NAIC/CONSUMER LIAISON COMMITTEE

NAIC/Consumer Liaison Committee Nov. 19, 2024, Minutes

NAIC/American Indian and Alaska Native Liaison Committee Nov. 18, 2024, Minutes (Attachment One)

Draft Pending Adoption

Draft: 12/5/24

NAIC/Consumer Liaison Committee
Denver, Colorado
November 19, 2024

The NAIC/Consumer Liaison Committee met in Denver, CO, Nov. 19, 2024. The following Liaison Committee members participated: Grace Arnold, Chair (MN); D.J. Bettencourt, Vice Chair (NH); Lori K. Wing-Heier represented by Heather Carpenter (AK); Mark Fowler (AL); Alan McClain represented by Crystal Phelps (AR); Peni Itula Sapini Teo (AS); Ricardo Lara represented by Lucy Jabourian (CA); Mike Conway represented by Kate Harris (CO); Andrew N. Mais represented by Kurt Swan (CT); Karima M. Woods represented by Howard Liebers (DC); Trinidad Navarro (DE); Dean L. Cameron represented by Randy Pipal (ID); Ann Gillespie represented by KC Stralka (IL); Vicki Schmidt (KS); Timothy J. Temple represented by Nina S. Hunter (LA); Marie Grant (MD); Anita G. Fox represented by Renee Campbell (MI); Chlora Lindley-Meyers and Jeana Thomas (MO); Mike Chaney represented by Ryan Blakeney (MS); Jon Godfread represented by John Arnold (ND); Eric Dunning represented by Martin Swanson (NE); Judith L. French represented by Jana Jarrett (OH); Glen Mulready represented by Ashley Scott (OK); Andrew R. Stolfi (OR); Micheal Humphreys (PA); Cassie Brown represented by Randall Evans (TX); Jon Pike (UT); Scott A. White and Zuhairah Tillinghast (VA); Mike Kreidler (WA); Nathan Houdek represented by Sarah Smith (WI); and Allan L. McVey represented by Joylynn Fix (WV).

1. Observed the Presentation of Consumer Representatives' Excellence in Consumer Advocacy Awards

Bonnie Burns (California Health Advocates—CHA) and Brenda J. Cude (University of Georgia) presented Commissioner Mike Kreidler (WA) with the Bonnie Burns Excellence in Consumer Advocacy Award for his lifelong efforts in protecting insurance consumers. Dr. Cude said Commissioner Kreidler is the only person who has received this award twice. Amy Bach (United Policyholders—UP) and Christa Stevens (Autism Speaks) presented the award to Commissioner Michael Humphreys (PA) for his work on consumer health insurance issues, especially long-term care (LTC) and mental health insurance issues. Consumer representatives purchase the awards and select the state insurance commissioners who receive them.

2. Adopted its Summer National Meeting Minutes

Commissioner Bettencourt made a motion, seconded by Stralka, to adopt the Liaison Committee's Aug. 12 minutes (*see NAIC Proceedings – Summer 2024, Consumer Liaison Committee*). The motion passed unanimously.

3. Announced the Reaffirmation of its 2024 Mission Statement for 2025

The Liaison Committee conducted an e-vote that concluded Oct. 16 to reaffirm its 2024 mission statement for 2025. The motion passed.

Commissioner Arnold also noted that the Consumer Participation Board of Trustees met earlier to discuss how the new online Consumer Representative Application for 2025 worked during the Aug. 31 through Oct. 31 application period and discussed steps for a plan to revise the application accordingly next year. She said the Board will select the consumer representatives for the 2025 calendar year when it meets Dec. 16.

4. Heard a Presentation from UP on How State Insurance Regulators Can Help Consumers Reduce Risk and Reverse a Non-Renewal

Bach said the extensive use of misleading aerial and satellite photos of properties used by insurance companies in determining risk scores has resulted in a dramatic increase in non-renewal of homeowners insurance policies.

She said UP has seen a sharp uptake in calls to its consumer helpline regarding non-renewal notices and has developed tools that empower consumers with knowledge and steps they can take to reduce their risk and reverse a non-renewal. Bach said UP hosts a shopping and renewal guide on its website. She said the media noticed this use of satellite (now drone) images and has pointed consumers to UP for steps to take to avoid non-renewals and keep homeowners from being dropped from their insurance coverage by being aware of their vulnerability to it.

Bach said UP's proposal to state insurance regulators includes four parts: 1) requiring insurance carriers to give the property owner date-stamped copies of the images of their homes that show conditions that are out of compliance with the insurer's guidelines and/or impact the property's risk score taken by the carrier in the last 12 months; 2) requiring companies to provide an appeal process so that the consumer can correct any errors (i.e., incorrect address, solar panels mistaken for roof damage, etc.); 3) requiring the companies to give the consumer notice in a reasonable timeframe prior to non-renewal (the default is 30 days, but California's notice is 75 days); and 4) requiring companies to offer new or renewal policies to consumers who have "cured" the carrier's concerns before the non-renewal date.

She said challenges to these steps include: 1) the age of the images being used; 2) the underwriting requirements being used that companies do not want to share; 3) the risk scoring system used by the carriers; and 4) the companies' reluctance to provide details about the reason for the non-renewal. Bach said this is an important topic as it provides consumers with a way to keep their homeowners insurance coverage and protect their property. Commissioner Arnold asked if these non-renewals included commercial properties. Bach said that California wineries and other commercial properties are being hit and noted that most businesses have hired their own risk managers to address this issue. Commissioner Arnold said Minnesota has been in conversations with affordable housing groups about this issue as well.

5. Heard a Presentation from the AEPI on the "Election to Repair" Remedy

Erica Eversman (Automotive Education & Policy Institute—AEPI) said partial loss policy remedies include paying the loss in dollars and paying the cost to repair or replace damaged property. She gave legal citations of the history of repair remedy for fire insurance, which is over 150 years old: 1) Morrell v. Irving Fire Ins. Co., 33 N.Y. 429, 437 (1865) (repair "election, converted the contract of insurance into a building contract, the amount of the insurance named in the policy ceased to be a rule of damages."); 2) Buckeye Mutual Fire Ins. Co., 43 Ohio St. 394, 2 N.E. 420 (1885) (insurers who elect repair convert the insurance contract of monetary indemnity into a repair contract); and 3) Zalesky v. Iowa State Ins. Co., 102 Iowa 512, 518, 70 N.W. 187, 189 (1897). She also gave the following examples for automobile insurance: 1) Gaffey v. St. Paul Fire & Marine Ins. Co., 221 N.Y. 113, 115, 116 N.E. 778, 778 (1917) NY; 2) LETENDRE v. Auto. Ins. Co., 43 R.I. 410, 412-13, 112 A. 783, 784 (1921) RI; 3) Buerkle v. Superior Court of Los Angeles County, 59 Cal. 2d 370, 29 Cal. Rptr. 509, 379 P.2d 941 (1963) CA; 4) State Farm Mutual Automobile Insurance Co. v. Dodd, 276 Ala. 410, 162 So. 2d 621 (1964) AL; 5) Gregoire v. Insurance Co. of N. Am., 128 Vt. 255, 261 A.2d 25 (1969) VT; 6) Venable v. Import Volkswagen, Inc., 214 Kan. 43, 519 P.2d 667 (1974) KS; and 7) Mockmore v. Stone, 143 Ill. App. 3d 916, 919, 493 N.E.2d 746 (Ill. App. Ct. 3d Dist. 1986) IL.

Eversman said the effect of repair election is that the insurer converts the insurance contract into a repair contract and takes control of the property. She said this means that the insured must cooperate with the insurer for repairs and sign consumer protection authorization for repairs. Eversman said this gives the insurer complete control over the provider used and the cost because the insurer becomes the general contractor for the repair, and the provider is 100% liable to the insured or third parties for repair. Thus, the repair contract erases all terms and limitations contained in the policy, and the policy limits disappear. In accordance with Home Mut. Ins. Co. v. Stewart, 105 Colo. 516, 520, 100 P.2d 159, 160-61 (1940), the steps for electing repair: 1) must be made within a reasonable time after damage or loss; 2) must be clear, positive, distinct, and unambiguous; 3) must make repairs or replacements within reasonable time; 4) cannot be coupled with offer of compromise or be made for the

purpose of forcing a compromise, but must be an election made with no alternative; and 5) when election made, repair or replacement must be suitable and adequate.

Eversman said some states have anti-steering laws or regulations that prohibit insurers from requiring the use of specific auto repair providers. She said some problems with this election to repair in its application are that: 1) automobile insurers do not tell insureds which partial loss policy remedy it has chosen; 2) telling an insured to select a repairer and to take their vehicle to be repaired is not electing a repair remedy; 3) merely having a preferred provider network is not electing to repair; and 4) insurers insert themselves into insured's repair to control costs, but disclaim any liability. For homeowners, Eversman said requiring the use of a provider implies repair election; and exposes the insurer to liability. She said her recommendations to state insurance regulators are to, by official means: 1) require insurers to notify the insured in writing of the remedy provision chosen under the policy within a specific time; 2) notify insurers that they cannot combine pay loss in money and elect to repair remedies; and 3) require insurers to select the repair remedy and its responsibilities if the insurer intends to require the use of specific providers or to inject themselves into the repair process.

Evans said the issue of storage fees associated with repairs was raised during the Anti-Fraud (D) Task Force's meeting, as there has been a lack of understanding as to whether this applies to repairers. He said the opinion was set forth that it only applies to tow trucks and that the insurer can negotiate on behalf of insureds.

6. Heard a Presentation from SULC on the Use of Criminal History Data in Insurance Underwriting and Claim Evaluation

Peter Kochenburger (Southern University Law Center—SULC) said criminal history records that include arrests without convictions and publicly available online are being incorporated into predictive insurance models. He said misdemeanor and felony arrests, minor traffic offenses, and municipal ordinance violations (e.g., jaywalking, excessive noise, building code violations) are also captured and used in these models. He said the U.S. has one of the highest incarceration rates in the world and that its criminal justice system is typically skewed against people of color in policing, arrests, sentencing, and incarceration rates.

Kochenburger said there is a general lack of information about how criminal records are used in insurance underwriting, claims, and fraud detection. He said research of public records recently revealed that many accusations were: 1) incomplete or inaccurate; 2) not updated when cases were dropped or closed without convictions; 3) not sealed in a consistent, timely manner; and 4) disproportionately affected underprivileged populations. He said the National Conference of Insurance Legislators' (NCOIL's) July 17, 2021, "Resolution Regarding the Use of Certain Rating Factors" resolved that "…NCOIL views as contrary to public policy and unfairly discriminatory the use of all data in the underwriting of private, non-commercial insurance that is: related to non-pending arrests, charges and indictments that do not result in conviction; related to convictions that do not relate in any way to fraud; or are not related to the insurability of a prospective or existing policyholder, and urges state legislatures to prohibit its use…." He said the full resolution is available on NCOIL's website.

Kochenburger said the Federal Credit Reporting Act (FCRA) applies to insurance and prohibits the use of criminal history (other than for convictions of crimes) that are more than seven years old, with limited application to life insurance (15 USCA 1681c(a)(2), (b)(2)) and that state laws may further restrict its use. He said that FCRA requires consumer reporting agencies and insurers and creditors that utilize their information to provide detailed disclosures and information to consumers, along with rights to see and correct inaccurate data and information. Kochenburger said some questions state insurance regulators might want to consider include: 1) when third-party vendors are subject to the FCRA or related state laws; 2) whether/how they are complying; 3) any history of FCRA complaints or violations; 4) whether state insurance regulators know they are complying; 5) recalling third-party data vendors'/modelers' early enthusiasm over what their models could do and their lack of knowledge of

insurance law and regulation they demonstrated when explaining their products; and 6) whether the rights under the FCRA and state laws are provided to insurance consumers.

Kochenburger also suggested state insurance regulators obtain information from insurers and their third-party vendors on how they collect and use criminal history records. He said the draft Special (EX) Committee on Race and Insurance survey questions to life insurers provide an excellent place to start and that similar surveys should be sent to property/casualty (P/C) and health insurers. Kochenburger said P/C insurance may use criminal history information more frequently than other lines, especially for personal auto and homeowners. He said these surveys should not trouble insurers; state insurance regulators are simply asking how criminal history is used, a necessary question before considering what limitations to propose. Kochenburger said transparency to state insurance regulators provides them with the information necessary to determine compliance with existing federal and state laws, specifically, the FCRA, which applies nationwide, and to consumers who have the right to know what criminal history data was collected and utilized. He said it also provides clear procedures to obtain this information and a clear process to question the accuracy. He said transparency to consumers does not include (and has never included) disclosure of proprietary algorithmic models or similar intellectual property. He said this is often an industry canard used to minimize information disclosure to consumers.

Kochenburger suggested the discriminatory impact of inaccurate, incomplete, or simply non-existing, (other than the fact that an individual was arrested) records must be addressed. He said that for basic fairness and equity reasons, the use of criminal arrests not associated with a later conviction should be significantly limited in insurance operations, including underwriting and claims. He said ordinance violations or other non-criminal infractions should never be considered or utilized as a criminal record for insurance purposes. He suggested that, depending on the Special (EX) Committee on Race and Insurance's survey results, state insurance regulators request insurers and their vendors demonstrate that no other non-discriminatory factors can achieve a similar level of risk precision as the criminal history data they use.

Commissioner Humphreys said that during the Special (EX) Committee on Race and Insurance's Life Workstream, companies proposed a rate based on the type of conviction over 10 years and said it would not insure such risks if it could not use this basis. He asked if this was due to available studies or a lack thereof. Kochenburger said he did not know because the public has no access. He said it would be more prevalent in life insurance and whether homeowners' coverage would be annually renewed. He said he could not address it with health insurance. Commissioner Humphreys said the challenge is the intersection with clean state laws, such as employment applications whereby one's felony record should not stay with them forever. Kochenburger said the key is transparency so the consumer can see what is being used and how it is being used. Commissioner Humphreys said that the Special (EX) Committee on Race and Insurance and other workstreams need to continue investigating this issue.

7. Heard a Summary from the CCHI, NHeLP, and DREDF on the NAIC Consumer Representative AI and Health Insurance Report: *Artificial Intelligence in Health Insurance: The Use and Regulation of AI in Utilization Management*

Adam Fox (Colorado Consumer Health Initiative—CCHI) said that the use of artificial intelligence (AI) and algorithms in insurance practice is proliferating rapidly. He said that the use of AI in utilization management (UM) and prior authorization (PA) are an increasing area of focus and concern in health insurance practice and that the *Artificial Intelligence in Health Insurance: The Use and Regulation of AI in Utilization Management* report is intended to support state insurance regulators and the NAIC in informing potential actions. The report examines how health insurers use AI and finds that while AI presents opportunities for plan efficiency, it also poses potential risks for consumers, including the likelihood of exacerbating existing bias and discrimination. He said the research was divided into three phases: 1) an environmental scan to review and summarize white and grey literature to examine the current landscape of AI in health insurance decision-making processes, with a focus on PA as a form

of UM, and preliminary efforts to regulate it; 2) key informant interviews to supplement the environmental scan to create a more holistic view of the industry's current use and challenges of AI, including information not publicly known or published; and 3) synthesis (i.e., white paper development) to combine the environmental scan and in-depth interview findings with policy recommendations.

Fox said a summary of the report findings indicated that: 1) the use of AI is already a regular part of UM activities and continues to expand; 2) proponents cite the potential value of reduced administrative burden and expedited approvals (however, there are significant risks of exacerbating biases, prioritization of misaligned incentives, and use of technologies outside their intended use case or design leading to unintended harm); 2) all stakeholders interviewed noted the opportunities with the use of AI, but also the need for the proper safeguards; and 3) while some states have begun to regulate the use of AI in health insurance, for the most part, they have not been able to keep pace with the rapid proliferation of AI use. This has created a challenging but essential problem to solve.

Wayne Turner (National Health Law Program—NHeLP) said the key issues and concerns are that: 1) the limitations that AI has for healthcare determinations are one-size-fits-all but do not work for everyone; 2) navigating automated systems can be challenging; and 3) insurers using AI/machine learning (ML) systems for UM need to provide an off-ramp for individualized care assessments because people with chronic conditions need access to treatments that work for them (e.g., HIV, multiple sclerosis, and irritable bowel syndrome [IBS] have repeated step therapy or encounter a PA fight) and people in health crisis need immediate access to needed care as it is a race against time and insurers should defer to providers in these cases. Turner said consumers need meaningful transparency to access the criteria used for utilization management to appeal wrongful denials. He said up-to-date clinical standards should support coverage decisions, and the criteria must be evidence-based and nonproprietary, not determined by third-party entities that fall outside of state insurance regulation.

Turner said "ascertainable standards" are required under Medicaid due process per Salazar v. District of Columbia, 596 F. Supp. 2d 67, 69 (D.D.C. 2009). Turner said another limitation is the practice of exchanging denials for dollars. He said insurers are accountable for the vendors and other third parties they contract and should not be permitted to dial down or up PA approvals with an eye toward profits. He also said that insurers and agencies cannot subcontract away their obligations under nondiscrimination and other laws. Turner said the last limitation is testing on three levels: 1) pre-deployment testing for accuracy and bias; 2) post-implementation testing and monitoring so that data on the use of AI/ML is publicly available to study potential disparate impact from systems that may appear facially neutral; and 3) periodic, independent auditing with the insurer, as self-reporting of testing, performance monitoring, review, and corrective action is insufficient.

Silvia Yee (Disability Rights Education and Defense Fund—DREDF) said recommendations and next steps for state insurance regulators include meaningful transparency. She said it is critical and must be clear to both state insurance regulators and consumers when health insurance plans are using AI for the purposes of UM, as well as what role AI plays in making determinations about coverage for care. Yee said transparency must extend to disclosures about the data used to develop, train, and test AI tools (with an emphasis on consent for use and representativeness of the population) and the extent to which any AI tool can begin to train itself. She said existing laws used to regulate data should be assessed for their applicability to AI in UM. Yee said the reliance on proprietary technologies obscures accountability for decisions when harm is done. She said transparency is a necessary precursor for any complaint or action taken to enforce regulation and that regulatory standards must clearly identify which parties are accountable (e.g., health plans, technology developers, etc.) when AI tools are used in UM decisions that lead to consumer harm, including discrimination, breaches of privacy, and incorrect adverse determinations.

Yee said regular audits, conducted on behalf of state regulatory agencies by parties with a specialization in testing AI technologies, can be an effective way to understand the ways AI is used in making UM decisions and hold the plans accountable for its use. She said AI tools intended for UM decisions should be built on standards of care that

aim to achieve the highest level of quality, and penalties for non-compliance need to be significant enough to have influence. Yee said governance structures that measure and prevent harm to historically marginalized and minoritized populations must be required. She said human oversight is important but is not a panacea, and accessible appeals processes must be prioritized. Yee said robust and accessible appeals processes for coverage denials need to be established and considered a guaranteed right for all health insurance consumers, and human oversight must be embedded into UM when AI is used. She said those reviewers must have the authority and ability to overturn decisions made by the AI without undue consequences. Yee said AI regulation needs to be considered an evolving practice that relies on collaboration between regulators, technical experts, industry stakeholders, consumers, and consumer advocates to keep it relevant.

8. Heard a Presentation from CHA and a Consumer Advocate on Consumer Challenges Accessing Medicare Advantage and Medicaid

Burns said this presentation sheds light on a fundamental problem created when providers of Medicare Advantage plans leave the market, leaving a gap situation for unsuspecting consumers. She said federal guidance is being sought to give consumers direction on how and what they are eligible to replace those plans with. She said consumers are facing challenges in 2025 accessing healthcare through Medicare Advantage plans. She said that, in addition to a shorter open enrollment period that ends Dec. 7 this year due to the timing of the election and Thanksgiving holiday, providers are leaving Medicare Advantage plans, and insurers are leaving the Medicare Advantage market. She said that providers can leave Medicare Advantage plans anytime with 30 days advance notice, not just during the annual enrollment period (AEP), so whole health systems, rural hospitals, and medical groups are doing just that.

Burns said this has resulted in a reduced number of Medicare Advantage plans and options being available to Medicare beneficiaries. She said the effect on Medicare Advantage members has been a loss of established health care providers; narrowed provider networks; rescheduled services and medical procedures; remaining network providers not taking new patients; long delays for appointments with remaining network providers; used and incurred cost for out-of-network providers; network adequacy issues; and time, distance, and location issues, especially in rural areas. Burns said Medicare Advantage members are locked into the plan because while it is true that Medicare Advantage members can change their plan at any time, they have no federal right to a Medicare supplement insurance (Medigap) policy when their health care providers leave a Medicare Advantage plan. She said even if Medicare Advantage members had the right to change to a Medigap policy, they might not be able to obtain one as Medigap carriers screen out applicants with health conditions. She said a Special Enrollment Period (SEP) is needed in these cases and has sent a request for one to the U.S. Secretary of Health and Human Services (HHS) and the federal Centers for Medicare & Medicaid Services (CMS). Burns said the NAIC consumer representatives sent a letter to the Senior Issues (B) Task Force, and the NAIC sent a letter to the CMS Administrator.

Burns said access to Medigap policies is limited. She said consumers can access it only when they first become eligible for Medicare and have Open Enrollment rights or following certain federally protected events, which are listed in *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, #MO-651* and other applicable federal guaranteed issue events. These include retirees covered through employers whose eligibility is deferred until they leave employment, at which time they can have Consolidated Omnibus Budget Reconciliation Act of 1995 (COBRA) coverage and Medicare at the same time, or veterans who can use the U.S. Department of Veteran's Affairs (VA) or Medicare and can switch from one to another. She said there are also other guaranteed issue events granted by state law to those younger than 65 years old and for certain other events or situations. Burns said, however, that few states allow voluntary transition from a Medicare Advantage plan to a Medigap policy. She said the Secretary has broad authority to create an SEP, and the *NAIC Model Regulation #MO-651* provides a guaranteed issue for eligible persons with Section 12(e) indicating, "The individual meets such other exceptional conditions as the Secretary may provide." Therefore, an SEP should be broadly

applied and include the right to Medigap when a consumer experiences a loss of providers from a Medicare Advantage plan.

Burns suggested that state insurance regulators: 1) create state SEPs that are coordinated with the AEP, with a Medigap guaranteed issue right; and 2) monitor the industry for illegal practices such as kickbacks to agents, brokers, and producers, and agent churning based on commissions where Medicare Advantage and Medigap commissions are used as an incentive or disincentive for replacements or churning. She said state insurance regulators could also require the following agent training specific to Medicare: 1) pre-licensing and continuing education (CE) tied to license renewal; 2) understanding Medicare and other coverage; 3) Medicare, Medigap, Medicare Advantage, and Part D plans; 4) other forms of health coverage with Medicare; 5) Medicaid and Medicare Savings Programs; and 6) federal and state replacement rules. Burns said state insurance regulators could also require producers to refer applicants to state insurance departments, State Health Insurance Assistance Programs (SHIPs), and state Medicaid programs for additional information.

Amy Killelea (Consumer Advocate) said there have been questions recently about whether Section 1557 of the Affordable Care Act (ACA) applies to Medigap plans and other excepted plans. She said Section 1557 is the nondiscrimination protection in "Health Programs and Activities" and clearly applies broadly to "any health program or activity, any part of which is receiving Federal financial assistance" (42 U.S. Code § 18116). She also said Section 1557 protections apply to all operations of the entity receiving federal financial assistance, even lines of business that do not directly receive the federal financial assistance, and that the application of civil rights laws to all operations of an entity receiving federal financial assistance is not new and did not originate with Section 1557 but through the Age Discrimination in Employment Act (ADEA). Killelea said the federal government does not require private companies to make Medigap available to disabled beneficiaries under age 65; however, 35 states have regulations directing insurers to have at least one type of policy available to select groups of younger Medicare recipients.

Killelea said neither the ACA nor Section 1557 include a list of discriminatory practices, but the standard cited in the final rule is that the plan practice or plan design may not be based on unlawful animus or bias or constitute a pretext for discrimination. Killelea said that if a plan design is determined to be discriminatory, the covered entity may provide a legitimate, nondiscriminatory reason for the plan's benefit design. For example, the covered entity may say compliance will make the plan unaffordable or force the issuer to stop selling the plan altogether. She said that when a nondiscriminatory reason is proffered, the U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR) will consider the evidence presented to determine whether the reason is legitimate and not a pretext for discrimination. She said that in the case of disability discrimination, covered entities may also prove that modifying a plan to comply with Section 1557 would fundamentally alter their health program or activity.

Killelea said the ACA and final rule do not address whether underwriting based on a protected class is now prohibited in Medigap and other excepted benefit plans. She said that following the discrimination inquiry outlined in the rule, a few potential paths for how plans will be reviewed are revealed. For instance, a Medigap plan that underwrites plans based on disability and charges people with disabilities a higher premium could warrant a discrimination claim that the practice is based on animus or bias against this protected class. To this claim, the Medigap plan could offer evidence that the underwriting practice is not based on bias toward a protected class but on a legitimate business reason to charge this population more in premium. She said the OCR would then have to determine if that business reason is legitimate. To do that, the OCR might look at whether evidence is presented that removing underwriting based on this protected class would send the plan into a death spiral and weigh the business interests against the interest of protecting people with disabilities from higher premiums.

Killelea said other potentially discriminatory practices might include: 1) refusing to accept third-party payments from charitable or government programs for people with disabilities (e.g., HIV); 2) denying coverage based on a disability; or 3) charging people higher premiums based on gender. She said state insurance regulators should consider: 1) assessing Medigap and other excepted benefits markets and the extent to which enrollment, premiums, and plan designs exclude or limit coverage based on age, disability, sex, or race; 2) consulting with consumer groups and other experts on how excepted benefits markets impact consumers based on age, disability, sex, and race; and 3) developing guidance for regulated entities on how Section 1557 impacts products regulated by the state. Killelea said there is a cost to this benefit, as companies may drop out of the market if they cannot sell how they want, so there is a need to balance it. She said, however, that there are also other alternatives, such as state legislative initiatives. Commissioner Arnold said there have been recent changes in Minnesota's Medicare market, so this information is valuable.

9. Heard an Update from the ACS CAN, NAMI, and LAC on How Recent and Upcoming Federal Actions Will Impact State Regulation of the Health Insurance Market

Deborah Steinberg (Legal Action Center—LAC) said recent and upcoming federal actions may affect state regulation of health insurance as the U.S. Department of Labor (DOL), HHS, and CMS released new rules. She said a newly issued Mental Health Parity and Addiction Equity Act (MHPAEA) final rule established a new purpose to interpret all provisions of the regulations consistent with the fundamental purpose of the MHPAEA and that no greater burden on access to mental health or substance use disorder (MH/SUD) benefits than medical/surgical benefits. She said it also amends the definitions of MH/SUD and medical/surgical benefits to align with generally recognized independent standards of current medical practice and the International Classification of Diseases (ICD) or Diagnostic and Statistical Manual of Mental Disorders (DSM) to note that eating disorders, autism spectrum disorders (ASDs), and gender dysphoria are MH conditions for the purposes of the MHPAEA and comparative analyses.

Steinberg said plans must provide meaningful coverage. For example, core treatment for an MH/SUD must be offered in a benefit classification if a core treatment for medical/surgical is offered in that benefit classification and to consult generally recognized independent standards of medical practice (i.e., medications for opioid use disorder [OUD] and outpatient counseling for OUD). She said it also amends the non-exhaustive list of non-quantitative treatment limitations (NQTLs) with medical management standards, including PA; standards related to network composition, including admission or continued participation; reimbursement rates; procedures for ensuring network adequacy; and methods for determining out-of-network rates. Steinberg said NQTL analysis requires a two-prong test: Test 1 analyzes the design and application of the NQTL, and Test 2 evaluates outcomes data. She said the new rule also requires NTQL analyses and enforcement that codifies the six-step process for analyzing NQTLs that state insurance regulators can request at any time. Steinberg said state insurance regulators may require plans to stop applying an NQTL upon a final determination of non-compliance. She said an insufficient or non-compliant comparative analysis could also result in state insurance regulators requiring a plan to cease applying an NQTL and that other corrective/enforcement actions are also permissible.

Anna Howard (American Cancer Society Cancer Action Network—ACS CAN) said the ACA created tax credits for low- and moderate-income individuals who purchase marketplace coverage. She said that the American Rescue Plan Act (ARPA) and the Inflation Reduction Act (IRA) provided even more enhanced tax credits by increasing those who qualify and the amount of money saved; however, absent Congressional action, the enhanced ACA tax credits will expire Dec. 31, 2025, and, unless Congress acts swiftly, all marketplace enrollees will see significant premium increases for plan year 2026 and beyond, and millions of insureds will drop their coverage. Howard said the NAIC has already reached out to Congress in a letter requesting an extension of these tax credits beyond the end of the year. She said states need to reach out to other stakeholders in their communities, work with their congressional delegations, and continue their outreach to Congress with education about the need for immediate action and the potential ramifications if Congress delays action.

Howard said the Braidwood v. Becerra case threatens the provisions of the ACA that require most insurance plans to cover preventive services recommended by the U.S. Preventive Services Taskforce (USPSTF), Advisory Committee on Immunization Practices (ACIP), and Health Resources and Service Administration (HRSA) without cost-sharing. She said the case was appealed to the Supreme Court of the U.S. (SCOTUS) in September, and a decision as to whether the court will take it up is still pending. She said that while litigation is currently pending, state insurance regulators should ensure continued ACA preventive service coverage and cost-sharing protections by incorporating them into state law. Howard also said CMS issued a new frequently asked questions (FAQ) document requiring issuers to cover all forms of pre-exposure prophylaxis (PrEP) (including long-acting) without PA, and that addresses billing and coding issues. She said that other federal rules of note are the Short-Term, Limited-Duration Insurance (STLDI) rule and the preventative services proposed rule.

Jennifer Snow (National Alliance on Mental Illness—NAMI) said the HHS Proposed Notice of Benefit and Payment Parameters (NBPP) for 2026 was published Oct. 10 with comments due Nov. 12. She said the NBPP establishes standards for health insurance marketplaces for the 2026 plan year. Snow said it addresses agent and broker changes that are being discussed at the Improper Marketing of Health Insurance Plans (D) Working Group due to the unauthorized plan switching, with fraudulent actors reassigning broker designations and switching consumer enrollments without their permission or knowledge, causing consumers to suffer because the plans do not include their doctors or medications; have higher deductibles than their original coverage choice; and can result in consumers owing back taxes if their income or eligibility for premium tax credits is misrepresented during the exchange.

Snow said the changes proposed would: 1) increase oversight and accountability for brokers and agents in response to problems with switching consumers' enrollment; and 2) clarify that lead agents are subject to the same rules as individual brokers, agents, and web brokers and that enforcement action can be taken against the lead agents if they explicitly or implicitly condone misconduct or fraud. She said the NBPP broadens CMS's authority to suspend broker and agent system access, inclusive of instances of suspected misconduct that affects eligibility determinations, operations, applicants, or systems, and it expands the model consent form to include documentation of the broker reviewing and confirming the accuracy of submitted application information with the consumer.

Snow said the proposed NBPP has new premium payment thresholds that give issuers new options to avoid triggering late enrollment grace periods. She said the goal is to minimize termination of coverage for consumers who owe a small amount, based on a fixed dollar threshold of $5 or less or a percentage-based premium threshold of 95% of net premium or 99% of gross premium. She said the rule also proposed: 1) improving plan options by requiring carriers that operate in the federal marketplace to offer a standardized plan option at every product network type and metal level (excluding non-expanded bronze plans) in each service area where they offer non-standardized plan options; 2) updating standardized plan options for 2026 to ensure that every plan matches the actuarial value assigned to the plan's metal tier; and 3) requiring issuers that offer multiple standardized plan options to meaningfully differentiate between these plans. She said the changes proposed would help consumers to better understand what benefits, networks, and drug coverage are included in each plan when making their selections.

Snow said other proposals include extending failure to file and reconcile notifications to two consecutive plan years to help increase awareness so consumers do not lose out on subsidies; publicly releasing the State-based Marketplace Annual Reporting Tool (SMART) and financial and program audits and data to help increase transparency; clarifying that the marketplace can deny certification to any plan that does not meet applicable criteria to help ensure consumers have access to coverage that meets standards; and user fee updates that are dependent on the Advance Premium Tax Credit (APTC) to between 1.8%–2.5% in 2026 for Federally Facilitated Marketplace (FFM) states; and between 1.4%–2% in 2026 for State-based Marketplaces-Federal Platform (SBM-

FPs). Snow said that regardless of the election outcome, 2025 will bring the expiration of the APTC; implementation of the IRA; expiration of the Tax Cuts and Jobs Act (TCJA); and reinstatement of the debt limit. She said, however, that through all of that, consumer representatives are here to be a resource for state insurance regulators.

Harris asked how to keep consumers from being overburdened when they have been automatically enrolled in a plan. Snow said the key is to keep consumers fully informed prior to the auto-enrollment.

Having no further business, the NAIC/Consumer Liaison Committee adjourned.

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Draft Pending Adoption

Draft: 11/27/24

NAIC/American Indian and Alaska Native Liaison Committee
Denver, Colorado
November 18, 2024

The NAIC/American Indian and Alaska Native Liaison Committee met in Denver, CO, Nov. 18, 2024. The following Liaison Committee members participated: Glen Mulready, Chair (OK); Trinidad Navarro, Vice Chair (DE); Lori K. Wing-Heier (AK); Dean L. Cameron (ID); Grace Arnold (MN); Chlora Lindley-Meyers (MO); Mike Causey (NC); Jon Godfread (ND); Scott Kipper (NV); Andrew R. Stolfi (OR); Larry D. Deiter (SD); Jon Pike represented by Tanji J. Northrup (UT); Mike Kreidler represented by Todd Dixon (WA); Nathan Houdek (WI); and Jeff Rude (WY).

1. Adopted its Summer National Meeting minutes.

Director Wing-Heier made a motion, seconded by Commissioner Rude, to adopt the Liaison Committee's Aug. 14 minutes (*see NAIC Proceedings – Summer 2024, NAIC/American Indian and Alaska Native Liaison Committee*). The motion passed unanimously.

2. Announced the Reaffirmation of its 2024 Mission Statement for 2025

Commissioner Mulready announced that the Liaison Committee conducted an e-vote that concluded Oct. 15 to reaffirm its 2024 mission statement for 2025. The motion passed unanimously.

3. Heard a Presentation from the University of Washington School of Medicine and Leavitt Partners on the AIMES Alliance

Bill Snyder (Leavitt Partners) said that as a South Dakota resident who worked with Medicaid, he saw the need for better health care first-hand. He said Leavitt Partners manages the American Indian Medical Education Strategies (AIMES) Alliance. Leavitt said the Alliance brings together voices from all sectors to collaboratively drive solutions forward that will bring graduate medical education (GME) to Tribal communities. He said there are numerous founding members that include health plans, associations, universities, health systems and tribes. Dr. LeeAnna Muzquiz (University of Washington School of Medicine) said this program is collaboratively advancing federal and Tribal solutions that expand GME opportunities in Indian Country through communications, outreach, and policy development to reduce physician shortages in Tribal medical facilities. She said the goal is to keep up to date on the latest policies, activities, and developments focused on reducing physician shortages and expanding GME in Tribal medical facilities by joining the AIMES Alliance community in providing broader medical access for American Indians and Alaska Natives (AI/ANs). Dr. Muzquiz said this is also important because it provides another avenue for outreach that states can use via a partnership with the AIMES system. She encouraged state insurance regulators to use their influence to help expand membership in the AIMES Alliance nationally, as it currently has members in only 19 states with seven tribal partners; 14 medical schools; four teaching hospital systems; one health plan; one residency program, and five physicians and medical education advocates.

Dr. Muzquiz said the diversity of the AIMES Alliance membership is its strength. She said AIMES Alliance members include those from Tribal nations, urban and rural Tribal organizations, medical institutions that grant Doctor of Medicine (MD) and Doctor of Osteopathic Medicine (DO) degrees, teaching hospitals, residency programs, and physician and workforce advocates.

Dr. Muzquiz said that despite the billions of dollars put toward training physicians, hardly any money goes to Tribal medical facilities even though they could benefit the most from improved staffing. She said AI/ANs suffer from some of the highest rates of avoidable deaths from preventable and treatable causes. For example, from 2020–

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2021, the U.S. rate of deaths before age 75 from preventable causes per 100,000 population was 231.9. For AI/AN individuals, however, that rate was more than double the national rate, at 478.9. In one state, the rate of preventable deaths was more than four-and-a-half times the national rate, at 1,394 deaths from preventable causes per 100,000 population. Snyder said the AIMES Alliance is working to accomplish its mission through communications, outreach, and policy development. Dr. Muzquiz said the AIMES Alliance envisions an environment where urban and rural Tribal members benefit from access to fully staffed medical facilities filled with physicians who provide high-quality and culturally appropriate care and invest in the communities they serve. She said the Alliance also envisions a medical education and training environment where allopathic and osteopathic physicians have extensive opportunities to benefit communities and further their education and training in urban and rural Indian Health Service (IHS), Tribal-administered, and other Indigenous clinics and facilities.

Dr. Muzquiz said Dr. Donald Warne leads the AIMES Alliance as its convener and is currently serving as co-director of the Johns Hopkins Center for Indigenous Health. She said Warne is an acclaimed physician, one of the world's preeminent scholars in Indigenous health, health education, policy, and equity, as well as a member of the Oglala Lakota Tribe from Pine Ridge, SD. She said Warne will also serve as Johns Hopkins University's new Provost Fellow for Indigenous Health Policy. Davis said that because Warne comes from a long line of traditional healers and medicine men and is a celebrated researcher of chronic health inequities, he is also an educational leader. Warne created the first Indigenous health-focused Master of Public Health (MPH) and Doctor of Philosophy (PhD) programs in the U.S. or Canada at North Dakota State University and the University of North Dakota, respectively. She said Warne previously served at the University of North Dakota as a professor of Family and Community Medicine and associate dean of diversity, equity, and inclusion (DE&I), as well as director of the Indians into Medicine and Public Health programs at the University of North Dakota School of Medicine and Health Sciences.

Dr. Muzquiz said Dr. Michael Toedt serves as the AIMES Alliance's senior advisor and is the founder and chief executive officer (CEO) of Toedt Health Solutions. She said Toedt is a North Carolina-licensed and board-certified family physician and the former chief medical officer (CMO) of the IHS, as well as their chief medical informatics officer (CMIO). Dr. Muzquiz said Toedt is a retired rear admiral with over 30 years of experience as a physician executive, public health expert, health information and technology expert, and flag officer in the U.S. Public Health Service Commissioned Corps. She said that Toedt, as a Uniformed Services University of the Health Sciences graduate, has first-hand experience serving in IHS, Tribal, U.S. Department of Defense (DoD), and U.S. Department of Veterans Affairs (VA) health care facilities. He has served on numerous U.S. Department of Health and Human Services (HHS) committees. She also said Toedt has experience working with local, regional, Tribal, state, and federal governments, emphasizing eliminating health inequity and improving health outcomes for vulnerable and underserved populations.

Snyder said GME is the period of training performed after medical school where physicians gain specific skills and experiences in a particular medical specialty (residency) or subspecialty (fellowship). This formal training must be completed to practice medicine in the U.S. He said GME is primarily funded by four federal programs and agencies (Medicare, the Health Resources and Services Administration [HRSA], the VA, and the DoD) and one joint federal-state program (Medicaid). Snyder said GME residents and fellows in Tribal medical facilities create an ecosystem of sustainable, high-quality care locally, reducing the need for travel, long waits, and paying for high-cost locum tenens positions (a locum, or locum tenens, is a person who temporarily fulfills the duties of another; the term is especially used for physicians. For example, a locum tenens physician is a physician who works in the place of the regular physician). Dr. Muzquiz said physicians invested in the community are more likely to provide consistent, accessible, and culturally appropriate care to Tribal members. She said that while IHS-operated medical facilities are frequently viewed by non-Tribal individuals as the most visible medical care provider in Indian Country, IHS is only part of the greater system that provides medical care to AI/ANs. She also said this system is referred to as the I/T/U in reference to the three categories of participating facilities: IHS, Tribal-operated, and Urban Indian

Organizations (UIOs). She said this system finds creative ways to help patients and GME provides an opportunity for this type of creative training.

Dr. Muzquiz said the goal was for medical students to go back home to do their residencies and post-graduate training; however, there are no training centers in those areas, so it is hard for new physicians to get back into serving their own communities during the GME training cycle. Snyder said a tool was released last week to help medical students find GME training in their native lands. Dr. Muzquiz said the University of Washington has started a program to rotate student training through the Flat Head organization and Pine Ridge Medical Center to address this situation. Dr. Muzquiz invited state insurance regulators to proactively engage with urban and rural Tribal nations and Tribal organizations in their state; let policymakers know that GME opportunities in Tribal communities are important to state insurance regulators and the organizations they represent; check out the Tribal GME opportunities tool on the AIMES Alliance website and share it with interested individuals and organizations in their networks; and encourage organizations interested in joining the AIMES Alliance to contact herself or Snyder.

4. Heard a Presentation from Tribal First on Producer Outreach to Tribal Members Providing Access to Affordable Insurance Products

Commissioner Mulready said the Liaison Committee has discussed outreach to tribal communities for many years; however, it has not heard from producers until now.

Brendan McKenna (Tribal First) said his presentation is designed to provide insight into the innovations being used to make affordable health care more accessible to all Native Americans and give tribal leaders the ability to self-govern the health care arena. He said tribes in the Pacific Northwest have been taking a more liberal approach to tribal self-governance recently by exercising self-governance to Deliver Health Care. At the turn of the century, he said there were 15 million native Americans. Over the past 35 years, the number of native Americans has been on the same path as the buffalo, in that both have dropped dramatically to almost extinct levels, with tribal members going from 250,000 to only 5,000 in recent years. McKenna said much of this decline has been the result of failed U.S. government policies, with over 2,500 treaties being broken—not by the tribes, but by the federal government. He said another big part of the decline was in the lack of proper medical care caused by reduced federal funding of tribal nations and the condensing of Indian Country into ever smaller areas of land on a per-person basis.

McKenna said that in 1994, Indian Country used Publication 638 to take authority for tribal self-governance to do what it needed to serve and meet the needs of its own people without relying on the federal government. He said the Indian Self Determination and Education Assistance Act identified the need and set forth plans to meet it. He said the Indian Health Care Improvement Act allowed the use of federal appropriations wherever and however tribal members needed it, whether it was to buy insurance plans on the open market; use federal funds to self-insure; or open their own medical facilities to serve their people. He noted that annual federal appropriation for general prison populations in 2024 is $11,400 per prisoner; however, it is only $4,500 per person for federal-recognized tribal members. McKenna said the Medicare Prescription Drug, Improvement, and Modernization Act finally allowed native Americans to access Medicare. He said the Patient Protection and Affordable Care Act (ACA) included AI/ANs for the first time and the Public Health Service Act included the 340 B Drug Pricing Program, which is the Tribal Healthcare Model Plan that tribes can now purchase as self-funded outside of state authority. McKenna said self-governance gives tribes the opportunity: 1) to promote tribal sovereignty to serve the needs of plan participants for generations without IHS or state oversight; 2) to secure PRC Program Authorities to collaborate across stakeholders (tribes, brokers, TPAs, Tribal First and Tribal Care), continue to pool appropriations, and exercise PRC authorities (to purchase health care services, deliver health care services, and enforce Payor of Last Resort rules); and 3) to promote strength in numbers to align efforts to serve Tribes/Pueblos across Indian Country and install best practices shared by all. He said the Prevention, Retention, and Contingency

(PRC) program provides short-term assistance to low-income families and individuals in need of emergency help. The program is run by the local County Department of Job and Family Services.

McKenna said Tribal Cost Management Resources through the Medicare Modernization Act and PRC Rates Rule allow Medicare-like rates which saves 75% of billed charges on hospital-based or professional medical claims; through Indian Self-Determination and Education Assistance Act (ISDEAA); Indian Health Care Improvement Act (IHCIA); Affordable Care Act (ACA); Marsh McLennan Agency (MMA); Public Health Services Act (PHSA) which provides the authority of sovereignty and self-governance for the purchase and delivery of health services; the Public Health Services Act with its 340B drug purchasing that saves 50% compared to the traditional PBM model and all plan participants are eligible; and by Exchange Sponsorship where fully-insured state exchange plans are purchased by tribes for their members on a monthly basis. McKenna said resource integration was the key as it included plan administration by the preferred TPA partner, PRC program coordination, SPD compliance, and reporting; stop loss via preferred carrier partners, premium reward program, SPD complaints, and reporting; and broker support with its account support services, vendor partner relations, and reporting.

5. Heard a Panel Discussion from Commissioner Glen Mulready (OK) and Director Lori K. Wing-Heier (AK) on How State Insurance Regulators Support Tribal Communities.

Commissioner Mulready and Director Wing-Heier joined Dr. Muzquiz, Snyder, and McKenna to answer questions from attendees.

Julia Juarez (CA) asked how California could partner with the AIMES Alliance for outreach to Tribal communities. Dr. Muzquiz said to contact her or Bill Snyder following the meeting at their contact information noted on their last presentation slide.

Director Wing-Heier said health care accessibility is a huge challenge in Anchorage and other rural areas, as the cost is excessive, and the governor is working with HHS and the DOI on potential solutions.

Dixon said Washington is publishing a 12-page document that provides insurers with a handbook to meet the requirements of federal Tribal rules about networks, care, medical practice, etc. He suggested it might be a good topic for a future NAIC meeting.

Commissioner Mulready said he would like to thank our speakers, panelists, committee members and their staff for helping to promote the outreach of our NAIC community to Native American communities today, especially since November is officially recognized by the federal government as Native American Heritage month.

Having no further business, the Liaison Committee adjourned.

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