)(B) and (b) of this subsection if an insured, acting in good faith and with reasonable diligence, encounters unavoidable delays in obtaining a construction permit, lacks necessary construction materials, lacks available contractors to perform necessary work or encounters other circumstances beyond the insured's control.

(3) Subsection (2) of this section does not prohibit an insurer from allowing an insured additional time to collect the full replacement cost for lost or damaged property or for additional living expenses.

(4) A policy of homeowner insurance may not limit or deny a payment of the replacement cost or building code upgrade cost, including a payment of any extended replacement cost available under the policy coverage, for an insured's structure that was a total loss on the basis that the insured decided to rebuild in a new location or to purchase an existing structure in a new location if the policy otherwise covers the replacement cost or building code upgrade cost, except that the measure of indemnity may not exceed the replacement cost, building code upgrade cost or extended replacement cost for repairing, rebuilding or replacing the structure at the original location of the loss.

SECTION 3. If a loss covered under a policy of homeowner insurance, as defined in ORS 746.600, occurs in a location that was subject to a declaration of emergency under ORS 401.165 and the loss is directly related to the emergency that was the subject of the declaration, the policy of homeowner insurance must require the insurer to combine coverage limits that apply to claims for a loss of the insured's primary dwelling and claims for a loss of other covered structures if the coverage limit that applies to the insured's primary dwelling is insufficient to pay for rebuilding or replacing the primary dwelling. The amount an insurer pays under the total combined coverage limits may not exceed the amount that would be necessary to repair the actual damage to, or replace, as appropriate, the insured's primary dwelling. The insurer shall pay in accordance with the terms of the policy of homeowner insurance the amount of any claim for a loss other than damage to the insured's primary dwelling.

SECTION 4. An insurer shall provide to an insured every other year at the time the

insurer offers to renew a policy of homeowner insurance, as defined in ORS 746.600, an opportunity to obtain a new estimate of the cost necessary to rebuild or replace the covered property if the insured provides information necessary for the estimate.

SECTION 5. Sections 2, 3 and 4 of this 2021 Act apply to policies of homeowner insurance that an insurer issues or renews on and after the effective date of this 2021 Act.

SECTION 6. Section 4 of this 2021 Act becomes operative on July 1, 2022.

SECTION 7. This 2021 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2021 Act takes effect on its passage.