NAIC/CONSUMER LIAISON COMMITTEE

NAIC/Consumer Liaison Committee August 5, 2019, Minutes
NAIC/American Indian and Alaska Native Liaison Committee August 4, 2019, Minutes

Draft Pending Adoption

Draft: 8/15/19

NAIC/Consumer Liaison Committee
New York, New York
August 5, 2019

The NAIC/Consumer Liaison Committee met in New York, NY, Aug. 5, 2019. The following Committee members participated: Stephen C. Taylor, Chair (DC); Michael Conway, Vice Chair (CO); Lori K. Wing-Heier, represented by Alida Bus (AK); Jim L. Ridling (AL); Ricardo Lara and Lucy Jabourian (CA); Andrew N. Mais represented by Kurt Swan (CT); Trinidad Navarro represented by Frank Pyle (DE); David Altmaier (FL); Dean L. Cameron represented by Geoff Bauer (ID); Doug Ommen represented by Sonya Sellmeyer (IA); Stephen W. Robertson represented by Karl Knable and Alex Peck (IN); Vicki Schmidt (KS); Nancy G. Atkins represented by Russell Hamblen (KY); James J. Donelon represented by Ron Henderson (LA); Al Redmer Jr. represented by Erica Bailey (MD); Steve Kelley represented by Grace Arnold (MN); Chlora Lindley-Myers (MO); Mike Causey represented by Kathy Shortt (NC); Bruce R. Ramge (NE); John G. Franchini and Paige Duhamel (NM); Barbara D. Richardson (NV); Linda A. Lacewell represented by Troy Oechsner (NY); Jillian Froment represented by Jana Jarrett (OH); Glen Mulready (OK); Andrew Stolfi (OR); Jessica Altman (PA); Todd E. Kiser represented by Tanji Northrup (UT); Scott A. White represented by Don Beatty (VA); Tregenza A. Roach represented by Dolace McLean (VI); Mike Kreidler represented by Jane Beyer (WA); and Mark Afable (WI).

1. Heard Opening Remarks

Commissioner Taylor welcomed John F. King (GA) to the NAIC Consumer Participation Board of Trustees and noted that the Board of Trustees, which is comprised of six state insurance regulator members and six funded consumer representative members, met Aug. 4 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, to finalize its revisions to the consumer representative criteria and applications for 2020 in accordance with the revisions to the Plan of Operation for the NAIC Consumer Participation Program. He said the revisions to the Plan of Operation were adopted by the Executive (EX) Committee on June 25 and will be reported up to the Executive (EX) Committee and Plenary for consideration of adoption during its Aug. 6 meeting.

2. Adopted its Spring National Meeting Minutes and Reaffirmed its 2019 Mission Statement for 2020

Commissioner Taylor asked if members had any changes to the 2019 mission statement being considered for reaffirmation for 2020.

Hearing none, Director Lindley-Myers made a motion, seconded by Ms. Duhamel, to adopt the Liaison Committee's April 8 minutes (*see NAIC Proceedings – Spring 2019, Consumer Liaison Committee*) and to reaffirm its 2019 mission statement for 2020. The motion passed unanimously.

3. Observed the Presentation of the Excellence in Consumer Advocacy Award

Birny Birnbaum (Center for Economic Justice—CEJ) said the NAIC consumer representatives were pleased and grateful to present the 2019 Excellence in Consumer Advocacy Award to James Regalbuto, the Deputy Superintendent for Insurance at the New York Department of Financial Services (NYDFS). He said with this award, the consumer representatives express their heartfelt appreciation to Mr. Regalbuto for his work on behalf of consumers here at the NAIC and in New York. As Deputy Superintendent for Life Insurance in New York for many years, Mr. Birnbaum said Mr. Regalbuto has been active in identifying and solving a variety of consumer protection issues for consumers of life insurance and annuities. He said there is not enough time to describe all the pro-consumer issues that Mr. Regalbuto has been a part of, but a few highlights are: 1) best interest standard of care for life insurance and annuities – Mr. Regalbuto and New York have been at the leading edge of upgrading the standard of care for annuity consumers to a true best interest standard. Mr. Birnbaum said the NYDFS not only adopted a true best interest standard of care for annuities, but also extended it to life insurance; 2) cost of insurance increases – Mr. Regalbuto and New York represent the only state to formally address the improper cost of insurance fee increases for universal life insurance through thoughtful rulemaking; 3) big data in life insurance – Mr. Regalbuto and New York represent the only state to collect information from life insurers about the sources and types of non-insurance data used for accelerated underwriting. As a result of this information gathering, Mr. Regalbuto and New York issued important consumer protection guidance to insurers regarding the use of such data; 4) indexed universal life (IUL) illustrations – in addition to advocating for pro-consumer reforms of the NAIC *Life Insurance Illustrations Model Regulation* (#582) and *Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest* (AG 49) to stop the abuses in IUL illustrations, Mr. Regalbuto and New York crafted a comprehensive regulation in New York regarding illustrations; 5) consumer information

Draft Pending Adoption

– Mr. Regalbuto has been active in the NAIC *Life Insurance Buyer's Guide* and online guide working groups, supporting the consumer representative efforts to upgrade and modernize the types of and delivery mechanisms for consumers to shop for and use life insurance products.

Mr. Birnbaum said Mr. Regalbuto brings a depth of experience and expertise to his work at the NAIC and in New York and, as a result, his efforts and arguments are substantive and fact-based. He said while informed by strong consumer protection values, Mr. Regalbuto's efforts rise above talking points and lead to meaningful and functional solutions. Mr. Birnbaum said we know that the NYDFS Superintendent values Mr. Regalbuto's work, and the NAIC consumer representatives want all who participate at the NAIC, the management at the NYDFS and, most of all, Mr. Regalbuto, to know how much they appreciate and value his diligent work and dedication. Mr. Birnbaum said they hope to continue to work with Mr. Regalbuto for many years on consumer protection issues at the NAIC and in New York and that Mr. Regalbuto joins just a few other recipients of Excellence in Consumer Advocacy Award for senior insurance department staff: Joel Laucher (CA); Bob Wake (ME); Angela Nelson (MO); and J.P. Wieske (WI). Mr. Birnbaum congratulated Mr. Regalbutofor his work at the NAIC on behalf of insurance consumers.

4. Heard a Presentation on Direct Enrollment in the Marketplace and Coverage that Lacks Protections for Consumers from the CBPP

Sarah Lueck (Center on Budget and Policy Priorities—CBPP) said that brokers and producers, including web brokers, can sell Health Insurance Marketplace (Marketplace) plans if they meet federal and state requirements and complete a certification process. She said some broker and insurer websites have gotten approval to conduct "direct enrollment" in states that use the Federally Facilitated Marketplace (FFM), which means they can use their own websites to help people apply for Marketplace plans and subsidies. Ms. Lueck said that in direct enrollment, a consumer starts out on the broker or insurer website, is transferred electronically to the Marketplace to apply for eligibility; and is then transferred back to the broker or insurer website to complete plan selection. She said two primary entities—HealthSherpa and Stride Health—currently have approval to conduct "Enhanced Direct Enrollment" in which the eligibility and plan selection process can be completed by consumers, insurers, brokers, etc. on their non-Marketplace websites. Ms. Lueck said the different standards that apply to federal Affordable Care Act (ACA) Marketplaces and non-Marketplace websites can lead to disparate consumer experiences. For instance, the ACA Marketplace is operated by the federal or state governments, while the non-Marketplace is operated by online brokerage or insurance companies. She said another difference is that the ACA Marketplaces display all qualified health plans (QHPs) the person could buy, while the non-Marketplace may not. Ms. Lueck said one of the most important differences is that the ACA Marketplace provides for "no wrong door" eligibility—a process that helps people to connect with a QHP (including those with subsidies) or with Medicaid or a Children's Health Insurance Program (CHIP) if they are eligible. She said the non-Marketplace may lead consumers to the ACA eligibility application, but, in some cases, website features may lead consumers to non-ACA plans or fail to connect them with other health care programs for which they are eligible.

Ms. Lueck said the purpose of allowing enhanced direct enrollment was to demystify the health care buying process. However, one of the restrictions is that direct enrollment plans cannot show ACA and non-ACA plans side-by-side for consumer comparison. She said consumers can get inaccurate or incomplete eligibility information due to filters on direct enrollment websites that may work as screening tools to sell non-ACA-compliant plans so that if the consumer selects Obamacare, Short-Term and no Pre-Ex, he or she may encounter an adverse selection issue. Ms. Lueck said some direct enrollment sites may ask for personally identifiable information (PII), which is not allowed, via pop-ups and use it to market other products. In some cases, consumers may sign away some of their rights to obtain a QHP without realizing it. She said they may miss low-cost benefits or the ability to sign up a child. Ms. Lueck said a consumer's ability to compare plan details may be reduced by direct enrollment sites because it creates a fractured shopping process and may not show all the plans available.

Claire McAndrew (Families USA) said states can use their authority to protect consumers and insurance markets by: 1) knowing which entities are selling insurance in your state, whether they are using ACA Marketplace or non-ACA Marketplace websites, and which brokers and insurers are selling off-Marketplace or non-ACA-compliant plans in ways that may confuse consumers; 2) notifying consumers about the differences between the official Marketplace/Exchange site and other sites like those used by direct enrollment brokers and insurers that do not display all of the choices of benefits and costs available to consumers; 3) inform consumers about how to contact state health insurance regulators with complaints or concerns, as well as to act as a conduit to federal information; 4) consider state standards for plan display that will promote competition on price and quality, and help consumers more easily compare the plans available to them; and 5) consider improving state standards to ensure consumers are fully informed about the coverage they may be eligible for or to be morphed into, including Medicaid, CHIP and subsidized QHPs.

Draft Pending Adoption

Commissioner Conway asked if direct enrollers are licensed as brokers or producers by the states and if states regulate them as unfair trade practices. Ms. Lueck said they may be licensed as web advisors and that she is not aware of any actions taken by states against them. Commissioner Altman asked if consumers were aware they were being diverted to other areas. Ms. McAndrew said since these are not insurance company websites, consumers may not realize they are looking at plans from more than one company, but rather may think it is an Exchange website.

5. Heard a Presentation on Section 1557 Updates and the Role of State Insurance Regulators from The AIDS Institute, DREDF and NCTE

Carl Schmid (The AIDS Institute) said Section 1557 of the federal Affordable Care Act (ACA) prohibits discrimination based on race, color, national origin, sex, age or disability in any health program or activity that receives federal financial assistance. He said Section 1557 incorporates existing federal civil rights laws and applies them to federally funded health care programs. Mr. Schmid said Section 1557 regulations cover any entity that receives federal financial assistance, including: 1) insurers that sell Marketplace plans, Medicare Advantage plans, Medicare Part D plans, CHIPs and Medicaid managed care plans; 2) health insurance marketplaces; 3) state agencies that provide Medicaid and CHIP coverage; 4) entities that receive Medicare or Medicaid payments (e.g., hospitals, nursing facilities, home health agencies, community health centers (CHCs) and Federally Qualified Health Centers (FQHCs) and public health agencies; and 5) U.S. Department of Health and Human Services (HHS) health programs (Centers for Medicare and Medicaid (CMS), Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA), etc.). He said Regulation 92.207(b)(2) of Section 1557 prohibited discriminatory actions through benefit designs or marketing practices. Mr. Schmid said the current administration had gutted Section 1557 regulations with regard to who is covered and benefit design, replacing it with a proposed rule that: 1) removes the definition of "covered entity"; 2) removes explicit benefit design and marketing practices protection; 3) makes it more difficult for consumers to know their legal rights and responsibilities; and 4) lacks the clear guidance needed to protect against discriminatory benefit design. He said the result has been an erosion of the care provided with drugs and services not being covered when they should have been.

Luc Athayde-Rizzaro (National Center for Transgender Equality—NCTE) said there has been recent discrimination against transgender consumers as noted by the U.S. Transgender Survey conducted in 2015 indicating that 25% of transgender consumers are either uninsured or underinsured. He said due to the barriers to health care they face, 33% avoided going to a doctor when needed in the last year because of the cost, and 25% faced insurance discrimination in the last year, including being denied preventive tests, care related to gender transition and other necessary care because of being transgender. Mr. Rizzaro said Section 1557 protections include prohibition of discrimination based on sex under Title IX; recent court rulings regarding sex stereotypes and gender identity; and a 2016 final rule that clarifies protections and obligations for insurers and transgender consumers regarding payors and coverage. He said the final federal rule in 2016 prohibited plans from: 1) excluding services related to gender transition; 2) excluding or limiting services in any way that discriminate against transgender consumers; and 3) denying test or treatments solely based on gender coding. He said, however, solutions can include a special claims modifier to be flagged for prompt review. Mr. Rizzaro said 19 states and Washington, DC, have issued bulletins or regulations prohibiting broad or categorical exclusions of care related to gender transition. He said state bulletins are based on state laws on sex and gender identity discrimination, unfair insurance practices and mental health parity. Mr. Rizzaro said state enforcement includes states reviewing plans to ensure no plans contained improper transgender exclusions and states responding to consumer complaints on denial of care that is medically necessary by reaching agreements on recurring improper denials or criteria. He said a 2019 marketplace analysis of 622 silver plan options from 129 insurers in 38 states indicated only eight insurers in five states (6%) had transgender exclusions; 41% of plans had affirmative coverage language; 24.8% had broad cosmetic exclusions; and 10% had no information available.

Mr. Rizzaro said the 2019 Notice of Proposed Rule Making (NPRM) erases all prior references to: 1) the ACA's protections against discrimination on the basis of gender identity; 2) long-standing U.S. Supreme Court precedent recognizing protection from discrimination on the basis of sex stereotypes; and 3) gender identity and sexual orientation in several other long-standing HHS regulations (including QHPs, marketplace). He said the proposed rule cites a Franciscan Alliance preliminary injunction on HHS enforcement of gender identity portions of the rule. However, he said several other federal courts arrived at the opposite conclusion and have found plain language of ACA includes gender identity protections regardless of HHS interpretation. Mr. Rizzaro said the expected impact of the NPRM is that it will: 1) create an uneven playing field in the insurance market and confusion among payers about their obligations; 2) encourage insurance companies to deny coverage for health care services that they cover for non-transgender people; and 3) discourage transgender patients from seeking coverage in the first place or appealing denials. He thanked Commissioner Lara and the 17 other insurance commissioners who have signed onto the letter being circulated in support of the transgender efforts in this regard.

Draft Pending Adoption

Silvia Yee (Disability Rights, Education and Defense Fund—DREDF) said limited English proficiency(LEP)-related health care disparities include: 1) poor provider communication with patients, which decreases rates of medication adherence, patient satisfaction and patient-centered care; and 2) increases in negative clinical experiences, risks of errors, health disparities and malpractice exposure. She said a 2016 survey of more than 4500 hospitals found only 56% offered some level of linguistic/translation service (which was a 2% improvement over the findings of a 2011 survey), while in a 2008 survey, 97% of physicians said they have at least some LEP patients. Ms. Yee said adults with disabilities are 58% more likely to experience obesity, three times more likely to be diagnosed with diabetes, four times more likely to have early-onset cardiovascular disease, nearly three times more likely to have not accessed needed health care because of cost, and twice as likely to have unmet mental health needs. She said non-discriminatory benefit design helps to reduce the non-insurance rate and increases the likelihood of having a regular health care provider.

Ms. Yee said recent language and disability changes: 1) weaken the individualized standards for when oral interpretation and written translation is required for meaningful access; 2) eliminate the requirement for notices and taglines in a state's top 15 languages spoken by LEP persons; 3) eliminate the prohibition against discrimination on the basis of association; and 4) seek comment on current standards on provision of auxiliary aids and services, and on architectural standards relevant to people with disabilities. She thanked state insurance regulators for what has already been done by states and asked them to consider keeping Section 1557 law and regulations intact. Ms. Yee said states have and can pass their own discrimination and patient protections while at the same time they must uphold and enforce existing federal and state laws and regulations. She asked states to remember that effective notice of consumer rights is a key concern of all state insurance regulators. Ms. Lee said state insurance regulators should consider submitting their own comments, provide information on outcomes of non-discrimination and disparity-related measures in their state, provide examples of discrimination cases and investigations brought in their states, and include any data on the development and operation of state measures to reduce language, structural accessibility or disability communication barriers among health care providers and entities in their states.

6. Heard a Presentation on How State Insurance Regulators Can Protect Consumers Shopping for Short-Term Health and Other Limited Benefit Products from the DPC

Jackson Williams (Dialysis Patient Citizens—DPC) said the loss ratios for specified disease policies in the group market are governed by the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171). However, he said short-term products are represented online in confusing and misleading ways. He said that health insurance is already confusing to consumers and that the concept of insurance that lacks ACA protections adds to this confusion. Mr. Williams said the presentation of insurance products on the two key aggregator websites understates the key differences between "short-term" products and real health insurance.

Mr. Williams said the first problem is the creation of inflated impressions of the products' protections because information on the aggregated website turns out to be a fixed indemnity product rather than a preferred provider organization (PPO), so there is clearly a need to regulate these products. Mr. Williams said another inflated impression is that a plan provides 36 months of coverage when, in fact, it does not as revealed by clicking on an icon that is not visible on the main page, but that says: "You are selecting a 12-month policy term with an attachment that will allow you to extend your coverage by two additional terms. Your deductible and coinsurance and all benefit limits will reset with each policy term. If you have not selected the pre-existing conditions waiver or if the waiver is not available for your plan, then medical conditions developed during your prior term may not be covered by your additional terms. Prices may change at the start of each new policy. You can cancel anytime." He said inflated impressions also apply to an apparent $2 million policy limit that includes pre-authorization requirements. Mr. Williams recommended that states implement a moratorium on these types of products.

Mr. Williams said the second problem is dollar limitations for the most common unexpected illnesses for the first six months of coverage that are quite inadequate when compared to the actual cost of treatment for such illnesses (e.g., $2500 for an appendectomy, which would cost more than four times that amount). Mr. Williams also recommended that state insurance regulators set some standard of comprehensiveness that must be met if products are to be marketed as "short-term health insurance." He said products that do not meet the standard should be marketed as "limited benefit insurance."

Mr. Williams said the third problem is the need for uniform examples in advertising such products. His recommendations for this are that state insurance regulators promulgate uniform "coverage facts examples" showing the most common procedures in the 18–64 age group and realistic statements of actual charges that consumers would face. He said they shouldprescribe uniformity in the display of other attributes, such as bottom-line prices and out-of-pocket maximums, where variations make price comparisons impracticable.

Draft Pending Adoption

Mr. Williams said the overarching problem in this market is the lack of price competition. He said the web broker websites do not allow a consumer to do comparisons, and NerdWallet does not display such information as it does not think it can recommend any of these plans to consumers. Mr. Williams said states should standardize the display of plan finder information for these types of plans much like the Medicare plan finder does. He said state insurance regulators should give consumers ways of assessing the product value and comparing products by mandating disclosure of the loss ratios for each at the point of sale. Mr. Williams said this is not unprecedented as two jurisdictions—Connecticut and Washington, DC—have statutes that require this already for some types of insurance. He said a loss ratio number between 0 and 100 listed for each product would provide a simple reference point for consumers to compare value.

Amy Bach (United Policyholders) asked if there was any chance of changing the name of such products to better describe and disclose the type of product being marketed, to which Mr. Williams said he hopes so.

7. Heard a Presentation of Approaches State Insurance Departments Can Employ for Consumer Input When Designing Consumer Education, Information and Disclosures from the University of Georgia and The University of Texas at Austin

Brenda J. Cude (University of Georgia) said consumer testing is the gold standard for seeking consumer input when designing effective consumer education, information and disclosure delivered online, via apps and in print. She said the 2012 NAIC *Best Practices and Guidelines for Consumer Information and Disclosures* includes a brief but useful section about consumer testing, such as cognitive interviewing, and structured focus groups, along with online testing and surveys. Ms. Cude said while the NAIC consumer representatives strongly encourage consumer testing when feasible, they also recognize that it is not always practical. She said cognitive interviewing is when consumers think out loud while looking online at information on a personal computer using heat or thermal imaging to determine how much time a consumer spends looking at any one item on the screen, which takes more time to conduct. Ms. Cude said focus groups—usually more than one—are made up of five to six people who give their impressions of the product. She said the gold standard is not always practical. Ms. Cude said in this presentation, they offer ideas about ways insurance departments can get feedback from consumers without formal consumer testing and share responses from a survey of state insurance departments

Karrol Kitt (The University of Texas at Austin) said in June, 20 NAIC members (five in the West; five in the Central region, five in the South, and five in the East) were asked three questions about how they engage consumers currently. She said Idaho, Mississippi and New York did not reply. Ms. Kitt said the questions were designed to determine: 1) how states could engage consumers in designing consumer information, education or disclosures; 2) how states could engage with consumers without formal consumer testing; and 3) what states could learn by engaging with consumers. She said when states were asked if their department reached out to insurance consumers as a part of the process of designing consumer information, education and/or consumer disclosures, five states responded, “Yes.”

Ms. Kitt said California used several focus groups to learn the best ways to publicize its programs. She said the attendees were compensated to participate in group interviews at a specific location. Ms. Kitt said the attendees were asked to provide feedback to questions and photographs, and the department learned who consumers would trust, what would attract consumers’ attention, how consumers felt about the program, and consumers’ thoughts on cost.

Ms. Kitt said Washington, DC, conducted a web survey in the fall of 2018 that included consumers. She said it was distributed by email and posted on the department’s website so all visitors could participate. Ms. Kitt said the intent of the survey was to invite feedback on, and evaluate, the information, content (including insurance information), design and navigation of the site. She said they also hold numerous presentations throughout the year on topics that include homeowners and renters insurance. At the end of each presentation, participants answer a survey that asks them to evaluate the presenter and the content of the presentation. Ms. Kitt said consumer materials and presentations are revised based on feedback received from the surveys. She said key recommendations for the website based on survey results included: 1) reorganizing information on the website; 2) improving content and organization of licensing-related matters; 3) improving searches by using more relevant keywords; 4) using videos to explain each program’s function on each page; 5) updating the site more regularly; and 6) adding frequently asked questions (FAQ). Ms. Kitt said community presentation survey results showed that consumers would like more information on ways to file a complaint (insurance-related and otherwise), as well as on other services and programs provided.

Ms. Kitt said Texas asked for volunteers for a “virtual focus group” through its social media accounts and website. She said about 100 people responded, and the state sent drafts of its consumer materials to this group, using consumer feedback to make changes. She said its focus group was composed of people who were already looking at the state’s information, so they may not have been reflective of the average insurance consumer. Ms. Kitt said Texas considered this survey as a first step in its effort to get more direct consumer feedback on its material. She said for more information on Texas, the state posted a story on

its focus group recently that included examples of the changes the state has made in materials based on the focus group's feedback at www.tdi.texas.gov/news/2019/tdi05292019.html.

Ms. Kitt said Pennsylvania worked with advocacy groups and the library association to create health insurance literacy videos (https://*www.insurance.pa.gov/literacy*) and written materials. Pennsylvania said it worked with the American Association of Retired Persons (AARP) and Libraries for Education for Seniors. The state said the libraries have been a good partner, providing feedback on other insurance presentations (e.g., auto, homeowners) She said Pennsylvania also worked with the American Automobile Association (AAA) to get information to senior drivers about mandatory discounts available to drivers that take approved safety courses. Ms. Kitt said the insurance commissioner attended a first-time homebuyers seminar sponsored by NeighborWorks to introduce a brochure on how to access the *Comprehensive Loss Underwriting Exchange* (CLUE) report on the home the consumer is considering buying to see if any homeowners' insurance claims were filed in the previous seven years. She said the health insurance literacy videos were part of the workgroup led by the state that included providers, insurers, advocacy groups and other state agencies. Ms. Kitt said partnering with the libraries allowed the state a good opportunity to reach consumers directly. She said certificates were presented by the insurance commissioner to seniors who completed the senior driving classes and then sent to their insurance companies to ensure that they received the mandatory 5% discount on their automobile insurance coverage. Ms. Kitt said that through this process, the state learned that its initial work product was written at too high of a reading level and that it had too much insurance jargon in it. She said insurance professionals tend to forget that most consumers are not insurance professionals themsevles.

Ms. Kitt said Washington takes a user-centered methodology to designing its website and online information to ensure consumers can find what they need and understand what they read. She said the state's web service team plans and conducts task-based web usability testing on its online consumer information. Ms. Kitt said the state conducts the tests at a state-owned web usability testing lab and typically recruits eight to 10 participants, who are asked to complete 10 to 12 tasks. She said the state observes, records and documents how well participants can complete each task and understand the information. The test data is then analyzed, and recommendations are developed based on the findings. Ms. Kitt said each study costs about $3,000 for the testing lab facility and participant requirement. She said the state uses analytic tools such as Google and Crazy Egg web service testing to gain insights on how well its website is performing, track user behavior and test improvements. Ms. Kitt said the state strives to ensure its online consumer information is written in plain language and follows best practices for writing for the web. She said the state learned that the benefits of conducting usability testing include not only being able to test how easy consumers can get their questions answered, but also to gain insights into their insurance buying needs and perceptions of its agency. Ms. Kitt said that during usability testing, participants are encouraged to speak out loud as they complete the tasks, and their comments often help the state understand what terminology consumers use. She said sometimes just a small change in terminology can have a big impact on making consumer information more user-friendly.

Ms. Kitt said 12 states responded "no" to the question of consumer outreach, including Florida, Nebraska, Nevada, North Carolina and Tennessee. She said Louisiana and Maine use their public information staff for consumer outreach. Ms. Kitt said Missouri, New Mexico, Oregon and Rhode Island rely on NAIC consumer outreach. She said Wisconsin is planning on making consumer outreach a central piece of its public education or engagement efforts going forward. Ms. Kitt said the state is in the process of following a "nothing about us without us" philosophy regarding outreach, wherein they are actively seeking feedback from impacted stakeholders so that it can design materials that will be readable, relevant and responsive to the groups they are targeted towards. She said moving forward, the state hopes to sit down with consumers to understand what issues consumers see in the insurance world so it can understand what consumers would like more information on, as well as how it should be presented.

Ms. Cude asked how might the NAIC more fully engage in this topic. She said the NAIC Market Regulation and Consumer Affairs (D) Committee has requested comments on the *Best Practices and Guidelines for Consumer Information and Disclosures* paper. Ms. Cude said they encourage the NAIC to update this paper to include, among other improvements, more information about consumer testing, as well as ideas about other ways the NAIC and insurance departments can engage with consumers when designing consumer education, information and disclosures.

Commissioner Lara asked Ms. Cude if she has any ideas on how to move forward with consumers regarding long-term care insurance (LTCI) outreach focus groups throughout California. Ms. Cude said the most difficult piece would be recruiting consumers as it would be difficult to identify the policyholders of such policies to contact about such issues.

8. Heard a Presentation on Credit-Related Insurance from the CEJ

Mr. Birnbaum (CEJ) said credit-related insurance is insurance sold in connection with a credit transaction, including: 1) consumer credit insurance sold in connection with auto, personal and real-estate secured loans or with credit cards;

2) lender-placed (which is also known as force-placed) insurance sold to lenders and loan servicers to ensure continuous insurance coverage on vehicles and properties servicing as collateral for auto and mortgage loans; 3) private mortgage insurance sold in connection with mortgages to protect lenders or investors in the event of default on the loans; and 4) title insurance sold in connection with real estate transactions to ensure marketable title for lenders and to defend and compensate purchasers if title is challenged. He said the varieties of consumer credit insurance include: 1) credit life; 2) credit accident and health (A&H), also known as credit disability; 3) credit involuntary unemployment; 4) credit family leave; and 5) credit personal property.

Mr. Birnbaum said regulation of credit-related insurance could be found in the following NAIC models: 1) for credit life (which pays off a loan upon death), disability (which covers the monthly payment to a lender while the insured is disabled) and involuntary unemployment (which covers the monthly payment to a lender while the insured is unemployed) insurance – *Consumer Credit Insurance Model Act* (#360) and *Consumer Credit Insurance Model Regulation* (#370); 2) for credit personal property (which is sold by retailers to either repair or replace purchases) insurance – *Credit Personal Property Insurance Model Act* (#365); for lender-placed insurance – *Creditor-Placed Insurance Model Act* (#375) (which is for automobiles) and Real Property Lender-Placed Insurance Model Act (which has been in progress for the last few years). He said NAIC models include rate standards and that under Model #360#370 and Model #365, rates must be reasonable in relation to the benefits provided.

Mr. Birnbaum said reasonable rates means expected loss ratio of not less than 60%. He said under the Real Property Lender-Placed Insurance Model Act, Alternative 1 is that rates are not excessive, not inadequate and not unfairly discriminatory. Additionally, he said Alternative 1 is that rates must be reasonable in relation to benefits provided, with reasonable rates meaning having an expected loss ratio of not less than 60%. Mr. Birnbaum said these are the two alternatives because these are captive markets wherein coverage is chosen by the lender and can only be purchased through a lender. He said a few states have adopted loss ratio standards of 60%, with one state having established "minimum" loss ratio standards as low as 35%, while several other states have established "minimum" loss ratios of only 40% to 45%. Mr. Birnbaum said that most states have established minimum loss ratio standards of 50% or 55% and that only a few states have established minimum loss ratio standards of 65% or more.

Mr. Birnbaum cited some statistics. He said on average: 1) countrywide, loss ratios are far below 60%; 2) countywide, credit life loss ratios have been consistently around 45% for a decade; 3) countrywide, credit disability loss ratios have declined from the mid 40% range to the low 30% range; 4) countrywide, credit unemployment loss ratios have been in the single digits or low teens, with the exception of 52% in 2009 and 25% in 2010 (during a period of the highest unemployment since the Great Depression and the longest average duration of unemployment in history); 5) credit family leave loss ratios have been 0%; 6) credit personal property loss ratios have been in the teens; 7) force-placed auto and home loss ratios have historically been in the mid-20 percentile but have risen to the mid 40 percentile from 2016 to 2018, perhaps due to flood losses; and 8) for most of the 2000s, force-placed loss ratios have been half of those for auto, physical damage and homeowners insurance.

Mr. Birnbaum said credit life and credit disability loss ratios vary significantly by state, with many states failing to enforce the minimum loss ratio standards, including states with low loss ratio standards. He said that NAIC tables show 2016–2018 experience by state for credit life, credit disability, credit unemployment and for these three coverages combined, as well as for credit personal property, force-placed auto and force-placed home insurance. Mr. Birnbaum said state regulatory action is needed to protect consumers. He said when it comes to credit-related insurance, states need to enforce minimum loss ratio standards for credit life and credit disability and credit unemployment. He said where the commissioner has authority to establish the minimum loss ratio standard, there needs to be an increase of the standard to at least 60%. For other types of credit-related insurance, states need to enforce the "not excessive" rate standard. Mr. Birnbaum said loss ratios are low because insurers pay lenders compensation to access the lender's customers. He said the lender compensation is as much or more as the claim payments made to the lender on behalf of the consumer. Mr. Birnbaum said credit-related insurance markets are characterized by reverse competition, which is defined by the NAIC as competition among insurers that regularly takes the form of insurers vying with each other for the favor of persons who control, or may control, the placement of the insurance with insurers. He said reverse competition tends to increase insurance premiums or prevent the lowering of premiums so that greater compensation may be paid to persons for such business as a means of obtaining the placement of business. In these situations, the competitive pressure to obtain business by paying higher compensation to these persons overwhelms any downward pressures consumers may exert on the price of insurance, thus causing prices to rise or remain higher than they would otherwise.

Mr. Birnbaum said higher loss ratio standards are reasonable and necessary because credit-related insurance is a group policy issued to the lender, with certificates from the group policy being issued when coverage under the group policy is issued. He said sales costs are very low, and it is sold by limited lines producers with a very brief explanation to consumers. Mr. Birnbaum said the bulk of non-claim expenses are unjustified payments to lenders. He said the payments to lenders are unjustified because the lender benefits greatly when a consumer purchases credit insurance, even if the lender received no commission or

compensation. Mr. Birnbaum said the lender benefits because the consumer is paying to protect the lender's loan in the event the borrower suffers a life event affecting her or his ability to repay the loan. He said by purchasing credit insurance, the borrower protects the lender from having to expend funds to collect from a disabled or unemployed borrower or the family of a deceased borrower or avoids the costs of hiring a debt collector or writing off the loan. Mr. Birnbaum said the consumer pays for this protection for the lender. He said it is unreasonable for the consumer to pay premiums twice what a reasonable premium would be so the lender can extract additional profits from the borrower. Mr. Birnbaum said given the reverse competitive nature of credit insurance markets, consumers have no market power to discipline insurers or lenders on price and must rely upon state insurance regulators to establish loss ratios that represent benefits that are reasonable in relation to rates and that might reflect the loss ratios that would occur if markets were, in fact, normally competitive.

Commissioner Kreidler asked what percentage of the credit market is regulated through the states versus the federal government. Mr. Birnbaum said all credit insurance is related through the states. He said only those sold through federal banks for auto guaranty loans are federally regulated. Ms. Bach asked what state enforcement would look like. Mr. Birnbaum said that actual loss ratios, which are minimums and not ceilings, would be monitored like Maine, Vermont and New York.

Having no further business, the Consumer Liaison Committee adjourned.

W:\National Meetings\2019\Summer\Cmte\CONSUMER\Consumer_08min.Docx

Draft Pending Adoption

Draft: 8/15/19

American Indian and Alaska Native Liaison Committee
New York, New York
August 4, 2019

The American Indian and Alaska Native Liaison Committee met in New York, NY, Aug. 4, 2019. The following Committee members participated: Michael Conway, Chair (CO); Lori K. Wing-Heier, Vice Chair (AK); Trinidad Navarro (DE); Matthew Rosendale represented by Steve Matthews (MT); Mike Causey represented by Kathy Shortt (NC); Jon Godfread represented by Sara Gerving (ND); John G. Franchini represented by Paige Duhamel (NM); Glen Mulready represented by Tyler Laughlin (OK); Andrew Stolfi and Brian Fordham (OR); Larry Deiter represented by Jill Kruger (SD); and Mike Kreidler represented by Melanie Anderson (WA). Also participating was: Todd E. Kiser (UT).

1. Adopted its Spring National Meeting Minutes and Reaffirmed its 2019 Mission Statement for 2020

Commissioner Conway said the Liaison Committee met Apr. 7 to discuss the recent rise in youth suicide amongst American Indian and Alaska Native communities.

Director Wing-Heier made a motion, seconded by Mr. Laughlin, to adopt the Liaison Committee's Apr. 7 (*see NAIC Proceedings – Spring 2019, American Indian and Alaska Native Liaison Committee*) minutes. The motion passed unanimously.

Commissioner Conway read the 2019 Mission Statement listed on the agenda, and he asked if the Liaison Committee members had any changes. Hearing none, Mr. Fordham made a motion, seconded by Director Wing-Heier, to reaffirm the Liaison Committee's 2019 Mission Statement for 2020. The motion passed unanimously.

2. Heard a Panel Presentation from the BCBSNM and KPI on Best Practices for Working with Tribal Leaders on Suicide Prevention and Access to Care

Commissioner Conway said the Liaison Committee's focus this year was on behavioral health issues, especially in the tribal communities. He said there has been a problem with youth suicide in Colorado, with a significant rise in the rate of suicide since the first of the year. However, it is bigger than that; it involves a lot of behavioral health issues as well. In addition to that, we need to be very cognizant of our cultural differences. We need to be aware that these tribal communities are sovereign nations as well, so we need to approach them in a manner that is culturally appropriate. Commissioner Conway said he wanted to have some education as part of this panel.

Bonnie Vallo (Tribal Affairs Specialist, Community Outreach, Blue Cross and Blue Shield of New Mexico—BCBSNM) said hello in Keresan, her native tongue, as she is a member of the Laguna Pueblo—one of 19 Pueblos speaking five different languages within the 23 New Mexico tribes represented by: the Navajo Nation (To'hajiilee Band, Alamo Band, and Ramah Band), which speaks Diné; the Jicarilla Apache Nation, which speaks Jicarilla Apache; and the Mescalero Apache Nation, which speaks Mescalero Apache. She said the Blue Cross Blue Shield Association (BCBSA) is a division of the Health Care Services Corporation (HCSC), which creates health care programs in Illinois, Montana, New Mexico, Oklahoma and Texas. She said Montana, New Mexico and Oklahoma have high numbers of Native Americans with similar types of health disparities, including diabetes, heart disease, cancer, and other health concerns. She said as a company, the BCBSA has a tribal relations work group where it comes together to share best practices in working with tribal communities across the five states. She said Montana leads the nation in deaths due to suicide, and this is a major issue with their tribal nations. She said in Montana, American Indians make up the largest minority of the state's population; in Oklahoma, they represent 13%; and in New Mexico, they represent 10%. She said the BCBSA in Montana recently created the Big Blue Sky Initiative, which focuses on drug addiction, suicide prevention, and healthy living in Montana. She said in Oklahoma, the Caring Van Program assists tribal nations in specific health needs and preventative health services in the different geographic areas. She said they are guided by the tribes' direction and their resources. She said the BCBSA's tribal relations in New Mexico tribal communities are spread across the northwest corner of New Mexico, but they all have different tribal reservations or tribal lands. She said one of the elders explained to her the difference between reservation and tribal land—he said the Laguna Pueblo is part of tribal lands, and it has been there forever, as they were never assigned to live in that area—they have always lived there, so they are considered tribal lands. He told her that areas like the Apache Nation land are considered a reservation, where they were assigned to live; so that is just one of the distinctions that stands out regarding the differences between tribal nations. Ms. Vallo said when a tribal leader tells you to remember something, you really need to remember that.

Draft Pending Adoption

Ms. Vallo said it is important to know the tribal languages spoken, as it helps to build the strong relationships necessary to work with different tribal members with its own government and traditions. She said with each of the tribal governors, chiefs, elders and tribal councils, it really helps during initial visits with new tribes to learn at least a few words or a greeting in that tribe's native tongue, then to learn about the local tribal ways and traditions. She said they are very busy as leaders of sovereign nations dealing daily with local, state and federal governments. She said this was well-illustrated by one of the local tribal governors who told her that a tribal member called him to say there was a dead snake under their trailer when the tribal governor was dealing with a lot of federal government issues. She said the local tribal governors' areas of responsibility are broad, so her unit was very honored when the governor let the BCBSA take the time to introduce themselves, talk with them about their issues, and take the time to ask their permission to speak with their people and continue to work with their agencies. She said most of the tribes have their own health behavioral departments, and they have their own strategies to address the behavioral health needs in their communities. She said they have a responsibility in New Mexico to understand all tribal relationships and partnerships (e.g., between the tribe and the local government, the tribe and the state government, and the tribe and the federal government) all on a government-to-government basis. She said there are different processes and protocols for every Pueblo and tribe, which helps to navigate their business within that tribe. She said the tribal level of the BCBSA's outreach protocol is that each year they meet with the new leadership to introduce themselves, share their intent, and ask for the permission of the leadership to continue to work with the tribe and other tribal nations. Sometimes, she said it takes a long time to get an appointment with tribal leaders, but she said it is very important for them to ensure that they are meeting with those tribal officials and creating those connections because it is all about honoring sovereignty. She said it is part of their job to honor sovereignty throughout the country with all the tribes.

Ms. Vallo said the key areas the BCBSA focuses on are setting up annual meetings with tribal leadership, working and partnering with tribal agencies and organizations, educating tribal leadership and tribal members on MCO (Multicultural Organizations or Managed Care Organizations), and providing information to tribal councils and programs. She said ITU is an acronym for Indian Tribal Healthcare Units, Tribal 638s, and the tribal health centers. She said these are the main health care systems that all tribal members use to access health care and which they are the most familiar with. She said it is important that tribal members are familiar with health care systems outside of the ITUs in order to access a wider selection of doctors, including those who provide specialized care (e.g., oncology, dental health services, behavior health care providers, etc.). She said for the behavioral health care services, the Navajo Nation has a Navajo Division of Behavioral and Mental Health Services. She said most tribes and Pueblos have their own tribal and health care services within their own tribes. She said these types of health care are always based on funding and the availability of providers. She said sometimes at an Indian Health Service (IHS) unit, there may not be enough providers for people to go and see. She said the last time she checked at one of their health care units, they only had a podiatrist on hand because they were so short-staffed, so they had to send people off to other areas for their care. She said the other thing to mention is that there are school-based health centers at some of the schools and rural communities where they have doctors come in, and they have behavioral health programs that are set up directly at the schools.

Director Wing-Heier asked how that works with the IHS or a 638 contractor—i.e., what the relationship would be and how behavior health care would be accessed—when they do not have the facilities or the providers on tribal lands or at the ITU. Ms. Vallo said when there is no availability and the person does not have insurance, they will be referred out to what is called "purchase-referred care" through the IHS system; but, if the person does have insurance, then they have the option to utilize their insurance to go to a provider anywhere in the city or in a neighboring town. She said that is why it is so important for tribal liaisons to provide education to tribal communities as to where they can go to get the care that they need in order to widen that net of health care. Ms. Duhamel asked if it would be correct to say that tribes can use tribal 638 funds to help their members access this type of specific care elsewhere if it is not available in their local IHS or 638 clinics. Ms. Vallo said 638 funding goes to the IHS, and it is called "purchase-referred care" that has the direct services that it provides. The "purchase-referred care" is when they have to send someone out to a podiatrist, they get a referral that they take to a provider and that provider then bills IHS for those services. She said the BCBSNM holds the contract nationwide for the IHS to take care of their "purchase-referred care" services, so the BCBSNM processes all those claims for them; so that is another relationship that they have with the IHS.

Ms. Vallo said New Mexico has an Indian Affairs Department with a cabinet-level secretary that was established in 2008 and tribal liaisons in most of their state departments. She said it is very helpful to them when they are working with tribal communities that they can communicate with Theresa Belanger, the Human Services Department (HSD) tribal liaison, who works with all the different tribal liaisons for all the tribal MCOs in New Mexico. Ms. Vallo said they participate in the New Mexico Behavioral Health Collaborative, whose focus is on behavioral health prevention, treatment and recovery to work as one in an effort to improve mental health and substance abuse services in New Mexico. She said part of that health care collaborative is what they call the Native American Subcommittee (NASC), whose quarterly meetings are where providers, community members, and the local collaboratives come together to share information about the different things that are happening across Indian Country in New Mexico in terms of behavioral health. She said recovery issues are addressed, as is

suicide prevention; anything and everything that is going on is part of these meetings. She said the meetings can be very long, but there is a lot of information that is shared, so the BCBSNM participates in both the Behavioral Health Collaborative, as well as the NASC. She said another important item is that their internal Medicaid programs within the BCBSA are under the Centennial Care program, which is required to have six tribal liaisons working with all of the tribes in all of these different departments, their care coordination team, the provider network, the social services area, and the community outreach team. She said their behavioral health and physical health care coordinators operate on behalf of the members, and one thing they have learned over time is that it is important for tribal members to know and feel comfortable with those who are coming onto tribal lands. She said when they meet with their tribal leaders, they take their care coordinators with them, so they can explain the Medicare programs and insurance issues that may not have anything to do with the Centennial Care program, but are really just general health care questions that tribal leaders are not aware of, so they try to help educate at that high level as well. She said it is important to bring their care coordinators with them when they visit tribal lands, as the tribal leaders have rules about who can come onto their lands (e.g., one of those rules is that a tribe asked them to drive slow through their village so their dogs do not get hit by the cars). She said another Pueblo asked them to check in at their senior service center, so what rules are encountered just depends on the tribe, as they all have different needs, so it is important to meet with them in person to see what their specific needs are and who they need to collaborate with in that community.

Ms. Vallo said their provider network specialists have a direct line to their tribal liaisons and ITUs in order to work with any contracting they have, which keeps them all working closely together with the tribal leaders in order to set up a 638 behavioral health service program so they can handle their billing through the BCBSA. She said their group specialists also work with the ITU business offices, and they present quarterly at the Navajo Nation IHS and the Albuquerque area IHS, which is, of course, the umbrella for all the service units underneath. She said that is how the BCBSA helps with the third-party billing because when IHS bills an insurance company, the insurance company gets the bill, then it goes to their bank in San Francisco, CA, and sometimes the information it needs to route the information back to their internal systems' link gets lost. She said their offices were able to trouble-shoot and resolve most of these issues. She said third-party billing is important due to the complexity of the amount and the way federal dollars come into the system (which changes from year to year). She said an example is the Zuni Tribe Pueblo she toured and for whom, during the first year of bringing in third-party billing, they were able to bring in an additional $2 million to use in expanding their facility and providing better quality services in that area. She said they have a community social service team within the Centennial Services Team that was able to provide their members with access to the care and resources that they need. She said their social services team helps members with the soft skills necessary to apply for the benefits that they need, such as emergency food boxes from their partnering with the local Road Runner food bank, or having wood chopped and hauled to them for heating their homes and cooking their meals, as these are very rural areas. She said their peer recovery health teams work with members who have complex behavioral health needs, so they work directly face-to-face with clients; they have meetings with them month to month; and they connect them to care coordination. She said they also have contracts with wellness centers across the state, so families that are BCBSA members can go to a wellness center and get the support they need to help them live with a family member who is suffering from substance abuse issues, mental health issues, or behavioral health issues. She said it is growing because people are using the services across the state.

Ms. Vallo said the peer recovery health teams are working on a justice program right now, and they have made connections with all the tribal detention facilities to work with the members that are getting out of jail to help the tribes develop that support service with any need that they might have with their medical health issues when they get out. She said their community outreach team is the center of things that are happening with the tribal liaison. She said the recovery support team also hosts the Native American Advisory Committee (NAAC), and as part of their contract, they are required to have four meetings a year in Indian Country at locations that are close to tribal areas that need this type of care where there are the highest numbers of members, such as Zuni, Farmington and Gallup. At these meetings, their entire team comes to share information about their members' plans, their benefits, how the health care system works, and what to do and who to contact if they have any health care issues. Ms. Vallo said 90 people attended the last meeting they had in Zuni land, and it was standing room only. She said the team called members individually to invite them to attend, so there was a lot of interest due to the personal connections that the team made.

Director Wing-Heier asked if all the different languages used by the various tribes served as any kind of a barrier to the success of her team and if there was, how they overcame it. Ms. Vallo said there could be a barrier, but so far she said in the Navajo-speaking communities, they have a person who speaks fluent Navajo so they have meetings in Navajo and in English at the same time; or they pull the Navajo speakers aside and have separate Navajo only meetings, but they happen simultaneously. She said in those communities where the team does not speak the language, they work with their partners in that area who do speak the language. Luckily, she said they have a new peer-support person from Zuni, so he was able to translate the last time they were in Zuni land. She said it is important to have those types of connections in the communities to make sure you have someone who can speak the language because sometimes it is hard to understand some things in a language with which you

are not familiar. She said they meet with their partner agencies to find out what their needs are and to let them know that the BCBSA is there to support them with educational needs, information, or anything to assist that community. She said part of their outreach strategy is to determine their impact on communities so they have two Care Vans that operate across the state and they serve as mobile clinics that they take to different community events like feast days where they partner as a first aid station with the tribe. She said during the New Mexico State Legislature's American Indian Day, they provide flu shots for people who are attending, as it is a big event where tribal leaders come from all over the state. The vans do screenings, blood pressures and vaccinations. She said they also have their Blue Bear mascot that goes with the team to different tribal events, fairs and parades. She said the bear has his own Healthy Habits Education Program, which is taken to schools all over the state. They always try to dress the bear up with some type of traditional garb in keeping with the tribal lands he is visiting.

Ms. Vallo said their Community Giving Program is another outreach to the community. She said they partner with the KaBOOM! Playground to provide imagination playgrounds to several tribal areas, which was only a portion of the $1.2 million that the BCBSNM gives back to communities throughout New Mexico. She said one of the fund raisers they have been doing for the past 18 years is Operation Back to School to help raise $18,000–$20,000 in a certain amount of time to donate back to provide school supplies to Title 1 kids. She said they have 127 self-identified American Indian employees at the BCBSNM, representing the Acoma Pueblo, Ohkay Owingeh Pueblo, and the Omaha Tribe (which is not from New Mexico, but there are a lot of Native Americans who work at the BCBSNM in all the different departments). She said they have business groups as part of their Native Americans in Progress program, where they provide information about who and where the different tribes are located, and they have events where they have a third-generation rug weaver do a demonstration using a traditional Navajo loom. She recommended that Liaison Committee members look up the feast days of the tribes in their respective states. She said many of the tribes open their feast days to the public so you can go to the tribal members homes and have a meal with them at their table in their villages, as they are very hospitable.

Ms. Vallo said most tribes are quite small, and they carry their traditional, historical differences with them forever, so it is very important to recognize these differences when working with Native American tribes. She said it is very important to follow through with action if you say you are going to do something, because they will remember it forever if you make a mistake and do not follow through. She said even if you move to a different state or go to work for a different company, that tribal person or leader will always remember your name and that you did not do what you said you would do. She said she could only speak to the tribes in New Mexico, as the tribes outside of her state have another set of historical differences. She said some of the lessons they have learned are to: 1) identify the tribes within your state; 2) become familiar with each Tribal Government structure; 3) learn that tribal outreach is achieved by building trust; 4) develop meaningful connections; 5) recognize, acknowledge and honor the Tribal Leaders in the community, as they need to be able to identify with the consumer assistance person and insurance commissioner conducting the outreach; 6) understand that cultural competency is important—that as a tribal liaison, you represent yourself, your tribe, and your family, as well as the face of your employer when you are in tribal communities; 7) collaborate internally to provide a full service approach to tribes across the state; and 8) most importantly, work from the heart and always remain humble. Ms. Vallo said she really appreciated the Liaison Committee's vision statement and what it said about caring for people in tribal communities, as that is very near and dear to their hearts, and that they take care of their people no matter where they are.

Commissioner Conway asked if all the carriers have tribal liaisons in New Mexico or just the BCBSNM. Ms. Vallo said all the carriers have tribal liaisons that work very closely with the state tribal liaisons having quarterly meetings with them and all the MCO tribal liaisons. Ms. Duhamel said the private commercial carriers have tribal liaisons and programs to them as well. She said when Molina Healthcare left its Medicaid program, it kept staff on to help with Native American issues.

Ernest House, Jr. (Senior Policy Director, Keystone Policy Institute—KPI) said he is a member of the Rural Mountain Ute tribe in southwestern Colorado—not far from his Pueblo neighbors—and he has spent the last decade working as Colorado's American Indian Executive Director for the Colorado Commission of Indian Affairs, which was established in the 1970s. He said his experience is very similar to what Ms. Vallo does in that he was the state liaison under the direction of three governors and four lieutenant governors in both political parties. He said one of the most interesting things when we talk about working in Indian Country, especially the 757 tribal nations when looking at your representative states and your constituencies, is that who you represent, is the majority or the bulk of American Indian or tribal nations. He said the Liaison Committee is tasked with dealing with the most complex issues surrounding health care, and a lot of people in the general public do not know that American Indians have been on federal health care since the federal Robert T. Stafford Disaster Relief and Emergency Assistance Act went into effect in the 1920s and which has been reauthorized over the years, then coming into the U.S. Department of War, the IHS, and the U.S. Department of Health and Human Services (HHS) umbrella and system. He said this is a preface that he is no longer the Director of the Colorado Commission of Indian Affairs, having left eight months ago to join the KPI because one thing he saw when he was with the state, and which was the most challenging, was not only the state's historical wrongdoing, but on a national level, that we as states were not addressing the state tribal government-to-government

relationship. He said the federal tribal relationship is clear; however, there is a crucial component that is left out – which is a lack of coordination between our state governments and our tribal governments.

Mr. House said what makes it even more complex is that there are federal laws being passed in the U.S. Congress (Congress) that are being pipelined down to our state agencies (e.g., our Colorado Department of Health Services) that if they are not getting the right amount of federal dollars for Indian Child Welfare, Title IV.E. Foster Care Placement, or Elder Care for rural tribal nations like his, those dollars never get there because they do not know who to contact on the other side of the phone. He said what they found out in Colorado is that they did not have, and did not do a good job of getting, information on the communication process out to those who needed it the most. He said we in government all know how to do that, and we often take for granted just how much of a life that is for most people to get a consistent communication process to work effectively. He asked what that looks like in a tribal community where every year is an election year or in non-tribal communities where every off year is an election year, especially to someone in his position where the leadership had a shelf life of four years. However, the Lieutenant Governor was the Chair of the State Tribal Indian Affairs, so they had an opportunity to do something about that and launched a State Tribal Consultation Program in 2011. He said New Mexico did it in 2004, so other states were light years ahead and other states may have, but a lot of states have not because they are not required to do so. He said the federal government has passed different policies over the years having to do with health care or education that now require specific state agencies to conduct tribal consultations into such policies. He said they were not meeting any of those in Colorado, so he had a lot of their executive directors ask where those federal dollars were going to come from, what was needed to get them, what meaningful consultation even meant, and what the return on investment is that can really be seen in results on the backend. He said they now have ongoing, annual state consultations; the governor does individual one-on-one outreach, but that also turned into including other state agencies like the HHS, the Public Health and Environment, and the Department of Healthcare Policy and Financing. He said they quickly added on the Department of Education and others, as seen fit. He said they then established subcommittees for various special issues; and all this is to say that it became necessary to codify the process, so tribal leaders could rely on these policies staying in place year after year without the need to recreate the wheel every year or whenever a new administration took office.

Mr. House said especially dealing with health care and third-party billing while being in a rural community that is in reservation border towns that have border-town racism, it is pretty clear, and it has been well-documented that in some of these communities, the only hospital is in Cortez. There was an incident when due to a third-party billing situation, over $600,000 in bills had not been paid and it created such a division to a point where there was a case of turning patients away—also known as patient-dumping. Mr. House said it was the first successful case in the state of Colorado that their Civil Rights Commission brought successfully to a court and defeated, but that was just eight years ago. He said these issues have been going on for well over 100 years in Colorado and continue today.

Mr. House said the reason he talked about this was to get the Liaison Committee members to look at their own states to see where they are in the process and to take action where they find it is needed to provide consultation and communication with Native Americans in their states. He said many people in Colorado government did not know that the average age for the life expectancy of a Native American man was 52 years, and as we talk about youth suicide, southwestern Colorado (which happens to hold the only two Native American tribes in the state) runs the highest youth suicide rates in the state. He said the American Indian population in Colorado is 60,000, which is about 2% of the state's total population. He said 40,000 of these people live in the Denver metro area where there are no reservations. He said the last U.S. Census in 2010 showed that over 72% of the Native American population live off reservation. He said by 2020, that number will be over 80%, so as we are trying to come up with successful programs on reservations, the population is moving away from them—so he asked what we are doing for urban Indian populations. He said they are leaving to get jobs, go to school, and get higher education; and it needs to be addressed, not just by the State American Indian Liaison, but by all state agencies. He said the consultation agencies that they created started to incorporate all such state agencies, as it should. He said when they talked about mental health needs, the lack of socio-economic status, etc., Indian Country is impacted more than anybody else because of the outdated, convoluted systems that have been in place. He said the most successful state programs for tribal nations are those that have been tribal-driven and tribal-supported. He said the biggest thing he would tell the Liaison Committee members when working with tribal leaders is not to say you are with the government, but you are here to help. He said it is so much more important to say we are here to work with you to develop solutions that work for you. What worked for one tribal nation in the past may not work for another tribal nation now. Every tribal culture should dictate what works specifically for them. Mr. House said on their feast days they have two dances—one public community celebration and one private celebration. He said they have the Sun Dance and they have the Bear Dance. He said for the Bear Dance, they invite everyone to come and dance with them and on the third day to feast with them, but there are certain procedures, and that is what they walk people through. He said it is important for the states to go back in their history, even before statehood to learn about Indian Country in order to understand the culture now. He said it is important for each state's tribal consultation commission to educate all state agencies about Native Americans as it pertains specifically to the tribal members in your state, so they can use what they learn in consultations with tribal leaders

going forward. He said it is important to learn what term each tribe prefers to be called, where each of the tribes is located, what the demographics of the tribal communities are, etc. He said they will be launching a Southwest Mental Health Initiative with more specifics about teen suicide. He said one thing to remember about Indian Country is that they do not care if you are a Republican or Democrat—they just want to know that the leaders are there to pass legislation at the state and federal level that will help them. He said what tribal leaders want the most is a seat at the table because they believe there are only two possible places for them—you either have a place at the table or you are on the menu.

Mr. Laughlin asked about the utilization of telemedicine in Indian Country, specifically from the BCBSNM, as they are looking into it in Oklahoma because his wife is a Native American from a tribe in the eastern part of the state. Ms. Vallo said it was still in its introductory phase because they do offer MDLIVE, so as long as folks have a smart phone, they can download the app and see a doctor that way. She said part of the challenge is that someone who might be from the Zuni tribe would have to drive to Gallup for any prescriptions, even after they saw the doctor online. She said it would take time for people to get used to it, and most of the people she works with prefer face-to-face time with a doctor in order to build a relationship with that person. Commissioner Conway said one of the main problems in Colorado is broad-band access, and that is an essential component of telemedicine. Mr. House said he agreed, and his experience is that if the wind blows hard enough, it blows away broad-band access, so their internet access is gone for the rest of the day. He said during the time you are building relationships in the community, it is critical to do it in person. Commissioner Conway said one of the items he is particularly interested in with the suicide issue is the schools; perhaps they can partner with the schools specifically since their broad band is typically much better than in their homes, so it could be an access point.

Commissioner Conway asked Ms. Vallo for more details about how to go about asking for permission to visit tribal villages on an annual basis. Ms. Vallo said in New Mexico, some tribes elect a new leader every year and some of the tribes are still very traditional where the religious leader appoints the tribal governor and the whole staff gets appointed that way. It does not matter what their educational background is or what their knowledge is; if the traditional leaders feel that these folks can take on that role, then they get appointed. Asking for permission to work in the community or to serve the community is part of the whole tradition of the tribes. For some tribes, you do not have to, but it is still a good idea to do it. Even if it is not required, most of the tribal leaders or governors are insulted if people just come onto their Pueblo or lands without asking permission. It takes the first three months of every year to get it done, with 60% of the leaders that will grant permission.

Commissioner Conway said one of the things he has taken away from the presentations is that there is a first step that we need to figure out of how to communicate and the respectful way to work with the tribe regardless of what the subject matter is. He said the Liaison Committee needs to be moving toward accomplishing a good work product at the end of this, perhaps a how-to document about having conversations with the tribes, whether it is about behavioral health or something else, but to have that for insurance commissioners and their staff, because the entire team has to be culturally aware in order to have these conversations. He said he was very pleased with the way the conversation went, and it was exactly what he had hoped it would be.

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

W:\National Meetings\2019\Summer\Cmte\CONSUMER\AMERICAN_INDIAN\Americanindian_08min.Docx

