NAIC/CONSUMER LIAISON COMMITTEE

NAIC/Consumer Liaison Committee Aug. 14, 2020, Minutes
  NAIC/Consumer Liaison Committee June 19, 2020 Minutes – Attachment One
NAIC/American Indian and Alaska Native Liaison Committee Aug. 3, 2020, Minutes – Attachment Two
  NAIC/American Indian and Alaska Native Liaison Committee Apr. 29, 2020 Minutes – Attachment Two-A

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Draft Pending Adoption

Draft: 8/26/20

NAIC/Consumer Liaison Committee
Virtual Summer National Meeting
August 14, 2020

The NAIC/Consumer Liaison Committee met via conference call Aug. 14, 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 (AL); Ricardo Lara (CA); Andrew N. Mais represented by Kurt Swan (CT); Karima M. Woods (DC); Trinidad Navarro represented by Frank Pyle (DE); David Altmaier (FL); John F. King represented by Martin Sullivan (GA); Doug Ommen (IA); Dean L. Cameron (ID); Robert H. Muriel represented by Sara Stanberry (IL); Stephen W. Robertson (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); James J. Donelon represented by Ron Henderson (LA); Kathleen A. Birrane (MD); Steve Kelley (MN); Chlora Lindley-Myers (MO); Mike Chaney (MS); Mike Causey represented by Kathy Shortt (NC); Jon Godfread represented by John Arnold (ND); Bruce R. Ramge (NE); Russel Toal represented by Robert Doucette (NM); Barbara D. Richardson (NV); Linda A. Lacewell (NY); Jillian Froment represented by Jana Jarrett (OH); Glen Mulready represented by Ron Kreiter (OK); Jessica K. Altman (PA); Raymond G. Farmer represented by Joe Cregan (SC); Kent Sullivan represented by Dan Danzeiser (TX); Scott A. White represented by Don Beatty (VA); Mike Kreidler (WA); and James A. Dodrill (WV). Also participating were: Elizabeth Kelleher Dwyer (RI); Larry D. Dieter (SD); Todd E. Kiser (UT); and Jeff Rude (WY).

1. Adopted its June 19 and 2019 Fall National Meeting Minutes

Commissioner Stolfi made a motion, seconded by Commissioner Altman, to adopt the Committee's June 19 (Attachment One) and Dec. 9, 2019, (*see NAIC Proceedings – Fall 2019, NAIC/Consumer Liaison Committee*) minutes. The motion passed unanimously.

2. Heard a Presentation on COVID-19-Related Business Interruption Claims, Coverage Issues, Disputes and Litigation

Amy Bach (United Policyholders—UP) said Part 1 of the NAIC Property and Casualty Insurance Business Interruption Data Call on premiums and policy information related to COVID-19 was completed in June. She said companies were asked about: 1) whether forced closure orders, infiltration of insured premises, and/or imminent risk of grave harm met the common requirement of direct physical loss of, or damage to, insured property; 2) whether losses due to mandatory closure were covered under civil authority; 3) speculative, yet unknown loss projections or losses in progress possibly leading to trillion dollar loss projections and solvency fears; 4) the number of actual claims filed; 5) the volume of litigation; 6) the number of claims accepted or being processed; 7) the number of claims denied; and 8) litigation outcomes or forums. She said many, if not most, small businesses, especially restaurants, bars, and concert venues that were mandatorily closed by public safety orders, either do not have Business Interruption (BI) coverage or have BI coverage with virus exclusion. She said some higher education institutions have coverage for losses related to communicable diseases, and some large businesses have BI coverage without virus exclusions. She said the current administration has been quoted as saying insurance companies should pay for BI claims. She said one insurer reported spending $19 million in legal expenses defending BI claims. She said the company posted a $41 million underwriting loss, compared with a $48 million profit, which was attributed to $231 million of catastrophe and $65 million of pandemic-related losses and expenses according to *Best's News, July 27, 2020*. She said the company's net income more than doubled to $909 million in the second quarter after the company recognized an $825 million increase in the fair value of equity securities held. However, she said in 2003, Mandarin Oriental hotels in Hong Kong, Malaysia, Singapore and Thailand all lost business due to cancellations and reduced local food and beverage sales stemming from the severe acute respiratory syndrome (SARS) outbreak; and Mandarin Oriental International Limited received $16 million from its insurers to pay for business interruption losses suffered by the group's hotels in Asia as a result of the SARS outbreak. She asked: 1) what regulators were told by insurers at the time that the 2006 Insurance Services Office (ISO) virus exclusion was added; 2) whether there should have been a rate decrease when the virus exclusion was adopted if insurers paid out on SARS claims; and 3) whether current assertions by insurers that pandemic losses were never covered are contradicted by the fact that SARS claims were paid in 2003. She also asked what insurers told business policyholders when policies were renewed with this new exclusion, but without any rate reduction. She said most policies do not mention pandemics nor government closures via public safety orders. She said the COVID-19 Coverage Litigation Tracker at *https://cclt.law.upenn.edu/* indicated that filings peaked the week of May 4, with a cumulative total on July 31 of 312 cases being brought against three insurers with business income, extra expense and civil authority being the relief most frequently sought.

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Commissioner Conway said COVID-19 is probably not going to be the last pandemic seen. He asked how the industry can make sure that coverage is available when the next one hits. Ms. Bach said her hope is that the entrepreneurial spirit would kick in to make that happen. She said some businesses will request full coverage, but most will want at least some coverage.

3. Heard a Presentation on Digital Claims Handling and Photo Estimating

Erica Eversman (Automotive Education & Policy Institute—AEPI) said photo estimating has serious side effects. She said the advantages are that it is fast and easy putting the insurer on notice of claim immediately and giving the company the opportunity to provide consumers with assistance, should the need arise. Another advantage is that it allows the consumer to file a claim without personal contact, as required during a pandemic. Ms. Eversman said the disadvantages are that it is substantially under-reserving because photos only show what the consumer thinks looks damaged. She said consumers do not know what is important to capture in a photo. She said insurers are using desk reviewers to evaluate such claims, and only the insurer knows if the initial claim payment is being underestimated; the consumer does not. She said many consumers do not have their vehicles repaired, so they are not receiving the full benefits owed to them under the final claim settlement. She said this creates windfall profits for insurers because consumers just do not have the ability to protect themselves. She said there is confusion regarding the remedy elected because auto insurers do not inform consumers of the remedy elected under the policy. She said photo estimating suggests payment of loss in money remedy; but once a vehicle is in repair, the insurer wants involvement in the repair decisions being made. She said there is also insurer confusion over what election to repair truly means; however, there is nothing in an auto policy that allows an insurer to blend remedies or change a remedy election mid-claim. She said state laws may preclude photo estimating; and due to the pandemic, states have suspended requirements of in-person adjustment. She said consumers are entitled to have in-person claims adjustment, unless the insurer agrees that it is only paying the full loss in money and has no need or right to review the damage. She said digital claims handling makes it is easy to transfer adjustment activity to an adjuster or appraiser not licensed in the state. She said out-sourcing adjustments to third-party adjusters (TPAs) not licensed in the state leads to cross-border claims adjusting and a lack of accountability. She said consumers are told by TPAs that only insurers can provide estimates. She said when the consumer contacts the insurer, the consumer is told that only the TPA can provide such an estimate. She recommended that state insurance regulators: 1) require insurers to notify consumers that photo estimating will likely lead to them missing substantial damage that needs to be repaired; 2) alert consumers that even if the consumer chooses not to repair the vehicle now, the consumer can still have it repaired at later date; and 3) insurers offering photo estimating are required to over-reserve the claim by a specific percentage (e.g., 100–1,000%).

Commissioner Conway asked under what circumstances over-reserving of 50%, 100% or 1,000% would be appropriate over a photo estimate. Ms. Eversman said these percentages were derived from national surveys of actual consumer auto claims and payments. Commissioner Dodrill asked how additional damage, such as rust, might be addressed if a consumer decided not to have their vehicle repaired immediately following an accident, but to have it repaired later. Ms. Eversman said if the wait was desired due to the COVID-19 pandemic, the insurer and the consumer would have to address it later, with the insurer required to let consumers know that the initial payment check would not mean that the consumer cannot bring the vehicle in for a full estimate at a later date and receive more money over the initial claim amount received.

4. Heard a Presentation Proposing a Model Law to Modernize Insurance Rate and Form Regulation that Would Address Algorithmic Bias Plans Used on Patients and Markets

Birny Birnbaum (Center for Economic Justice—CEJ) said following the murder of George Floyd, insurers and state insurance regulators pledged to fight systemic racism and inherent bias in insurance. He said understanding the history of such bias would help industry to identify the actions needed to address this issue in insurance going forward. He said there has been a lack of minority voices and experience in insurer and state insurance regulator leadership, as well as an imbalance between consumer and insurer or producer access to critical regulatory and legislative processes. He said trade associations have been fighting to protect practices that reflect and perpetuate systemic racism in insurance. He also said regulatory authorities and infrastructure had been failing to keep up with seismic changes in insurer practices. He said to address systemic racism and modernize insurance market regulation, a model law should include: 1) reinforcement of risk pooling and cost-based practices as the foundation of insurance; 2) ensuring that consumers, generally, and minority consumers, particularly, have a strong voice in regulatory processes; 3) defining fair and unfair discrimination in insurance, including proxy discrimination against protected classes; 4) requiring insurers and state insurance regulators to proactively identify and minimize proxy discrimination against protected classes and provide safe harbors for insurers for such actions; 5) providing meaningful oversight by state insurance regulators of insurers' use of data, algorithms and artificial intelligence (AI), including modernizing the definition and oversight of advisory organizations and statistical agents; 6) improving consumer control over their data, including Fair Credit Reporting Act (FCRA)-type protections for all personal consumer information used by insurers; and 7) improving competition in insurance markets with more accessible and actionable information to consumers. He said intentional discrimination is that which leads to disparate treatment, and proxy discrimination is that which leads to disparate impact. He also said intentional

discrimination and proxy discrimination can be addressed by regulatory oversight and statistical or technical treatment within the cost-based framework of insurance. He said systemic injustice means that systemic racism and inherent bias have so pervaded a particular community, that insurance costs are inseparable from the class characteristic. He said addressing this type of unfair discrimination by prohibiting racial discrimination is the role of legislators. He said fair discrimination means adherence to cost-based practices for pricing, claims settlement, and other aspects of insurer operations so consumers who are similarly situated are treated in a like manner. He said for pricing, including underwriting, rating, and payment plan eligibility, fair discrimination means charging the same rates and payment options to consumers posing similar expected costs for the period of coverage. He said rates should also not be excessive or inadequate. He said fair discrimination in claim settlement means similar claims outcomes for similar claims.

Mr. Birnbaum said unfair discrimination means treating similarly situated consumers differently without a justification based on expected claim costs or expenses associated with the transfer of risk for the period of coverage provided or claim presented to the insurer; based on a protected class; or the use of any data or characteristic of the consumer, vehicle, property, or natural or built environment unless approved by the commissioner. He said a protected class is consumers grouped together based on race, religion, national origin or another characteristic. He said discriminating on the basis of disparate treatment means that the outcomes are determined by the explicit application of a protected class characteristic. He said disparate impact or proxy discrimination means that the outcomes have a disproportionate impact on a protected class or practices that serve as a proxy for disparate treatment. He recommended that state insurance regulators strengthen consumer voices within the regulatory processes by establishing a public agency dedicated to representing insurance consumers before the department of insurance (DOI) and legislature and fund the Bureau of the Insurance Consumer Advocate (BICA) through a $0.10 to $0.25—depending on size of the state—assessment on every individual policy and certificate under a group or master policy issued in the state. He said BICA has standing to intervene on behalf of consumers in any insurance regulatory proceeding, including rulemaking and review of rate and form filings. He said BICA has access to non-public information received by the DOI subject to the same confidentiality as the DOI and related to the purposes of BICA. He said the Director of BICA would be selected by the Governor from a list of candidates prepared by an advisory committee of individuals engaged in consumer advocacy and would have a five-year term. He also recommended additional oversight of data, algorithms and advisory organizations via routine reporting by insurers of data sources, data uses, data vendors, and providers of algorithms. He said the definitions of advisory organization, statistical agent and statistical plan should be modernized to create a level playing field for the providers of algorithms used by insurers for marketing, pricing, claims settlement and anti-fraud prevention. He said advisory organization should be required to file algorithms so commissioners will have the authority to permit use of new data sources, algorithms and AI within a controlled environment for the purposes of data creation, data collection and evaluation. He recommended FCRA-type consumer protections for all consumer data used by insurers, such as the disclosure of data to be used, the source of data, the uses of data permission, consumer consent, notice of adverse action, consumer access to their own data, the ability to dispute and correct incorrect data, and the ability to request reconsideration based on corrected data; requiring the destruction of consumer data by the insurer when the insurer no longer needs it for business purposes; limiting the use of consumer data to stated and disclosed purposes; opt-in or consent for any purpose, with particular attention to consumer-generated data from devices used for insurance exposure and loss assessment and prevention.

Commissioner Conway asked if stress testing would be used to determine how the safe harbor would play into his recommendations. Mr. Birnbaum said he was looking for a more holistic approach, and it would be determined by responses to advisory organization examinations via proxy discrimination because the test is on the algorithm. Commissioner Conway asked if a penalty or restitution is a concern, but he said he would address his other questions with Mr. Birnbaum offline. Commissioner Ommen said state insurance regulators in Iowa and other states already had the authority and tools, such as the Unfair Trade Law and Federal Trade Commission, to regulate discrimination and account for the balance of injury. He asked Mr. Birnbaum why he thought that state insurance regulators need a new model to do it. Mr. Birnbaum said he was not recommending a trade-off of racism for risk pricing, and a model is needed because so many laws exist that a holistic approach is needed to address them all in the same model.

5. Heard a Presentation on Improving Equity in Health Care Access

Deborah Darcy (American Kidney Fund—AKF) said data from the U.S. Centers for Disease Control and Prevention (CDC) shows a disparate impact of COVID-19 among cases with known ethnicity and race. She said Hispanic persons represent 18% of the U.S. population but 33% of COVID-19 cases; black persons represent 13% of the population but 22% of COVID-19 cases; American Indian and Alaska Native persons represent 0.7% of the population but 1.3% of COVID-19 cases. She said there is also evidence of health disparities due to COVID-19 related to underlying illnesses, such as hypertension. She said hypertension is higher also with 40.3% of black persons, 27.8% of white persons, 25% of Asian persons, and 27.8% of Hispanic persons reported as having it. She said 21% of COVID-19 fatalities were individuals with hypertension, and 67% had circulatory diseases. In a nut shell, she said equitable access to coverage and care for people of color, people with disabilities,

people who are LGBTQ+, and people for whom English is not the first language means: 1) access to health insurance coverage with affordable premiums and cost sharing; and 2) access to providers within reasonable geographic proximity, without physical or language barriers, and who are able to provide culturally competent care.

Ashley Blackburn (Community Catalyst—CC) said the closing of rural hospitals left many geographic areas, most of them in the south and in lower income areas, without specialty care or other languages spoken, and it has rendered access to care nearly impossible. She said this problem was compounded during the pandemic due to the remaining hospitals at or over capacity with COVID-19 cases for weeks.

Wayne Turner (National Health Law Program—NHLP) said Section 1557 is the nondiscrimination portion of the federal Affordable Care Act (ACA) that applies to all health care plans. He said the current administration removed this section in June, exempting most of the nondiscrimination language via rule change. He said this did not change the law, and there are currently many lawsuits pending. He said the states that have taken positive actions to date include California, Colorado and Illinois. He also said America's Health Insurance Plans (AHIP) has also helped to fill the gap. He said telehealth can help fill the gap in health inequity by increasing access for underserved communities and providing a convenient form of care, particularly for those with limited transportation access, work obligations and childcare responsibilities. However, he said there are still barriers to telehealth due to a lack of internet and broadband access. He said the best practices of some states include: 1) reimbursing telehealth service at the same rate as comparable in-person services (Colorado); 2) no cost-sharing for telehealth services during COVID-19 (Colorado); 3) requiring health insurers to allow all in-network providers to deliver clinically appropriate, medically necessary covered services via telehealth (New Hampshire); 4) allowing the home or any place to be the originating site—i.e., where the patient is located—(NC) or the distant site—i.e., where provider is located—(Colorado); 5) reimbursing for audio-only phone services (Arizona, Colorado, Connecticut and Kansas); 6) expanding the list of services or providers who can participate in telehealth and be reimbursed (Alabama, Colorado and Mississippi); and 7) enrolling consumers in Medicaid via telehealth (California).

Commissioner Lara said California offers health care coverage to everyone, including immigrants. He said it is discriminatory to forbid immigrants from paying into the ACA. He also said innovation under a Section 1332 Waiver is needed to allow such payment, as it could save the states money because immigrants have the money and are willing to pay into the ACA. Immigrants are keeping the economy going and making money delivering goods, picking produce, etc. Commissioner Altman asked about the role of network adequacy and culturally competent care. Ms. Blackburn said in past years, NAIC consumer representatives have done lots of work on best practices for the states on network adequacy, and she does not know how to include this other than to look at each state. Mr. Turner recommended looking at what California had done as a starting point. Commissioner Stolfi said Oregon is working on this issue now, but it has not found much on it, so it wants to do more offline.

6. Heard a Presentation on Addressing the Needs of Patients and Consumers in the COVID-19 Pandemic

Amy Killelea (National Alliance of State and Territorial AIDS Directors—NASTAD) said there are many ways to address the needs of patients and consumers, but she will focus on utilization management (UM). She said UM techniques include step therapy, prior authorization, cost-sharing tiers, quantity limits and pharmacy restrictions. She said the principles used to govern UM regulation are to: 1) ground UM decisions in clinical guidelines or evidence; 2) streamline and make transparent UM clinical reviews and appeals processes; 3) promote market competition through access to cost-effective medications; 4) create safeguards for affordable access in the case of market failure (e.g., limited competition); and 5) ensure uninterrupted access to treatment. She said patient protections have been critical to ensure uninterrupted access to medications during the pandemic. She said a deep dive into human immunodeficiency virus (HIV) pre-exposure prophylaxis (PrEP) indicated that UM can be arbitrary or clinically based depending on which state is selected with higher incidents of prior authorization required in the southeast and midwest. She said different levels of prior authorization are used for different PREP medications with a lighter prior authorization required for generic brands when they are available. She said she is not advocating for free and open access to name brand PREP medications, but rather for reasonable prior authorization. She said reasonable prior authorization would mean no prior authorization on TRUVADA or tenofovir/emtricitabine (TDF/FTC); no prior authorization to identify risk for HIV; and light prior authorization on DESCOVY to ensure that the individual has the clinical markers making TDF/FTC not clinically indicated (e.g., bone and kidney disease). She said considerations for state insurance regulators would be to engage a range of stakeholders on solutions to cost and access; collect data from issuers on prior authorization, including frequency and timing of approvals and denials; require regular review of prior authorization criteria and issue guidance for issuers, particularly for conditions that are vulnerable to discriminatory plan design (e.g., PrEP U.S. Preventive Services Task Force [USPSTF] Bulletins); and ensure continued access to medications during public health emergencies (e.g., waive certain issuer restrictions for the duration of the emergency). She said recommendations for state insurance regulators and lawmakers to protect consumers during the COVID-19 pandemic include uninterrupted access to affordable insurance coverage, affordable COVID-19 and non-COVID-19 services, forward policies that mitigate health disparities and recognize the disproportionate

impact of COVID-19 on communities of color, and affordable access to LTC and supports; and developing comprehensive consumer education materials about COVID-19.

Commissioner Conway said a study done in late 2019 by New York on case management and health equity indicated that disparate racial impact for one group might be of value in a study of this issue. Ms. Killelea said she would look into it, and she noted that in the south, the group most discriminated against was young black and Latino gay men. She said prioritizing generic medications would help alleviate discrimination and disparate access to care.

7. <u>Heard a Presentation on COBRA, Medicare and Model #120</u>

Bonnie Burns (California Health Advocates—CHA) 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 the federal Centers for Medicare & Medicaid Services (CMS) to revise Medicare materials to include a clear explanation of Medicare and Consolidated Omnibus Budget Reconciliation Act of 1986 (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).

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

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Conference Call
June 19, 2020

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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

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.,

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

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. <u>Heard a Presentation on Additional Areas for State Leadership and Consumer Protection</u>

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

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 Goggle 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

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. She encouraged everyone to contact UP for help or other questions and see 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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Draft: 8/24/20

NAIC/American Indian and Alaska Native Liaison Committee
Virtual Summer National Meeting
August 3, 2020

The NAIC/American Indian and Alaska Native Liaison Committee met via conference call Aug. 3, 2020. The following Liaison Committee members participated: Michael Conway, Vice Chair (CO); Trinidad Navarro (DE); Dean L. Cameron (ID); Steve Kelley (MN); Matthew Rosendale represented by Bob Biskupiak (MT); Mike Causey (NC); Jon Godfread (ND); Russel Toal represented by Paige Duhamel (NM); Andrew R. Stolfi (OR); Larry D. Deiter (SD); and Mike Kreidler (WA).

1. Adopted its April 29 Minutes

Commissioner Conway said the Liaison Committee met April 29 to discuss COVID-19-related state outreach to Native Americans regarding federal Affordable Care Act (ACA) coverage.

Commissioner Godfread made a motion, seconded by Commissioner Navarro, to adopt the Liaison Committee's April 29 minutes (Attachment One). The motion passed unanimously.

2. Discussed the Significant Impact of COVID-19 on the Health and Economies of American Indian and Alaska Native Populations

Commissioner Conway said the Navajo Nation in Colorado is comprised of two tribes. He said they were able to shut down quickly, so they were able to keep tribal infection and death rates down. However, their economy took a heavy hit. He said last year, Colorado passed internet gaming, so that also helped tribal nations. Mr. Biskupiak said a substantial amount of the federal stimulus dollars Montana received was committed to native tribes with mixed results. He said infection and death rates were kept low throughout the state except in the southeastern part of the state, where the Crow and Northern Cheyenne (especially assisted living and nursing homes) were hit hard. Ms. Duhamel said when the governor put half of the Navajo in New Mexico on lock down, especially over weekends when infection and death rates hit their peak, the numbers went down significantly. However, she said the numbers jumped up again following the July 4 holiday weekend.

3. Discussed Coverage Available Through the ACA Plans and Tribal Programs

Ms. Duhamel said the Exchange has done its outreach to tribal communities primarily through newspapers and that it has not been particularly effective. She said the numbers via commercial and Exchange coverage have not been coming in either, partially due to many of the protests in Albuquerque, NM, being led by tribal youth. Commissioner Conway said their Medicaid numbers were like those in New Mexico, but not too high yet. However, he thought the numbers would go up now that the $600 income stimulus was gone. Ms. Duhamel said New Mexico had started to include health care coverage flyers in the care packages being distributed to tribes, which is generating additional leads. She said she has heard that the best Boots on the Ground care has been delivered with food even though it is not specified in the flyer, but that the flyer does have the insurance department's contact information in it. Ms. Duhamel said the "no wrong door" approach is being taken, offering a variety of coverages through brokers, high-risk pools and government ACA/ACA Exchanges with a warm handoff if the consumer is not eligible for other plans.

4. Heard a General Overview on What the Recent U.S. Supreme Court Decision Means to the Insurance Industry, Health Care, Etc.

Ron Kreiter (Oklahoma Insurance Department) said that what the recent U.S. Supreme Court decision, *McGirt v. Oklahoma*, U.S. Supreme Court, October Term, 2019, decided on July 9 means or could mean to the insurance industry, health care, etc. is yet to be seen. However, he said at this time any American Indian who commits an offense will argue that the definitions of "Indian reservation" in ancient cases applies, which means that the state lacks authority to prosecute the offense. Oklahoma maintained that land grants overruled the old definitions, but the Court said they did not when the tribes appealed the decision. Mr. Kreiter said the state was still looking into the possible effect on insurance but thought that it only applied to criminal offenses for now. Commissioner Conway said the main takeaway was that the treaty was still in effect, so state law could not apply. He said the potential overlap into insurance is yet to be seen. Ms. Duhamel asked if other states recognized tribal licenses for producers. Commissioner Conway said he did not know what Colorado does, but he would check. Mr. Kreiter said in

Oklahoma, tribal members must get a license through the state department of insurance (DOI) if the producers are to sell to nontribal consumers. Erica Eversman (Consumer Representative) asked when state DOI laws do not apply, are tribes to participate in state-based or federal ACA plans, or do the tribes set up their own Exchanges. Commissioner Conway said some states have open enrollment year-round, but he said he is not sure about what a tribal ACA would do. He said they probably would not have open enrollment year-round. Mr. Kreiter agreed with Commissioner Conway that if American Indian territorial rules apply for crime, then what about insurance and a myriad of other legal issues. Commissioner Conway said this decision will produce a host of questions searching for an answer. Ms. Alexander said the documents submitted by Oklahoma on this case would be posted to the NAIC website after the meeting.

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

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Draft: 6/3/20

NAIC/American Indian and Alaska Native Liaison Committee
Conference Call
April 29, 2020

The NAIC/American Indian and Alaska Native Liaison Committee met via conference call April 29, 2020. The following Liaison Committee members participated: Lori K. Wing-Heier, Chair, Sarah Bailey and Anna Latham (AK); Michael Conway, Vice Chair, Kate Harris and Debra Judy (CO); Trinidad Navarro and Leslie Ledogar (DE); Dean L. Cameron represented by Kathy McGill (ID); Steve Kelley represented by Grace Arnold, Mary Otto and Sergio Valle (MN); Mike Causey represented by Tracy Biehn, Ted Hamby and Kathy Shortt (NC); Jon Godfread represented by John Arnold (ND); Russel Toal, Colin Baillio, Leatrice Geckler and Paige Duhamel (NM); Larry D. Deiter and Maggie Dell (SD); Mike Kreidler represented by Jane Beyer and Steve Valandra (WA); and Jeff Rude (WY). Also participating were: Mary Boatright (AZ); Stephen Kim (CA); Angela Burke Boston (IA); Karen Dennis (MI); Rebecca Ross (OK); Courtney Bullard (UT); and Julie Walsh (WI).

1. Adopted its 2019 Fall National Meeting Minutes

Director Wing-Heier said the Liaison Committee met Dec. 8, 2019. Commissioner Conway made a motion, seconded by Director Cameron, to adopt the Liaison Committee's Dec. 8, 2019, minutes (*see NAIC Proceedings – Fall 2019, NAIC/Consumer Liaison Committee, Attachment One*). The motion passed unanimously.

2. Discussed How the States Are Conducting Outreach to Native Americans Regarding ACA Coverage Opportunities

Director Wing-Heier asked the Liaison Committee vice chair to kick off the discussion of how the states are conducting outreach to Native Americans about the federal Affordable Care Act (ACA), specifically regarding COVID-19. Commissioner Conway said the biggest concern was with the unhoused in Denver, and he said he had been working with hotel partners to create more non-congregate housing for Native Americans. He said Colorado is looking into the best way to handle transitional housing for Native Americans in urban settings like Denver, as well as those in rural settings like those around Durango, which is in the southwest corner of the state and in close proximity to New Mexico, sharing the concerns of the Navajo nation with other states.

Ms. Duhamel said the Navajo nation is spread over Arizona, Colorado, New Mexico and Utah. She said the New Mexico Department of Health is doing COVID-19 contact tracing, and it has learned that the Native American community is at extremely high risk due to current living conditions with several family members living together in a limited amount of space—often one room—with no water and no access to health care or testing. She said that is why all casinos in Gallup and Farmington are closed at this time, with one of those casinos having been converted into transitional quarantine housing for those just out of the ICU and those testing positive. She said the insurance superintendent is leading the effort particularly with out-of-network air ambulance carriers airlifting COVID-19 patients to access care. She said one hospital has been designated as responsible for all medical billing.

Director Wing-Heier said most Alaska natives are enrolled at a health care facility only when the person comes in for an appointment. Like Colorado, she said Alaska has concerns about housing and access to health care, as this population is unable to get intensive health care where they are sheltering in place, with most patients needing this type of care having to be flown out because the limited number of ventilators sent out into communities could not handle the number of cases. She said one would think that a population spread out in as large an area as Alaska would not have social distancing concerns, except in the larger metropolitan areas. However, she said COVID-19 has been spreading to rural areas, surprising government officials who locked villages immediately to avoid a repeat of the 1918 pandemic, which decimated many native villages. She said government officials worked extensively with the Alaska Native Tribal Health Consortium (ANTHC) and Indian Health Service (IHS) in trying to keep "foreigners" out of villages by using media to note that villages do not want tourism or commercial fishing during the pandemic. She said the Alaska National Guard was instrumental in air lifting critical patients because half of the plans exclude government alternative sites from covered sites.

Ms. Duhamel said the Native American population in New Mexico was decreasing, so the Housing Commission declined requests for additional outreach assistance. She said enrollment into the exchange had slowed, so the Housing Commission did not see any need to promote year-round enrollment. She said the department of insurance (DOI) was putting pressure on the

exchange to do more outreach because the feedback that was received indicated that lots of Native American's were eligible for Medicaid due to New Mexico enacting Medicaid expansion and Medicaid having retroactive coverage. However, she said there was a lot of confusion amongst Native Americans about how tribal members could access benefits through the U.S Department of Health and Human Services (HHS). She asked if New Mexico could get open enrollment and participation numbers for Native Americans separated by Medicare, the New Mexico Health Insurance Exchange, and tribal coverage. She asked Oklahoma if it would share information about outreach vehicles it used, as both states have similar numbers of tribal members who are eligible for open enrollment, yet the federal Centers for Medicare & Medicaid Services (CMS) reports indicated that New Mexico enrollment was in the hundreds and Oklahoma enrollment was in the thousands. She asked NAIC staff to obtain issuers' enrollment data numbers for tribes, especially on 100% cost sharing and for those under 300% of the poverty level from the CMS, and then distribute this information to Liaison Committee members.

Superintendent Toal said an open enrollment flyer developed with the Oklahoma state high risk pool was sent to recipients of Medicaid and unemployment benefits, Native American groups, and two alternative care sites that had been opened with all participating carriers for plans covered. He said information sharing about billing instructions, claims filing and premium payments was completed with these groups within a 24-hour period. It was also shared through radio stations. Ms. Ross said she could not speak to this issue until the CMS releases the information. She said she spoke to the tribal chief about getting enrollment and other health information to tribal members. The tribes utilized television and radio to spread this information. She said the Oklahoma DOI staff went to tribal health provider locations to provide education about enrollment. As a result, she said thousands of children were enrolled who previously were not due to this proactive outreach to increase tribal enrollment. She said agents and brokers were active in this outreach effort, which was also successful because enrollees can join monthly rather than just during a limited open enrollment period. She said the hope is that other states will take similar action, but she said it does take a lot of time for DOI staff to do the outreach and build the trust amongst tribal chiefs and members. She said Oklahoma only saw a handful of zero cost sharing and zero premium during the outreach. She said it was seeing fewer now, and it wondered what effect this would have on the ratings for 2021. She said she will release Oklahoma information to other states if she can.

3. Discussed Retroactive Coverage Through ACA Plans and Tribal Coverage Programs

Ms. Duhamel said New Mexico is interested in how Alaska set up its retroactive coverage, and it would like to see if the CMS would allow other states to use similar practices under certain circumstances. Mr. Baillio said his background is in consumer advocacy, and he has heard that tribal members who signed up for health coverage in a provider's office could not get the care they needed until a later date when the coverage became effective. He said what tribal members really need now is for DOIs to guarantee part of the premium for consumers to ensure that services are available immediately and paid for retroactively. He said a federal change may be required to allow this to happen. He asked if anyone knows of a way that states could set up coverage like Alaska in order to get retroactive coverage.

Ms. Ross said Oklahoma did not expand Medicaid under the ACA, but it did establish rules in 2019 to not provide coverage retroactively, so their hands are tied with all coverage effective the first of the month following enrollment.

Director Wing-Heier said Alaska is on the federal exchange, but it wishes it had a state exchange. It is not perfect though, as natives enroll at their provider when they come in for care, then drop the coverage after two or three months when they no longer need care. She said tribal members go without coverage until the next time they need care, when the cycle starts all over again and repeats itself continually. She said her office pushed the CMS hard for open enrollment for all, but they were not successful. Commissioner Conway said Colorado recently opened a special enrollment for a month and a half, which will end soon. He said Colorado has seen a 7–8% increase to date, and it expects the final increase in enrollment to be even higher. Ms. Beyer said 10,000 individuals were enrolled when Washington opened enrollment for 60 days recently. She said Washington has 29 tribes and a tribal navigator program, so most tribes have their own navigator to assist with enrollment. She said American Indians account for 1.8% of the population in Washington, but only 1% of the exchange, so enrollment is still low.

4. Discussed Other Matters

Ms. Duhamel asked if other states were seeing junk insurance plans being sold to this segment of the population. Director Wing-Heier said Alaska is seeing some but not a lot, as the state is shutting them down quickly. Commissioner Conway said Colorado has generally not seen many, as it does not allow short-term health plans at all, which may have helped keep the

numbers down. Ms. Duhamel said New Mexico does not allow short-term health plans either, but it has had lots of junk plans to deal with.

Silvia Yee (Disability Rights Education and Defense Fund—DREDF) asked if the states are gathering granular information on discriminatory practices that are specific to the tribes as a subgroup. Director Wing-Heier said the NAIC issued a data call, but it is too early for credible information about trends regarding who and where to be available. She said Alaska is planning to review it closely, especially the data on individual surgeries, and it has reached out to Washington regarding how it is being coded so she can run its own data. She asked if the data call included the number of the American Indian and Alaska native population enrolled and how that number was determined. Ms. Duhamel said New Mexico's tool requires self-declaration for the CMS to list it, but some states require more categories. Director Wing-Heier said it is on the CMS form for states that use the federal exchange, but states with their own exchanges have their own requirements. Ms. Beyer said Washington's state exchange form uses self-reporting. Commissioner Conway said Colorado's does as well.

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

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