

# Draft Pending Adoption

Attachment One  
NAIC/Consumer Liaison Committee  
8/14/20

Draft: 8/11/20

NAIC/Consumer Liaison Committee  
Conference Call  
June 19, 2020

The NAIC/Consumer Liaison Committee met via conference call June 19, 2020. The following Liaison Committee members participated: Michael Conway, Chair (CO); Andrew R. Stolfi, Vice Chair (OR); Lori K. Wing-Heier represented by Anna Latham (AK); Jim L. Ridling represented by Mark Fowler (AL); Ricardo Lara (CA); Andrew N. Mais (CT); Karima M. Woods (DC); Trinidad Navarro represented by Frank Pyle (DE); David Altmaier (FL); Doug Ommen (IA); Robert H. Muriel represented by Lauren Peters (IL); Vicki Schmidt (KS); Sharon P. Clark (KY); James J. Donelon represented by Ron Henderson (LA); Kathleen A. Birrane represented by Joy Hachette (MD); Steve Kelley (MN); Chlora Lindley-Myers (MO); Mike Chaney represented by Ryan Blakeney (MS); Mike Causey represented by Tracy Biehn and Kathy Shortt (NC); Jon Godfread (ND); Bruce R. Ramage (NE); Russel Toal represented by Paige Duhamel (NM); Linda A. Lacewell represented by Sumit Sud (NY); Jillian Froment represented by Jana Jarrett (OH); Glen Mulready (OK); Jessica K. Altman (PA); Kent Sullivan (TX); Scott A. White represented by Don Beatty (VA); Mike Kreidler (WA); and James A. Dodrill (WV). Also participating were: Yada Horace, Gina Hunt and Steve Ostlund (AL); Alan McClain (AR); Vanessa Darrah and Tom Zuppan (AZ); Natalie Bruton-Yenovkian, Bryant Henley, Lucy Jabourian and Camilo Pizarro (CA); Peg Brown, Kate Harris and Debra Judy (CO); Kurt Swan (CT); Howard Liebers, Flavian Marwa and Sharon Shipp (DC); Janice Davis, Carolyn Diggs, Becky Griffith, John Reilly and Chris Struk (FL); Chance McElhaney (IA); LeAnn Crow (KS); Shawn Boggs (KY); Jackie Horigan (MA); Renee Campbell (MI); Grace Arnold, Peter Brickwedde, Martin Fleischhacker, Jonathan Kelly, T.J. Patton and Matthew Vatter (MN); Carrie Couch (MO); John Arnold, Janelle Middlestead and Johnny Palsgraaf (ND); Martin Swanson (NE); Denise Lamy and Christopher Nicolopoulos (NH); Viara Ianakieva (NM); Winston Berkman-Breen, Avani Shah, and My Chi To (NY); Tynesia Dorsey (OH); Jim Marshall and Mike Rhoads (OK); Larry D. Deiter (SD); Jennifer Ramcharan and Vickie Trice (TN); Doug Danzeiser (TX); Todd E. Kiser (UT); Mike Beavers, Julie Blauvelt, Katie C. Johnson and Rebecca Nichols (VA); Todd Dixon and Hailey Hamilton (WA); and Mark Afable (WI);

## 1. Heard Opening Remarks

Commissioner Conway said in acknowledgement of Juneteenth and the death of George Floyd, he and Commissioner Stolfi have given considerable thought toward cancelling or postponing this meeting. In the end, Commissioner Conway said they decided to move forward with the meeting due to the critical nature of the COVID-19 subject matter during the global pandemic. He said some insurers voluntarily reduced their premiums and gave consumers premium refunds; however, he said not all insurers are acting so responsibly.

## 2. Observed a Presentation on Consumer Protection Issues Resulting from, or Heightened by, COVID-19 and Measures to Reduce or Flatten Infections

Birny Birnbaum (Center for Economic Justice—CEJ) said state insurance regulators have responded to the pandemic with many important pro-consumer actions. However, he said personal auto insurance rates went from meeting statutory standards to becoming extremely excessive overnight due to quarantines. He said when vehicle miles traveled declined by 50–90% from late March through April, personal auto claims dropped dramatically because such claims are directly related to the number of vehicles on the road. He said empty roads meant far fewer claims. He said while some state insurance regulators encouraged insurers to provide relief, only three states have ordered relief to date. He also said state insurance regulators have not provided any guidance on the amount or method of relief. For example, the promise of relief upon policy renewal made by a few insurers does not provide relief for current premiums, and it does not get relief to consumers now when they need it most. Mr. Birnbaum said the pandemic has revealed the inadequacy of routine insurance regulatory data collection for market monitoring and market analysis. He said the most recent independent personal auto insurance data available to state insurance regulators is 2017 data, as published in the 2020 Auto Insurance Database. He said the absence of timely market regulation data contrasts sharply with detailed financial data that is reported frequently. He said the rapid transition to digital business in insurance has generally not resulted in consumer protection safeguards in two key areas—Algorithmic Bias and Dark Patterns—which are digital designs created to benefit the business, not the user. He said state insurance regulators believe they have the authority to address proxy discrimination against protected classes, NAIC model laws, and state statutes that do not explicitly recognize disparate impact against protected classes as unfair discrimination. He said there are no requirements for state insurance regulators and insurers to identify and minimize such proxy discrimination within the overall cost-based pricing framework. He said the time to

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explicitly recognize disparate impact against protected classes as unfair discrimination in insurance is long past due. He said regulatory modernization requires this recognition plus guidance for state insurance regulators and insurers on how to identify and minimize such disparate impact and safe harbors for insurers who follow best practices. He said paper disclosures are not effective when digitalized, and they promote misleading marketing in volatile markets like a pandemic. He said the pandemic has brought volatility to financial markets, causing rapid swings in the price of financial instruments, which is challenging to consumers because it leaves consumers vulnerable to misleading promises about the cost and performance of financial products. He said life insurers have moved their focus from death benefit products to investment type products, which are sold with illustrations that are used to show applicants and policyholders how the products they are considering purchasing operate. He said misleading illustrations have been a long-standing problem in the life insurance and annuity markets. He also said NAIC model revisions continue to permit illustrations of risky investments without risk and the ability to borrow money from the policy without having to pay it back because the policy accumulates such great returns. He said significant re-engineering of the illustration regime for annuities and life insurance is needed. He said the design of illustrations must be consumer-driven, utilizing best practices in consumer information, education and disclosure, including consumer testing. He said the rapid completion and state implementation of the Lender-Placed Insurance Home Model Law, along with increased scrutiny of credit-related insurance market outcomes for consumers, is urgently needed. He said states insurance regulators need to identify risk classifications rendered unreliable by the pandemic and prohibit adverse actions until the reliability can be established.

Brendan Bridgeland (Center for Insurance Research—CIR) said life insurance applications containing questions related to COVID-19 are being filed with state insurance regulators. He said these questions are not uniform; many are vague and unlikely to solicit useful information. He said some of these questions inquire about antibody tests, despite these tests being shown to be unreliable. He said questions are also being asked about COVID-19 diagnosis in extended family members, regardless of whether they reside in the same household or country. He said coverage may be denied based on the answers to these extremely vague questions, leading to unfair and arbitrary underwriting. He said consumers may be restricted to Temporary Life Insurance Agreements instead of full coverage and permitting vague and irrelevant questions may invite post-claims underwriting, which is particularly problematic when the applicant is deceased and surviving partners or children are under duress. He said state insurance regulators should be evaluating COVID-19-related insurance questions, especially those for long-term care insurance (LTCI), and making them more uniform.

Commissioner Conway asked how stress tests should be done. Mr. Birnbaum said consumer outcome should be monitored using timely data on a granular level to determine its accuracy. He said NAIC data is from 2017, so it is not timely, leading to proxy discrimination in algorithms. He also said state insurance regulators need to act to minimize the effect of negative factors, especially those related to criminal history or biased data, used in correlation to data on consumers in a protected class set.

Commissioner Mais thanked Mr. Birnbaum for keeping these issues in the forefront for regulators. He suggested many states had attempted to address these issues on an individual basis. He said New York Circular No. 1 tried to address the issue of disparate impact last year. However, Commissioner Mais said perhaps not relying on individual states, but rather a NAIC model could be created as an application to address disparate impact; or perhaps a general data pool. Mr. Birnbaum suggested the NAIC develop a model law or revise existing procedures that insurers use to demonstrate compliance with a safe harbor for companies using the guidelines and additional data collection to determine if disparate impact is occurring. He said the most robust data collection, much like financial regulation, should be used for market regulation. Commissioner Conway said a couple of workstreams are already in place within the NAIC framework into which this issue would naturally fall. He said he was committed to working with these groups to help address these issues.

### 3. Heard a Presentation on the Importance of High-Quality, Affordable Coverage During the Crisis: COVID-19 Testing

Amy Killelea (National Alliance of State and Territorial AIDS Directors—NASTAD) said COVID-19 testing is a rapidly evolving landscape wherein categorization is still underway. She said there are four types of diagnostic tests that detect active infection—Polymerase Chain Reaction (PCR), which is the most accurate; PCR rapid; PCR home; and Antigen—and one type of serologic, or antibody, test that has limited accuracy. She said COVID-19 testing guidelines by the U.S. Centers for Disease Control and Protection (CDC) are also evolving as a high priority for hospitalized patients with symptoms; healthcare facility workers, workers in congregate living settings, and first responders with symptoms; residents in long-term care (LTC) facilities or other congregate living settings, including prisons and shelters, with symptoms; persons with symptoms of potential COVID-19 infection; and persons without symptoms who are prioritized by health departments or clinicians, for any reason (e.g., public health monitoring, sentinel surveillance, etc.). She said many questions about testing remain unanswered, such as what the criteria for asymptomatic testing are, what recommendations employers should follow to safely reopen workplaces (e.g.,

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frequency of serial testing), and what constitutes “medically necessary” testing. She said the COVID-19 crisis highlights another important question of who pays for testing—private insurance or public health—which usually brings the issue of medically necessary diagnoses used by private insurance carriers versus surveillance used by public health authorities into question. She said there is no such thing as surveillance testing in the payor system. She said insurance coverage mandates include the Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) requirements for Medicaid, Medicare and private insurance to cover diagnostic COVID-19 testing, including serologic tests, without cost sharing. She said government public health funding includes \$10 billion in Epidemiology and Laboratory Capacity (ELC) funding to health departments to ramp up testing, contact tracing and surveillance. She said uninsured provider compensation includes \$3 billion across several stimulus packages to reimburse providers for COVID-19 testing for uninsured individuals. She said the human immunodeficiency virus (HIV) and hepatitis testing case study should be used as a lens to look at COVID-19 testing issues. She said routine HIV and hepatitis C testing must be covered without cost sharing—U.S. Preventive Services Task Force (USPSTF) Grade A and B, respectively—where coverage is not based on risk, but on age cohorts. She said antibody testing is generally covered, as it helps to guide treatment decisions. She said health department HIV and hepatitis programs: 1) are encouraged to bill third parties for testing built from the immunization “Billables Project”; 2) are focused on billing in clinical settings; and 3) allow health departments to target resources by focusing on population testing in community-based settings. She said considerations for state insurance regulators are to: 1) issue guidance for issuers to apply transparent “medically necessary” criteria to testing coverage; 2) protect consumers from surprise out-of-network lab bills by prohibiting balance billing; and 3) work with public health programs in their state to ensure coordinated response across agencies.

Commissioner Conway asked about pop-up testing for which cities could split the cost of set up without a payment infrastructure. Ms. Killelea said drive through testing had been set up by public health and the federal government. She said urgent care in parking lots is more difficult to determine, but it should be paid by insurance coverage. Commissioner Conway asked how Medicaid would determine who pays. Ms. Killelea said there should be extra flexibility under the federal Centers for Medicare & Medicaid Services (CMS) to cover the uninsured in the same way as Medicaid. Harold Ting (Healthcare Consumer Advocate) said a change should be made to nursing home coverage to address testing due to the COVID-19 crisis. Katie Keith (Out2Enroll) asked if companies had asked for more public coverage. Ms. Killelea said she was not aware of any instances where that had occurred.

#### 4. Heard a Presentation on the Impact of COVID-19 on Vulnerable Populations and Specific Issues for Older Adults

Ashley Blackburn (Community Catalyst) said according to the COVID-19 Tracking Project, there is a disproportionate impact due to the COVID-19 pandemic in the more vulnerable black and Native American communities where 23,251 black lives have been lost. She said black people account for 13% of the population and 24% of the deaths where race is known, which means the percentage of cases are two times higher than their population share. She said American Indian Studies at the University of California, Los Angeles (UCLA) illustrated a disparate impact in tribal nations and states with a total of 200 or more reported cases per 100,000 in population. She said the framework for solutions should include: 1) data collection disaggregated by race, ethnicity, gender identity, sexual orientation, age, socioeconomic status, disability status and county; 2) coverage and affordability with coverage expansion for the uninsured and coverage for treatment without cost sharing; 3) access and quality with equal access to testing/treatment, public health information provided in their primary language, and expanded access to telehealth services; and 4) Social Determinants of Health (SDOH) to address food and housing security and reduce incarceration. She said state insurance regulators should coordinate with state commissions or workgroups charged with centering equity in COVID-19 response efforts like Michigan, New Jersey and Washington; evaluate their community connections; create feedback loops to help them understand problems; and improve data collection and transparency by ensuring that the data being collected informs a more equitable response in their state.

Anna Howard (American Cancer Society Cancer Action Network—ACS CAN) said due to COVID-19, there has been a decline in cancer screenings since March due to the public delaying most of their regular screening appointments. She said delayed cancer screenings equals undiagnosed cancer, which leads to more deaths attributable to cancer. She said colorectal cancer is the second leading cause of death for men and women combined. She said between mid-March and mid-April, the number of colonoscopies fell by nearly 90%. She said the United States Preventive Services Task Force- USPSTF, which is an independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness and develops recommendations for clinical preventive services, recommends colonoscopy and at-home non-invasive screening tests for colorectal cancer. She said patients who receive a positive result from a non-invasive home test should receive a follow-up colonoscopy to complete the colon cancer screening colonoscopy. She said the problem is that patients can face cost sharing

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associated with the follow-up colonoscopy that could prohibit them from completing the screening process. As a solution, she recommends that state insurance departments should make it clear to the public and industry through regulations or bulletins that insurers should waive cost sharing for invasive follow-up colonoscopies.

Bonnie Burns (California Health Advocates) said there has been a significant increase in the number of employed elders. In fact, she said 2019 recorded the highest number of working elders in the last 55 years, with pre-COVID-19 employment projections indicating that one-third of Americans age 65–70 would be employed by 2024. She said the employment numbers after COVID-19 resembled those in 2008 with Americans age 55 and over being the last hired and the first losing their jobs or being furloughed. She said while this segment of the population is eligible for Medicare, there is widespread ignorance about it due to no federal notice, which led to failure to enroll. She said there is also a disconnect between Social Security and Medicare, because Medicare eligibility is automatic at age 65, but there is no federal notice or automatic Medicare enrollment. However, full retirement for Social Security is roughly age 67 and may be higher or lower depending on the person's date of birth. Ms. Burns said those who are disabled are automatically enrolled after receiving 24 months of Social Security Disability Income payments.

Ms. Burns said the reason why employed seniors are ignoring Medicare while they are working is because they do not know that their eligibility began at age 65, so they are waiting until they are eligible for Social Security retirement benefits. She said many consumers think that since they already have health coverage through their employer, they should wait until their employment ends so they do not duplicate employer costs or benefits and do not incur additional premium payments. They are completely unaware of Medicare eligibility rules. Ms. Burns said when it comes to employer health benefits and Medicare, Medicare Secondary Payer (MSP) rules apply to Employer Group Health Plans (EGHP) in that employer health benefits are primary: 1) at the employee's age 65+ if the employer has 20 or more employees; 2) if the employee is disabled and the employer has 100 or more employees; and 3) for the first 30 months of End Stage Renal Disease (ESRD), regardless of the employer's size. She said Medicare is secondary only while someone is actively employed according to U.S. Internal Revenue Service (IRS) rules; and for smaller employers, MSP rules do not apply, so Medicare is the primary payor and the employer health plan is secondary.

Ms. Burns said MSP rules also do not apply to the continuation of benefits under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), except during a 30-month coordination period for people with ESRD when COBRA is primary. She said MSP only applies to those actively employed, and Medicare is always primary to COBRA benefits, even if the person is not enrolled for Medicare Part B benefits; i.e., phantom benefits. She also said such mistakenly paid primary benefits are recoverable by a COBRA carrier.

Ms. Burns said the *Coordination of Benefits Model Regulation* (#120) unfairly penalizes Medicare beneficiaries, and only Medicare beneficiaries, by allowing and facilitating phantom benefits. She said the Medicare Part B exception to coordination of benefits within this act should be changed to, "A person is eligible but not enrolled for benefits in Part B of Medicare." She said state insurance regulators should: 1) remove unfair Medicare penalties from Model #120 by deleting phantom benefit language so it does not allow the same application to any other existing health benefits; 2) encourage CMS to revise Medicare materials to include a clear explanation of Medicare and COBRA decisions; 3) encourage COBRA carriers to use updated COBRA notices; and 4) coordinate anti-fraud efforts with state Senior Health Insurance Information Programs (SHIIPs) and Senior Medicare Patrols (SMPs).

Thomas Callahan (Massachusetts Affordable Housing Alliance) asked Ms. Blackburn if companies should be using their reserves for investments that address racial equity, such as affordable housing. Ms. Blackburn said UnitedHealthcare is providing affordable housing with onsite healthcare and treatment at this time.

### 5. Heard a Presentation on Additional Areas for State Leadership and Consumer Protection

Lucy Culp (Leukemia & Lymphoma Society) said the COVID-19 pandemic has served to highlight the importance of comprehensive health care plans and emphasize the lack of coverage provided along with the extremely high cost sharing evidenced in short-term limited-duration (STLD) plans—i.e., \$45,000 versus \$6,000 for comprehensive plans—in the first six months of lymphoma treatment. She said the marketing and misrepresentation of the benefits provided by such plans via cold calls and the re-routing of online consumer searches to STLD plans from HealthCare.gov continuing despite regulatory actions in some states intended to stop it. She said state insurance regulators need to ensure that consumers can afford the coverage

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and the care they need by banning surprise medical bills, not just through COVID-19 but on an ongoing basis, and improving premium affordability through reinsurance, additional subsidies, and more premium support.

Ms. Keith said there is a need for permanent solutions, such as providing companies with the flexibility to meet consumers' needs through special enrollment periods, premium grace periods, expanded access to telehealth, waiving prior authorization requirements, and ensuring access to medications. She said in looking to the 2021 rate review process, state insurance regulators should look at the record-high minimum loss ratio (MLR) rebates in the past two years, be concerned about the impact of COVID-19 on rates, and remember that rates should be informed by real-world experience. She said there is a need for more consumer education and support. She said insurance departments and other state officials, as trusted sources of information, should do more outreach and education, as it is even more critical now than ever before considering the increase in fraudulent activity surrounding COVID-19.

Commissioner Conway said Caitlin Westerson had successfully led the consumer outreach and education efforts in Colorado about STLD plans and surprise billing. Commissioner Altman said several good points were made with telehealth spurring the conversation, and she asked how they would recommend working with legislators on it long-term. Ms. Keith said the Health Insurance Portability and Accessibility Act of 1996 (HIPAA) is a big part of the question, especially in rural areas where everyone that needs telehealth cannot be reached. She said the payment issue still needs to be addressed as well. Commissioner Clark said HIPAA guidance on this issue is available only through July 24 according to CMS and that it needs to be expanded. Ms. Culp said a task force is being developed at this time; however, it has not yet been determined who will be on it or what issues it will address. She said the real concern is that those who are immune compromised still desperately need telehealth due to the pandemic. Commissioner Conway said he is hopeful that CMS will expand it as needed.

### 6. Heard a Presentation on Stop the Spread—COVID-19 and Insurance Fraud

Matthew J. Smith (Coalition Against Insurance Fraud—CAIF) said the full impact of COVID-19 on fraud has yet to be seen, but based on historical data, early indicators seem to point to it being the largest spike in insurance fraud ever seen, surpassing that during the Great Depression and catastrophic natural disasters. He said Google statistics show internet searches on arson have increased 125% since the pandemic began with questions like, “How do I burn my [home, vehicle, etc.]” topping the list and other searches like email scams up 600% and auto disappearance and theft up 67%. He said life and health insurance scams such as fake plans and endorsements, vaccine scams, tele-med phishing, cargo theft, and life insurance “incentives” are all on the rise. He said popular auto scams—rate rebate refusals; sanitizing scams by repair, towing and storage companies; staged accidents; “jump-ins”; vehicle arsons; and caregivers' auto break-ins—are also on the rise. He said workers' compensation scams are up as quarantining is redefining the workplace, so providing owed coverage has become increasingly difficult for claim investigations because there are no witnesses to interview and the only verifications are via tele-medicine, which is not optimal for the determination of claim authorization. He said property and commercial scams include business interruption, inventory losses, arsons, thefts and mysterious disappearances with their own set of investigation limitations. He said this all leads to a litigation explosion of coverage issues like business income and virus or pandemic exclusions; COVID-19 lawsuits regarding liability limits; and the public's perception about the impact of fraud. He said state insurance regulators who ask what can be done about the approaching tide of insurance fraud can saturate department of insurance websites with current fraud data and tools that insurance consumers can use to help them detect and prevent fraudulent scams before those consumers become victims of it. He said bumping up media relations via free educational webinars and podcasts with live interviews and infographics would also be helpful as a line of defense and protection for consumers. He said states could more actively monitor insurers, expedite prosecutions, and work with the federal government to pass the Stop Senior Scam Act. He said state insurance regulators could also issue emergency orders, actively participate in the Antifraud (D) Task Force and seek to update state laws to address insurance fraud, especially that due to COVID-19. He said the CAIF is a valuable resource and ally in the fight against insurance fraud. He invited state insurance regulators to become partners with the CAIF, the National Insurance Crime Bureau (NICB), the Senior Medicare Patrol-SMP, and the Federal Trade Commission (FTC) in this battle.

### 7. Observed a Tour of the United Policyholders COVID-19 Loss Recovery Library

Amy Bach (United Policyholders—UP) said due to public safety orders and layoffs of employees, thousands of businesses need insurance benefits to cover losses brought about by required compliance with such orders. She said companies have paid hundreds of thousands of dollars in premium for this type of insurance only to find that the policies have exclusions for viruses and pandemics. To be clear, she said some policies have such exclusions and some do not; however, she said rumors are rampant about no coverage leading to insolvency. She said the sheer volume of claims being triggered by the COVID-19 pandemic has led insurance companies to clamp down on such claims and actively campaign against any such claims being

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covered, even under policies without exclusions for viruses or pandemics. She said state insurance regulators need to go on facts such as the hard data on claims that is pending with the NAIC and state data calls to be reported to the U.S. Congress (Congress) on July 22. She said reinsurance is intended for catastrophic losses like this, and 30-day maximum benefits for Civil Authority losses is common in the industry. She said insurance benefits that businesses have already paid for need to be honored along with Paycheck Protection Program (PPP) funds needed to restore economic health, jobs and consumer confidence in the value of insurance as a viable consumer product. She said to assist policyholders, UP established a COVID-19 Loss Recovery initiative, a national advisory team, a searchable library, and Amicus briefs promoting fair and efficient resolution of claims disputes via a new Website at [www.werbig.org](http://www.werbig.org). She encouraged everyone to contact UP for help or other questions and see [www.uphelp.org/COVID](http://www.uphelp.org/COVID) to track the battle against COVID-19.

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

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8/14/20

Draft: 12/26/19

NAIC/Consumer Liaison Committee  
Austin, Texas  
December 9, 2019

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. Ramage (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 regulator-to-regulator 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 Conway 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 his 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)

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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, a 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 he would display the award proudly but said it really should say the Colorado Division of Insurance—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 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 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 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 few 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.

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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 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 created wonderful curriculum regarding education from kindergarten through 12<sup>th</sup> grade and college through employer-based programs to create insurance and risk management courses makes sense.

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 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 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.

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.

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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, noting 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. She said the most recent data does not reflect or measure the full impact of non-renewals 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-risk 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 the states prevent insurers of last resort from getting too big.

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### 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—e.g., 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 state insurance departments 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 insurance department 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 maybe they should.

Commissioner Taylor said 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 state insurance department 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 Insurance Department has anecdotal information, but it does not have the type of documented evidence that would be helpful in Kansas.

### 7. Heard 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

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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 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.

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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 the 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) 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 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

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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

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.

Dan Kreitman (HFPP) said the HFPP is a voluntary, public-private partnership, with approximately 20 partners. He said in the past 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 federal 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.

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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 the HFPP uses 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

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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 the HFPP is 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.

Ms. Duhamel said in cases where abuse or mental illness is present, New Mexico is seeing evidence that consumers are being shuttled out of state or out of the country to receive treatment. Mr. Kreitman said the HFPP is seeing evidence of this, as well as 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.

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