OUR MEETING WILL BEGIN SHORTLY

WELCOME TO THE CONSUMER LIAISON COMMITTEE

March 21, 2023

IN-PERSON ATTENDEES
Wi-Fi Network: NAIC2023 ; Password (case sensitive): Spring2023

VIRTUAL ATTENDEES
• Audio will be muted upon entry
• If virtual attendees would like to speak, please use the "Raise Hand" feature and we will let the Chair know you'd like to speak
• Enter with video on or off (your choice)
• Use the “Chat” feature for questions, comments, or assistance
• If you have joined by phone, to mute and unmute your line, press *6
• For additional help, please contact NAIC Technical Support team at MeetingTechHelp@naic.org or call (866) 874-4905

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS
CONSUMER LIAISON COMMITTEE

2022 Fall National Meeting Minutes – Attachment One

Andrew R. Stolfi, Oregon Insurance Commissioner

March 21, 2023
CONSUMER LIAISON COMMITTEE

Medicaid Unwinding and Best Practices

Shamus Durac, Rhode Island Parent Information Network
Anna Schwamlein Howard, American Cancer Society Cancer Action Network
Maanasa Kona, Georgetown University, Center on Health Insurance Reforms

March 21, 2023
Medicaid Unwinding and Best Practices

Governor Latinos

NAIC Spring National Meeting 2023

March 21, 2023
Where are we now?
The “Old Normal” - Medicaid Redetermination Requirements

Medicaid eligibility was determined:

- At time of application
- During regular redeterminations
  - For MAGI populations (most children, pregnant women, parents, expansion adults), once every 12 months
  - For non-MAGI populations (most blind, disabled, or elderly enrollees), at least once every 12 months
- When Medicaid agency received new eligibility information
  - Self-reporting by enrollees
  - State data-matching systems (for income, assets, disability, immigration status, etc.)

42 CFR § 435.916
Pandemic-Era Changes

- At the beginning of Covid-19 Public Health Emergency (PHE), Medicaid annual redeterminations were paused & most computer checks were not done

- Medicaid terminations were also prohibited under the Families First Coronavirus Response Act (except in very limited circumstances)

- This was originally set to extend through the end of the PHE, but the Inflation Reduction Act of 2022 set March 31, 2023 as the end of this “continuous coverage” requirement
Resumption of Annual Recertifications

- States have 12 months to initiate (and 14 months to complete) recertifications for all current Medicaid enrollees
  - As of October 2022, 91.3 million Americans were enrolled in Medicaid or CHIP, 20.2 million (28.5%) more than in February 2020
- Most individuals no longer eligible for Medicaid have other coverage options
  - Employer-sponsored coverage
  - Marketplace plans
  - Medicare
- ASPE projects that as many as 15 million Americans will lose Medicaid coverage during unwinding
  - 8.2 million who have lost Medicaid eligibility
  - 6.8 million who will be disenrolled despite remaining eligible (administrative churn)
  - More than half of those expected to be disenrolled despite continuing eligibility are children under age 17
How will renewals take place?

- **Ex Parte renewal**
  - Done when Medicaid agency can verify income and all other eligibility information independently
  - Enrollee will be passively renewed and will simply receive a notice informing them of renewal

- **Full renewal**
  - Done when Medicaid agency does not have sufficient information for passive renewal, when individual has changed category, or when ex parte renewal processes have not been established
  - Requires that enrollee respond providing information and documentation to demonstrate continuing eligibility for Medicaid
CONSUMER LIAISON COMMITTEE
Obstacles to Medically Necessary Care – Part 1: Delays and Red Tape Due to Prior Authorization

Ashley Blackburn (Health Care For All), Lucy Culp (The Leukemia and Lymphoma Society), Eric Ellsworth (Consumers’ Checkbook), and Carl Schmid (HIV + Hepatitis Policy Institute)

March 21, 2023
Barriers to Health Care for Consumers with Insurance: Prior Authorization

Presented By:
Ashley Blackburn,
Health Care for All Massachusetts

Eric Ellsworth,
Consumers’ Checkbook

Lucy Culp,
The Leukemia & Lymphoma Society

Carl Schmid
HIV+Hepatitis Policy Institute

NAIC Consumer Liaison Meeting
March 21, 2023
I wrote about high-priced drugs for years. Then my toddler needed one.

As a health and science reporter, I’ve studied the maze of U.S. health care. But when my son got sick, I still got lost.

Perspective by Carolyn Y. Johnson
Staff writer
January 30, 2023 at 6:30 a.m. EST

Put more simply: Health care is a battlefield. Patients often become cannon fodder. I knew all this. I expected it. Still, when our appeal was denied in October, I felt like I had been punched.

The struggle varied, depending on the insurer and the specific drug that the child needed, but it seemed especially cruel in this case, because “there isn’t a clear alternative that has a reasonable chance of being effective,” said Grant Schulert, a pediatric rheumatologist at Cincinnati Children’s Hospital.
United Healthcare Tried to Deny Coverage to a Chronically Ill Patient. He Fought Back, Exposing the Insurer’s Inner Workings.

by David Armstrong, Patrick Rucker and Maya Miller

Feb. 2, 5 a.m. EST

Christopher McNaughton sits on the campus of Penn State University. He has been battling United Healthcare for coverage of his treatment for ulcerative colitis. Nate Smallwood, special to ProPublica

After a college student finally found a treatment that worked, the insurance giant decided it wouldn’t pay for the costly drugs. His fight to get coverage exposed the insurer’s hidden procedures for rejecting claims.
Same patient, same drug, same insurer — coverage denied

By Tara Bannow  March 2, 2023

The reason the drug was covered in 2014 is because BCBSMA didn’t require prior authorization around the use of rituximab for most conditions at the time, Yeats said. Prior authorization means the insurer has to do a clinical review to see whether medical evidence supports coverage. Since then, the company has added specific indications for which it doesn’t think there’s enough evidence to warrant coverage, FSGS being one of them.
Figure 1

HealthCare.gov Issuers Denied 17% of In-Network Claims in 2021

Share of 291.6 million in-network denied claims

Claims denied (48.3 million) 17%
Claims paid (243.3 million) 83%

SOURCE: CMS Transparency in coverage data for 2021 plan year - PNG
Figure 4
Consumers rarely appeal denied health insurance claims
Share of 48.3 million denied claims appealed by consumers in 2021 through internal issuer appeals process

NOTE: This figure only includes denied claims for issuers that show data on appealed claims.
SOURCE: CMS Transparency in coverage data for 2021 plan year • PNG
<table>
<thead>
<tr>
<th>Total In-Network Denials</th>
<th>Denials for Lack of Prior Authorization or Referral</th>
<th>Denials for Excluded Service</th>
<th>Denials for Medical Necessity (behavioral health)</th>
<th>Denials for Medical Necessity (all other services)</th>
<th>All other reasons</th>
</tr>
</thead>
<tbody>
<tr>
<td>44.7 million</td>
<td>3.6 million (8.0%)</td>
<td>6 million (13.5%)</td>
<td>150,000 (0.3%)</td>
<td>770,000 (1.7%)</td>
<td>34.2 million (76.5%)</td>
</tr>
</tbody>
</table>

Insurance Practices (Such As Prior Authorization and Fail First) Disproportionately Impact Black and Hispanic Americans

<table>
<thead>
<tr>
<th>Group</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>White Americans</td>
<td>44%</td>
</tr>
<tr>
<td>Black Americans</td>
<td>55%</td>
</tr>
<tr>
<td>Hispanic Americans</td>
<td>64%</td>
</tr>
</tbody>
</table>

Q: Have any of the following happened to you or your family over the past three months? Please answer regarding any kind of prescription medicine for any condition or illness.
Base: 3,624 Patients who take prescription medicines
Source: Patient Experience Survey, November 30 - December 18, 2021
Checks like prior authorization may be in place to ensure that the right patients are getting the right care at the right time, and that valuable resources are not being invested where risks of HIV are low.
Examples of Prior Authorization

▶ Arkansas Blue Cross/Blue Shield
  - Long-Acting PrEP Policy
  - Must have evidence of non-compliance to daily oral PrEP
  - If a woman who can be pregnant must be sterilized or on long-acting birth control
    (FDA Label doesn’t prohibit Rx use during pregnancy)

▶ Cigna
  - Long-Acting HIV Treatment Policy
  - PA requires patient to be virally suppressed 12 and 6 months before start of therapy
  - Must have difficulty maintaining compliance with a daily regimen
43% of respondents described required PAs 1-25% of the time for treatment naïve patients.

51% of respondents described PAs for medication switches 26-50% of the time.

Over the last 5 years, 64% of respondents noted an increase in PAs.

Source: https://programme.aids2022.org/Abstract/Abstract/?abstractid=10835
Roughly 67% of participants needed dedicated staff for PAs.

Overall, 72% of participants reported UMTs hindering their ability to prescribe optimal ART therapy.

50% described UMTs caused prescribing a less desirable ARV regimen.

Source: https://programme.aids2022.org/Abstract/Abstract/?abstractid=10835
Will prior health insurance authorization for medications continue to hinder hepatitis C treatment delivery in the United States? Perspectives from hepatitis C treatment providers in a large urban healthcare system

Marjan Javanbakht1, Roxanne Archer1, Jeffrey Klausner1,2

1 Department of Epidemiology, Fielding School of Public Health, University of California, Los Angeles, California, United States of America, 2 Division of Infectious Diseases, Department of Medicine, David Geffen School of Medicine at University of California, Los Angeles, California, United States of America

Results

Providers noted that successful HCV treatment delivery was reliant on a care model involving close collaboration between a team of providers, in particular requiring a highly coordinated effort between dedicated nursing and pharmacy staff. The HCV care team overwhelmingly reported that the process of insurance authorization was the greatest obstacle delaying treatment initiation and noted that very few patient level factors served as a barrier to treatment uptake.
Manatt Report for LLS

- Interviews with 25+ insured patients or caregivers who experienced barriers to care
- Documents the “coverage journey” inextricably linked to a patient’s treatment journey
- Offers policy recommendations for state and federal lawmakers

Available at: https://www.lls.org/sites/default/files/2023-01/vital_access_2023.pdf
Action is Needed By Federal and State Policy Makers

Advances in Science and Proliferation of Effective Therapies for Cancer Patients

Misaligned and Outdated Regulatory Frameworks Governing Insurance Products

Moral Imperative to Address Systemic Inequities in Access to Health Care Services

Increasingly Sophisticated tools Available to Stakeholders to Better Promote Access
Competing Priorities in Claims Adjudication

Access
- Barriers To Care
- Surprise Costs to Patients
- Provider Burden

Affordability
- Unaffordable Premium And Out-of-Pocket Costs
- Low Value Care
- Waste, Fraud, Abuse

Fair, transparent, and effective claims adjudication is essential for US healthcare to be both accessible and affordable.
Providers can't figure out what will be covered or what the patient will pay

Consumers cannot shop for coverage of key services

Patients have no way to know what they'll pay until after claims are adjudicated

Patients get a stream of baffling and financially threatening EOBs and bills

Poor data on denials hampers oversight/research

• Lack of clarity on reason for denial

• Unclear, disjointed, and burdensome UM documentation processes

• Fragmented, non-standard documentation of medical necessity criteria

• Disjointed coding requirements across payers

• Very low appeals rate

• Medical Necessity Criteria

• Coding Rules

• Additional Documentation

• Code-Based Claims

• Utilization Management

• Appeals
## CMS Rule on Interoperability in Prior Authorization

<table>
<thead>
<tr>
<th>Category</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Access</strong></td>
<td>• Add status of existing prior authorizations, including status for existing years</td>
</tr>
<tr>
<td></td>
<td>• Prior auth status updates posted w/in 1 business day</td>
</tr>
<tr>
<td><strong>Provider</strong></td>
<td>• Allow providers to access claims for their patients</td>
</tr>
<tr>
<td></td>
<td>• Payers must oversee attribution of patients to providers</td>
</tr>
<tr>
<td><strong>Payer-to-Payer</strong></td>
<td>• Transfer member claims from one payer to another upon new enrollment</td>
</tr>
<tr>
<td></td>
<td>• Allow current payer to assemble better longitudinal record of patient</td>
</tr>
<tr>
<td><strong>PAARD (Prior Auth)</strong></td>
<td>• Payers must make prior auth documentation requirements searchable</td>
</tr>
<tr>
<td></td>
<td>• Does not directly address underlying structure of documentation</td>
</tr>
<tr>
<td><strong>Reporting Requirements</strong></td>
<td>• Percentages of services requested, approved denied, expedited vs standard</td>
</tr>
<tr>
<td></td>
<td>• Time frame of responses and extensions</td>
</tr>
</tbody>
</table>
CMS Rule on Interoperability in Prior Authorization

**Authority and Deadlines**

- Applies to:
  - QHPs
  - Medicaid/CHIP Managed Care + FFS
  - Medicare Advantage
- Proposed Effective Date of January 1, 2026
- Does not supersede more stringent state laws (esp on timelines)

**Implementation Considerations**

- Builds on FHIR standards
  - FHIR workgroups are eager for stakeholder involvement
- Proof of Concept: [Documentation Lookup for Medicare FFS](#)
- ONC has software for monitoring these APIs
  - Lantern is open source
  - States can run their own versions
State Action: Massachusetts

An Act Relative to Reducing Administrative Burden
Improving Access to and Continuity of Care

• Prohibits prior authorization for:
  ✓ Generic medications
  ✓ Medications and treatments with low denial rates, low variation in utilization, or an evidence-base to treat chronic illness

• Requires prior authorization to be valid for the duration of treatment (or at least 1 year)

• Requires insurers to honor a patient’s prior authorization from another insurer for at least 90 days
Promote Transparency and Fairness

• Requires public data from insurers as it relates to approvals, denials, appeals, wait times, and more

• Requires the Health Policy Commission to issue a report on the impact of prior authorization on patient access to care, administrative burden, and system cost

• Prohibits retrospective denials if care is preauthorized

• Requires carriers to notify affected individuals about any new prior authorization requirements
Improve Timely Access to Care and Administrative Efficiency

- Establishes a 24-hour response time for urgent care

- Requires insurers to adopt software to facilitate automated electronic processing of prior authorization and the Division of Insurance (DOI) to implement standardized forms
Recommendations for Regulators

• Monitor implementation and compliance with the federal interoperability rule
• Utilize existing authority to monitor carrier conduct
• Support efforts to improve access and continuity of care, including reduced wait times
• Increase public transparency around utilization management, including details of initial and final denials
• Require the use of standard forms and electronic processing
• Require standardization in documentation and publication of medical necessity criteria
Questions
CONSUMER LIAISON COMMITTEE
Obstacles to Medically Necessary Care – Part 2:
Refusal of Care and Network Adequacy

Dorianne Mason, National Women’s Law Center
Wayne Turner, National Health Law Program

March 21, 2023
Health Care Refusals: How Departments of Insurance Can Protect Patient Access

National Association of Insurance Commissioners
Spring 2023 National Meeting, Consumer Liaison
Health Care Refusals

• What are they?
• Statutory and regulatory landscape
• Denying medically necessary care harms patients
• How state regulators can help protect access
  • Prioritize patient access
  • Review network adequacy
  • Require transparency
• Resources
What are health care refusals?

- **Denial of medically necessary care**
  - Refusing to provide referral
  - Failing to inform patient of other treatment options

- **Individual provider**
  - Citing personal or religious objections

- **Religiously-affiliated health care systems**
  - Ethical and Religious Directives (ERDs)
  - Small and large provider groups, health insurers, Medicaid managed care organizations

- **Medically necessary services**
  - Reproductive health services, LGBTQ+, end-of-life care
Health care refusals harm patients

“A physician shall, while caring for a patient, regard responsibility to the patient as paramount.”

AMA Code of Medical Ethics

- Denial of care contrary to standards of care, scientific evidence, good medical practice, and patient needs
- Refusing to inform patient of treatment options defies informed-consent
- Health care is different from other kinds of services
Statutory and regulatory landscape
Federal and State Landscape

**Federal Statutes**
- Weldon Amendment, Consolidated Appropriations Act, 2009, Pub. L. No. 111-117, 123 Stat 3034, Title V, Sec. 508
- Church Amendments, 42 U.S.C. § 300a-7
- Coats Amendment, Public Health Service Act, 42 U.S.C. § 238n

**Federal Regulations**
- Proposed Partial Rescission - RIN 0945-AA18

**State legislation and regulations**
Denying medically necessary care harms patients
Refusing reproductive health care

**Ethical and Religious Directives (ERDs)** promulgated by US Conference of Catholic Bishops prohibit:

- all birth control methods
- sterilization
- abortion
- certain miscarriage management techniques
- the least invasive treatments for ectopic pregnancies
- infertility treatments such as in vitro fertilization (IVF)
- treatment options to prevent pregnancy as a result of sexual assault, such as oral emergency contraception pill
Refusals harm LGBTQ+ individuals and families

According to a Center for American Progress 2023 report:

• 15% of transgender people were refused gender affirming care
• 20% of transgender people of color reported that a provider refused to see them due to the provider's religious beliefs or the stated religious tenets of the health care facility

Reports of physicians refusing to prescribe PrEP to Gay and Bisexual men

- See How Some US Doctors Are Hindering HIV Prevention, Getting to Zero SF

But, nondiscrimination laws apply

See, e.g., Hammons v. University of Maryland Medical System
Patients should direct their own end-of-life care

Ethical and Religious Directives (ERDs) require:

- medically assisted nutrition and hydration for those who cannot take food orally. This obligation extends to patients in chronic and presumably irreversible conditions (e.g., the ‘persistent vegetative state’)

“If you get in a car accident and suffer irreversible brain damage, you could be forced to live indefinitely on a ventilator, regardless of whether you have an advance directive and a healthcare advocate indicating that is not what you would want.”

Religiously-affiliated providers dominate some markets

Source: Community Catalyst: *Bigger and Bigger: The Growth of Large Catholic Health Systems* (2020)
The expansion of Catholic health care has had a disproportionate effect on the sexual and reproductive health care available to women of color in many communities.

- Women of color were more likely than white women to give birth at a Catholic hospital
- In nineteen of thirty-three states and one territory, Catholic hospitals reported a higher percentage of births to women of color than did non-Catholic hospitals.
Recommendations for Dols

- Prioritize patient access in federal and state rulemaking and legislation
- Conduct state assessment on access to services to identify coverage gaps (e.g., Oregon Reproductive Health and Access to Care Work Group)
- Include health care refusals as part of network adequacy reviews
- Require transparency for exclusions and ERDs including provider directories
- Consider refusals when reviewing health plan/provider mergers and acquisitions
Resources

National Women’s Law Center:
• Refusals to Provide Health Care Threaten the Health and Lives of Patients Nationwide
• Health Care Refusals Harm Patients: The Threat to LGBT People and People Living with HIV/AIDS

National Health Law Program:
● Health Care Refusals & How They Undermine Standards of Care
● The Ethical & Religious Directives: What the 2018 Update Means for Catholic Hospital Mergers

See also:
• National Center for Lesbian Rights: Re: Request for Information on Merger Enforcement, Federal Trade Commissioner (April 2022)
• Compassion & Choices: Refusals to Provide Care
CONSUMER LIAISON COMMITTEE –

The Dilemma of Current Assumption Policy Illustrations (Not Just Indexed Universal Life)

Richard M. Weber, Life Insurance Consumer Advocacy Center

March 21, 2023
The Dilemma of Current Assumption Policy Illustrations (not just IUL)

Richard M. Weber, MBA, CLU, AEP
Life Insurance Consumer Advocacy Center
The Dilemma of Current Assumption Policy Illustrations (not just IUL)

Richard M. Weber, MBA, CLU, AEP
Life Insurance Consumer Advocacy Center
Brief comments will address ...

The consumer challenge of policy illustrations for Current Assumption / Universal Life;
Brief comments will address ...

Regulated policy illustrations cannot reflect long-term likelihood of sustaining to its ultimate use as a needed death benefit with an initial (low) “premium;”
Brief comments will address ...

There are 3 major policy developments that have emerged since the 1995 Illustration Model Regulation was adopted - with challenges to address those products with the earlier Model Regulation.
LIFE INSURANCE ILLUSTRATIONS
MODEL REGULATION (1995)

Purpose:

“Protect consumers and foster consumer education.”

Goal:

Ensure that illustrations **do not mislead** purchasers of life insurance and to **make illustrations more understandable** ...”
U.S. Life Insurance Stats (end of 2021)

Death Benefits in force $21 Trillion
   of which Term/Group is $15 Trillion
Lifetime policies* $  6 Trillion

*Whole Life / Universal Life (UL)
  Variable UL / Indexed UL
All Universal Life Designs combine “term” with “cash value”
All Universal Life Designs combine “term” with “cash value”
All Universal Life Designs combine “term” with “cash value”
Universal Life utilizes *current assumptions* to attract customers – but guarantees are minimal

Cash accumulation  Will fluctuate; not apparent on Illustration
Universal Life utilizes current assumptions to attract customers – but guarantees are minimal.

Cash accumulation: Will fluctuate; not apparent on Illustration

Policy Expenses: Have been increased by some carriers
Universal Life utilizes *current assumptions* to attract customers – but guarantees are minimal

- Cash accumulation: Will fluctuate; not apparent on Illustration
- Policy Expenses: Have been increased by some carriers
- Policy Illustrations: Are NOT projections – even though used to suggest a specific outcome
How Universal Life credits its Cash Value is the main difference in UL policy “types”

Cash accumulation with a minimum guaranteed crediting rate ➔ “Original” Universal Life (General Account)
How Universal Life credits its Cash Value is the main difference in UL policy “types”

Cash accumulation with a minimum guaranteed crediting rate

A “brokerage account” with market-driven UPS and DOWNS

“Original” Universal Life (General Account)

Variable Universal Life (A Security)
How Universal Life credits its Cash Value is the main difference in UL policy “types”

Cash accumulation with a minimum guaranteed crediting rate

“Original” Universal Life (General Account)

A “brokerage account” with market-driven UPS and DOWNS

Variable Universal Life (a Security)

Cash accumulation based on an external INDEX - with “no negatives” in exchange for a “capped” maximum credit

Indexed Universal Life (General Account)
Variable Universal Life is essentially TERM INSURANCE coupled with mutual fund-like sub-accounts dependent on “the market”.
GRAPHIC view of VUL Illustration with “what’s the lowest premium?” (Notice “constancy”)

$5,900 annually
55 “Bingo Cubes”

1000 times ... hypothetical illustrations: How many “successes” @ $5,900?
When exposed to randomized historic returns in client’s chosen asset class ...

$5,900 annual “premium”
When exposed to randomized historic returns in client’s chosen asset class …
To explain the wide variations in potential outcomes, we change the paradigm from

“who has the best PRICE?”

to ...

What’s your minimum *probability of success*?
What’s your minimum *probability of success*?
What’s your minimum *probability of success*?

- **Probability of Success**: 8%
- **Annual Premium**: $5,900
- **Illustration Rate**: 10%
What’s your minimum *probability of success*?

- **Probability of Success**: 8%
- **Annual Premium**: $5,900
- **Age First Lapse**: 75
- **Illustration Rate**: 10%
What’s your minimum *probability of success*?

- **Probability of Success**: 8%
- **Annual Premium**: $5,900
- **Age First Lapse**: 75
- **Illustration Rate**: 10%

- **Age 91**
What’s your minimum probability of success?

- Probability of Success: 8% vs. 70%
- Annual Premium: $5,900 vs. $9,800
- Avg. Life Expectancy: 75 vs. 84
- Age First Lapse: 75 vs. 84
What’s your minimum *probability of success*?

<table>
<thead>
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<th>Probability of Success</th>
<th>8%</th>
<th>70%</th>
<th>80%</th>
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<td>Annual Premium</td>
<td>$5,900</td>
<td>$9,800</td>
<td>$10,900</td>
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<tr>
<td>Avg. Life Expectancy</td>
<td>75</td>
<td>84</td>
<td>86</td>
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What’s your minimum probability of success?

<table>
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<th>Annual Premium</th>
<th>Avg. Life Expectancy</th>
<th>Age First Lapse</th>
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<tbody>
<tr>
<td>8%</td>
<td>$5,900</td>
<td>75</td>
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</tr>
<tr>
<td>70%</td>
<td>$9,800</td>
<td>84</td>
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<tr>
<td>80%</td>
<td>$10,900</td>
<td>86</td>
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<tr>
<td>90%</td>
<td>$12,250</td>
<td>88</td>
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What’s your minimum *probability of success*?

<table>
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<tr>
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<th>70%</th>
<th>80%</th>
<th>90%</th>
<th>99%</th>
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<tbody>
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<td>Annual Premium</td>
<td>$5,900</td>
<td>$9,800</td>
<td>$10,900</td>
<td>$12,250</td>
<td>$16,500</td>
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<tr>
<td>Avg. Life Expectancy</td>
<td>75</td>
<td>84</td>
<td>86</td>
<td>88</td>
<td>96</td>
</tr>
</tbody>
</table>

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- Probability of Success: 8% 70% 80% 90% 99%
- Annual Premium: $5,900 $9,800 $10,900 $12,250 $16,500
- Avg. Life Expectancy: 75 84 86 88 96
- Age First Lapse: 75 84 86 88 96
What’s your minimum *probability of success*?
Key Points / Action Items

• Current Assumption / Universal Life policies are challenging to explain to consumers;

• The regulated policy illustration is NOT a projection - it can’t possibly reflect the long-term likelihood of sustaining to its ultimate use as a needed death benefit with an initial (low) “premium;”

• No-lapse and Indexed Universal Life weren’t prominent at the time the 1995 Illustration Model Regulation was adopted; Variable products weren’t really addressed;

• We recommend re-opening the Life Insurance Illustration Model Regulation!
Dark Patterns in Digital Communications - - -
Addressing the Perils of Moving from Paper to Digital Consumer Interactions

Birny Birnbaum, Center for Economic Justice

March 21, 2023
Dark Patterns: Manipulative Digital Design

NAIC Consumer Liaison

March 21, 2023

Birny Birnbaum
Center for Economic Justice
The Center for Economic Justice

CEJ is a non-profit consumer advocacy organization dedicated to representing the interests of low-income and minority consumers as a class on economic justice issues. Most of our work is before administrative agencies on insurance, financial services and utility issues.

On the Web: www.cej-online.org
About Birny Birnbaum

Birny Birnbaum is the Director of the Center for Economic Justice, a non-profit organization whose mission is to advocate on behalf of low-income consumers on issues of availability, affordability, accessibility of basic goods and services, such as utilities, credit and insurance.

Birny, an economist and former insurance regulator, has worked on racial justice issues for 30 years. He has been involved with and studied insurance consumer disclosures for over 30 years as a regulator, consultant and consumer representative. He has served for many years as a designated Consumer Representative at the National Association of Insurance Commissioners and is a member of the U.S. Department of Treasury’s Federal Advisory Committee on Insurance, where he co-chairs the subcommittee on insurance availability.

Birny served as Associate Commissioner for Policy and Research and the Chief Economist at the Texas Department of Insurance. Prior to TDI, Birny was the Chief Economist at the Texas Office of Public Insurance Counsel, a state agency dedicated to representing consumers before the TDI.

Birny was educated at Bowdoin College and the Massachusetts Institute of Technology. He holds Master’s Degrees from MIT in Management and in Urban Planning with concentrations is finance and applied economics. He holds the AMCM certification.
Why CEJ Works on Insurance Issues

**Insurance Products Are Financial Security Tools Essential for Individual and Community Economic Development:**

CEJ works to ensure *fair access* and *fair treatment* for insurance consumers, particularly for low- and moderate-income consumers.

**Insurance is the Primary Institution to Promote Loss Prevention and Mitigation, Resiliency and Sustainability:**

CEJ works to ensure insurance institutions maximize their role in efforts to reduce loss of life and property from catastrophic events and to *promote resiliency and sustainability* of individuals, businesses and communities.
“Dark patterns are user interface techniques that benefit an online service by leading consumers to make decisions they might not otherwise make. Some dark patterns deceive consumers, while others exploit cognitive biases or shortcuts to manipulate or coerce them into choices that are not in their best interests.”

As documented in several research studies, consumers may encounter dark patterns in many online contexts, such as when making choices to consent to the disclosure of personal information or to cookies, when interacting with services and applications like games or content feeds that seek to capture and extend consumer attention and time spent, and in e-commerce, including at multiple points along a purchasing journey.

“At their core, dark patterns are a specific type of choice architecture in website and app design that interfere with user autonomy and choice. Dark patterns modify the presentation of choices available to users or manipulate the flow of information so that users make selections that they would not otherwise have chosen—to their own detriment and to the benefit of the website or app provider. Hallmarks of dark patterns include imposing asymmetric burdens to achieve competing choices, restricting the choices available at the same time (or at all), and hiding information or presenting information deceptively.”

“Dark patterns can exist when one option is more aesthetically prominent or attractive, or when the alternative is hidden or arduous to select. For example, a website may offer a popup with only a “yes” button, but leave out a “no” button and/or require more clicks to achieve the “no” option. Or, a button may have undesired consequences, as when closing a popup banner functions as acceptance rather than rejection.”

Dark User Experience is Different from Bad User Experience

Bad UX is accidental. It is a bad design from a lack of knowledge in design. Whereas, dark UX is intentional and purposely designed to promote the brand’s best interests at the user’s expense.

- Bad UX: Confusing checkout processes.
- Dark UX: Purposefully making it difficult to find “x” that closes a pop-up.

Brands that use dark UX know exactly what they’re doing. They are well aware of the UX concepts that make websites great and use that knowledge to manipulate their users.

Source: https://medium.com/galaxy-ux-studio/how-do-dark-ux-patterns-affect-users-e74a4496c06e
What are Examples of Dark Patterns Techniques?

From Jamie Liguri published in “Shining a Light on Dark Patterns.”

Nagging: Repeated requests to do something the firm prefers.

Confirmshaming: Choice framed in a way that makes it seem dishonorable or stupid.

Forced Action: Requiring opt-out of optional services, manipulative extraction of personal information and information about other users.

Social Proof: False/misleading notices that others are purchasing or offering testimonials.
Roach Motel: Asymmetry between signing up and canceling

Price Comparison Prevention: Difficulty in understanding and comparing prices

Hidden Information / Aesthetic Manipulation: Important information visually obscured
From the European Consumer Organization, “Fast Track to Surveillance”
https://www.beuc.eu/fast-track-surveillance

“During this signup process, which involves consumers taking important decisions about how Google will process their personal data, the tech giant uses a combination of deceptive design, unclear language, misleading choices and missing information:

- With only one step (“express personalisation”), the consumer activates all the account settings that feed Google’s surveillance activities. Google does not provide consumers with the option to turn all settings ‘off’ in one step.
- If consumers want to try to protect their privacy, it requires “manual personalisation”: five steps with ten clicks and grappling with information that is unclear, incomplete, and misleading.

Consider the consent for use of cookies on most websites. In almost every case, one click is required to accept all cookies. If you want to avoid sharing your personal information, it requires many clicks.
How Effective are Dark Patterns?

From Liguri and Strahilivetz Testing:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Acceptance Rate</th>
<th>Adjusted Acceptance Rate (treats drop-outs as declines)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control Group</td>
<td>11%</td>
<td>11%</td>
</tr>
<tr>
<td>Mild Dark Pattern</td>
<td>26%</td>
<td>25%</td>
</tr>
<tr>
<td>Aggressive Dark Pattern</td>
<td>42%</td>
<td>37%</td>
</tr>
</tbody>
</table>
“Normative Take-aways” from Liguri and Strahilivetz

• The mild dark patterns are the most insidious. They significantly increased acceptance of a program with dubious benefits without alienating consumers or causing large numbers of them to log off

• Less educated subjects were particularly vulnerable to dark patterns

• Effects of dark patterns swamp effects of price changes

• Dark patterns vary substantially in terms of potency

• Dark patterns have proliferated because they work
Legislative and Regulatory Actions on Dark Patterns

- California Consumer Privacy Act
  - (l) “Dark pattern” means a user interface designed or manipulated with the substantial effect of subverting or impairing user autonomy, decisionmaking, or choice, as further defined by regulation.
  
  And
  Hovering over, muting, pausing, or closing a given piece of content does not constitute consent. Likewise, agreement obtained through use of dark patterns does not constitute consent.

Source: https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?division=3.&part=4.&lawCode=CIV&title=1.81.5
• Colorado Privacy Act
  o "DARK PATTERN" means a user interface designed or manipulated with the substantial effect of subverting or impairing user autonomy, decision-making, or choice
  
  Source: https://leg.colorado.gov/sites/default/files/2021a_190_signed.pdf#page=4

• Connecticut Personal Data Privacy Act
  o "Dark pattern" (A) means a user interface designed or manipulated with the substantial effect of subverting or impairing user autonomy, decision-making or choice, and (B) includes, but is not limited to, any practice the Federal Trade Commission refers to as a "dark pattern".

  Source: https://www.cga.ct.gov/2022/ACT/PA/PDF/2022PA-00015-R00SB-00006-PA.PDF#page=2
Federal Legislation: Senate Bill 1084 – Deceptive Experiences to Online Users Reduction Act

- (1) IN GENERAL.—It shall be unlawful for any large online operator
  (A) to design, modify, or manipulate a user interface with the purpose or substantial effect of obscuring, subverting, or impairing user autonomy, decision-making, or choice to obtain consent or user data;
  (B) to subdivide or segment consumers of online services into groups for the purposes of behavioral or psychological experiments or studies, except with the informed consent of each user involved;

Source: https://www.congress.gov/116/bills/s1084/BILLS-116s1084is.pdf
“The Federal Trade Commission issued a new enforcement policy statement warning companies against deploying illegal dark patterns that trick or trap consumers into subscription services. The agency is ramping up its enforcement in response to a rising number of complaints about the financial harms caused by deceptive sign-up tactics, including unauthorized charges or ongoing billing that is impossible cancel.

The FTC’s policy statement puts companies on notice that they will face legal action if their sign-up process fails to provide clear, up-front information, obtain consumers’ informed consent, and make cancellation easy.”

“Today, the Consumer Financial Protection Bureau (CFPB) is filing a lawsuit against TransUnion, two of its subsidiaries, and longtime executive John Danaher for violating a 2017 law enforcement order. The order was issued to stop the company from engaging in deceptive marketing, regarding its credit scores and other credit-related products. After the order went into effect, TransUnion continued its unlawful behavior, disregarded the order’s requirements, and continued employing deceitful digital dark patterns to profit from customers.

Critical for Regulators to Understand and Address Dark Patterns

- Insurance regulatory disclosures are based on and designed for paper, not digital interfaces. What does it mean to “prominently display” certain information or provide in a “10-point” font when the disclosure and consent are done on a computer or mobile phone?

- Paper disclosures are static. Digital disclosures are dynamic and change based on the particular consumer, the method of consumer interaction and the choices by the consumer during the process.

- There has been a massive and rapid increase in digital interactions in place of paper or face-to-face interactions between consumers and insurers. Consider digital claim settlements as well as interactions involving insurance application and receipt of policy and other information.
How Should Regulators, D Committee, NAIC Address Dark Patterns?

• Learn -- Train Analysts and Examiners to Recognize Dark Patterns and Manipulative Digital Design.

• Compile Resources on Manipulative Digital Design.

• Review Existing Disclosure Requirements – Do They Make Sense for a Digital Interface and Protect Against Dark Patterns?

• Update Guidance in Regulations as Needed – Not Just Revisions in Disclosures and Disclosure Requirements, but Articulating Dark Patterns as an Unfair and Deceptive Trade Practice.

• Develop Relevant Methods of Regulatory Review / Update the Market Regulation Handbook.
Additional Resources

- Liguri and Strahilivetz, “Shining a Light on Dark Patterns”

- “Warning Signals about Dark Patterns in Insurance Marketing”

- FTC Report Shows Rise in Sophisticated Dark Patterns: Disguised Ads, Difficult-to-Cancel Subscriptions, Buried Terms, and Tricks to Obtain Data

- “FTC Action Against Vonage Results in $100 Million to Customers Trapped by Illegal Dark Patterns and Junk Fees When Trying to Cancel Service”

Birny Birnbaum
Center for Economic Justice

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Manipulative Digital Design: Dark Patterns
NAIC Consumer Liaison
March 21, 2023
“German Authority and EU Bodies Target "Dark Patterns" in Trading Apps and Online Interfaces”

The Regulatory Review, “Dark Patterns Cannot Stay in the Dark”

Harry Brignull’s Deceptive Design Website: https://www.deceptive.design/

CHOICE (Australia), “Consumers being harmed by “dark patterns” in web design”

Squire, Patton Boggs LLP, “Dark Patterns are Focus of Regulatory Scrutiny in the United States and Europe”

European Data Protection Board, “Dark patterns in social media interfaces: How to recognize and avoid them”

“5 Online Tricks Retailers Use to Trick Us,” https://www.msn.com/en-us/money/other/5-online-tricks-retailers-use-to-manipulate-us/ss-AA183Cea
CONSUMER LIAISON COMMITTEE

Aftermarket Parts: Imitation Often is Not Equal

Erica L. Eversman, Automotive Education and Policy Institute

March 21, 2023
AFTERMARKET PARTS:
IMITATION IS OFTEN NOT EQUAL

National Association of Insurance Commissioners
LOUISVILLE, KY  MARCH, 2023

Erica. L. Eversman, J.D.
Automotive Education & Policy Institute
AFTERMARKET PARTS: WHAT ARE THEY?

ANY part that is not factory-installed.

- Original Equipment Manufacture (“OEM”) (auto maker) part installed after vehicle has left assembly line.
- Part made by any third party (“imitation”), whether the third party is unrelated or makes parts for an OEM.
Imitation PARTS: WHAT ARE THEY?

- Any part made for use in the repair of a motor vehicle that has not been authorized or sanctioned by the auto maker.
Aftermarket (imitation) parts Model Act MDL 891
- Adopted in 1987
- Uses “like, kind and quality” as standard
- Only applies to external sheet metal and plastic parts

No requirements over:
- Structural parts: (e.g.)
  - Bumper reinforcement (where airbag timing sensors are)
  - Core support
- Functional components: (e.g.)
  - Suspension components
  - Radiators
  - Air conditioning condensers
Like, Kind, and Quality:

Evolution of arguments in favor of imitation parts

• Purely cosmetic; no impact on crashworthiness or safety
• Identical to OEM parts
• Made by the same part manufacturer as the OEM
Like, Kind, and Quality: Evolution

• Ford Motor Co. successfully sues parts makers and distributors for design patent infringement
  • Now, imitation parts, NOT “purely” cosmetic

• Identical to OEM parts
  • TX House introduces HB 1131 requiring non-OE parts to: 1) meet fit, finish, and quality criteria established by OEM; 2) be of same weight and metal hardness as OE; and 3) be crash and safety tested using same criteria as OE
  • LKQ argues no auto maker would ever provide specifications or standards information to imitation parts makers (April 13, 2021)

• Made by the same factory/part manufacturer as the OEM
  • Implied that imitation parts made with manufacturer specifications, stamping tools, and materials
  • CAPA launches “Tier 1” replacement parts program Summer 2021
    • Tier 1 parts identified as those made by “the same factory, [with same] tooling, materials, and manufacturing processes”
    • https://www.capacertified.org/wp-content/uploads/2021/06/CAPA_Launches_Tier_1_Replacement_Parts_Verification_Program-.pdf (Wayback machine)
Imitation Parts Organizations

- CAPA (Certified Automotive Parts Association)
- ABPA (Automotive Body Parts Association)
- AutoCare Association
- APA (Automotive Parts Association)
- LKQ Corp.
  - Keystone
- Many, many others

- SEMA (Specialty Equipment Market Association)
Vehicle Warranty Implications

- Auto makers routinely void/restrict auto warranties
  - Damage
  - Neglect or abuse
  - Any portion of vehicle on which insurance claim paid


- 15 USC § 2304(c) Waiver of standards. The performance of the duties under subsection (a) of this section shall not be required of the warrantor if he can show that the defect, malfunction, or failure of any warranted consumer product to conform with a written warranty, was caused by damage (not resulting from defect or malfunction) while in the possession of the consumer, or unreasonable use (including failure to provide reasonable and necessary maintenance).
“Extended Warranty” Implications

• "Warranty" by federal definition applies solely to consumer products and are included in the sale price of the product. *15 USC § 2301, et seq., 16 C.F.R. 700.1, et seq.*

• Mechanical Breakdown Insurance Policies or Service Contracts
  • Typically apply same restrictions to coverage as vehicle limited written warranty

• Good News: If the “EW” is regulated as insurance, it is pro rata refundable to the insured/consumer
Use Your Melon

• Honda demonstrates dire results of airbag timing issues

• https://mygarage.honda.com/s/video-detail-page?key=MCB6DAOQFX2ZGD5OMECP46SCLOWE
Imitation Parts Failures

- Nov. 2009 Collision Industry Conference (CIC) expert demonstrated functional differences and weaknesses between OEM and imitation bumper reinforcements
  - Toby Chess followed up with specifics: https://www.vehicleservicepros.com/collision-repair/article/21180416/toby-chess-has-some-questions-on-aftermarket-parts

- CAPA issues press release Feb. 1, 2010:
  - "CAPA has tested numerous bumpers for comparability to their car-company-brand counterparts. "In testing what appear on the surface to be reasonably well-manufactured aftermarket bumpers, our laboratories discovered serious deficiencies in mechanical properties such as strength and metal hardness, material thickness, and fit. These deficiencies potentially place the driving public, who trust body shops to repair their vehicles with safe quality parts, at serious risk."
CAPA Decertification: NON-OEM Headlights

• 100% of Imitation Headlights failed FMVSS 108 (federal motor vehicle safety standard) 2003 and 2004 testing

• CAPA Decertification Parts Report
  • Parts routinely “decertified” every month
    • March 2021, 12 lots of headlights decertified
    • April 2021, 3 lots of headlights decertified
      • Also 1 lot of bumper reinforcement decertified

• Register for CAPA decertification reports at: https://e1.intertek.com/capa/
Who is Responsible for Curing?

Consumer Notification, Payment, Method?

• Not CAPA
• Not Insurer (“We guarantee the repair”?)
• Not Distributor
• Not Repairer
• Manufacturer (largely in Asia)
NHTSA?

- NHTSA (National Highway Traffic Safety Administration)
  - Almost NO ability to recall imitation parts (or salvage)

- GAO (Government Accountability Office)
  *http://www.gao.gov/assets/240/231055.pdf*
SEMA Federal Regulation FAQ

• **What is “self-certification”?**
When offering a product for sale, the manufacturer is required to certify that the product meets all applicable FMVSS (since it is illegal to market a product that does not comply). Most aftermarket products are not covered by the FMVSS.

• **How do I certify my product?**
Manufacturers must have some reasonable basis for certification but “crash-testing a car” is not required. Certifications may be based on, among other things, engineering analyses, actual testing and computer simulations.

• **Does NHSTA “approve” vehicles and equipment?**
No. NHTSA relies on self-certification. It does not require submission of any documentation regarding the safety of aftermarket parts unless it is triggered by an investigation. Each year, NHTSA crash-tests a limited number of cars manufactured by the automakers to confirm that they meet the FMVSS.

[https://www.sema.org/federal-regulation-aftermarket-parts](https://www.sema.org/federal-regulation-aftermarket-parts)
Recommendations

• Require auto insurers to establish and publish:
  • Recall methodology for decertified or defective imitation part (whether “AM” part or not)
  • Mechanism for insured/consumer to obtain replacement part and installation
  • Mandate payment for replacement part and installation
• Establish charge in C Committee for NAIC/States to:
  • Revisit what an “aftermarket part” is
  • Establish concrete definition and criteria for determining proper use in insured/consumer repair
QUESTIONS?

Erica. L. Eversman, J.D.