The NAIC/Consumer Liaison Committee met in Austin, TX, Dec. 9, 2019. The following Liaison Committee members participated: Stephen C. Taylor, Chair (DC); Michael Conway, Vice Chair (CO); Lori K. Wing-Heier represented by Anna Latham (AK); Jim L. Ridling represented by Mark Fowler (AL); Andrew N. Mais represented by Kurt Swan (CT); Trinidad Navarro (DE); David Altmaier represented by Mike Yaworsky (FL); John F. King (GA); Doug Ommen (IA); Dean L. Cameron represented by Randy Pipal (ID); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt (KS); James J. Donelon represented by Ron Henderson (LA); Steve Kelley and Peter Brickwedde (MN); Chlora Lindley-Myers (MO); Mike Causey represented by Tracy Biehn (NC); Jon Godfread represented by Janelle Middlestead (ND); Bruce R. Ramge (NE); John G. Franchini and Paige Duhamel (NM); Barbara D. Richardson (NV); Linda A. Lacewell (NY); Jillian Froment represented by Jana Jarrett (OH); Glen Mulready (OK); Andrew Stolfi (OR); Jessica Altman (PA); Kent Sullivan and Cindy Wright (TX); Todd E. Kiser represented by Tanji Northrup (UT); Scott A. White represented by Don Beatty (VA); Tregenza A. Roach (VI); Mike Kreidler and Todd Dixon (WA); Mark Afable (WI); and James A. Dodrill, represented by Ellen Potter (WV).

1. **Heard Opening Remarks**

Commissioner Taylor said as chair of the Consumer Participation Board of Trustees, he wanted to mention that the Consumer Participation Board of Trustees, which is composed of six state insurance regulator members and six funded consumer representative members, met Dec. 8 in a closed, confidential session pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings. He said the Board of Trustees discussed selection of 2020 consumer representatives and consumer members of the 2020 NAIC Consumer Participation Board of Trustees. In accordance with the terms in the plan of operation for the consumer participation program, selection is required by the end of the year, and notification about all appointments occurs after committee assignments early next year.

2. **Adopted its Summer National Meeting Minutes**

Commissioner Schmidt made a motion, seconded by Commissioner King, to adopt the Liaison Committee’s Aug. 5 minutes (see NAIC Proceedings – Summer 2019, NAIC/Consumer Liaison Committee). The motion passed unanimously.

3. **Observed a Presentation by NAIC Consumer Representatives of the Excellence in Consumer Advocacy Award**

Matthew Smith (Coalition Against Insurance Fraud—CAIF) and Katie Keith (Out2Enroll) presented Commissioner Michael Conway (CO) with the Excellence in Consumer Advocacy Award. Ms. Keith said the NAIC consumer representatives enjoy the great fortune to work Commissioner Conway and his staff on a variety of critical consumer protection issues. She said in Colorado and at the NAIC, Commissioner Conway champions the needs of consumers, especially in promoting access to affordable, quality health insurance products. Ms. Keith said he leadership in Colorado has been critical to innovative new programs such as the Peak Health Alliance, a state-based reinsurance program that directs additional premium relief to rural communities, and to some of the nation’s most extensive consumer protections against surprise medical bills. She said his office is currently in the process of engaging stakeholders around a unique public option proposal that could be introduced in the state soon, offering additional affordable options for consumers. Ms. Keith said beyond these broad-scale initiatives, Commissioner Conway and his staff continue to ensure that Colorado consumers, including consumers with preexisting medical conditions, have equal access to the health care they need. These policies include new drug formulary protections for patients with chronic conditions and nondiscrimination provisions for LGBTQ Coloradans. Mr. Smith said in addition to his leadership in Colorado, Commissioner Conway devotes a significant amount of time to promoting consumer interests at the NAIC. He said Commissioner Conway serves as chair of the Regulatory Framework (B) Task Force, which is tasked with ensuring that the major working groups of the Health Insurance and Managed Care (B) Committee continue their important work, and chair of the NAIC/American Indian and Alaska Native Liaison Committee, among other leadership positions at the NAIC. Mr. Smith said Commissioner Conway’s office is always open to hearing input from the consumer representatives, and his staff go out of their way to help on issues at the NAIC and beyond. He said it is therefore our privilege and honor to present the 2019 NAIC Consumer Representative Excellence in Consumer Advocacy Award to Commissioner Conway.

Commissioner Conway said this award means so much as it is an award for his entire team in Colorado because it is the team that does the work noted by Ms. Keith. He said he often gets the credit, but without the people behind him, he could not have done any of those things. Commissioner Conway said thank you so much from the folks in Colorado. He said that he would
display the award proudly but said that it really should say the Colorado Department of Insurance (DOI)—not Michael Conway—as they are ones who get things done.

4. **Heard a Presentation on What State Insurance Regulators Can Do to Promote Retirement Security from the CEJ**

Birny Birnbaum (Center for Economic Justice—CEJ) said retirement security encompasses a broad spectrum of financial tools, including many insurance-related products and services such as life insurance, annuities and long-term care insurance (LTCI). He said the marketing and sales of these products are also areas that fall under the retirement security umbrella. Mr. Birnbaum said state insurance departments and the NAIC could play an important role in helping American consumers prepare for financial security because insurance is a key part of a comprehensive retirement plan. He said the NAIC focuses on three major areas of retirement security: 1) education; 2) consumer protection; and 3) innovation. Mr. Birnbaum recommended that the NAIC and state insurance regulators promote retirement security in four ways. He said one way was by identifying and removing retirement insecurity caused by 1) insurance rate and price increases for long-term care (LTC) products; 2) misleading sales materials and illustrations; and 3) hollowed-out property and health insurance policies resulting from major exclusions and massive deductibles. Mr. Birnbaum said that state insurance regulators no longer allow insurers to recoup costs in the form of rate increases or permit the continued use of, or approve new, LTCI products with no cap on future rate increases. He said the current framework for life insurance and annuity illustrations need rethinking, reengineering and modernization in order to serve—not defeat—consumers’ retirement planning. Mr. Birnbaum said the growth in exclusions and higher deductibles in insurance products designed to guard against natural and health catastrophic events undermines the role of these types of insurance products in recovery and retirement security.

Mr. Birnbaum said the second way was by supporting strong public social programs that deliver benefits more efficiently and effectively than the private sector. He said private insurers could deliver flood insurance more effectively and efficiently than the federal National Flood Insurance Program (NFIP). Mr. Birnbaum said public programs like Social Security and Medicare deliver retirement benefits and health care far more efficiently than the private sector. He said the decline of employer-based pensions and the rise of individual retirement accounts has caused much higher transaction costs for individuals. Mr. Birnbaum said that while the insurance industry has critical problems to offer to help with retirement security, he suggests state insurance regulators should support the strengthening of public programs when those programs deliver benefits more efficiently and effectively.

Mr. Birnbaum said the third way was to ensure that insurance products deliver good value to consumers and to not strip consumers of crucial retirement assets. He said an essential role for state insurance regulators is to ensure life insurance and annuity products deliver solid value to consumers, meaning most of the premium dollars are spent on benefits paid to the consumer. Mr. Birnbaum said insurance products that deliver only little value in the form of low premium dollars being spent on consumer benefits systematically strip consumers of scarce retirement assets. He said ensuring good value in products means that state insurance regulators need to assess the value of the products approved for sale and to communicate that value to consumers.

Mr. Birnbaum said the fourth way was to develop insurance consumer information, education and disclosures that identify the value and cost of the insurance proposition, as well as to focus on the value-added by state insurance regulators. He urged the NAIC to focus on activities for which state insurance regulators have expertise and can best leverage that expertise, such as partnering with educators and other organizations already deeply engaged in research and education related to American’s savings and financial practices. Mr. Birnbaum said there is a need to inventory and review annuity and LTC models related to retirement security and to recommend improvements and coordination as needed. He said there is currently little or no information regarding the value of life insurance and annuity products as measured by traditional benefit (claims) ratios. However, Mr. Birnbaum said we regularly see the loss ratios and aggregate value to consumers of most types of property/casualty (P/C) insurance and health insurance. He said developing and publishing benefit ratios and/or the cost of insurance would better enable consumers to see the value of insurance products. Mr. Birnbaum said when consumers buy an auto or home insurance policy, they pay a premium and know the cost of the insurance protection they are receiving. However, when a consumer buys an indexed life insurance policy that provides important insurance protections, the cost of those protections is not currently available to the consumer. He suggested that the NAIC develop methods and metrics to assess the cost and benefits of life insurance, annuity and LTCI products.

Commissioner Taylor said as chair of the NAIC’s Retirement Security (A) Working Group, he found this presentation very helpful.

Brenda J. Cude (University of Georgia) said education is not the NAIC’s comparative advantage but that content and subject matter expertise is. Therefore, partnering with the many organizations whose expertise is education and who have already
Commissioner Mulready said at the beginning of the presentation, Mr. Birnbaum mentioned rate caps for LTCI. He asked what rate cap Mr. Birnbaum would recommend as proper for LTCI. Mr. Birnbaum said he would start with no more than a 50% rate increase over the life of the product as it would give some opportunity to address some of the vagaries of LTCI over a long period of time, and it would also give some certainty to consumers. He said that after 40 years of experience, insurance companies should be able to develop a product in which they can provide a rate cap on that as there are many other types of insurance products for which companies have been able to do this. Mr. Birnbaum said this is not only possible, but also it is necessary.

Commissioner Roach said he is curious about the comment Mr. Birnbaum made about flood insurance being more effectively delivered by the private sector. He said at present, it is subsidized federally, so he is curious about how states could maintain price competitiveness if it were provided privately. Mr. Birnbaum said that right now, the federal government is involved in the direct provision of flood insurance. He said it is done very inefficiently through existing carriers through the Write Your Own (WYO) Program, and it is subject to a variety of conflicting constraints imposed by the U.S. Congress, but most importantly, it is one of the few property insurance perils that is not regulated by states and offered as part of residential or commercial property insurance, which is regulated by the states. So, Mr. Birnbaum said it is his opinion that flood insurance should be given back to the states and that the NFIP, instead of being a direct provider of insurance, should be a mega-catastrophe reinsurer along the same lines as the Terrorism Risk Insurance Program, with states taking on flood insurance the way they have every other type of insurance peril, but there would be a mandatory offer of flood as part of every personal and commercial insurance.

5. **Heard a Presentation on Navigating Troubled Waters from United Policyholders**

Amy Bach (United Policyholders) said her presentation featured state insurance regulator approaches to controlling residual market growth when home insurance availability and competition shrinks dramatically. She said the once robust home insurance market has declined rapidly in recent years, necessitating intervention by state insurance regulators. Ms. Bach said a series of catastrophes caused private companies to flee the market due to what the companies called “rating inadequacies” and “uninsurable risks” like floods, fires, etc. When asked what the NAIC can do, she said it is imperative for state insurance regulators to keep a fine balance. Ms. Bach said on one hand, it is important to maintain an option for property owners to protect their assets and comply with mandatory purchase or mortgage requirements for the economic health of individuals and communities and for preserving real estate values through buy and sell transactions. She said it is also important for preserving the benefits to consumers of competition. Ms. Bach said it is possible for state-sponsored solutions to lead the effort by example on essential protections, quality claim handling, mitigation assistance and rewards. She said private market solutions would include non-admitted surplus lines insurance, risk pools, market assistance plans and cooperative buyer arrangements. Ms. Bach said shared market solutions would include assigned risk plans, joint underwriting associations and syndicates, as well as reinsurance facilities. She said regulatory and legislative solutions include moratoriums on non-renewals, limitations on non-renewals, enhancements to or creation of state-run insurer of last resort, and state-sponsored insurance or reinsurance programs.

Ms. Bach said due to Hurricane Andrew in 1992, Florida granted the insurance commissioner statutory emergency powers to issue emergency rules—29 in 1992 and 30 in 1993—valid for 90 days that included a rule activating the Florida Residential Property and Casualty Joint Underwriting Association (FRPCJUA) to provide property coverage to policyholders who became insolvent as a result of the hurricane and two rules setting and extending regulations relating to withdrawal of insurance companies. She said in 1993, a moratorium was imposed on the cancellation and nonrenewal of residential property coverage, and another moratorium of policies was imposed until the legislature had a chance to respond to the recommendations of a study commission on current insurance issues in special session. Ms. Bach said the stated purpose was that, “The Legislature further finds that the massive cancellations and nonrenewals announced, proposed, or contemplated by certain insurers constitute a significant danger to the public health, safety, and welfare, especially in the context of a new hurricane season, and destabilize the insurance market.” She said recommendations from the study implemented a three-year moratorium phaseout prohibiting an insurer from cancelling or nonrenewing more than 5% of its homeowner’s policies in Florida in any 12-month period and 10% of its policies in any county. Ms. Bach said it was immediately followed by a similar three-year phaseout moratorium requiring insurers to offer premium discounts for structural mitigation improvements and creating the Florida Hurricane Catastrophe Fund (FHCF) as a state trust fund that provides additional reinsurance for insurers writing residential insurance. She said Citizens Property Insurance Corporation (Citizens) was created in August 2002 as a nonprofit, tax-exempt, government entity as an insurer of last resort through a merger of the FRPCJUA and the Florida Windstorm Underwriting Association (FWUA). Ms. Bach said as of June 30, 2019, Citizens has the third largest market share in terms of Total Insured Value (TIV) of personal residential property. She said since Citizens’ recent peak number of accounts in 2011, there has been...
a high volume of depopulation activity. Ms. Bach said Citizens attributes its strong current financial position to depopulation driven by continued interest in the private market for Citizens’ policies, a healthy private commercial market, substantial levels of Citizens’ surplus and a robust risk transfer program.

Ms. Bach said California’s current crisis is that insurers dropped more than 350,000 homeowners in high fire risk areas in 2019 and that homeowners in ZIP Codes affected by 2015 and 2017 fires saw a 10% increase in nonrenewals last year per the California Department of Insurance (CDI). She said the most recent data does not reflect or measure the full impact of nonrenewals of homeowner policies linked to 2018 fires (i.e., Camp Fire, Carr Fire and Woolsey Fire). Ms. Bach said the California Fair Access to Insurance Requirements (FAIR) Plan is the insurer of last resort and that the number of FAIR Plan policies has grown by 177% between 2015 and 2018 in the 10 counties with the most homes in high or very-high risk areas. She said changes ordered to the California FAIR Plan include an option for an HO-3 Policy Equivalent no later than June 1, 2020; an increase in the option for combined coverage limit of $1.5 million to $3 million, not including the option for an additional $300,000 available for liability coverage, no later than April 1, 2020; and an option to pay for the policy in monthly installments, by credit card, or electronic fund transfer without any additional fees. Ms. Bach suggested states prevent insurers of last resort from getting too big.

6. **Heard a Presentation on Consumers Filing Complaints or Reporting Improper Insurer Behavior in the Automotive Repair Context from the AEPI**

Erica Eversman (Automotive Education and Policy Institute—AEPI) said department of insurance complaint systems typically accept complaints only from consumers. She said auto insurance consumers do not have the requisite knowledge or information to file an enforceable complaint; infrequently use auto insurance, unlike health insurance; do not know or understand how to frame such a complaint; and cannot explain why certain procedures or parts are necessary for safe, proper repairs. Ms. Eversman said insurers use consumer subrogation to allege fraud or recoup money from repair facilities for alleged overpayment for “unnecessary” procedures; rental charges for perceived excessive days in repair; or overpayment for “unauthorized” parts. She said if insurers are in privity with repair facilities for subrogation, then repairers must be in privity for complaint purposes because repairer information is needed to protect consumers.

Ms. Eversman said insurers are permitted to make complaints about repairers to repair oversight entities—i.e. Departments of Motor Vehicles (DMVs), attorneys general and secretaries of state—by claiming “qualified interest” to protect consumers. She said the reason why accepting complaints from providers is good for the system is that consumers do not file complaints because they believe DOIs will not do anything; they are afraid of retribution by insurers; repairers are able to articulate specific reasons why insurers are underpaying claims; and repairers have daily interaction with insurers, which enables them to identify unfair claims payment patterns and practices by insurers. Ms. Eversman said misinformation about complaints recently caused a New Hampshire state legislator to use the lack of any complaints in the state’s DOI database for insurers engaging in “improper repair” as the basis for derailing legislation for quality repairs. She said the failure is in not understanding that insurers do not repair cars and that complaint systems are not set up to address insurer involvement in unsafe repairs that result in complaints, so such complaints end up being filed under “insufficient claim payment.”

Ms. Eversman recommended state insurance regulators enable or permit motor vehicle repair professionals to submit complaints regarding insurer practices related to a specific consumer or to a specific claim; allow repair professionals to assist consumers with drafting and substantiating complaints to prevent insurers from bringing allegations of public adjuster regulations and statutes or unauthorized practice of law claims against repairers who assist consumers; and meet with vehicle repair professionals to understand their frustrations and concerns about insurers’ actions that compromise consumers’ ability to receive insurance payments for safe, proper vehicle repairs. She said insurance contracts do not include service providers as part of the contract but said that maybe they should.

Commissioner Taylor said that he liked Ms. Eversman’s ideas and that this is something he is going to look at when he goes back home.

Commissioner Schmidt said Kansas does take these types of complaints but that they do not do a good job of communicating that back to the body shops. She asked Ms. Eversman how state insurance regulators should go about doing that. Ms. Eversman suggested that if states could designate a contact person within each DOI or, at least on the complaint form, have an attention to, that would be helpful. Commissioner Schmidt said it could come into their general complaint division and then it could be handled by certain people from there. She agreed that the problem is a lack of data, so when legislators ask for things like this, they do not have any complaints documented. She said the Kansas DOI has anecdotal information, but it does not have the type of documented evidence that would be helpful in Kansas.
7. Heارد a Presentation on Protecting Patients from Surprise Medical Bills and the Impact of Other Federal Policy Changes on Consumers from Families USA and the CBPP

Claire McAndrew (Families USA) said the first key principle of consumer protections in surprise billing legislation is to hold consumers harmless. She said balance billing should be completely prohibited in any care situation where consumers cannot ensure they will see an in-network provider or visit an in-network facility, including in emergencies, at in-network facilities, and for air and ground emergency transit. Ms. McAndrew said for out-of-network care that individuals incur due to no fault of their own, they should pay no more than in-network cost-sharing (including copayments, co-insurance, and deductibles). She said out-of-pocket spending should count towards a consumer’s in-network out-of-pocket maximum. Ms. McAndrew said the second key principle is to hold down health care costs for everyone. She said to ensure that insurance premiums are not unfairly increased, a reasonable payment level between insurers and out-of-network providers for surprise billing situations must be established. Ms. McAndrew said a reasonable payment level should be based on actual costs for care and should not be inflationary (e.g., should not be based on billed charges, which almost always do not accurately reflect price). She said the third key principle is to ensure comprehensive protection nationwide. Ms. McAndrew said federal law should apply to surprise billing situations unless state law is equal or more robust in terms of consumer protections. She said federal law should determine the payment level owed by a plan to a provider in a surprise bill situation, except when a state law already established a payment level prior to passage of federal law. Ms. McAndrew said if the federal law covers surprise billing situations not covered by an established state law, the federal law should wrap around the state law to set the payment rate in those situations. She said even if states have robust surprise billing laws, federal law should apply to any situations that states cannot fully regulate, such as self-insured, federal Employee Retirement Income Security Act (ERISA)-regulated plans and air ambulance bills. Ms. McAndrew said the current status of federal congressional action is that the U.S. Senate Committee on Health, Education, Labor and Pensions (HELP) passed legislation that protects consumers and holds down costs and that the U.S. House Committee on Energy and Commerce passed legislation that protects consumers and holds down costs. She said the House Committee on Education and Labor and the House Committee on Ways and Means have not taken any action. Ms. McAndrew said the timeline for passage in 2019 is that Congress must pass government funding before the deadline on Dec. 20. She said leadership can include surprise billing legislation in this package, noting that it often includes miscellaneous legislation that are priorities and “must-pass” legislation that makes it hard for opposing members to vote “no.” Ms. McAndrew said state regulatory actions still matter because protections like those proposed in Colorado HB 19-1174 are needed in all care settings, include ambulances, to provide protections even if Congress does not act, as well as to examine current payment mechanisms and their impact on costs and premiums in states that already have a law in place.

Sarah Lueck (Center on Budget and Policy Priorities—CBPP) said everyone is still waiting for decisions to come down from the federal level that will affect issues like the Texas case rule changes and proposed changes to the benefit payment parameters, but she would like to focus on other issues. One is that the CBPP is seeing the first state respond to the federal administration’s guidance on changes to Section 1332 waivers. Ms. Lueck said the CBPP is seeing proposals from the state of Georgia to do reinsurance, which many are familiar with, but to also make some unprecedented changes to its marketplace. She said the CBPP has been concerned about policies that do not meet the guardrails set under the federal Affordable Care Act (ACA). Ms. Lueck said that the CBPP wants to make sure that states with Section 1332 waivers still provide consumers with affordable, comprehensive coverage and that they are enrolled to the same extent that they would have been without the waiver in place. She said Georgia’s recent Section 1332 waiver proposal includes exiting the Healthcare.gov platform without creating its own state-based marketplace so consumers could only enroll in coverage through private web brokers and insurers, who would also be responsible for many of the other marketplace functions that the Liaison Committee is familiar with. Ms. Lueck said in addition, the state is proposing establishing its own subsidies in place of the ACA’s. She said under the waiver, these subsidies could be used for plans that do not meet ACA standards, and the total amount of the subsidies would be capped and would be distributed on a first-in, first-out basis, which means that those most in need could potentially be denied benefits. Ms. Lueck said the CBPP is concerned about this proposal and how the structure of it could raise premiums for ACA-fully compliant coverage, push people into substandard plans and likely cause others to lose coverage altogether. She said it would also be a massive undertaking by any state requiring lots of legislative changes. Ms. Lueck said the CBPP continues to be concerned about short-term health plans and rule changes that allowed those to expand so more people could be covered under them for longer periods of time. She said the CBPP is beginning to see evidence that some consumers have been harmed by such plans and hearing in news reports about consumers who are being subjected to post-claims underwriting. Ms. Lueck said the CBPP is pleased that the NAIC is moving forward with its data calls to gather information about such coverages moving forward. She encouraged states to continue to be vigilant in protecting consumers.

8. Heard a Presentation on Clarifying Insurance Coverage of Living Donors from the AKF

Deborah Darcy (American Kidney Fund—AKF) said 37 million Americans have kidney disease and that it is the 9th leading cause of death in the U.S. She said it is End Stage Renal Disease (ESRD) or kidney failure, for which the treatment options are
dialysis and transplant. Ms. Darcy said Medicare spent $35.4 billion on ESRD patients in 2016 and that ESRD patients make up 1% of the total Medicare population, but they use 7% of the total Medicare budget. She said on July 10, President Trump signed an Executive Order on “Advancing American Kidney Health.” Ms. Darcy said the order has three policy goals: 1) to reduce the risk of kidney failure; 2) to improve access to and the quality of person-centered treatment options; and 3) to increase access to kidney transplants. She said only 30% of individuals with kidney failure are living with a functioning kidney transplant; there were 94,754 individuals on the kidney transplant waiting list as of June 18, 2019; and in 2018, there were 5,645 living donors and 14,516 deceased donors.

Ms. Darcy said advancing American kidney health includes increasing access to kidney transplants by 1) increasing the use of available organs from deceased donors by increasing organ recovery and reducing the organ discard rate; and 2) by increasing the number of living donors by removing disincentives to donation and ensuring appropriate financial support. She said the insurer of the kidney recipient is responsible for the health care costs of the donor associated with the surgery and that Medicare covers complications for the life of the donor. Ms. Darcy said there are currently no standards regarding the amount of time a kidney recipient’s insurance must cover the donor. She said the time frame is generally 90 days, but it can be shorter or longer depending on the insurance plan. She said that donors can be held responsible for complications. Ms. Darcy said living organ donors tend to be healthier than the general public. However, she said complications can occur. She said concerns about health coverage of complications outside of the contracted time can serve as a disincentive to organ donation and that the kidney community is working to address this disincentive.

Ms. Darcy asked state insurance regulators that receive a complaint from a living donor who is being charged for donor-related costs to ensure that the kidney recipient’s insurance pay for those costs. She asked that as the kidney community works with state legislatures to standardize private health insurance coverage for living donors, state insurance regulators are supportive of those who are giving the gift of life.

9. **Heard a Presentation on Raising Consumer Concerns About Wellness Programs from Out2Enroll**

Ms. Keith said the business of wellness programs is a booming $8 billion industry, with 84% of large employers offering wellness programs in 2019 and 14% of employers penalizing or rewarding workers for achieving a positive biometric outcome (e.g., body mass index [BMI]). She said studies show that wellness programs are ineffective, resonating with healthier employees but having little effect on medical spending or absenteeism. Ms. Keith said the first large-scale, multi-site randomized controlled trial indicated no significant effects on health outcomes, medical spending or utilization, or employment outcomes.

Silvia Yee (Disability Rights Education and Defense Fund—DREDF) said wellness programs are ineffective, with randomized controlled studies finding no impact on health or employment outcomes. She said such programs are legally questionable as evidenced by the AARP successfully challenging Equal Employment Opportunity Commission (EEOC) wellness rules under the federal Americans with Disabilities Act (ADA) and the Genetic Information Nondiscrimination Act (GINA). Ms. Yee said wellness programs discriminate against employees and dependents with disabilities and/or in poorer health. She said such programs are invasive because employees must disclose medical information and actions even during non-working (and unpaid) hours.

Ms. Keith said under the individual market wellness demonstration option, up to 10 states can participate in a wellness demonstration project in the individual market. She said participatory wellness programs are already allowed in individual markets (e.g., gym membership, gift card for smoking cessation, etc.) and would allow insurers to impose a “wellness” surcharge of up to 30% for health-contingent wellness programs (e.g., must reach a biometric outcome, such as a target BMI or blood pressure) to avoid the surcharge.

Ms. Yee said recommendations for state insurance regulators are to: 1) avoid the wellness demonstration project for the individual market; 2) monitor the use of wellness programs in the fully-insured markets; 3) consider learning more about the degree of take-up of participatory wellness programs in the individual market; and 4) collect data on the extent of use in the fully insured group market.

10. **Heard a Presentation on the HFPP and How it is Protecting Americans from Insurance Fraud from the CAIF**

Mr. Smith said the CAIF helped to create the Healthcare Fraud Prevention Partnership (HFPP). He said it was not created to investigate fraud committed by consumers. He said what it exists for is to aggregate medical fraud data throughout the nation, look at that data through a larger platform, and protect consumers from organized fraud in the medical arena that may not be identified through individual states, the federal government, other governmental agencies or private insurers.
Mr. Kreitman said the HFPP is a voluntary, public-private partnership, with approximately 20 partners. He said in the last 12 months, the HFPP membership has grown 33%; as of today, the HFPP has 147 partners, including 13 federal agencies, 71 private plans, 13 associations, and 50 state and local partners. Mr. Kreitman said the purpose of the HFPP is to be an unparalleled data source. He said the HFPP represents the full spectrum of health care payers and antifraud associations and enables the performance of sophisticated data analytics against a unique cross payer data set, as well as information-sharing for the benefit of all partners. Mr. Kreitman said the HFPP promotes collaboration and strategic partnerships. He said partners meaningfully participate, guide the partnership and have opportunities to establish strategic collaborations across diverse stakeholders. Mr. Kreitman said the HFPP wants to help partners move from a reactive approach to taking a preventive approach to address fraud when it first appears. He said the HFPP’s most important goal is generating comprehensive approaches and strategies that materially affect each partner’s effort to combat health care fraud, waste and abuse. Mr. Kreitman said the HFPP is the only organization through which partners can combine their data with public and private data, including the U.S. Centers for Medicare & Medicaid Services (CMS), in order to gain heightened antifraud insights. He said the aggregated data, across public and private sectors, provide partners with broader visibility into fraud, waste and abuse. Mr. Kreitman said partners share data, outcomes and lessons learned. He said participation in crowdsourcing on study ideas and design provides maximum impact to address emerging fraud, waste and abuse trends. Mr. Kreitman said by contributing claims data and conducting studies through a Trusted Third Party (TTP), each participating organization can reap the benefits of cross-sector analysis while maintaining the anonymity of their data. He said no partner—public or private—has access to the data of other partners. Mr. Kreitman said through a variety of HFPP events—including regional information sharing sessions, webinars on trending topics and working groups—partners leverage their collective experiences to play a leading role in shaping the future of the partnership and in combating health care fraud across the nation.

Mr. Kreitman said the HFPP can receive data on 112 million individuals, which is equivalent to more than one in three insured Americans. He said if all partners shared their data, at 228 million covered lives, the HFPP data set would represent more than three out of every four insured Americans. Mr. Kreitman said every additional partner that shares their data further increases the impact the HFPP cross-payer data set has in delivering outcomes for the partners. He said the principles of the partnership that underlie sharing claims for analysis start with data sharing, which is the driving force of the partnership. He said the TTP analyzes claims data contributed by participating entities for studies that offer a system-wide perspective. As a result, the information shared consists of cross-payer findings not otherwise available to partners. Mr. Kreitman said the TTP supports the HFPP in its day-to-day operations by: 1) delivering subject matter expertise in data analytics that facilitates the design and execution of studies; 2) providing a secure environment for hosting and sharing data; 3) ensuring that non-attribution and confidentiality is maintained for data-sharing partners; and 4) communicating timely and relevant information. He said the goals for HFPP studies include: 1) delivering actionable results based on current data; 2) limiting the additional analysis required to interpret the results; 3) incorporating ideas from partner meetings into studies; and 4) increasing the level of partner participation in all study phases. Mr. Kreitman said the purpose of data sharing is to gather a holistic view of federal, state and private payer claims that will give HFPP fraud studies a unique view of health care. He said the studies that the HFPP runs cannot be performed in any other environment, and the data collected can only be used for HFPP studies. Mr. Kreitman said partners must safeguard the information they receive and only distribute it as agreed upon. He said partner data is only accessible to the TTP; partners do not have access to each other’s data. Mr. Kreitman said the purpose of studies is to provide leads to partners. He said the TTP does not do investigations and that when partners use a TTP lead, they must determine based on their own data if there is a problem with a specific provider.

Mr. Kreitman said an important strategy to overcome differences in payer policies, as well as priorities and resources, is partner engagement. Therefore, he said the TTP study life cycle built in partner participation and collaboration from beginning to end, including a pipeline where partners can share successes and challenges related to program integrity activities and where partners can suggest study topics by sharing cases or schemes. Mr. Kreitman said it includes submissions of professional and/or institutional claims data to the TTP portal with initial submissions for the prior two years of data. He said updated claims may be submitted monthly, quarterly or semi-annually and that partners also submit reference files, such as member ID crosswalks that allow the TTP to securely assign HFPP IDs to each beneficiary during transmission, so personally identifiable information (PII) is never stored in the TTP. Mr. Kreitman said the HFPP IDs allow tracking of billings for the same beneficiary across multiple partners. He said each study relies on specific data elements from professional claims on a preplanned production schedule and that all available data is included in each study the TTP conducts unless it is not relevant (e.g., if the study is related to physical therapy, partners from a mental health carve out will not be included). Mr. Kreitman said partners receive a variety of outcomes from TTP studies that include their individual study findings, such as a report related to National Provider Identifiers (NPIs), that meet the study criteria and that partners use study results for qualified lead generation, corroborating evidence or their own analysis for allocating program integrity resources to address the issues related to the study. He said the TTP is currently conducting four types of studies to deliver a variety of value propositions across the payer spectrum.
Mr. Kreitman said the top two types of findings result from claims studies and that by applying algorithms to predefined combinations of current procedural terminology (CPT) codes and their modifiers, dates of service and other data elements, the TTP creates a unique cross-payer analysis of potential fraud, waste and abuse. He said evidence-based findings identify occurrences of suspected fraud, waste and abuse. For instance, the TTP conducts two studies that identify NPIs who have continued to bill partners after their NPI was deactivated from participation with federal programs, such as Medicare and Medicaid, with the findings revealing billing patterns across multiple payers after deactivation. Mr. Kreitman said outlier detection findings identify claims data patterns that indicate potential fraud, waste or abuse activities. For instance, the TTP conducts studies that compare the total amount of timed procedure codes billed by one NPI across partners with the findings revealing the sum of hours billed by NPIs to all partners included in the study. He said broader analytic activities that can incorporate non-claims information are informational findings such as white papers or issue papers that are typically about emerging topics or known complex fraud schemes. Mr. Kreitman said they use literature review and qualitative research, although sometimes the TTP can conduct sample or test studies and that the TTP is currently studying schemes related to genetic testing. He said aggregate findings come from studies that produce a compilation of results from other studies and include additional information. For example, the TTP creates a monthly Law Enforcement Review List that identifies all the organizational and individual NPIs that were identified in the claims-based studies the TTP conducted in the prior month. In addition, he said each NPI in the list has corresponding partner IDs and contact information, so law enforcement can coordinate investigational activities appropriately. Mr. Kreitman said because resources differ widely across participating partners, the TTP expanded its analytic products to suit a broader audience. For each study conducted, he said summary results are available for all HFPP partners, which include aggregate results of the impact on the partnership. Mr. Kreitman said participating entities receive an individual report containing an interactive dashboard with personalized results of the analysis and study results according to risk levels and a consolidated report with combined findings for all participating entities. He said the improved visualizations use Tableau software to more easily identify suspect providers because the application graphically illustrates study objectives and suspicious billing patterns. He also said a complimentary Tableau Reader application is available for partners.

Commissioner Taylor asked if there are any special obligations required for states to join the HFPP. Mr. Kreitman said there are not and that he would stay after the meeting to talk with states. A general memorandum of understanding (MoU) is signed to enter into partnership with the HFPP.

Ms. Duhamel asked what kind of fraud they are seeing from labs. Mr. Kreitman said they are seeing lab testing for drug abuse five days a week, which is unheard of in the industry because opiates and other types of drugs being abused stay in the bloodstream for several days. She said in cases where abuse or mental illness is present, they are seeing evidence that consumers are being shuttled out of state or out of the country to receive treatment. Mr. Kreitman said they are seeing evidence of this and fraudulent providers using so-called scholarships to entice patients into other states for treatment in fake treatment facilities.

Having no further business, the NAIC/Consumer Liaison Committee adjourned.
The NAIC/American Indian and Alaska Native Liaison Committee met in Austin, TX, Dec. 8, 2019. The following Liaison Committee members participated: Michael Conway, Chair (CO); Lori K. Wing-Heier, Vice Chair (AK); Trinidad Navarro (DE); Matthew Rosendale represented by Bob Biskupiak (MT); Mike Causey represented by Tracy Biehn (NC); Jon Godfread represented by Johnny Palsgraaf (ND); Andrew Stolfi (OR); Larry Deiter represented by Frank Marnell (SD); Mike Kreidler (WA); and Mark Afable represented by Olivia Hwang (WI). Also participating were: Brian Fordham (OR); and Todd Dixon (WA).

1. Adopted its Summer National Meeting Minutes

Director Wing-Heier made a motion, seconded by Ms. Biehn, to adopt the Liaison Committee’s Aug. 4 minutes (see NAIC Proceedings – Summer 2019, NAIC/American Indian and Alaska Native Liaison Committee). The motion passed unanimously.

2. Heard a Presentation on Improving How the States Work with Tribes

Vicki Lowe (American Indian Health Commission—AIHC) said she had worked with American Indian tribes for over two years. During that time, she has learned that the most important issue for tribes is sovereignty, which, along with Indian law, reigns over all else. She said tribes are distinct political communities. She said tribal sovereignty is exercised each time a tribe governs their own people, resources and lands. She said tribal powers include the establishment of government; the determination of membership; the policing and administration of justice; and the exclusion of people from reservation, charter business organizations, and sovereign immunity. Tribal sovereignty in practice means that tribes have the authority to govern themselves. Ms. Lowe said sovereignty ensures control over the future of the tribes and encourages the preservation of tribal culture, religions and traditional practices. She said tribes have the authority to, among other things, govern their people and their land; define their own tribal membership criteria; create tribal legislation, law enforcement and court systems; and impose taxes in certain situations. She said a lack of understanding of Indian law can have detrimental impacts to tribal governments, American Indians and Alaska Natives (AI/AN). She said one example was seen during a recent outbreak of measles when tribal leaders sought to distribute the limited vaccine themselves within their own tribes, giving the highest priority to the elderly and the very young. However, local health authorities had different priorities—giving the highest priority of the limited vaccine to those with chronic health conditions. The tribe refused to follow these priority guidelines, so the tribes received no vaccine, which resulted in many cases of measles that lead to deaths in tribal communities.

Ms. Lowe said in order to understand the Indian Health Care Delivery system, it is necessary to go back before relationships were established between the tribes and the federal government. She said prior to such contact in the 1880s, indigenous people lived everywhere across what is now known as the U.S., with many tribes inhabiting several states. She said history is the key to understanding Indian law more than any other type of law. She said it is heavily intertwined with federal Indian policy, which shifts back and forth with the flow of popular and governmental attitudes toward American Indians. She said Indian law is the body of law dealing with the status of Indian tribes and their relationship with the federal government and the consequences/impact of that legal status/relationship for tribes and their members, states and citizens, as well as the federal government and local jurisdictions. She said understanding and respecting Indian law can bring about great improvements for tribal nations—AI/AN—and benefit the citizens of each state. She said in 2010, the Washington Department of Social and Health Services, in conflict with federal law, attempted to require tribal health programs to obtain state licensure for their facilities. She said an insurance issuer’s failure to recognize a tribal health program as a licensed or certified facility can result in loss of funds for critically underfunded tribal health programs. She also said that a Washington court’s failure to recognize a tribal health programs as a licensed or certified facility can result in AI/AN unable to receive treatment from their tribal health program medical home. She said tribal members have triple citizenship—as Tribal citizens, Federal as America citizens, and as citizens of the state in which they live.

Ms. Lowe said Executive Order 13175: “Consultation and Coordination with Indian Tribal Governments,” which was issued by U.S. President Bill Clinton on Nov. 6, 2000, requires federal departments and agencies to consult with Indian tribal governments when considering policies that would affect tribal communities, and it reiterates the federal government's
previously acknowledged commitment to tribal self-government and sovereignty. She said based on this federal law, tribal governments have a government-to-government relationship with the federal government. She said tribal governments are not stakeholders, minority groups, or other community groups. She said they are consulted with as governments, which means there are certain notice requirements for federal and state policies and actions that other stakeholders do not have. She said through the Centennial Accord of 1989, Washington established a unique relationship with tribes that honors the government-to-government relationship. She said the accord is an agreement between Washington and the tribes in which each party “respects the sovereign status of the parties, enhances and improves communications between them, and facilitates the resolution of issues.” She said at the state level, Chapter 43.376 RCW requires state agencies to “make reasonable efforts to collaborate with Indian tribes in the development of policies, agreements, and program implementation that directly affect Indian tribes…” She said it requires state agencies to “develop a consultation process that is used by the agency for issues involving specific tribes.” She said RCW 43.376.050 also requires that: 1) at least once a year, the governor and other statewide elected officials must meet with leaders of Indian tribes to address issues of mutual concern; 2) the governor must maintain, for public reference, an updated list of the names and contact information for the individuals designated as tribal liaisons and the names and contact information for tribal leadership as submitted by an Indian tribe; and 3) an annual meeting between the governor and tribal leaders take place. She said it requires five state agency duties in establishing a government-to-government relationship with the tribes. State agencies must:

1. Collaborate. Make reasonable efforts to collaborate with Indian tribes in the development of policies, agreements and program implementation that directly affect Indian tribes.
2. Consultation Policy. Develop a consultation process that is used by the agency for issues involving specific Indian tribes.
3. Tribal Liaison. Designate a tribal liaison who reports directly to the head of the state agency.
4. Training. Ensure that tribal liaisons who interact with Indian tribes and the executive directors of state agencies receive training, as described in this chapter.
5. Reporting. Submit to the governor on activities of the state agency involving Indian tribes on implementation of this chapter.

Ms. Lowe said when things go south in a consultation, tribal leaders often cite one of the following as the cause:

- A misunderstanding of the difference between collaboration and consultation.
- Consultation is a formal process with specific requirements established in advance regarding:
  o The level or depth of the required consultation—it must be meaningful.
  o The result or goal of the consultation—it must be a regular, ongoing exchange of information and opinions resulting in a mutual understanding between Indian tribes as sovereign nations and the state on all policies and actions that directly affect Indian tribes.
  o Who the required parties to the consultation are.
    ▪ The Insurance Commissioner, Chief Deputy Insurance Commissioner, or Deputy Insurance Commissioner with the appropriate decision-making authority.
    ▪ Indian tribes represented by the Tribal President, Tribal Chair, Tribal Governor, an elected or appointed Tribal Leader, or their authorized representative(s).
    ▪ Urban Indian Health Programs.
    ▪ AIHC Board Chair or authorized representative who has the authority to make decisions on behalf of the AIHC. The AIHC is a not-for-profit entity that works on behalf of the Indian tribes and two urban Indian health organizations in Washington on health policy and priority AI/AN health issues that improve the Washington tribal health delivery system and the health of individual AI/AN residents. The AIHC does not represent any Indian tribe or Indian Health Service (IHS), Tribes and Tribal organizations, and urban Indian organizations (I/T/U) Provider.
    ▪ Tribal organizations organized under the Indian Self-Determination and Education Assistance Act (P.L. 93-638; 25 U.S.C. § 450 b (1)).
  o When tribal consultations must occur: prior to implementation of all Office of the Insurance Commissioner’s (OIC) policies and actions that directly affect Indian tribes except for emergency rulemaking, which means the development of policies, agreements and program implementation by the OIC that have substantial direct effects on Indian tribes or the relationship between the OIC and Indian tribes, and which may include rulemaking, interpretive and policy statements. These include, but are not limited to, rules regarding consumer access to health care providers/essential community provider provisions and health insurance issuer contract requirements.
The collaboration requirements: only tribes can determine what has tribal implications.

- Collaboration is an ongoing, informal process that usually occurs prior to formal consultation.

Ms. Lowe said tribal leaders are very familiar with the consultation policy, so agency staff and its leaders must be as well. She said common pitfalls are: 1) the agency does not keep its tribal liaison informed at the policy level; 2) an improper determination has been made regarding tribal implications; 3) agency staff are not following the consultation procedure due to a lack of training, awareness, willingness or presence; 4) tribes are engaged or consulted too late in the process; and/or 5) tribes are improperly viewed as stakeholders and not as sovereign governments.

Director Wing-Heier asked how often consultations are typically held. Ms. Lowe said consultations are held whenever needed, if they are needed more often than the required annual consultation.

Commissioner Conway asked Ms. Lowe to elaborate a little more on what happened with the H1N1 incident. Ms. Lowe said most of what the U.S. Centers for Disease Control and Prevention (CDC) does has been unclear because the federal government does not know what effect tribal implications have on the states, and the states are used to having total jurisdiction over everything. She said the local health offices are used to being an authority all unto themselves. She said they were very strictly following the instructions they had been given due to the limited number of vaccines available, so they would not give tribes any vaccine, as the tribes refused to follow those rules.

3. **Heard a Summary on the Removal of Tribal Resources from the HHS Website**

Holly Weatherford (NAIC) said that on March 6, 2019, Senators Udall, Cortez Masto and Tester co-signed a letter addressed to Alex Azar, Secretary of the U.S. Department of Health and Human Services (HHS), expressing concerns about the removal of “federal health services information for Tribal communities from HHS-run websites.” Senator Udall also requested information about what information is still available to tribal communities and answers to the following questions:

1. Why were the above referenced resources removed from the Office of Minority Health (OMH) website? When did this occur? When do you expect them to be restored?
2. In 2015, the Administration of Native Americans (ANA) offered technical assistance to tribes to provide strategies for increasing enrollment by AI/AN in Medicaid, the Children’s Health Insurance Program (CHIP), and insurance available through the Health Insurance Marketplace. The request forms are still available on your website.
   - Is that technical assistance still available to tribes? If no longer available, why not?
   - What are you doing to ensure that Native populations and tribes know about the technical assistance that this program provides?
3. How is the HHS working to ensure that Native populations and tribes can access the resources that the federal Affordable Care Act (ACA) provides?
4. How was Healthy Tribes financed originally? Did funding come from ANA appropriations or elsewhere at the HHS? What is the function of that program today?
5. If services provided under the Healthy Tribes program are no longer available, how has the ANA repurposed those funds?

To our knowledge, there has been no response to this letter. However, OMH Press Secretary Tony Welch, in response to questions about the removal of this information from the OMH website, commented the following to Government Executive:

- “As is standard website management practice, the Office of Minority Health [OMH] routinely reviews and updates the content on the OMH website. We also continue to make improvements to the site by reorganizing content on the site,” OMH Press Secretary Tony Welch said. He said some of the materials cited by the Web Integrity Project (WIP) have been “restructured” and made available.
- “As with the ACA, which is administered by the Centers for Medicare and Medicaid Services,” he continued. The minority health office “regularly supports the initiatives of other federal offices, summarizing or linking to their information and resources. When OMH updates its pages, information that has left the OMH site is still available to the public.”

One of the items initially removed from the OMH website included “ACA Guidance for American Indians and Alaska Natives.” This page featured an infographic providing an overview of how to receive benefits under the ACA. While this page is no
longer available, there is an article on the Administration for Children and Families website, also run by the HHS, titled “American Indians/Alaska Natives and the Affordable Care Act – General Information,” which includes a link directing users to the resource “Health coverage for American Indians & Alaska Natives” on the HealthCare.gov website.

A May 2019 article in MedPage Today states that for over a two-year period, “the Department of Health and Human Services has been removing or downplaying information about the rights, benefits, and services granted by the Affordable Care Act.” This is based on a report from the WIP, which is an arm of the Sunlight Foundation. The article goes on to say that since 2017, the HHS has removed at least 85 fact sheets, press releases, and other informational documents from its websites. In addition to minority health, the website changes have affected several issues, including climate change and women’s health. In March 2019, the Sunlight Foundation and American Oversight jointly filed a lawsuit in the U.S. District Court for the District of Columbia to compel the HHS to release records related to the Office of Women’s Health’s removal of fact sheets and other public information on multiple issues, including lesbian and bisexual health and affordable breast cancer screenings. This lawsuit is the result of unsuccessful Freedom of Information Act (FOIA) requests, and it seeks injunctive relief to require the delivery of documents related to the HHS’s communications with the public affairs firm Hager Sharp, which runs the website for the Office of Women’s Health. The lawsuit also calls for the delivery of communications involving website user messages to the women’s health website and the agency’s handling of the website.

No lawsuit has been filed to compel similar documents from the HHS regarding federal health care information specific to tribal communities removed from the OMH website, and we are unaware if any FOIA requests have been made. Federal agencies retain much of the responsibility and discretion to determine what information is posted to their websites and what deleted content is retained as federal records.

Ms. Weatherford said for next steps, NAIC legal staff could coordinate with HHS contacts on the hill, and they would also be happy to continue to track the progression of the lawsuit with reporting feedback to the Liaison Committee.

Commissioner Conway asked if it seemed like the OMH was going to respond to those FOIA requests. Ms. Weatherford said the OMH declined to respond to the FOIA requests. Commissioner Conway asked how the OMH declined. Ms. Weatherford said the OMH relied on some exceptions to the FOIA law that this group disagreed with. Commissioner Conway asked if the NAIC could provide resources to file FOIA requests or if the NAIC could help in pulling these resources off the HHS website in order to put the resources on the NAIC website or on the states’ websites. Ms. Weatherford said she would take this request to the NAIC Legal Division and then respond to the Liaison Committee.

4. **Discussed Other Matters**

Commissioner Conway said one of the Liaison Committee members, Superintendent Franchini, sent three of his staff members to participate with Lois Alexander (NAIC) at the Liaison Committee’s information booth during the 76th Annual Convention and Marketplace held by the National Congress of American Indians (NCAI) in Albuquerque, New Mexico Oct. 20–25, 2019. Hundreds of AI/AN were assisted with their insurance concerns by these Liaison Committee representatives.

Having no further business, the NAIC/American Indian and Alaska Native Liaison Committee adjourned.