Draft: 8/23/22

NAIC/Consumer Liaison Committee
Portland, Oregon
August 12, 2022

The NAIC/Consumer Liaison Committee met in Portland, OR Aug. 12, 2022. The following Liaison Committee members participated: Andrew R. Stolfi, Chair (OR); Grace Arnold, Vice Chair (MN); Alan McClain (AR); Andrew N. Mais represented by George Kurt Swan (CT); Trinidad Navarro (DE); David Altmaier (FL); Colin M. Hayashida represented by Martha Im (HI); Dean L. Cameron represented by Randy Pipal (ID); Vicki Schmidt (KS); James J. Donelon represented by Ron Henderson (LA); Kathleen A. Birrane represented by Alexander Borkowski (MD); Anita G. Fox represented by Renee Campbell (MI); Chlora Lindley-Myers represented by Carrie Couch (MO); Mike Chaney represented by Andy Case (MS); Mike Causey represented by Angela Hatchell (NC); Jon Godfread represented by Janell Middlestead (ND); Chris Nicolopoulos represented by David Bettencourt (NH); Barbara D. Richardson represented by David Cassetty (NV); Adrienne A. Harris represented by Sumit Sud (NY); Michael Humphreys (PA); Cassie Brown (TX); Scott A. White represented by Don Beatty (VA); and Mike Kreidler (WA).

1. Heard Opening Remarks

Commissioner Stolfi said the NAIC Consumer Board of Trustees met Aug. 1, 2022 to: 1) discuss next steps for adopting proposed revisions to NAIC Consumer Participation Plan of Operation; 2) receive an update on the survey to NAIC Consumer Liaison Committee members and NAIC consumer representatives on how to enhance the level of dialogue at NAIC Consumer Liaison Committee meetings, and 3) hear an update on the criteria and procedures the NAIC consumer representatives use to determine what NAIC Member should receive the Excellence in Consumer Advocacy Award.

2. Adopted its Spring National Meeting Minutes

Commissioner Arnold made a motion, seconded by Commissioner Schmidt to adopt the Committee's April 8 minutes (*see NAIC Proceedings – Spring 2022, NAIC/Consumer Liaison Committee*). The motion passed unanimously.

3. Discuss Recommendations for the Enhancement of the Consumer Liaison Committee Meetings and Consumer Liaison Engagement in NAIC Activities

Commissioner Stolfi said consumer protection is at the core of the mission for state insurance regulators and the input of the NAIC consumer representatives is very important to this mission. Because of this, Commissioner Stolfi said there was a survey of NAIC Consumer Liaison Committee members and NAIC consumer representatives on how to improve the Consumer Liaison Committee meetings and dialogue between the NAIC Member and NAIC consumer representatives.

Commissioner Stolfi said the survey results reflect three themes. There is a desire to broaden the perspectives shared at NAIC meetings and encourage more robust consumer representative participation, with some responses noting that participation sometimes feels repetitive or that not all consumer voices are heard. It is important that all commissioners, especially new commissioners, be well informed about the work of consumer representatives and have opportunities to collaborate with them. Many regulators would like to see more active and visible consumer representative participation in NAIC work outside the Consumer Liaison Committee.

Ken Klein (California Western School of Law) said it would be helpful if Commissioners would reach out to consumer representatives for input on topics that are of a sensitive nature and may not be appropriate for public

discussion in a large NAIC meeting. Birny Birnbaum (Center for Economic Justice) said NAIC consumer representatives do not attend NAIC meetings as individual consumers and attend NAIC meetings as experts representing consumers on insurance issues. Because of this, NAIC Members are going to hear from the same consumer representatives on certain issues. Mr. Birnbaum said the NAIC meetings are extremely important because consumer representatives do not have the same resources as industry representatives to engage with NAIC Members outside of NAIC national meetings. Mr. Birnbaum said he is concerned with the increasing number of regulator-to-regulator meetings and said there needs to be more open meetings for more stakeholder participation. Bonnie Burns (California Health Advocates) said she has specific expertise and NAIC Members are not likely to see her engage NAIC Committees addressing issues outside of her expertise. At the same time, Ms. Burns said she can call an insurance department to obtain assistance for a consumer or can assist an insurance department on an issue within her scope of expertise.

Amy Bach (United Policyholders) said it is important for consumer representatives to provide organized, specific presentations on issues for the Consumer Liaison Committee meeting. In addition, Ms. Bach said panel discussions, which include industry, academia, and consumer representatives may be beneficial at other NAIC committee meetings. Harry Ting (Consumer Advocate Volunteer) said it can be difficult for a new consumer representative to understand the best way to engage at NAIC meetings and additional assistance should be provided to help new consumer representatives understand the NAIC structure. Mr. Ting said consumer representatives may also be engaged with NAIC task forces and working groups.

Commissioner Stolfi said the survey feedback reflects three goals to guide changes. The first goal is to maximize the value of Consumer Liaison Committee meetings and presentations for members and consumer representatives. The second goal is to use diverse approaches to further encourage all consumer representatives, especially those not often heard from, to actively participate in all NAIC activities, not just Consumer Liaison Committee meetings. The third goal is to create more opportunities for meaningful interactions between regulators and consumer representatives, both at national meetings and elsewhere.

Commissioner Stolfi reviewed the following proposed changes for consideration:

a. Distribute a one-page preview of consumer representative presentations at each national meeting, with links to presentation slides and supporting materials, one week in advance of each meeting to help regulators and their staffs prepare for a discussion.
b. Distribute a summary of all presentations given at each national meeting, with links to presentation materials, after each national meeting.
c. Give consumer representatives time at each Consumer Liaison meeting to briefly highlight presentations being given at that national meeting, other than those given at the Consumer Liaison meeting.
d. Schedule the Consumer Liaison Committee meeting earlier in the national meeting week. Also begin the meeting later in the day to promote greater attendance.
e. Increase the time of the Consumer Liaison meeting to 2 hours from 1.5 hours.
f. Provide no less than 20 minutes (15-minute presentation, 5 min Q&A) for each presentation at national meetings (unless presenter requests less time, e.g., for an update).
g. Ensure appropriate split of time between presentations on a range of topics, including health and non-health issues, without having pre-determined time allocations.
h. Conduct post-meeting regulator surveys to provide consumer representative presentation feedback.
i. Find a more intimate meeting room set up.
j. Encourage consumer representatives to include local consumer organizations in presentations/discussions at national meetings when feasible.
k. Hold interim hybrid meetings when needed to discuss issues of interest.
l. Organize a themed consumer-focused symposium once a year, later in the day during a national meeting (comparable to CIPR events).

m. Schedule a meeting at each national meeting where several (2-3) states can present to consumer representatives (over a meal) on what is happening in their states.
n. At least once a year, poll regulators on the topics they would like to hear about from consumer representatives; share results with consumer representatives.
o. Assign each consumer representative, at least during their initial term, a regulator mentor.

Mr. Birnbaum said the NAIC Consumer Liaison Committee will be hearing a lot about health insurance if the Committee wants to hear from more consumer representatives since many consumer representatives have expertise in health insurance. Mathew Smith (Coalition Against Insurance Fraud) said consumer representatives do not always know what is most important to insurance regulators and feedback from insurance regulators on what topics are most important would be beneficial. Eric Ellsworth (Consumers' Checkbook/Center of the Study of Services) said it would be helpful to have meetings with NAIC Committee staff support. Wayner Turner (National Health Law Program) suggested the NAIC post the many reports and presentations from NAIC consumer representatives on a more visible NAIC Weblink so regulators and others could use these materials as resources.

Commissioner Stolfi said there will not be a formal vote on these ideas but recognized there was general agreement among NAIC Consumer Liaison Committee members and NAIC consumer representatives on the ideas presented today.

4. Hear Presentation on Updates to Section 1557 and the Role of State Insurance Regulators

Yosha Dotson (Georgians for a Health Future) said Section 1557 of the ACA prohibits discrimination against protect classes by health programs receiving federal funding. Ms. Dotson said the 2016 interpretation of Section 1557 provided nondiscrimination protections for gender identity, sex stereotypes, and pregnancy status but that a narrower interpretation in 2020 eliminated these protections. Ms. Dotson said the 2022 proposal seeks to reinstate the scope of Section 1557 to include all health and human services programs and activities. Ms. Dotson said the 2022 proposal goes further than the previous rule by requiring entities with fifteen or more employees to have a Section 1557 coordinator and prohibits discrimination in the use of algorithms to support decision making. Ms. Dotson said the 2022 proposed rule has explicitly recognized how individuals can experience compound discrimination and how network inadequacy can cause alienation from care and poor health outcomes.

Kellan Baker (Whitman-Walker Institute) said he wants to focus on one of the most substantial changes in the rule, which relates to the scope of sex nondiscrimination provisions. Mr. Baker said the ACA prohibits discrimination on the basis of sex, among other covered bases, and the 2016 rule indicated that gender identity sex stereotypes and pregnancy status were included under the definition of sex. The 2016 rule also included specific examples of gender identity nondiscrimination in coverage and care.

Mr. Baker said there are issues in coverage that affect the ability of transgender and other gender diverse people and populations to access appropriate care and services, including preventive screenings. This includes gender affirming care, such as hormone therapy or surgeries, as well as mental health counseling and any other type of healthcare that a transgender person might need. Mr. Baker said the 2016 rule was based on the concept of parity, meaning anything covered for a non-transgender person must be covered for a transgender person as well. The action in 2016 followed actions by more than twenty states to prohibit discrimination against transgender people, particularly in benefit design.

Mr. Baker said the 2020 rule eliminated gender identity, sex stereotyping and pregnancy nondiscrimination protections, and nondiscrimination protections in the marketing of qualified health plans, as well as in the essential health benefits. The 2022 rule is based on the 2020 Supreme Court decision of *Bostock v. Clayton County*, which re-establishes gender identity nondiscrimination protections under the basis of sex, adds sexual orientation, and re-establishes protections on the basis of sex stereotypes and pregnancy status. The rule clarifies that

religious/conscience exemptions will be considered on a case-by-case basis by the Office of Civil Rights under existing federal laws. The rule does not require providers to perform services outside of their scope of practice or area of specialty.

Mr. Baker said the rule requires the collection, analysis, and reporting of demographic data for various purposes, including civil rights enforcement, which is why the Office for Civil Rights includes a number of provisions and questions for commenters related to data collection and use. Several other provisions relate to data through research and clinical algorithms. Covered entities may not discriminate in federally supported research (e.g., in study enrollment). Clinical decision-making algorithms cannot incorporate bias that results in reduced access to health care or coverage benefits or services.

Mr. Baker said network adequacy is a major consideration in advancing health equity and ensuring high quality of coverage. This is a major consideration in advancing health equity and ensuring high quality of coverage. The Office of Civil Rights does not propose to establish a single network adequacy standard but notes that narrow networks may pose discrimination concerns.

Silvia Yee (Disability Rights Education and Defense Fund) said another key provision of the proposed rule is that it generally restores the breadth of application of the 2016 rule, including all the operations of entities that provide for or administer health insurance. This includes issuers of Medicare Advantage Plans. Ms. Yee said the proposed rule expands the scope of Section 1557 beyond the 2016 rule by including Medicare Part B providers, and this is often particularly important for people with disabilities, who need to see specialist who may not accept Medicare patients. The rule also provides for meaningful access and effective communication for persons with limited English proficiency. The proposed rule maintains the structural accessibility obligations of the 2020 rule and reaffirms that covered entities must provide reasonable modifications to people with disabilities unless doing so would be an undue burden or fundamentally alter the nature of the service. The proposed rule does not set an explicit requirement for accessible web content, but request comments on this issue. Ms. Yee said blind persons and people who have experienced vision loss have limited independence and choice when using Websites that other consumers use to make appointments, look up and compare insurance coverage, and find self-care information.

Ms. Yee said regulators should support health access during the comment period and have a broad perspective of what access means, including language accessibility, and diversity. Ms. Yee urged regulators to strengthen legal protections for consumers, including monitoring and enforcement against discrimination

5. Heard a Presentation Unpacking the Impact of Recent Federal Court Decisions on Consumers

Dorianne Mason (National Women's Law Center) said the decision in *Dobbs v. Jackson Women's Health Organization* is a devastating opinion that overturns *Roe v. Wade* and nearly 50 years of precedent. Ms. Mason said the Dobbs decision and subsequent state abortion bans dismantle patient care and force an uncertainty into the lives of all healthcare providers. This threatens the health and well-being of women. Ms. Mason said the Dobbs decision will disproportionately harm people who are already faced with unequal access to health care. Ms. Mason said patients may incur debt or lose income by taking leave from their jobs without pay because of the need to travel for care. Ms. Mason said others may be forced to carry pregnancies against their will and put their lives at stake.

Ms. Mason said insurance regulators should ensure compliance with existing laws and regulations, such as access to women's preventive services. Ms. Mason said insurance regulators should also reject regulations of reproductive care that inadvertently restrict access to reproductive healthcare. Ms. Mason said the National Women's Law Center has experts that can assist state insurance regulators in being innovative to address deficiencies to reproductive healthcare.

Jackson Williams (Dialysis Patient Citizens) said the United States Supreme Court decision in *Marietta Memorial Hospital v DaVita* involved the end stage renal disease provisions of the Medicare Secondary Payer Act, which allows enrollees to keep a group health plan for 30 months before Medicare becomes their primary payer. The language challenged in this case carved out dialysis treatment from the Preferred Provider Organization so there was no in network provider. Mr. Williams said the Supreme Court decision provided the need for maintenance dialysis was not the same as having end stage renal disease and permitted the carve out. Mr. Williams said insurance regulators should be concerned any time a change in insurance is triggered by an illness. Mr. Williams said there are two potential paths forward. The first path is to continue to pursuing population health strategies, such as health plans having prioritized detection and treatment of chronic kidney disease. The second path is to allow benefit consultants to aggressively sell dialysis carve outs to employers.

Katie Keith (Out2Enroll) said Section 2713 of the ACA requires health plans to cover a wide range of more than one hundred preventive services, such as cancer screenings, hypertension screening, tobacco cessation, immunization, contraception, and other preventive services for women. Ms. Keith said more than 150 million Americans benefited from this requirement in 2020 because it applies to all non-grandfathered plans, including both ERISA plans and fully insured plans. Ms. Keith said these requirements have led to a narrowing of health disparities.

Ms. Keith said there is a Federal court case in Texas, *Kelley v. Becerra (now known as Braidwood v. Becerra)*, in which the plaintiffs are arguing Section 2713 is unconstitutional. If this statutory provision is deemed unconstitutional, Ms. Keith said there would be no standard requirement for preventive services and consumers would see significant variations. Ms. Keith said this would lead to the widening of health disparities. Ms. Keith said insurers would not likely stop covering all one hundred preventive services but said she has concerns about ongoing coverage for contraceptives, screening colonoscopies, and HIV prevention medication. Ms. Keith said many states passed their own versions of Section 2713 in state law to protect the fully insurance market and encouraged all states to extend these protections.

Commissioner Stolfi said Oregon adopted a Reproductive Health Equity Act that went into effect in 2019, which had a list of required services to be covered at no cost. Commissioner Stolfi said Oregon found indications of non-compliance with both the state law and Section 2713 preventive service requirements, especially around cost sharing requirements. In response to Commissioner Arnold's question regarding what are the most important areas for a state insurance department to review, Mr. Baker suggested the following four items: 1) require plans to meet or exceed ACA requirements; 2) require plans to include a wider variety of provider types, such as community health workers and non-physician members of the healthcare workforce; 3) ensure the accuracy and accessibility of provider directories; and 4) explore the potential of standardized plans and related networks for specific conditions.

6. Heard a Presentation on Unpacking Social Inflation

Mr. Klein said there is a general assertion by industry that social inflation is causing insurance premiums and loss ratios to increase. Mr. Klein said social inflation is allegedly caused by plaintiff lawyers involved in insurance claims and Millennials having a sense of entitlement. Mr. Klein said insurers have claimed social inflation exists because incurred losses are rising faster than general inflation. The Casualty Actuarial Society recently issued a paper that identifies three lines of business that display characteristics of social inflation.

Mr. Klein said there is a misunderstanding of the litigation system that equates litigation with frivolous litigation. Mr. Klein said if a defendant loses a case this does not mean the verdict was wrong or the case was frivolous. Mr. Klein said litigation is only frivolous if it is unsupported by evidence and claims of social inflation often miss this

point. Mr. Klein said there is no compelling data that shows there is an overall increase in insurance litigation nationally and there is no compelling data reflecting an increase in frivolous insurance litigation by plaintiffs.

Mr. Klein said the insurance industry is claiming the following items as problematic: 1) rollbacks of enacted tort reforms; 2) third-party litigation financing; and 3) a proliferation of class actions. Mr. Klein said there is no evidence rollbacks of enacted tort reforms are impacting premiums and loss ratios. For example, Mr. Klein said the Kansas City metropolitan area is in both Kansas and Missouri and there is no data reflecting lower premiums and loss ratios in Kansas, which rolled back tort reforms. Mr. Klein said there should be data reflecting lower premiums and loss ratios between Kansas and Missouri residents within the Kansas City metropolitan area. Mr. Klein said finance professors from Harvard and Stanford issued a report that concluded third-party litigation financing is not driving up the cost of litigation and found litigation financing does deter defendants from engaging in aggressive settlement strategies. Mr. Klein suggested any increase in litigation costs may be caused by the increased costs of defense attorneys. Mr. Klein said funding of litigation may be leveling what was previously an unlevel playing field Mr. Klein said the court system is designed to punish those who cause injury to others and that larger verdicts do not equate to inaccurate verdicts. Regarding class action litigation, Mr. Klein said any proliferation of class actions suggests that defense attorneys are more aggressive in settling low value claims because class action litigation is a way for individuals to come together to seek appropriate remedies for low value claims.

Mr. Klein said the court system is designed to intentionally weed out frivolous claims. Mr. Klein said there is no evidence of social inflation, which is causing insurers to incur new, unusual, or higher expenses. Mr. Klein said insurance regulators should not permit premium increases or approve rate filings without confirming the assumptions about social inflation being presented.

Mike DeLong (Consumer Federation of America) said his organization completed a study in March of 2020, which concluded insurers' claims of increased costs were inaccurate. Mr. DeLong said insurers continued to earn profits throughout the pandemic. Mr. DeLong said the need for insurers to raise prices is questionable and any insurer, which is experiencing larger verdicts or more class action lawsuits, may be experiencing these things because of inappropriate behavior.

Mr. Smith said there is a crisis in the Florida insurance market with increased claim costs and litigation. Mr. Smith said one group should not be singled out as the cause and encouraged a review of the totality of issues to determine how all parties can better serve consumers.

Commissioner Schmidt said there is still more discussion occurring in Kansas regarding the Kansas Supreme Court case impacting tort reform and does not believe the Hilburn case is settled case law. Commissioner Schmidt also said there are many Kansas residents who do not live within the Kansas City metropolitan area. Because of this, Commissioner Schmidt said the comparison of Kansas and Missouri premiums within the Kansas City metropolitan area is not a fair comparison.

Commissioner Altmaier said he would strongly encourage the review of data from the regulatory community, which demonstrates a significant increase in litigation. Commissioner Altmaier said having additional costs within the claims settlement process is bad for consumers. Commissioner Altmaier said Florida is having a very challenged property insurance market and encouraged additional discussion on this issue using available, regulatory data.

7. Heard a Presentation on New Rules for Disaster Claims in California, Colorado, and Oklahoma

Ms. Bach said her organization has worked with industry, regulators, and legislators in California, Colorado, and Oklahoma to create new rules for disaster claims, primarily focusing on claims resulting from wildfires where there is not a causation question. Ms. Bach highlighted the following legislative reforms: 1) additional/temporary living

expense and replacement cost benefits must be available for at least 24 months and 36 months if reasonably necessary; 2) an underinsured homeowner can use "Other Structures" benefits toward the cost of rebuilding their dwelling even though "Other Structures" benefits are normally available only for garages and outbuildings, retaining walls, etc.; 3) a homeowner can opt to skip the challenges of rebuilding their home at its original location and instead access their dwelling, extended dwelling and building code and ordinance benefits toward the purchase of a replacement home; and 4) homeowners can avoid being underinsured by accessing their insurer's construction cost expertise and obtaining an estimate for insuring their home to its current replacement cost every other year or at inception.

Having no further business, the Consumer Liaison Committee adjourned.

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Innovation, Cybersecurity, and Technology (H) Committee and the
NAIC/Consumer Liaison Committee
Virtual Meeting
October 14, 2022

The Innovation, Cybersecurity, and Technology (H) Committee met Oct. 14, 2022, in joint session with the NAIC/Consumer Liaison Committee. The following Committee members participated: Kathleen A. Birrane, Chair (MD); Evan G. Daniels, Co-Vice Chair (AZ); Dana Popish Severinghaus, Co-Vice Chair, represented by Erica Weyhenmeyer and C.J. Metcalf (IL); Karima M. Woods represented by Joselyn Bramble(DC); John F. King represented by Martin Sullivan (GA); Amy L. Beard represented by Jerry Ehlers and Meghann Leaird (IN); Chlora Lindley-Myers (MO); Troy Downing (MT); Jon Godfread represented by John Arnold and Chris Aufenthie (ND); Adrienne A. Harris represented by Seema Shah (NY); Judith L. French (OH); Elizabeth Kelleher Dwyer (RI); Carter Lawrence represented by Stephanie Cope (TN); Kevin Gaffney (VT); and Mike Kreidler (WA). The following Liaison Committee members participated: Andrew R. Stolfi, Chair (OR); Grace Arnold, Vice Chair (MN); Mark Fowler (AL); Elizabeth Perri (AS); Evan G. Daniels (AZ); Ricardo Lara represented by Ken Allen (CA); Andrew N. Mais (CT); Karima M. Woods represented by Joselyn Bramble(DC); David Altmaier (FL); Colin M. Hayashida (HI); Dean L. Cameron represented by Weston Trexler (ID); Vicki Schmidt represented by Brenda Johnson and Shannon Lloyd (KS); James J. Donelon represented by Nichole Torblaa (LA); Kathleen A. Birrane (MD); Anita G. Fox represented by Chad Arnold (MI); Chlora Lindley-Myers and Cynthia Amann (MO); Mike Chaney represented by David Browning (MS); Jon Godfread represented by John Arnold and Chris Aufenthie (ND); Chris Nicolopoulos represented by Christian Citarella (NH); Barbara D. Richardson (NV); Adrienne A. Harris represented by Seema Shah (NY); Judith L. French (OH); Michael Humphreys (PA); Scott A. White represented by Don Beatty (VA); Mike Kreidler (WA); Allan L. McVey (WV); and Nathan Houdek (WI). Also participating were: Jason Lapham (CO); Doug Ommen (IA); Sharon P. Clark (KY); Timothy N. Schott (ME); and Larry D. Dieter (SD).

1. Heard Presentations on Algorithmic Bias and Approaches Insurance Companies Are or Can Implement to Manage and Mitigate the Risk of Unintended Bias and Illegal Discrimination When Developing and Using AI/ML

Commissioner Birrane said the goal of the joint meeting is to continue the education of state insurance regulators on the topic of algorithmic bias. She said during the Summer National Meeting, the Committee had such a full agenda that there was no time to hear comments from interested parties, and she committed to holding an interim virtual meeting prior to the Fall National Meeting to provide that opportunity. At the Summer National Meeting, Commissioner Stolfi also ran short on time to hear all the presentations scheduled for the Liaison Committee, so it made sense to meet jointly to complete that work. Commissioner Birrane said this meeting would not only provide an opportunity to hear presentations, but it would also provide ample opportunity for interested parties to speak.

Commissioner Stolfi said he agrees, and he is looking forward to hearing these presentations and engaging in meaningful dialogue. He said this is consistent with the goals of the Committee to look for ways to be more engaged outside of national meetings. He said the group discussed and agreed to hold interim meetings and get more involved with other committees. He said this meeting is an example of following through on that.

a. NAMIC

Tony Cotto (National Association of Mutual Insurance Companies—NAMIC) said NAMIC is opposed to unfair discrimination of any kind, and he understands the pressures policymakers are under, but he urges caution as they pursue developing solutions and mitigation techniques to minimize bias. He said in insurance, fairness is determined by actuarial soundness and risk of loss. He said insurers price based on risk, and they should analyze inputs rather than outcomes other than loss ratios. He stressed the benefits of risk-based pricing, but he said NAMIC agrees that there needs to be common terms defined, and that should be done in statute; however, he stressed that this will be a massive undertaking but must be done because of the importance of getting this right and ensuring understanding. In addition, he said limiting accuracy does nothing to reduce the cost of coverage, and it hurts access, which is what really matters. He said the good news is that there are many benefits, including helping to educate and incentivize risk avoidance. He said the use of this data and algorithms can reduce the cost to consumers.

Cotto said industry's use of data and models is nothing new; state insurance regulators have the authority to ask questions and get explanations if needed, and disparate impact has no place in insurance law. He added that state insurance regulators should not embrace frameworks from other industries, as insurance is very different. He said it should be flexible, principle-based, tailored to insurance, and considering company size and complexity.

b. ACLI

Karen Melchert (American Council of Life Insurers—ACLI) said the first pillar of the ACLI's Economic Empowerment & Racial Equity Initiative is expanding access to financial products to underserved communities. She said new methods for doing this are raising some regulatory concerns around algorithmic accountability. She said the ACLI has been working on this since the NAIC adopted its Artificial Intelligence (AI) Principles back in 2020. She said the ACLI started looking at algorithmic accountability and began with identifying proxy discrimination within the context of insurance. She said the goals of the algorithmic accountability framework are: 1) identify any potential unfair discrimination from the use of algorithms; 2) preserve innovation within the industry; 3) maintain a holistic view of the relationship between new technologies and their use in underwriting; 4) maintain consistency with existing underwriting requirements; and 5) allow for flexibility to accommodate unique uses of algorithms across the industry.

Melchert said the ACLI suggests a principle-based risk management approach that embraces the following four areas: 1) governance process; 2) testing requirements; 3) reporting requirements related to governance and testing; and 4) documentation and attestations related to the governance, testing, and reporting processes. She said a principle-based approach benefits all stakeholders, including consumers and state insurance regulators, and this should be an ongoing dialogue between insurers and state insurance regulators. She said the ACLI has submitted this proposal to the Colorado Insurance Department and presented it during the SB21-169 Stakeholder Engagement Process meeting on July 8. She said it could be used for a draft bulletin or regulation. She said this proposal focuses on unfair discrimination based on race and proxy discrimination because it is the only protected class for which there is any chance to test for given data currently available. She said it is also focused on underwriting because that is the most important use case in terms of the life insurance business, but it could be used for others as well. She said it also addresses third parties, mentioning the need to be compliant in all cases, with the *Unfair Trade Practices Act* (#880). She went on to describe the pillars in more detail, noting that it can also be found on the website supporting the Colorado Stakeholder Engagement Process.

c. APCIA

David F. Snyder (American Property Casualty Insurance Association—APCIA) said the APCIA is very committed to this effort. He said the APCIA agrees with the NAIC on the need to collectively determine how to tackle concerns related to fairness and preventing unlawful discrimination while seeking improvements that strengthen competitive markets and addressing potential inequities while preserving the risk-based foundation of insurance. He said this requires a balanced approach that considers competitive issues and protects investments that benefit consumers. He said the narrative too often starts with the negative. He reviewed the key benefits of AI/machine learning (ML), noting more efficiently meeting customer expectations; more rapidly responding to, settling, and paying claims; more accurately and objectively assessing risk; and providing the ability to analyze company performance to improve product offerings, customer service, and compliance.

Snyder said definitions are very important and present a challenge to provide constructive responses when they are unclear. He said the general definition of "bias" does not consider long-standing legislated insurance regulatory and judicial standards. He said robust governance is very important and should be a priority as a critical foundational element to focus on, as well as the prominent role of human review and decision-making. He said it should be flexible, proportionate, scalable, and explainable. He said in testing for bias, the APCIA found a lack of bias but a firm adherence to risk-based pricing. He said when considering transparency, information regarding what, how, and to whom should be provided and considered. He reviewed the attributes put forth by the National Institute of Standards and Technology (NIST) and encouraged state insurance regulators to consider them.

Snyder said this area is already subject to legislated, regulatory, and judicial standards, and they should neither be expanded nor contracted based on using AI/ML for activities previously performed by humans. He said risk-based pricing should continue to rule the day, and courts have defined the elements related to disparate impact, so that should continue to be recognized. He said data on many of these classes sought to be protected is simply not available.

In conclusion, Snyder said the APCIA is committed to working constructively with the NAIC and state insurance regulators in their work on AI/ML: 1) there is a need for clear definitions; 2) governance is paramount; 3) it is important to avoid inhibiting beneficial uses of AI/ML and legislated regulatory standards; and 4) judicial decisions should be applied. He said the APCIA is committed to addressing systemic racism where it is evident, but using pricing mechanisms to do that does not address the underlying issues.

2. Heard Presentations on Algorithmic Bias and a Holistic Approach to Confronting Structural Racism in Insurance

a. CEJ

Birny Birnbaum (Center for Economic Justice—CEJ) reviewed the importance of insurance products as financial security tools for individuals and community economic development. He reviewed two types of discrimination—actuarial and protected classes. He also reviewed why race and protected class characteristics are carved out regardless of actuarial fairness, noting that historical discrimination has left a legacy of outcomes that are embedded in data used for actuarial analysis. He said addressing proxy discrimination is easy; the data are not predicting insurance outcomes, so they violate both the actuarial and protected class requirements for unfair discrimination.

Birnbaum said "intent" in structural racism and its impacts are often unrecognized, unintentional, and cannot be a determining factor. He provided several examples. He said algorithms learn bias in data and models, and the fact that an insurer does not see race in an algorithm does not logically or factually result in no discrimination on the basis of race, and the only way to eliminate it is to measure the impact by explicit consideration of race and other protected class factors. He said there are statistical techniques that enable testing for proxy discrimination and disparate impact. He said principle-based governance is essential but not sufficient, and the testing of outcomes is essential and must be done simultaneously.

Birnbaum defined these terms as:

- ***Disparate Intent:*** The intentional use of race.
- ***Proxy Discrimination:*** Disproportionate racial outcomes tied to the use of proxies for race, not to outcomes.
- ***Disparate Impact:*** Disproportionate racial outcomes tied to historic discrimination and embedded in insurance outcomes.

Birnbaum said while pricing and rating has gotten the most regulatory attention, it is imperative for insurers and state insurance regulators to test algorithms used in all aspects of the insurance life cycle for racial bias, expanding on the use of algorithms in marketing. He said it is important to do holistic testing and not just individual factors in isolation. In closing, he said the property/casualty (P/C) trades routinely seek to justify pricing freedom, noting the use of any data source or characteristic of the consumer, vehicle, property, or built or natural environment; i.e., if it is predictive of risk and more refined, the risk prediction is always better and more fair. He said this formulation is problematic for several reasons, making the following key points:

- The purpose of insurance is to create a risk pool through which individuals can transfer risk to that pool. Risk-based pricing is a means to manage that mechanism safely and fairly, but it is not the purpose of insurance.
- Testing for and addressing structural racism in insurance is 100% consistent with and improves risk- and cost-based practices.
- Unfettered risk-based pricing without attention to structural racism will reflect and perpetuate historic discrimination.

b. <u>NFHA</u>

Dr. Michael Akinwumi (National Fair Housing Alliance—NFHA) introduced himself and talked about what the NFHA does. He said the NFHA has published a framework for identifying and removing risks that are associated with algorithmic systems related to disparate impact and proxy discrimination. He said the NIST risk management framework could be used to manage identified risks by the auditing framework published.

Morgan Williams (NFHA) said the NFHA Tech Equity Initiative can be found on the NFHA's website. He said compliance and regulatory oversight ultimately flow from the basis and scope of legal liability. He said the basis of civil rights causes of action involving a review of compliance principles of proxy testing and civil rights law prohibit policies and practices when there is evidence of disparate impact, intentional discrimination, and disparate impact that results in discriminatory outcomes. He said the NFHA focuses on disparate impact outcomes, such as facially neutral policy or practice, when the practice does not advance a legitimate business justification and the policy is not the least discriminatory means to advance that interest. He provided several examples of civil rights actions in insurance, and he reviewed civil rights management systems controls.

Dr. Akinwumi reviewed proxy testing control variables, the equation for rate-making using a generalized linear model (GLM), and how to mitigate for bias and discrimination using control variables. He said it introduces race as a control variable using a clustering technique and claims frequency and loss. He explained this technique in detail and the possible outcomes. He mentioned Bayesian Improved Surname Geocoding (BISG) as one of the techniques commonly used. He also said imageomics is also a brand of science that attempts to infer biological traits and biometrics from a person's image using ML techniques that use computer vision algorithms to infer gender and age.

c. Southern University Law Center and University of Connecticut School of Law

Peter Kochenburger (Southern University Law Center and University of Connecticut School of Law) said he wants to address a few points made by the industry presentations. He said it is often said that fairness in insurance is determined by actuarial fairness, but that is only one element in determining what is fair and not discriminatory. He said risk-based pricing is an important element, but it does not determine the regulatory structure (e.g., pre-existing conditions are not allowed to be used in health insurance plans). He said it is relevant, but there are other goals. He said secondly, industry says anything done should be within the existing regulatory framework, and it is already well regulated. He said that is not correct, and there is not a sufficient regulatory structure for this in place today, or we would not be having these discussions. He said the existing structure should be built upon, but we should not be confined to it, as it must evolve and respond to new things being introduced. He said there is a need to study and evaluate this area carefully, but the idea that everything must be defined and well understood before moving forward is simply not true and is merely a delay tactic. He stressed the need to move forward expeditiously or the development of the regulatory framework will fall to other regulatory bodies and be taken away from state insurance regulators.

3. Received Comments from Interested Parties

Brendan Bridgeland (CEJ) asked what steps industry has taken to prevent the duplication of risks by use of the same data elements in different data categories to prevent double counting. Birnbaum said that is handled through multi-variant analysis by simultaneously evaluating many factors and removing the correlation between them, so each factor is making a unique contribution.

Snyder said testing is fundamental and evolving. He said there is not a singular methodology, and industry is trying to see which best serves the purpose of determining what is socially acceptable. He said the key is accuracy regarding the testing methodologies, and all of this is under active consideration, but there is no one way to do this yet.

Michael DeLong (Consumer Federation of America—CFA) said there is a need for strong public input, but this work should not be delayed. If consensus cannot be achieved, the group should keep in mind that justice delayed is justice denied.

Dr. Akinwumi said when it comes to testing, looking at outcomes and loss ratios represents a retrospective look, whereas testing out variables and factors being used needs to happen before there are outcomes.

Melchert said it is important to have defined terms and a strong foundation, and it is not just a delay tactic. She said the ACLI has demonstrated that it wants to move forward, but definitions are important. Kochenburger said he did not mean to imply definitions are not important, but it would be a substantial undertaking to try to define everything and get consensus, which could take years and be an obvious delay tactic. Birnbaum said testing can take place by removing the correlative factor and seeing the outcome; industry already does this in their testing. Snyder said governance is improving, and the work with the NIST is noteworthy; industry shares concerns related to structural racism, and testing is important but complicated. Although, he said it is very important to get it right, and industry does not want to delay getting a framework in place for overseeing this space.

Having no further business, the Innovation, Cybersecurity, and Technology (H) Committee and the NAIC/Consumer Liaison Committee adjourned.

Attmt One-b_Joint H Cmte_Cons Liaison Minutes 101422 Final.docx

Draft: 10/24/22
Adopted by the Executive (EX) Committee and Plenary, Dec. XX, 2022
Reaffirmed by the NAIC/Consumer Liaison Committee, Oct. 21, 2022

2023 Reaffirmed Mission Statement

NAIC/CONSUMER LIAISON COMMITTEE

The mission of the NAIC/Consumer Liaison Committee is to assist the NAIC in its mission to support state insurance regulation by providing consumer views on insurance regulatory issues. The Liaison Committee provides a forum for ongoing dialogue between NAIC members and NAIC consumer representatives. The Liaison Committee's activities in 2023 will be closely aligned with the priorities of the NAIC Consumer Board of Trustees.

NAIC Support Staff: Lois E. Alexander

Attmt One-c Reaffirm Msn Stmt Consumer.docx

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Consumer Liaison Improvement Concepts

NAIC members and consumer representatives were separately surveyed and asked for feedback on Consumer Liaison Committee meetings and consumer representative participation in NAIC activities and potential improvements to the same. This memo outlines some of the key issues identified, a few goals to guide any changes, and specific ideas to improve the important interaction between regulators and consumer representatives.

Some common issues or themes found in the results of the surveys include:

1. Several respondents expressed a desire to broaden the perspectives shared at NAIC meetings and encourage more robust consumer representative participation, with some noting that participation sometimes feels repetitive or that not all consumer voices are heard.
2. Some respondents stressed the importance of ensuring that all commissioners, especially new commissioners, be well informed about the work of consumer representatives and opportunities to collaborate with them, and that more opportunities could be created to encourage interaction throughout NAIC activities.
3. Many regulators would like to see more active and visible consumer representative participation in NAIC work outside the Consumer Liaison Committee.

Based on the feedback received, the following goals are suggested to guide changes:

1. Maximize the value of Consumer Liaison Committee meetings and presentations for members and consumer representatives.
2. Use diverse approaches to further encourage all consumer representatives, especially those not often heard from, to actively participate in all NAIC activities, not just Consumer Liaison Committee meetings, and share knowledge and experience.
3. Create more opportunities for meaningful interactions between regulators and consumer representatives, both at national meetings and elsewhere.

Against this background, the following specific changes are proposed:

Consumer Liaison meetings

1. Distribute a one-page preview of consumer representative presentations at each national meeting, with links to presentation slides and supporting materials, one week in advance of each meeting to help regulators and their staffs prepare for a discussion.
2. Distribute a summary of all presentations given at each national meeting, with links to presentation materials, after each national meeting.
3. Give consumer representatives time at each Consumer Liaison meeting to briefly highlight presentations being given at that national meeting, other than those given at the Consumer Liaison meeting.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

4. Schedule the Consumer Liaison Committee meeting earlier in the national meeting week. Also begin the meeting later in the day to promote greater attendance.
5. Increase the time of the Consumer Liaison meeting to 2 hours (from 1.5)
6. Provide no less than 20 minutes (15 minute presentation, 5 min Q&A) for each presentation at national meetings (unless presenter requests less time, e.g. for an update).
7. Ensure appropriate split of time between presentations on a range of topics, including health and non-health issues, without having pre-determined time allocations.
8. Conduct post-meeting regulator surveys to provide consumer representative presentation feedback.
9. Find a more intimate meeting room set up.
10. Encourage consumer representatives to include local consumer organizations in presentations/discussions at national meetings when feasible.

Additional opportunities for collaboration

11. Hold interim hybrid meetings when needed to discuss issues of interest. Such meetings can be beneficial when waiting for the next national meeting will be too late (e.g. when Congress or a federal agency sets a deadline for comments that cannot be met by waiting for the next meeting).
12. Organize a themed consumer-focused symposium once a year, later in the day during a national meeting (comparable to CIPR events).
13. Schedule a meeting at each national meeting where several (2-3) states can present to consumer representatives (over a meal) on what is happening in their states.

Seek regulator feedback

14. At least once a year, poll regulators on the topics they would like to hear about from consumer representatives; share results with consumer representatives.

Mentor/mentee

15. Assign each consumer representative, at least during their initial term, a regulator mentor.

United Policyholders™
www.uphelp.org

The insurance claim landscape post-Hurricane Ian and Tropical Storm Nicole

2022 NAIC Fall National Meeting, Tampa, FL

Consumer Liaison Committee, December 12, 2022

The numbers…

Ian	Nicole
September 28, 2022	November 10th, 2022
Category 4 hurricane	Tropical Storm

OIR is requiring simplified catastrophe reporting for Hurricane Ian and Nicole

Lines of Business	Number of Claims Reported	Number of Open Claims with Payment	Number of Open Claims without Payment	Number of Claims Closed with Payment	Number of Claims Closed without Payment	Percent of Claims Closed
Residential Property	449,170	51,711	141,562	145,754	110,147	57.0%
Homeowners	358,555	40,614	110,812	112,444	94,689	57.8%
Dwelling	48,926	5,262	17,501	15,831	10,332	53.5%
Mobile Homeowners	38,937	5,650	11,496	16,994	4,797	56.0%
Commercial Residential	2,752	185	1,753	485	329	29.6%
Commercial Property	26,817	1,993	18,386	2,576	3,862	24.0%
Private Flood	3,260	241	1,923	725	371	33.6%
Business Interruption	439	71	147	174	47	50.3%
Other Lines of Business*	168,256	30,618	25,700	94,353	17,583	66.5%
TOTALS	647,942	84,634	187,718	243,582	132,010	58.0%

FLOIR **IAN** data, 11/30/22

Lines of Business	Number of Claims Reported	Number of Open Claims with Payment	Number of Open Claims without Payment	Number of Claims Closed with Payment	Number of Claims Closed without Payment	Percent of Claims Closed
Residential Property	32,176	912	9,930	12,468	8,866	66.3%
Homeowners	29,162	850	8,091	11,866	8,355	69.3%
Dwelling	1,954	30	1,081	428	415	43.1%
Mobile Homeowners	1,022	32	722	173	95	26.2%
Commercial Residential	38	0	36	1	1	5.3%
Commercial Property	660	7	616	5	32	5.6%
Private Flood	43	2	37	2	2	9.3%
Business Interruption	5	0	2	2	1	60.0%
Other Lines of Business*	12,186	2,571	2,051	6,539	1,025	62.1%
TOTALS	45,070	3,492	12,636	19,016	9,926	64.2%

Local conditions

- Logistics/access challenges
- Adjuster and housing shortage
- Local contractor/remediation prof'l shortage
- Imperative to tarp/prevent mold growth/further damage
- Wind vs. Water, Home insurance v. Flood insurance
- FL insurance marketplace:
  - Smaller, regional insurers
  - Building code requirement that if 25% of roof damaged, need new roof overturned by the legislature in 2022
  - 5% discounts for Managed Repair, ACV only on roofs
  - PHs warned by public officials not to hire public adjusters
  - TPAs, consultants, Independent Adjusters not staff adjusters

FL Citizens (insurer of last resort)

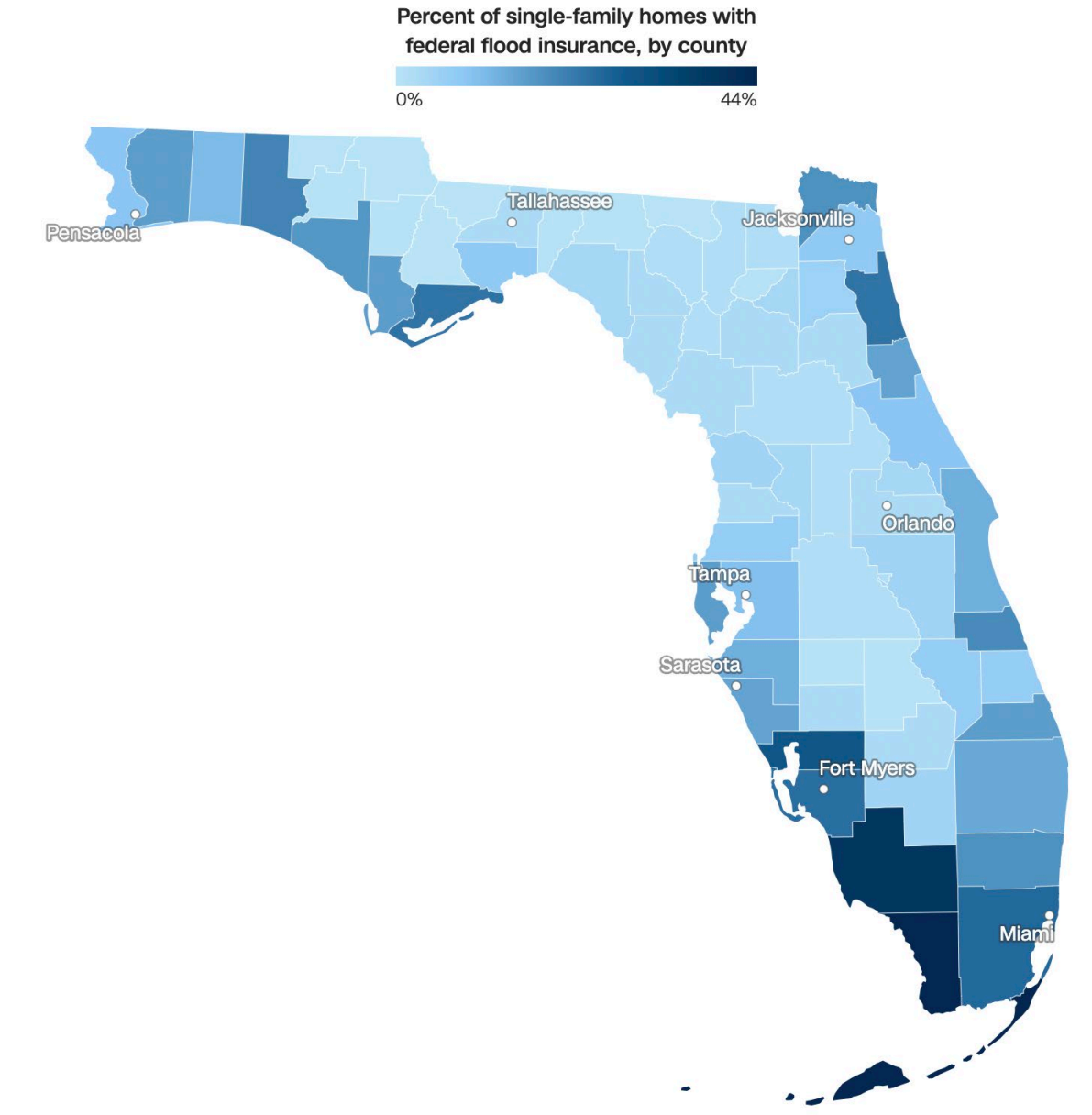
- 60k claims to date (100k projected)
- Ian loss estimate of $3.8 billion incorporates the results of two hurricane models, considers the actual claims activity to date, and includes additional provisions for litigation costs and inflation.
- A projected $1.4 B bill be ceded to the FHCF, net impact to Citizens' surplus is projected to be $2.4 billion.
- CAT bonds FL Citizens has in place are not expected to be triggered
- Citizens intends to modify policies to mandate arbitration, not litigation
- Nicole not projected to have a big impact on Citizens

NFIP

- As of Nov. 10, the National Flood Insurance Program (NFIP) has received more than 44,000 flood claims from Hurricane Ian and has paid nearly $437 million to policyholders.

- $20k advances upon request

- FEMA's initial estimate projects Hurricane Ian could potentially result in NFIP claims losses between $3.5 - $5.3 billion, including loss adjustment expenses. The losses include flood insurance claims received from five states, with the majority of claims coming from Florida.

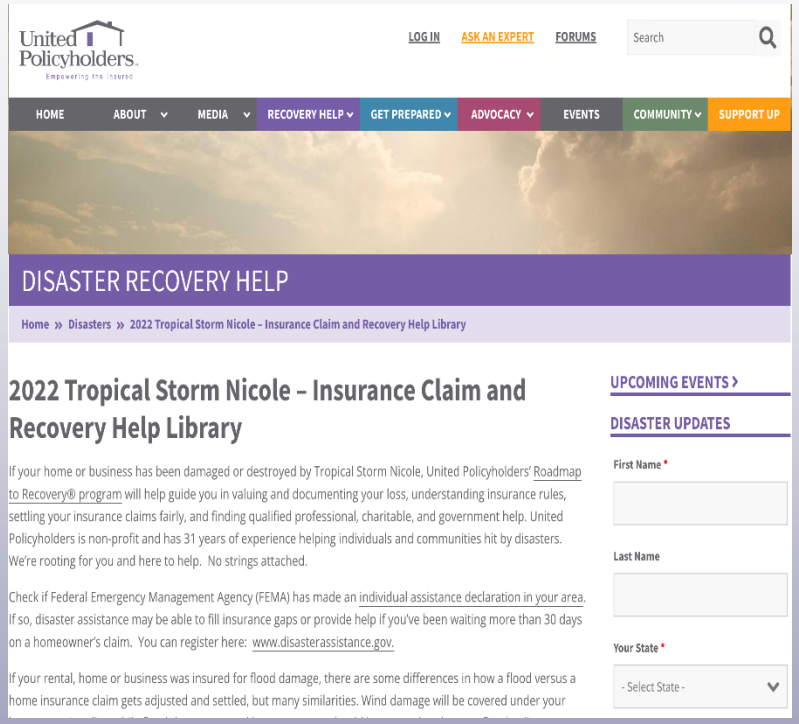


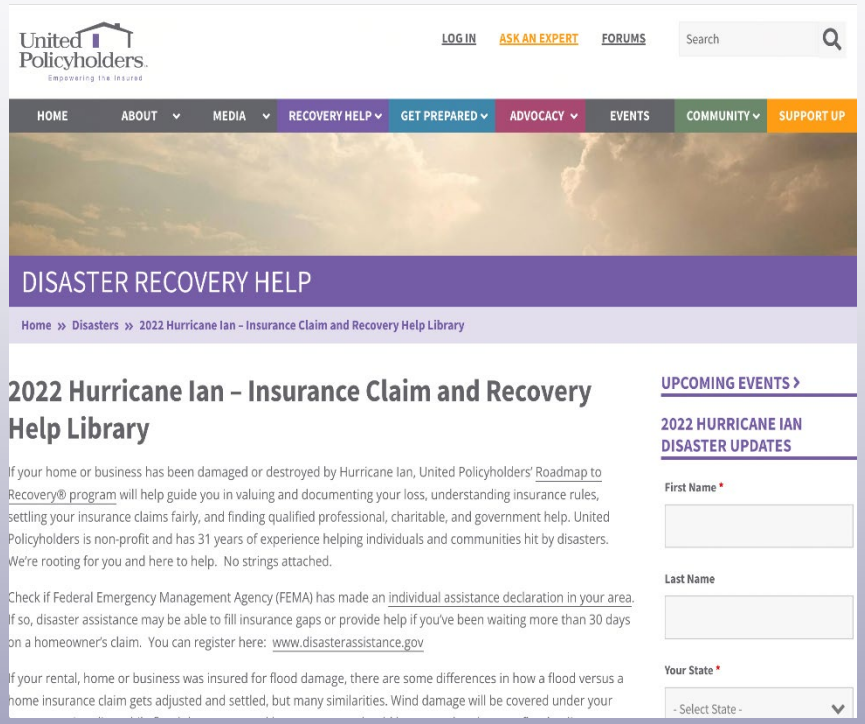
50% Sanibel Island
25% in Lee County
4% Seminole
3% Orange County

Statewide @ 13-18% according to the III,

Source: https://www.cnn.com/2022/10/09/us/hurricane-ian-central-florida-flood-insurance-invs

Online help resources





Orientation Webinar, November 2, 2022 https://uphelp.org/events/nov2webinar/

The order UP recommends…

1. Self help and tenacious ph (Speak UP) You paid for good claim service and coverage, use www.uphelp.org
2. If problems arise:
    1. Notify and seek help from DFS, NFIP, and your elected representatives
    2. If that fails, hire qualified professional help

    Licensed, reputable public adjuster 7-10% OR

    Policyholder/insurance consumer attorney 15 -33%

Do

- Focus on drying/cleaning out, avoiding further damage, and getting damage inspected, measured, and estimated by qualified, reputable, independent experts.

- Check license status of anyone you're thinking of hiring

www.myfloridalicense.com or call

(850) 487-1395

Do

- Give your home and/or flood insurer a chance to do the right thing, but…don't be a pushover

- Get a second opinion if a home or flood insurance adjuster says damage isn't covered or makes a lowball offer.

- Speak "UP" (politely push for fair treatment, advocate for yourself and be prepared to get help if you're not being treated fairly).

Don’t

- Sign away/give up your rights, prematurely assign your benefits to or hire a contractor who’s offering to negotiate with your insurer or “absorb” your deductible, hire or assign your benefits to a lawyer to negotiate with your insurer *until you’ve given your insurance company’s adjuster a chance to adjust your loss fairly*

- Allow anyone to rush you into signing a contract other than for temporary repairs.

- Think you’re powerless or alone – you are neither

Areas of concern

- Reports that insurers under financial stress are slow/low paying
- Consumer frustration w/poor claim service
- Deductibles and new limits causing confusion
  - Roof charts, ACV only on roofs
  - Managed repair/no consumer choice
  - ”Refusal to inspect” forms

”UPC Adjusters left desperate for information amid claims frenzy”

Tampa Bay Business Journal 12/2/22

An independent adjuster who works for UPC Insurance is raising concerns that the St. Petersburg-based company doesn't have adequate manpower to process the thousands of claims it has received in the wake of Hurricane Ian.

The adjuster, who was retained by UPC to assess that storm's damage and issue estimates of insured losses, told the Tampa Bay Business Journal on the condition of anonymity that they – and others – are desperately searching for instruction from UPC, which the adjuster said has failed to provide basic information and is generally unresponsive to their inquiries.

UPC Insurance is among the latest Florida-domiciled property insurance companies to have fallen on hard financial times this year. The company reportedly laid off around 80 employees in August, according to two of those employees, and at least seven key executives have left the company since mid-2020, according to documents filed with the U.S. Securities and Exchange Commission.

A public adjuster, Rick Tutwiler, said a trend started taking shape in 2016 of insurance companies eliminating adjusters from their payrolls as a cost-cutting measure and either replacing them with other professionals like building consultants or relying on a short supply of third-party independent adjusters.

“There's a shortage of manpower,” Tutwiler said. Thousands of claims are filed following a storm, and insurance companies have a 90-day window to assess damage, process initial claims and notify policyholders whether their claims were accepted or denied. Tutwiler said there are instances “across the board” of insurance companies pushing back on initial claim estimates from Hurricane Ian submitted by independent adjusters.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

ACTUAL CASH VALUE LOSS SETTLEMENT HURRICANE, WINDSTORM, OR HAIL LOSSES TO ROOF SURFACING

For Use With Dwelling Fire Form DP-3

This endorsement modified Section I-Loss Settlement Conditions in the policy form with respect to a covered loss for roof surfacing caused by the peril of hurricane, windstorm, or hail.

SECTION 1-CONDITIONS

In the Dwelling Fire DP-3 form:
5. Loss Settlement

Paragraph **a.(3)** is replaced by the following:
(3) Structures that are not buildings; including their roof surfacing.

The following is added to paragraph **a**:
(4) Roof surfacing on structures that are buildings if a loss to the roof surfacing is caused by the peril of hurricane, windstorm, or hail.

Paragraph **b.(1)** is deleted and replaced by the following:
b. Buildings under Coverage A or B at replacement cost without depreciation, subject to the following:
(1) If, at the time of loss, the amount of insurance in this policy on the damaged building is 80% or more of the full replacement cost of the building immediately before the loss, we will pay the cost to repair or replace, after the application of depreciation, with the exception that damage to roof surfacing caused by hurricane, windstorm or hail will be paid at actual cash value at the time of loss. In any instance, we will pay no more than the least of the following amounts:
(a) the limit of liability under this policy that applies to the building
(b) the replacement cost of the part of the building damaged for like construction and use on the same premises; or
(c) the necessary amount actually spent to repair or to replace the damaged building.

In the Special Provisions for Florida, SFIV DF 09 SP 12 11:
5. Loss Settlement

Paragraph **b.(4)** is revised as follows:
b.(4) we will initially pay at least the actual cash value at the time of loss, less any applicable deductible. We will pay any remaining amounts necessary to perform repairs as work is performed and expenses are incurred. If the loss is to the roof surfacing and is caused by hurricane windstorm or hail, we will only pay for the actual cash value at the time of loss, less any applicable deductible. In any instance, we will pay no more than the following amounts:

ROOF SURFACES PAYMENT SCHEDULE						
Age of Roof in Years	Roof Surface Material Type					
	Composition Shingle	Metal	Concrete/Clay Tile	Wood Shake/Shingle	Tar/Gravel	Other Roof
Less than 1	100%	100%	100%	100%	100%	100%
1 to less than 2	96%	99%	98%	98%	96%	96%
2 to less than 3	92%	98%	96%	96%	92%	92%
3 to less than 4	88%	97%	94%	94%	88%	88%
4 to less than 5	84%	96%	92%	92%	84%	84%
5 to less than 6	80%	95%	90%	90%	80%	80%
6 to less than 7	76%	94%	88%	88%	76%	76%
7 to less than 8	72%	93%	86%	86%	72%	72%
8 to less than 9	68%	92%	84%	84%	68%	68%
9 to less than 10	64%	91%	82%	82%	64%	64%
10 to less than 11	60%	90%	80%	80%	60%	60%
11 to less than 12	56%	89%	78%	78%	56%	56%
12 to less than 13	52%	88%	76%	76%	52%	52%
13 to less than 14	48%	87%	74%	74%	48%	48%
14 to less than 15	44%	86%	72%	72%	44%	44%
15 to less than 16	40%	85%	70%	70%	40%	40%
16 to less than 17	36%	84%	68%	68%	36%	36%
17 to less than 18	32%	83%	66%	66%	32%	32%
18 to less than 19	28%	82%	64%	64%	28%	28%
19 to less than 20	25%	81%	62%	62%	25%	25%
20 to less than 21	25%	80%	60%	60%	25%	25%
21 to less than 22	25%	79%	58%	58%	25%	25%
22 to less than 23	25%	78%	56%	56%	25%	25%
23 to less than 24	25%	77%	54%	54%	25%	25%
24 to less than 25	25%	76%	52%	52%	25%	25%
25 to less than 26	25%	75%	50%	50%	25%	25%
26 to less than 27	25%	74%	48%	48%	25%	25%
27 to less than 28	25%	73%	46%	46%	25%	25%
28 to less than 29	25%	72%	44%	44%	25%	25%
29 to less than 30	25%	71%	42%	42%	25%	25%
30 or older	25%	70%	40%	40%	25%	25%

HO-2795

ROOF SURFACES PAYMENT SCHEDULE ENDORSEMENT

APPROVED 09/04/2020

This endorsement modifies insurance provided under the following: HOMEOWNERS POLICY

SECTION I – LOSS SETTLEMENT COVERAGE A – DWELLING

1. **A1 – Replacement Cost Loss Settlement – Similar Construction.**
   The first paragraph in item 1.a. is replaced with the fol- lowing:

2022 legislative reforms

Separate Roof Deductibles

Property insurance companies are allowed to offer a policy with a separate roof deductible of up to two percent of the Coverage A (dwelling) limit of the policy or 50 percent of the cost to replace the roof, whichever is lower.

		Separate Roof Deductible Calculation
Coverage A	$300,000	2% = $6,000
Roof Replacement Cost	$15,000	50% = $7,500
Separate Roof Deductible	$6,000	The lesser of the calculations.

This is an opt-out endorsement, which means that you must be offered and allowed to decline the roof deductible by signing a form. If a roof deductible is added to your policy at renewal, the insurance company must provide a notice of change in policy terms and allow you to decline the separate roof deductible.

Insurance companies must offer a premium credit or discount for selecting a policy with a separate roof deductible.

The roof deductible does not apply to:

- A total loss caused by a covered incident.
- Damage caused by a hurricane.
- Damage caused by a tree or other hazard that damages the roof and punctures the roof deck.
- Damage requiring the repair of less than 50 percent of the roof.

When a roof deductible is applied, no other deductibles under the policy may be applied.

“Managed Repair”

People's Trust Insurance Company

Better Prepared. Simplified Recovery.

Simply a Better Way®

PREFERRED CONTRACTOR ENDORSEMENT

THIS ENDORSEMENT CHANGES YOUR POLICY. PLEASE READ IT CAREFULLY.

THIS ENDORSEMENT DOES NOT APPLY TO SINKHOLE CLAIMS.

In consideration of the premium credit shown on “your” Declarations Page, “you” agree to the following:

THIS ENDORSEMENT ALLOWS US AT OUR OPTION TO SELECT RAPID RESPONSE TEAM, LLC™ TO MAKE COVERED REPAIRS TO YOUR DWELLING OR OTHER STRUCTURES.

“You” agree that in the event of a covered loss to “your” dwelling or other structures on the “residence premises”, other than a sinkhole loss, “we” at our option may select Rapid Response Team, LLC™ to repair “your” damaged property as provided by the policy and its endorsements.

This endorsement does not reduce the applicable deductible under the policy. “You” will be responsible for paying the amount of the deductible to Rapid Response Team, LLC™.

In addition, the following provisions of the policy and its endorsements where applicable, are changed:

Early reports

- Prompt advance payments on NFIP claims
- Unfair tarring of the entire public adjusting profession
- Inadequate supply of insurance company adjusters, unresponsive, untrained adjusters
- Roofers/Attorney teams knocking on doors
- Claim payment offers based on engineering reports that offer pennies on the dollar

No flood insurance? Possible sources of $

- SBA loans
- Home equity loans
- Tax strategies
- Charitable aid
- FEMA IA (Individual Assistance Grants)
  - Average $5k, income/need based

Free dispute resolution options

Home insurance claim disputes:

Department of Financial Services, Mediation Program

Phone: 877-693-5236

https://www.myfloridacfo.com/division/consumers/mediation/

National Flood Insurance Program claim disputes:

FEMA, 400 C Street SW, 6th Floor SW, Washington, D.C. 20472-3010, or FEMA-NFIP-Appeals@fema.dhs.gov.

Reality check

- Strong anti fraud efforts are in place
  - DFS messaging/enforcement, SIUs, CAIF
- Legislative reforms May, 2022:
  - Contractor solicitation prohibitions
  - 25% of roof can be repaired/no oblig to match
  - Tort reform (AOB, Attorney fees, Bad Faith)

Recommendations

- Restore fairness/integrity to the appraisal process
- Let the legislative fixes work, don’t remove the deterrent and remedial value of civil litigation rights
- Market Conduct Exams
- Evaluate the impact of high and multiple deductibles, roof repair coverage limits and ACV only coverage on consumers and on the structural integrity of buildings

THANK YOU!

- FL Expert volunteers
- DFS and OIR staff
- NFIP staff
- Consumer Liaison Committee members for your time and attention

2022 FNM_Consumer_Slides_1ABach.pptx

WATCH WHERE YOU'RE GOING: TELEMATICS, AUTO INSURANCE, AND THE NEED FOR CONSUMER PROTECTIONS

BY MICHAEL DELONG

RESEARCH AND ADVOCACY ASSOCIATE AT CONSUMER FEDERATION OF AMERICA

INTRODUCTION AND OVERVIEW

- Auto insurers increasingly adopting telematics programs to get consumer-generated driving data from instruments
- This data is used for insurance pricing
- Programs show substantial promise for consumers but also pose major risks
- Strong, effective oversight and regulations are needed to ensure that programs benefit consumers and are not misused

AUTO INSURANCE IMPACTS NEARLY EVERY CONSUMER

- Drivers are required to purchase auto insurance
- Regulators have special responsibilities to ensure this product is affordable and consumers are not subject to unfair discrimination
- Robust government oversight needed to ensure this market functions well
- Oversight and regulations are especially important in relatively new areas and when dealing with technology

THE RISE OF TELEMATICS/USAGE BASED INSURANCE

- Insurance programs that capture data from consumers' cars and mobile phones while driving
- Data then used to calculate insurance premiums
- GPS was adapted for civilian use and paved the way for telematics
- Progressive started Snapshot back in 1998 and now all the largest auto insurers have their own programs

TYPES OF TELEMATICS DEVICES

1

MOBILE APPS

2

OBD BLUETOOTH

3

OBD W/ CELLULAR

4

12 V CONNECTOR

5

BLUETOOTH ASSIST

6

OEM INSTALLED

Wide Variety of Telematics Devices

GOAL IS TO EVALUATE CONSUMER DRIVING BEHAVIOR AND PRICE ACCORDINGLY

- Data allows insurance companies to directly evaluate consumers' driving behavior and calculate their rates based on that behavior
- Pricing meant to closely reflect risk
- Insurers state that another goal of programs is to encourage safer driving
- But insurers have generally withheld the full scope of these programs and there is little transparency

EXAMPLES OF DRIVING BEHAVIOR MEASURED IN TELEMATICS (THAT ARE PUBLICLY ACKNOWLEDGED)

- Hard braking
- Time of day or night driven
- Distance/miles traveled
- Acceleration
- Speed
- Cornering

POSSIBLE BENEFITS FOR CONSUMERS…

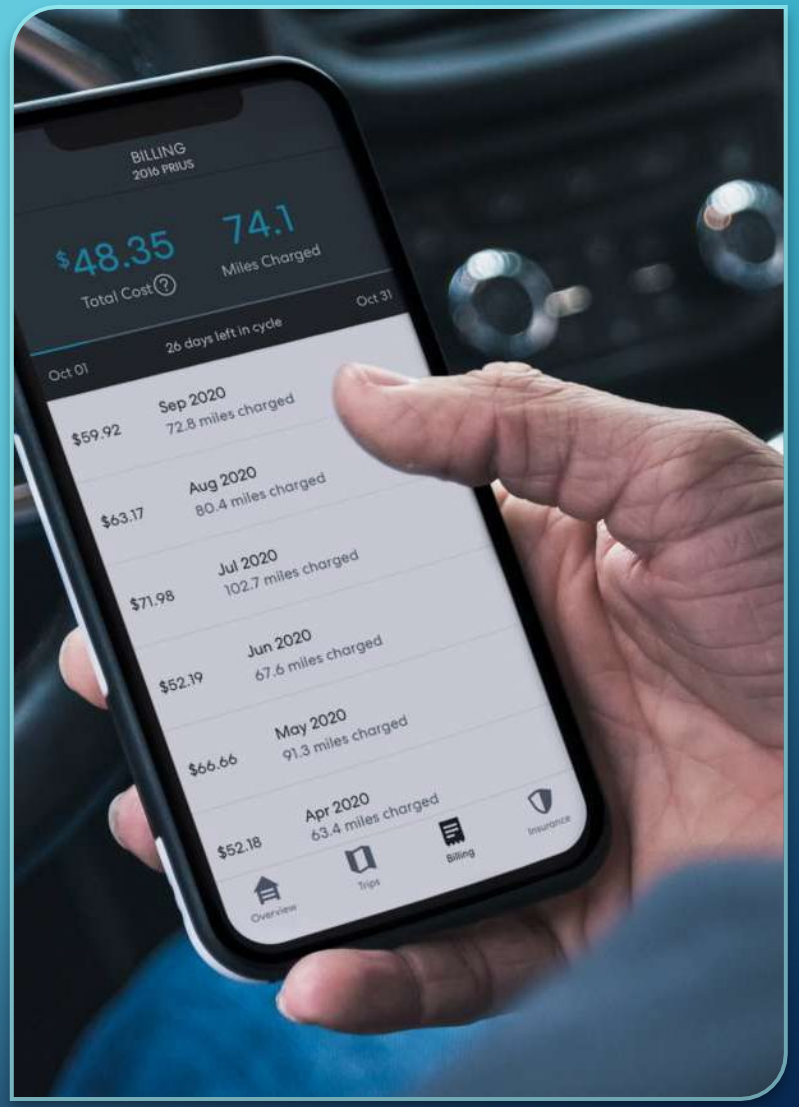
- Telematics could replace currently used non-driving factors (credit history, education levels, job, rental status, ZIP code, etc.) with better pricing systems
- Premiums could be more closely aligned with risk, theoretically reducing costs for safe drivers
- Better calculations of risk and likelihood of crashes and claims

BUT ALSO SERIOUS PROBLEMS FOR CONSUMERS

- Data privacy issues for consumers, including what information is being gathered and what it is used for
- Little or no transparency regarding algorithms and data models
- Unintended bias and unfair discrimination
- Continued use of non-driving factors—any rating system that relies on telematics should eliminate them
- Insurer abuse of programs to raise costs

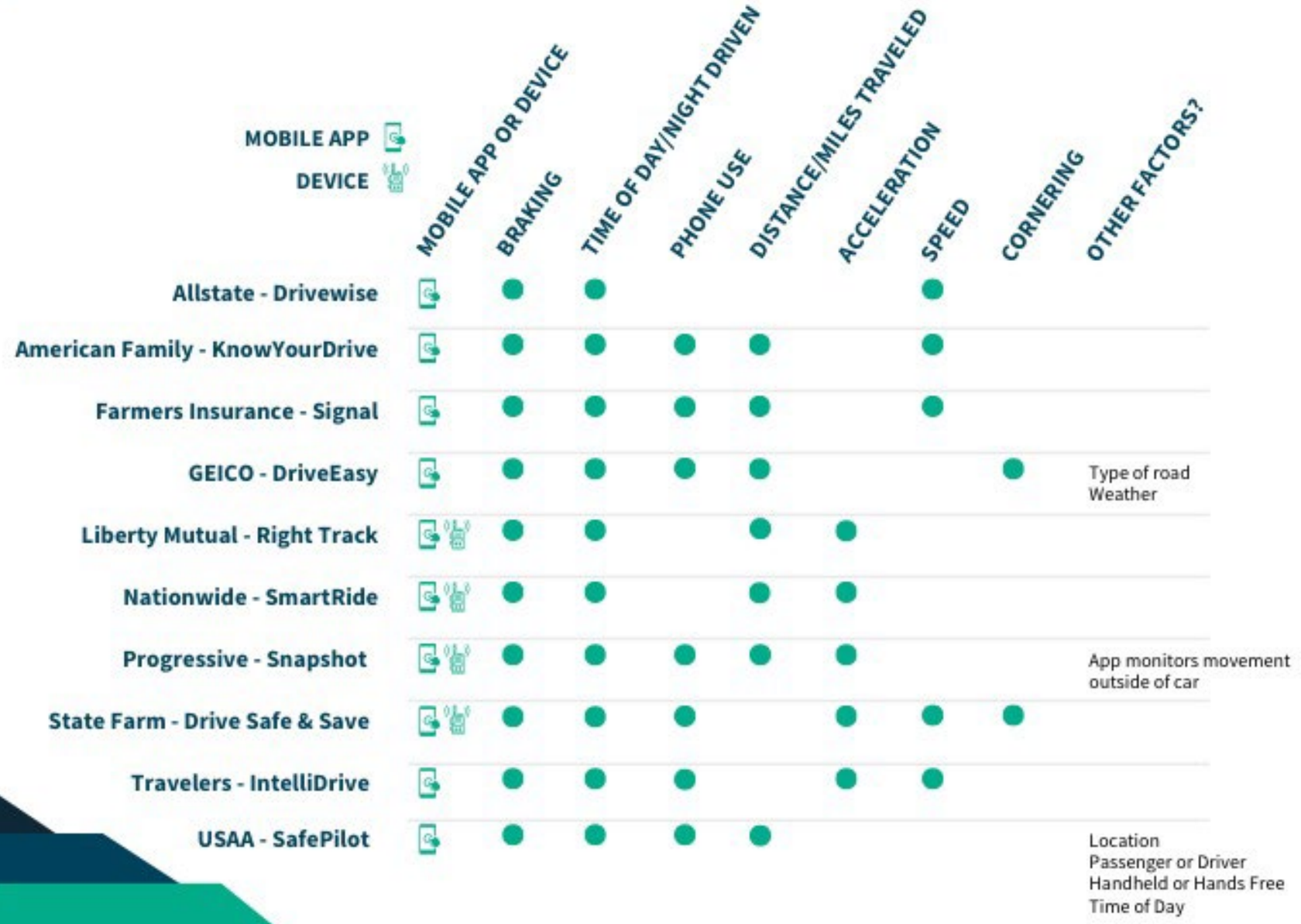
WHAT DATA IS COLLECTED, AND WHAT IS IT USED FOR?

- Insurers acknowledge some data that telematics systems collect, like miles driven, speed, hard braking
- But very likely other data points remain hidden
- CFA and Consumer Reports both investigated the data collected



TELEMATICS PROGRAMS

DRIVING BEHAVIORS INSURANCE COMPANIES USE TO CALCULATE PREMIUMS



INSURERS OFTEN PUBLICLY VAGUE ABOUT DEFINING RISK FACTORS

- GEICO's DriveEasy rates customers on driving "smoothness" and "the speed at which [they] are cornering" but doesn't explain how fast is too fast or what constitutes an abrupt stop
- Farmers told Consumer Reports that their program Signal determines discounts using information about the riskiest times and days to drive-but wouldn't provide specific information
- Farmers website uses general descriptions like early morning, rush hour, and late at night

SKEPTICISM FROM CONSUMERS ABOUT TELEMATICS

- Many consumers are wary of telematics programs, have been slow to sign up
- Insurers promoting telematics and trying to make it the default option
- Drivers put off by idea of Big Brother riding shotgun
- Telematics may also be vulnerable to hackers and other malicious actors
- Oldest programs have been around for over twenty years but are not used by everyone

68% OF AMERICANS WILL NOT INSTALL TELEMATICS DEVICES

- Recent Policy Genius study found that 68% of Americans would not install app that collects driving behavior or location data for insurance discounts
- 32% of Americans would use telematics if offered a discount
- Of those 32%, 67% would only use programs if it lowered their rates by half or more
- Getting telematics governance right is better than getting it fast

STATE REGULATION OF TELEMATICS-FLORIDA

- No specific laws or regulations about telematics
- OIR requires that auto insurers disclose the data collected and used in determining rates
- Data and methodology of telematics programs examined

NEW YORK'S TELEMATICS GUIDELINES

- Companies must note types of devices used
- Insurers cannot gather any data unrelated to discounts or rating insurance, or use data to harm policyholders
- No data collected without policyholders' approval

CALIFORNIA'S SYSTEM

- Requires premiums be determined mostly by driving safety record, miles traveled
- Insurers can only use factors related to risk of loss and adopted by Commissioner
- Telematics programs must be voluntary, can only use mileage

OUR RECOMMENDATIONS-DATA COLLECTION MUST BE TRANSPARENT AND PROGRAMS VOLUNTARY

- Consumers and regulators need to know all the data points collected by insurers and third party vendors
- Mileage and a few other datapoints cited publicly by insurers, but possible that other behaviors are being collected
- Telematics must be completely voluntary for consumers-no pressure or requirements

STANDARDS FOR DATA COLLECTED AND USED

- Strict limits on data collected and used by insurers in telematics programs
- Regulators should only allow, after review, data demonstrably related to the risk of loss
- Insurers must provide actuarial justification and causative explanation for each data point used—each component must be related to risk
- Third party vendors or developers should be subject to state insurance department oversight

TRANSPARENCY OF ALGORITHMS

- Regulators, elected officials, and consumers need to see how algorithms work- what goes into the calculations and what comes out
- All components and inputs should be identified and so should the weight given to them
- Algorithms should be presented to consumers in plain language, with weight percentages of each driving behavior

STRONG PRIVACY STANDARDS

- Consumers should have control over their driving behavior data and determine what it is used for
- Data should only be used for evaluating risk and not for other purposes
- Data should not be sold or shared with other corporations for advertising
- Consumers should receive regular accounting of the data collected and how it has been been used to rate their policy

TESTING FOR DISPARATE IMPACT

- Disparate impact analysis of telematics algorithms to find and correct unfair discrimination against protected classes
- Biased data can perpetuate and reinforce structural racism
- Colorado law SB 21-169 is a good solution to this problem—establishes stakeholder process for getting rid of unfair discrimination

CONCLUSION

- Insurers have been unwilling to disclose telematics information and the full scope of the data they collect
- Most states do not have comprehensive regulations specifically focused on telematics
- States should adopt thorough regulations of telematics and exercise careful oversight of these programs

Questions? Contact us at

mdelong@consumerfed.org

Tracking of NAIC Consumer Representatives' Requests
May 8, 2013

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1. From time to time, NAIC consumer representatives bring issues to the NAIC/Consumer Liaison Committee during NAIC national meetings.

2. If a consumer representative is requesting specific action by the NAIC, an "NAIC Consumer Liaison Representative Recommendation to the NAIC Executive (EX) Committee" request form with the specific action noted should be submitted to the NAIC. This request form should also be included as part of the presentation slides and handouts provided to the NAIC/Consumer Liaison Committee within thirty (30) days, or as soon as practical, after the presentation. (request form attached)

3. All requests will be provided to the Consumer Board of Trustees by the NAIC staff support for the NAIC/Consumer Liaison Committee. The Consumer Board of Trustees will review the requests for informational purposes and will serve as a central point for the tracking and communication of requests within the NAIC.

4. The NAIC staff support for the NAIC/Consumer Liaison Committee will coordinate with the NAIC staff support for the appropriate referral committee to obtain its feedback on the request.

5. The NAIC staff support for the NAIC/Consumer Liaison Committee will provide this feedback to the chair of the Consumer Board of Trustees and the chair of the NAIC/Consumer Liaison Committee within thirty (30) days, or as soon as practical, after receiving the consumer representative request during an NAIC national meeting.

6. The chair of the NAIC/Consumer Liaison Committee and the chair of the Consumer Board of Trustees will review the feedback and provide input to the NAIC Executive (EX) Committee, as may be appropriate.

7. For any request for an amended or new charge, no further action will be taken unless an amended or new charge is adopted by the NAIC Executive (EX) Committee and Plenary. The NAIC (EX) Executive Committee may pursue any action consistent with the NAIC Bylaws.

8. An update on the status of the NAIC consumer representatives' requests will be posted on the NAIC website and provided at each NAIC national meeting during the NAIC/Consumer Liaison Committee meeting and the Consumer Board of Trustees' meeting.

Advisory Note

NAIC committees generally adopt their annual charges during the NAIC Fall National Meeting.

The NAIC membership generally adopts its annual charges and sets the priorities for the year during or shortly after the NAIC Commissioners Conference in February.

Consumer representatives are encouraged to work within the normal committee process of the NAIC for the development and adoption of charges each year.

NAIC CONSUMER LIAISON

REPRESENTATIVE RECOMMENDATION

TO THE NAIC EXECUTIVE (EX) COMMITTEE

(Please submit completed request form to Lois Alexander (NAIC) for processing)

RECOMMENDED BY: Michael DeLong, Consumer Federation of America

DATE: 11/30/2022

ISSUE:

Auto insurers are increasingly using telematics programs to get consumer-generated driving data and using that data for insurance pricing. These programs show substantial promise for consumers but also pose substantial risks, especially regarding consumer privacy. Companies collect numerous factors such as hard braking, the time of day or night driven, the distance or miles traveled, acceleration, speed, and cornering. Since regulators require drivers to purchase auto insurance, they have a responsibility to protect consumers and oversee these programs. But most states have little or no specialized regulation and oversight to make sure consumers benefit from these technologies and that insurance companies do not abuse them. Strong and effective oversight, in the form of laws or regulations, is needed to ensure these programs help consumers and are not misused, and transparency is an essential first step in this process. The NAIC can encourage states to adopt reforms and new laws.

COMMITTEE REFERRAL RECOMMENDATION:

(A)_____ (B)_____ (C)__x__ (D)_____ (E)_____ (F)_____ (G)_____ **(H) X**

ACTION REQUESTED/CHARGE RECOMMENDED:

The NAIC should adopt a model bill governing the use of telematics in auto insurance, with the following requirements. Consumers and regulators should know all the data points collected by insurers and third party vendors. There should be strict limits on the data collected and used by insurers. Regulators should only allow, after careful review, data demonstrably related to the risk of loss. Algorithms should be completely transparent for regulators, elected officials, and consumers. All components and inputs should be identified, and so should the weight given to each of them. Consumers should have control over their driving behavior data and what it is used for, and it should only be used for evaluating risk—and not sold or shared with other corporations for marketing or other purposes. Finally, the bill should require testing for disparate impact—an analysis of algorithms and data models to find and correct unfair discrimination against protected classes.

NAIC ACTION:

RECOMMENDATION ACCEPTED: _____

RECOMMENDATION DECLINED: _____

G:\DATA\Consumers\EX Consumer BOT (LEA)\Spring 13\Tracking Consumer Rep Requests 050813 final.docx

“I BOUGHT AUTO INSURANCE, BUT HAVE NO IDEA WHAT IT MEANS OR WHAT IS ACTUALLY COVERED.”

NAIC FALL MEETING
TAMPA, FL DECEMBER, 2022

Erica. L. Eversman, J.D.
Automotive Education & Policy Institute

Eric Ellsworth
Consumers’ Checkbook

Auto Policy Access

- Do you know where to find your auto policy quickly?
  - *Is it online?*
  - *Is it available via a phone app?*
  - *How many pages/links to navigate to it?*

Once You Find Your Policy. . .

- Does it include all of your endorsements?
  - *Are these separate documents?*
  - *Are there links to them?*
  - *Do you have to access each one separately?*
- Can you read your policy and endorsements?

Policies Have Standard Provisions

- Many insurers utilize ISO form policies
  - *May customize certain language*
- Endorsements have standard provisions, also

Insurers Do Not Discuss All Features with Consumers

- May be required to discuss uninsured/underinsured medical coverage (per state law)
  - *May not discuss UM/UIM property loss coverage*
- OEM v. non-OEM parts
- Replacement cost for new vehicle
- Gap coverage for purchased vehicle
- Customization of vehicle (e.g. wheels, paint, audio, sensors)
- Rental car coverage and/or extended rental coverage

Consumers Have Expectations

- Expected benefit
- Expected features

- Without knowing the exact terms of the policy ***before*** purchase, consumers cannot know if expectations are reasonable
  - *Because insurance policies are not published online, consumers need easy access to what they purchased*

Easy Solution

- Make policies and endorsements readily available online
- Provide standard policy number to all consumers
  - *Print on insurance/financial responsibility card*
- Create QR code to allow consumer to go directly to:
  - *Policyholder's own policy, endorsements, & declaration page*
  - *Print QR code on insurance/financial responsibility card*

How Does This Benefit Consumers?

- Gives consumers easy access to individual policy & endorsements
- Allows consumers to get expert advice about benefits included in policy
- Allows consumers to determine gaps in coverage

Using Data for Consumer Protection

- Providing consumers easy access to their individual policy allows others to use the data in new ways:
  - Link specifics of "full" policy (including endorsements) to other datasets (reviews/complaints, performance measures, etc.)
  - Make computers do the tedious work of assembling and analyzing data about insurance– consumers should not have to do this
  - Build apps to provide information tailored to consumer's specific situation, without them having to learn complex insurance language or concepts

Enable-Value Oriented Shopping

- You already use technology to simplify shopping in the rest of your life, why not for insurance?
  - *Travel (Expedia, Kayak, Orbitz, countless others)*
  - *Real estate (Zillow, Redfin, Trulia, Realtor.com, so many more)*
  - *Cars (Carvana, Carmax, etc.)*

  All of these apps are built on access to consumer-specific data
- Feasible: One auto insurer starting providing consumers with comparison rate data decades ago
- Simplifying the process for consumers enables to them shop for insurance based on value not just premium

Recommendations

- Require insurers to provide:
  - *Put standard policy form number on all insurance cards (in addition to individual policy number)*
  - *QR code to access the policyholder's declaration page, policy, & endorsements all in one place*

QUESTIONS?

Erica L. Eversman, J.D.
erica@autoepi.org

Eric Ellsworth, M.S. M.B.A
eellsworth@checkbook.org

Our newest research study

Coalition Against Insurance Fraud

ADVOCACY • INFORMATION • OUTREACH

Why you should care.

- The first and only study of its kind.
- This study was done to help guide regulators.
- It contains valuable insight to guide the proper oversight of data both in anti-fraud and beyond.

Consumers are not data-ignorant

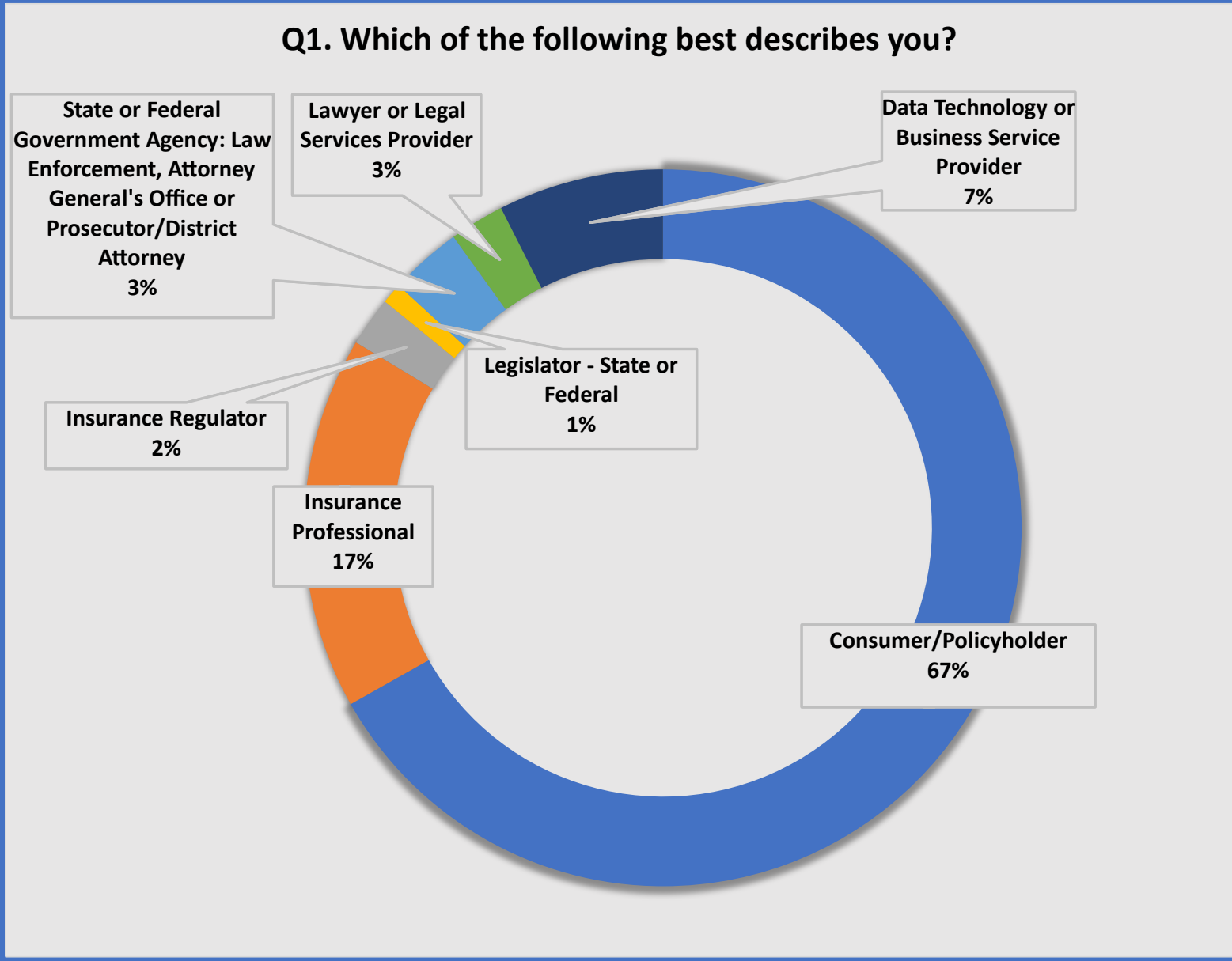
There is support for appropriate use of data in the world of insurance.

dynata™

How the study was done

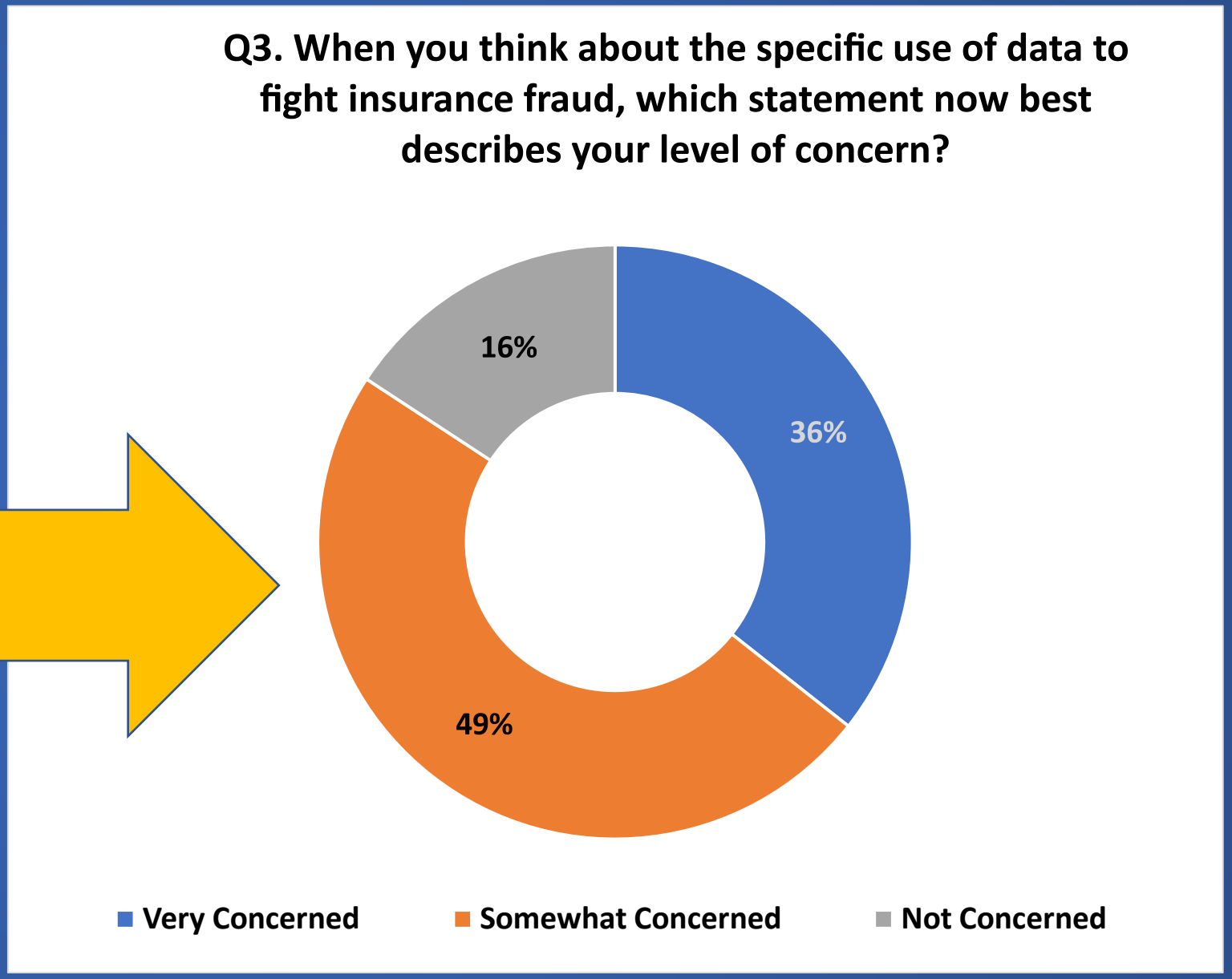
2,000+ respondents

- 67% Consumers
- 17% Insurance professionals
- 6% Legislator regulator government
- 10% Legal or data service

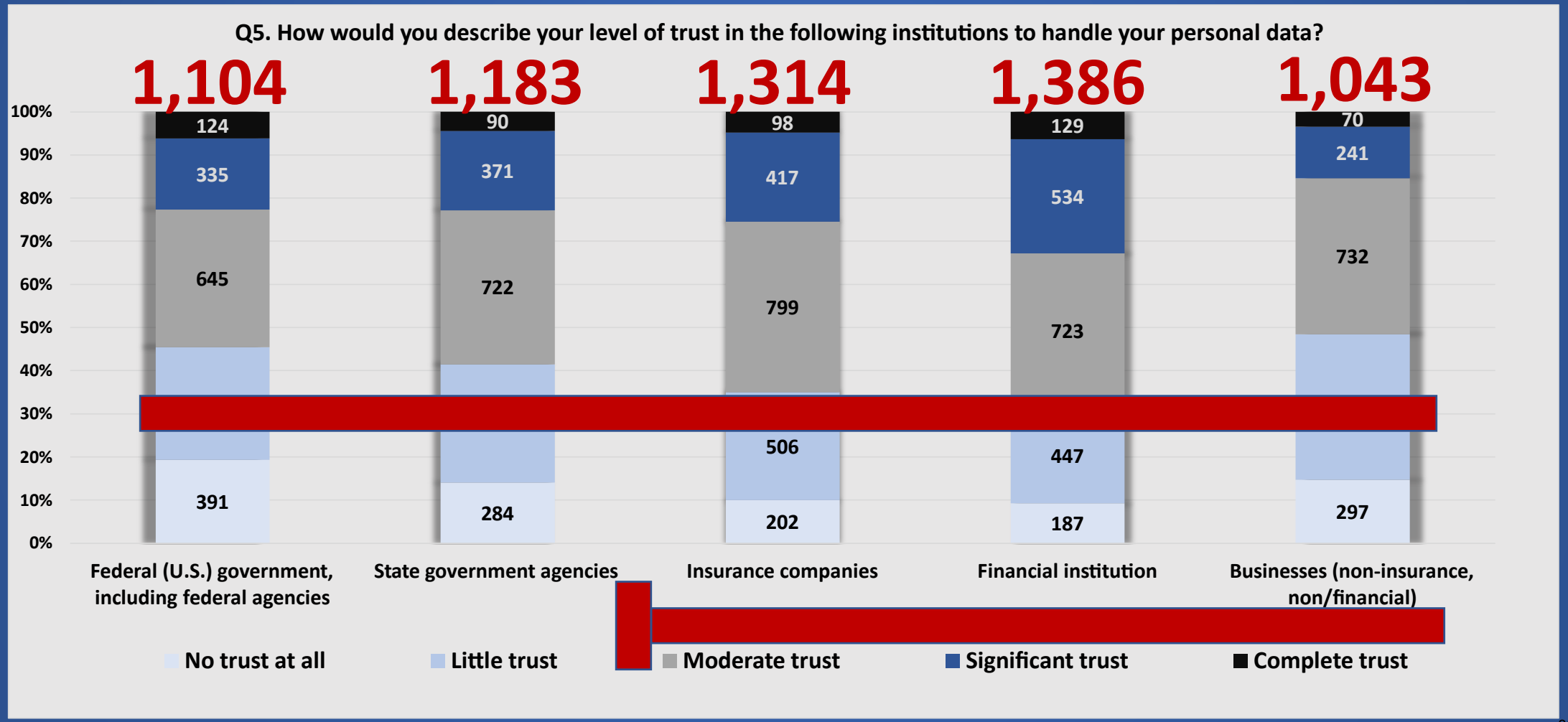


Americans care about data and insurance fraud

85%



Who do consumers trust with their data?



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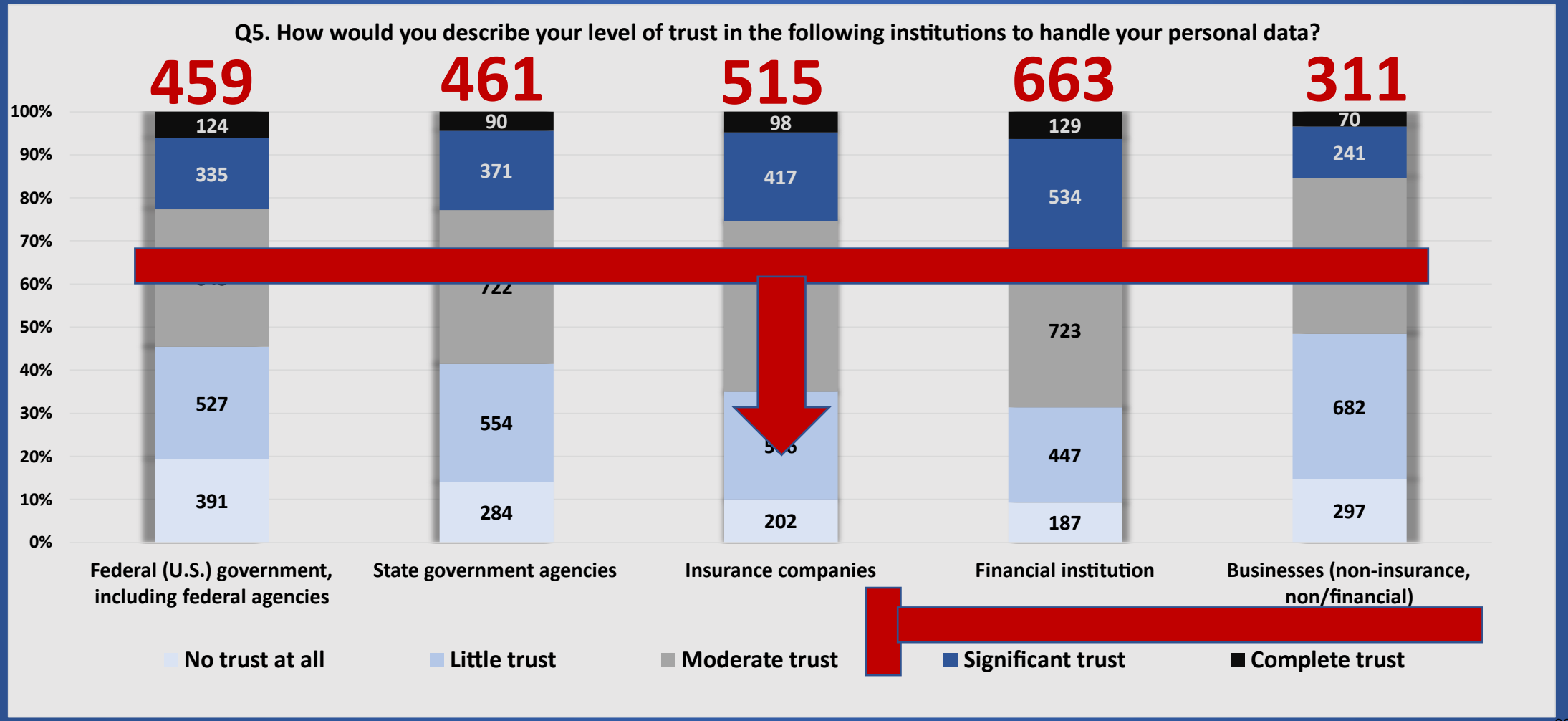
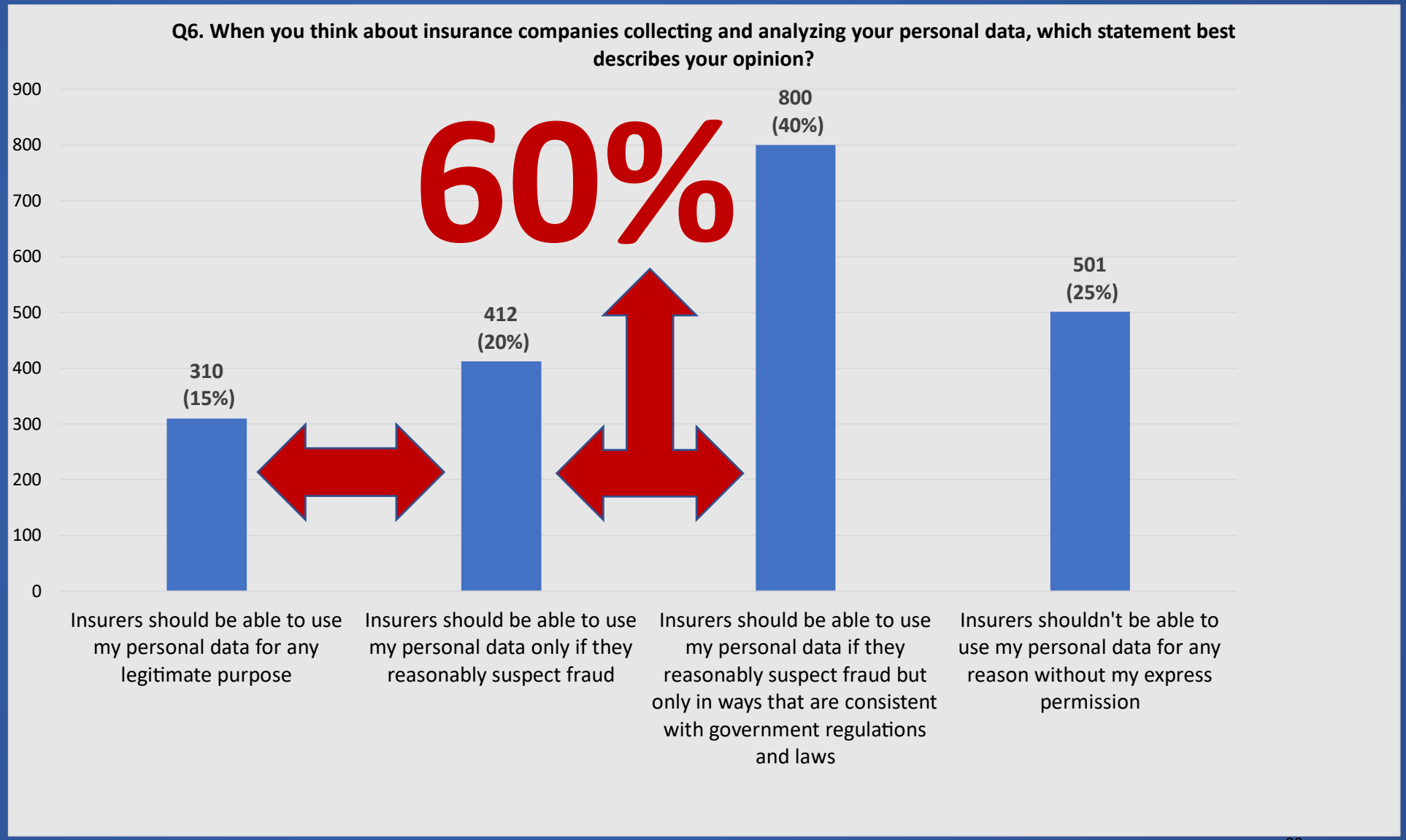


Consumers support insurers using data to fight fraud.



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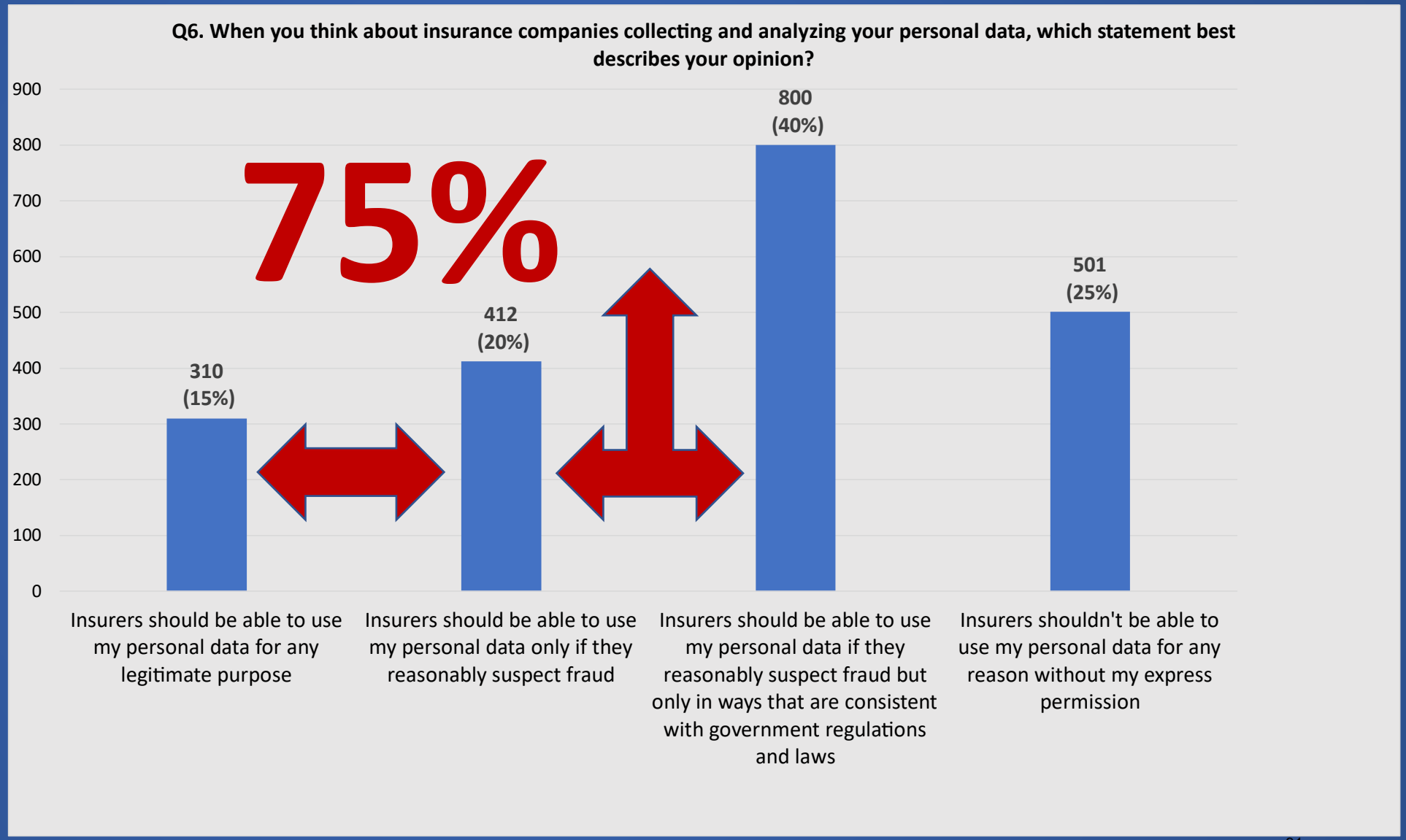
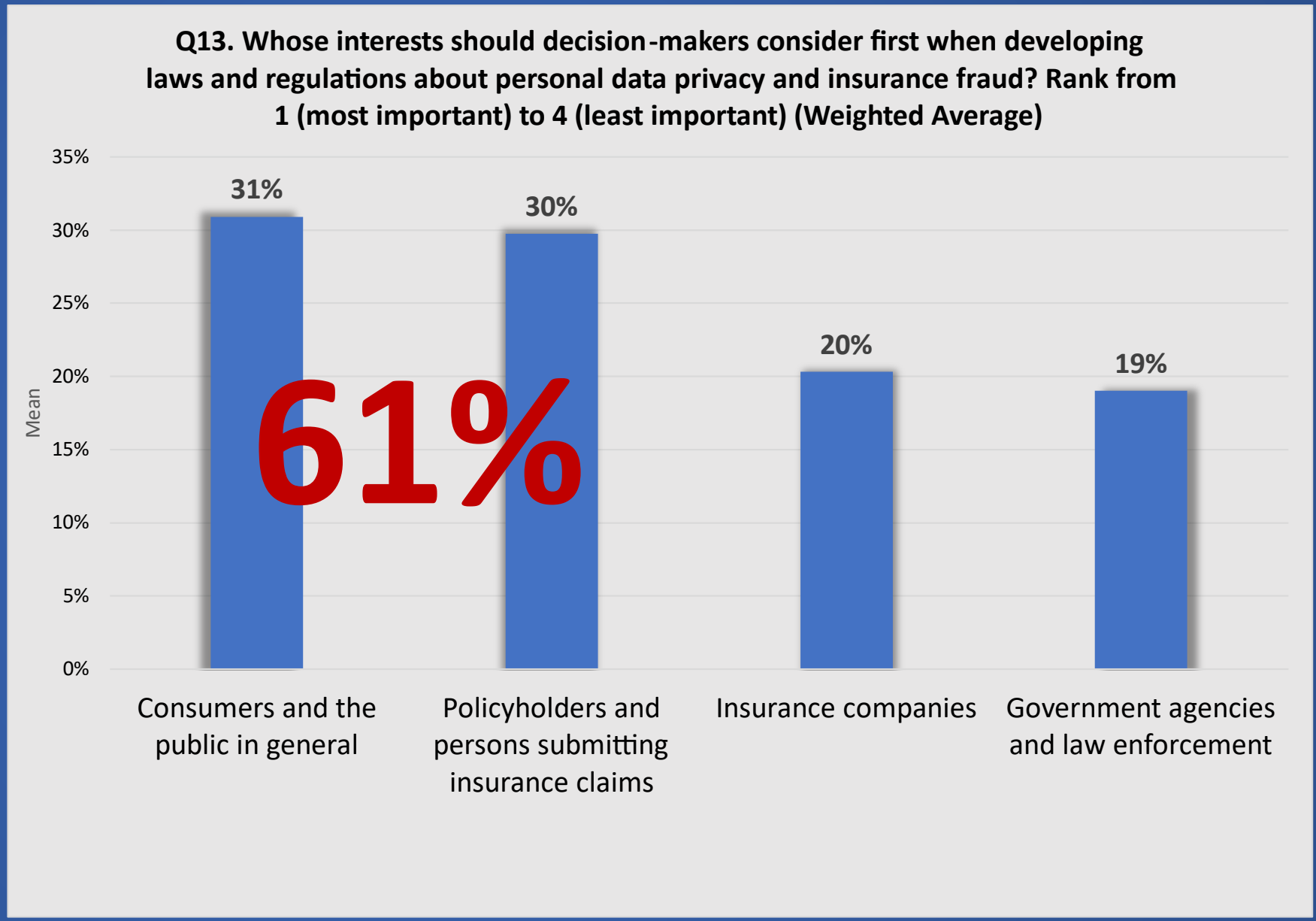
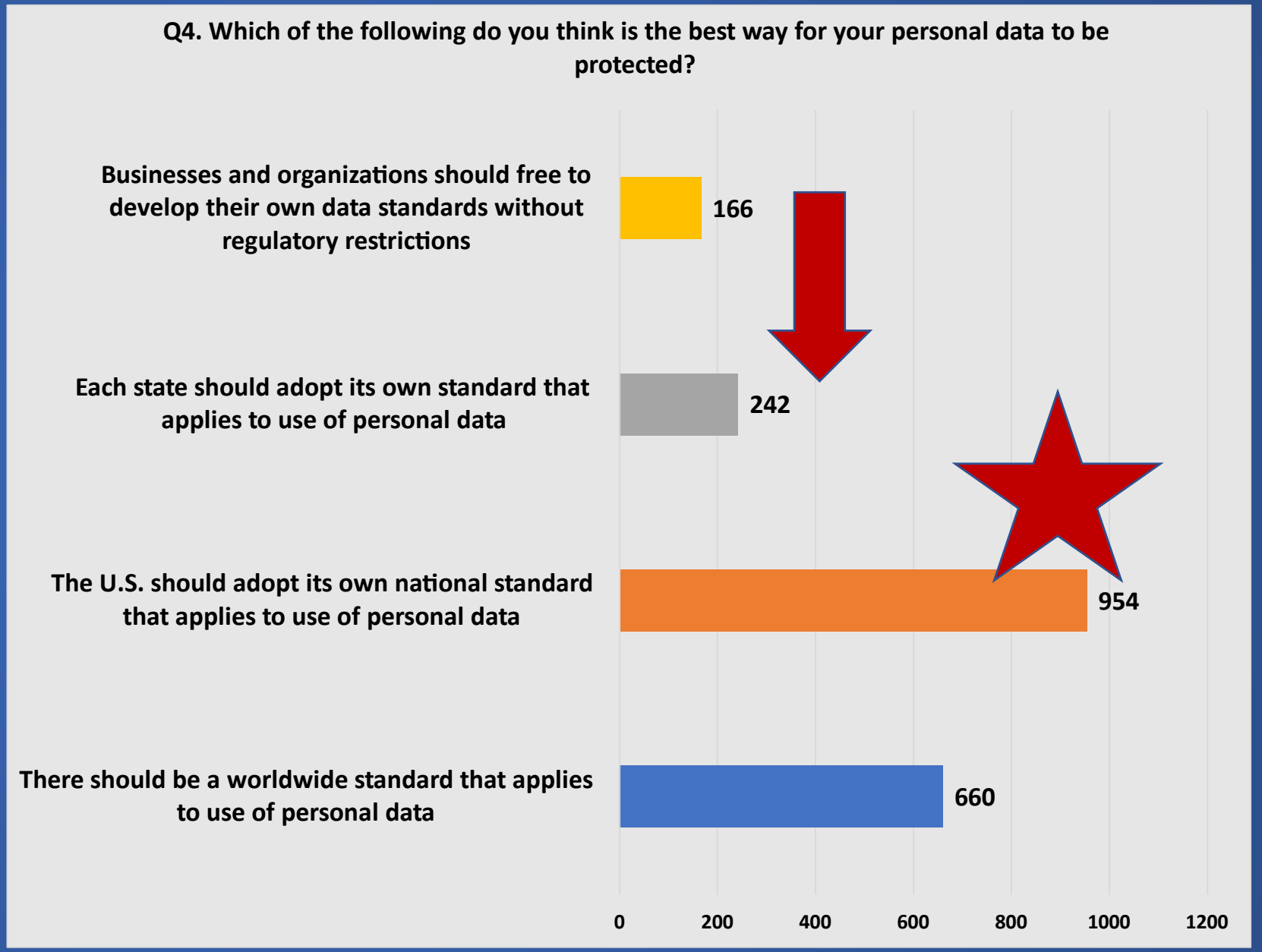


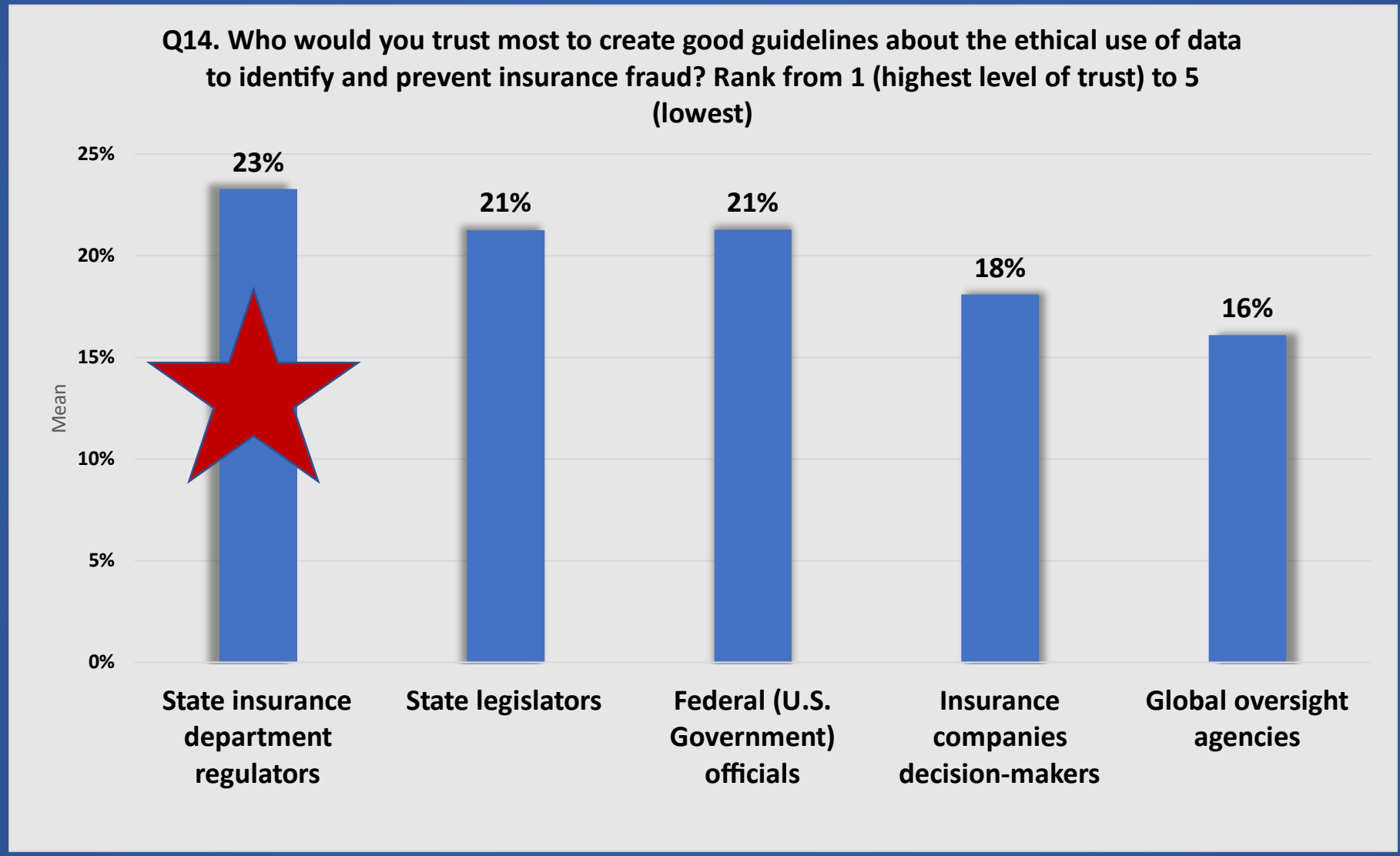
But want their interests protected first.



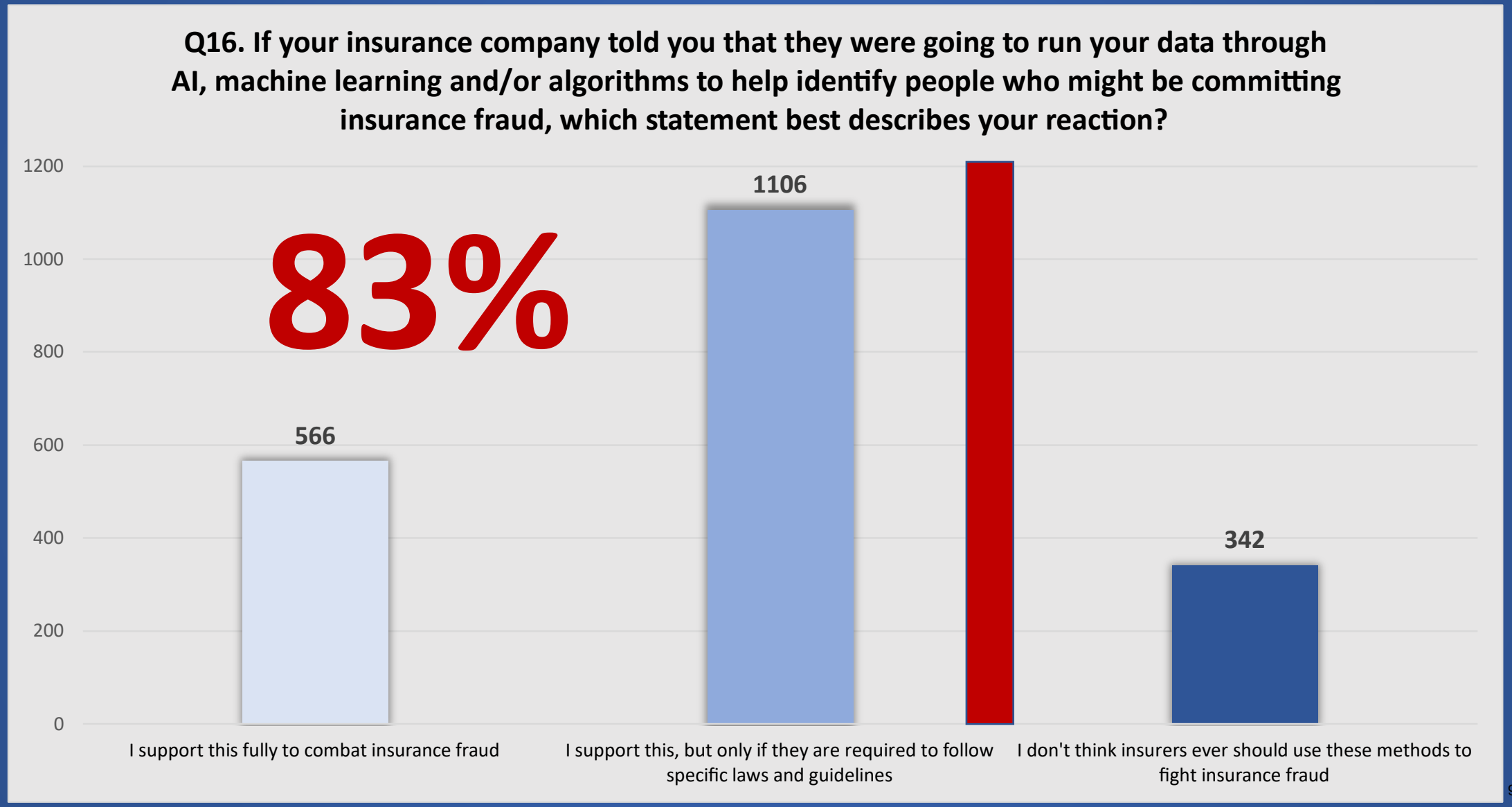
Consumers overwhelming support a national data protection standard



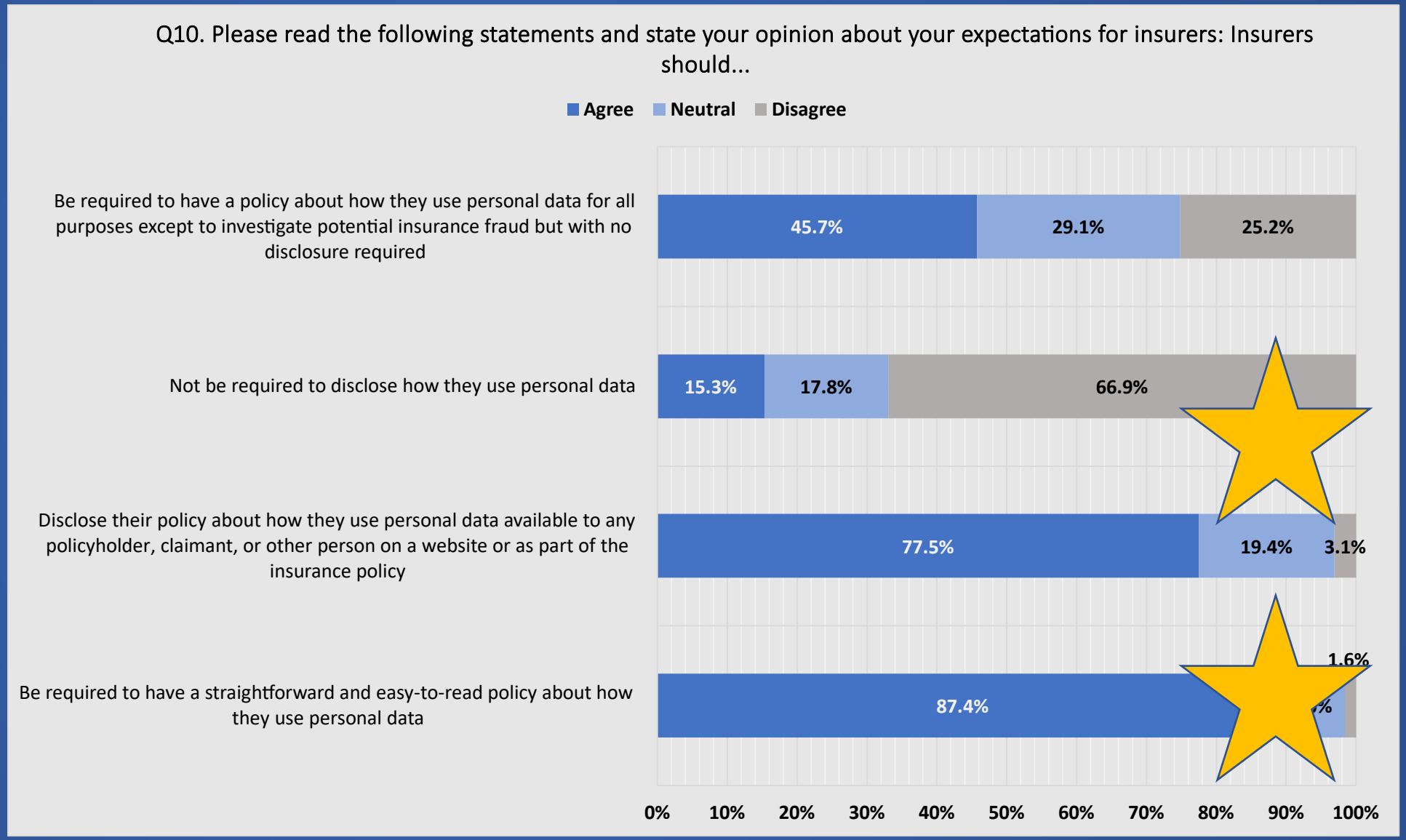
While placing high trust in state regulation



Consumers support data laws and guidelines

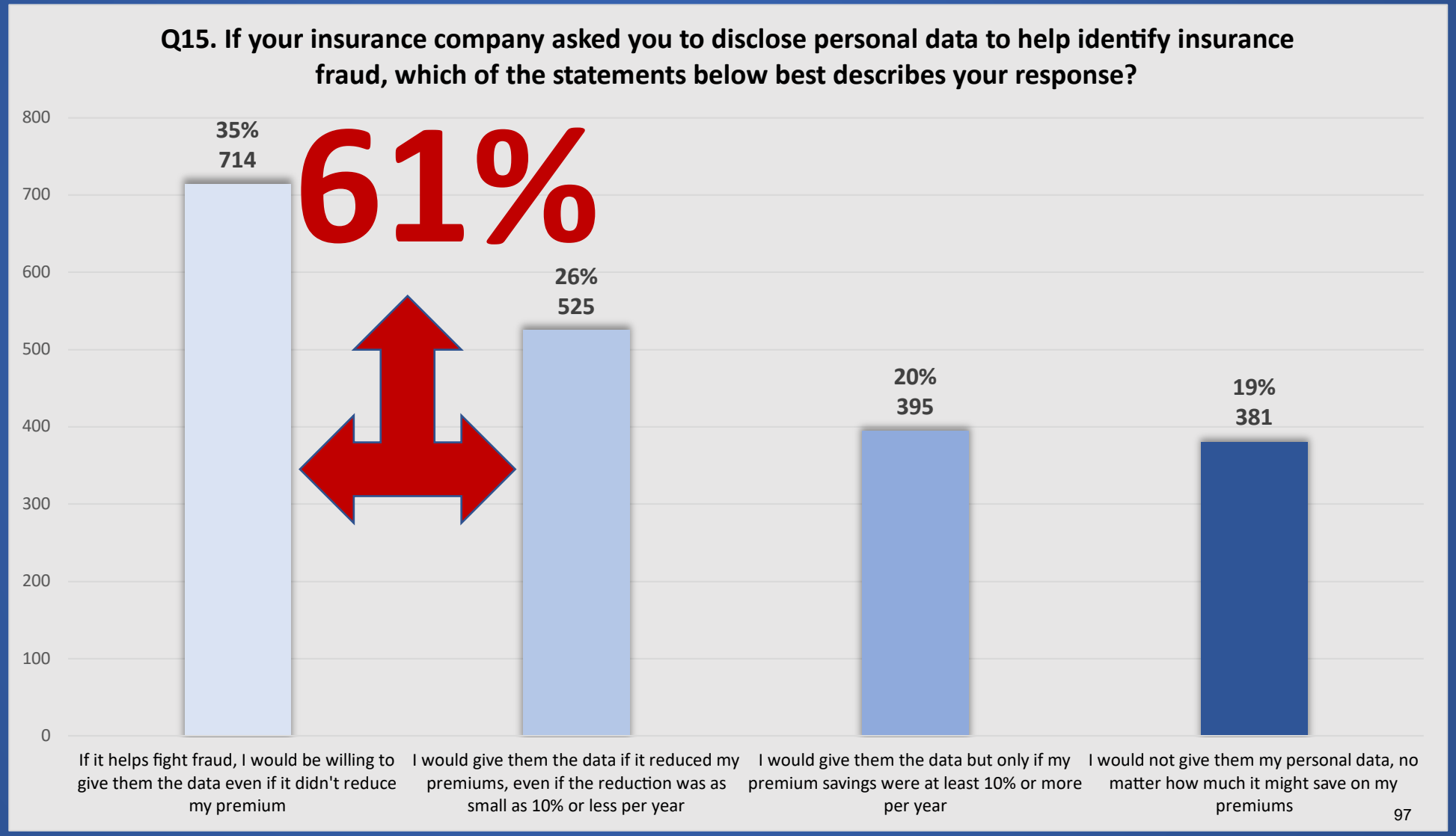


Disclosure and clarity are key to insurer data trust



Premium reductions tied to data usage

2 Views



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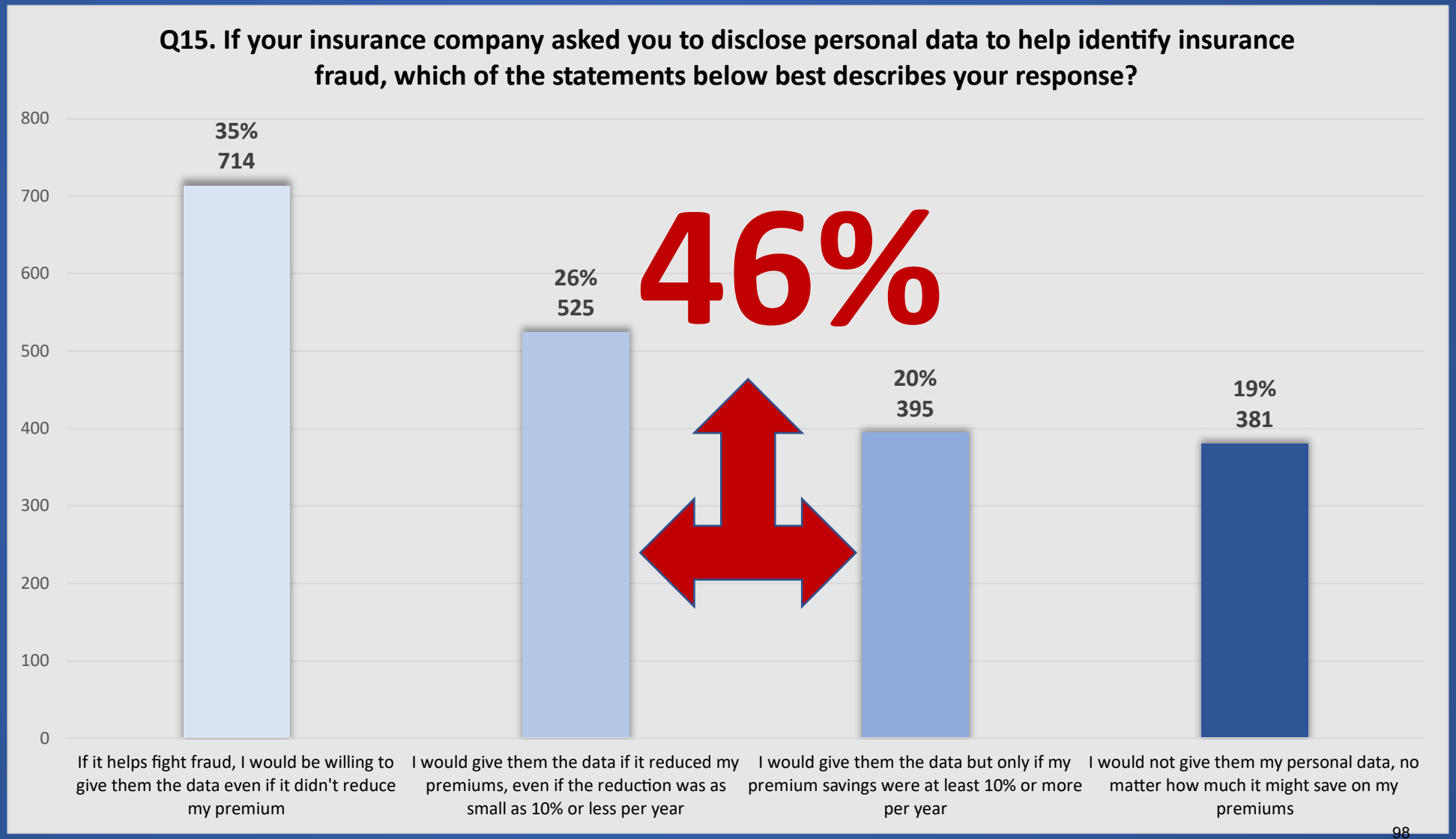
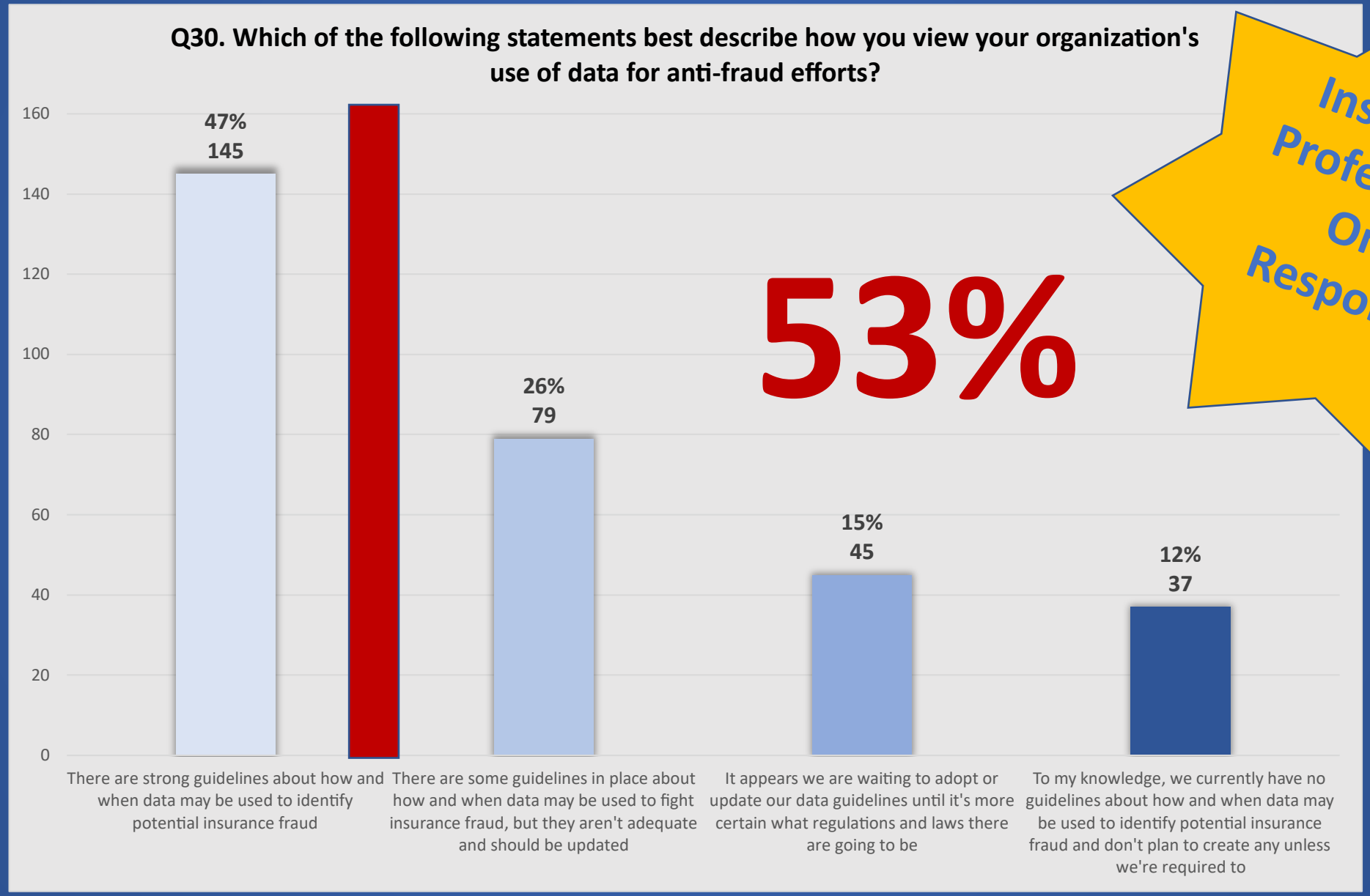


Are insurers properly overseeing data use?



Regulators must play a strong role

- Use this data to apply to your work both nationally and at the state level.
- Support the appropriate use of data to protect consumers from fraud.

Regulators must play a strong role

- Require clear data usage policy language with mandatory disclosure.
- Support anti-fraud protections in data privacy laws.

Regulators must play a strong role

- Address bias and prejudice.
- Whether intentional or unintended.
- Include 3rd party vendors and aggregators.

Coalition Against Insurance Fraud

ADVOCACY • INFORMATION • OUTREACH

THE ETHICAL USE OF DATA TO FIGHT INSURANCE FRAUD STUDY

Coalition Against Insurance Fraud

protiviti
Global Business Consulting

Federal health policy update

NAIC Fall Meeting
Consumer Liaison
December 12, 2022

Lucy Culp - The Leukemia & Lymphoma Society
Wayne Turner - National Health Law Program
Carl Schmid - HIV + Hepatitis Policy Institute

Roadmap

- Open enrollment
  - Family glitch fix
  - Standardized plans
- Rulemaking
  - Notice of Benefit and Payment Parameters
  - Essential Health Benefits Request for Information
  - Section 1557
- Litigation update
  - Copay accumulators
  - Preventive services

Open enrollment

Open Enrollment

- Just past the halfway point for 2023 Marketplace open enrollment
- The family glitch has been fixed!
- Average benchmark premiums increased, but consumer costs are aided by the continuation of ARPA subsidies
- Relaxed eligibility rules and increased navigator funding should aid consumers in signing up for coverage

Recommendation: Increase state and local outreach and enrollment efforts

Standard Plans

- Now available in most states
- Potential to help consumers by:
  - simplifying shopping experience
  - stabilizing cost sharing requirements
  - addressing health disparities
- Concerns about unmet potential and alternative plan design

Recommendation: Regulators can take further steps to aid consumers

  - Regulatory tools
  - Consumer education
  - Monitoring the marketplace

Rulemaking

Notice of Benefit and Payment Parameters (NBPP) for 2024

- Consumer and patient advocacy groups have submitted letters to HHS urging:
  - Improving benefits in select EHB categories (*e.g.*, Rx, pediatric services, maternity care)
  - Cost sharing
  - Network adequacy
  - Standardized plans
  - Broker standards
- HHS and states should take action against insurers and PBMs that evade ACA cost sharing protections by declaring certain benefits "non-EHB"
  - ➢ classifying a particular drug as covered but non-EHB means that a patient will pay the full cost of the drug until the deductible is met, share costs with the plan (via copay or coinsurance) until the plan's annual or lifetime cap is hit, and then the patient must pay out-of-pocket for all further costs for the drug

➢ Letters sent by advocates on priorities for NBPP 2024
- Health Partners Coalition Letter to Sec. Becerra
- NHeLP Letter to CCIIO Director, Ellen Montz - Re: Request for Modifications to the Federal Prescription Drug and Maternity Care Essential Health Benefit Standards

Essential Health Benefits - Request for Information

EHBs - minimum set of benefits that non-grandfathered individual and small group plans and Medicaid Alternative Benefit Plans must cover

ACA requires HHS Secretary to:

- Define EHB
  - Benchmarking, plus national minimums for Rx and habilitative services
- "Periodically" review and update EHB
  - difficulty in accessing services
  - ID coverage gaps
  - account for new evidence medical/scientific developments
  - report to Congress
- Update EHB "to address any gaps in access to coverage or changes in the evidence"
- CMS also seeks comments on substitution, changing the Rx classification system, pediatric services, and how plans describe benefits for consumers

Section 1557 Non-discrimination Rule

- Awaiting Final Rule-Comments on Draft Closed October 2022
- Restores Many Patient Protections that were eliminated in 2020, Expands Others
- Expands Scope: All HHS Health Programs & Activities
  - Includes all plans and operations by carriers, not just ACA plans
  - Includes Health Insurance
- Restores Inclusion of “Benefit Design” & “Marketing Practices”
  - Includes 3rd Party Contractors such as PBMs
  - Network Adequacy & Prescription Drugs
    - Labels Excessive Prior Authorization as Potential Discrimination
    - Seeks comments on whether Value Assessments using QALY’s is discriminatory
- States responsible for implementing & enforcement

Litigation update

Copay Accumulator Litigation

- **APA Complaint against HHS & CMS for 2021 NBPP Rule**
- **Filed by HIV+Hepatitis Policy Institute & Diabetes Groups in U.S. District Court for D.C.**
  - Case 1:22-cv-02604
- **Major Claims**
  - Violates the ACA Law
  - Contrary to ACA Regulations
  - NBPP Rule is Arbitrary and Capricious
- **US Government Moved to Dismiss for Lack of Standing**
- **Filed Amended Complaint w/3 affected patients**

ACA Preventive Services - Braidwood v. Becerra

- Challenges ACA requirements that most health plans cover certain preventive screenings and services without cost sharing (42 U.S.C. § 300gg-13)
- Judge O'Connor ruled that requiring coverage of USPSTF recommended services (A or B) is unconstitutional
- Also ruled that coverage of PreExposure Prophylaxis (PrEP) violates "religious exercise" of Braidwood (a for-profit corp.)
- Parties are currently briefing remediation (nationwide injunction?)
- Approx. 15 states have codified ACA requirements
- EHB preventive services, a separate ACA provision (42 U.S.C. § 18022(b)(1)(I)), requires coverage with cost sharing limits

Recommendation: regulators should remind issuers of their obligation to cover preventive services

  - State Leaders: Affordable Care Act Ruling in Texas Does Not Currently Change Covered Preventive Care
  - NM OSI - Cost-sharing protections for contraceptives and PrEP

Questions?

Contact us:

- **Lucy Culp - The Leukemia & Lymphoma Society - lucy.culp@lls.org**
- **Wayne Turner - National Health Law Program - turner@healthlaw.org**
- **Carl Schmid - HIV + Hepatitis Policy Institute - cschmid@hivhep.org**

Unwinding the Public Health Emergency: How Departments of Insurance Can Help Consumers

SHAMUS DURAC, RHODE ISLAND PARENT INFORMATION NETWORK

KAREN SIEGEL, HEALTH EQUITY SOLUTIONS

Rhode Island Parent Information Network

- Social Services Nonprofit, located in Warwick RI
- Founded over 30 years ago to provide special educational and health support to Rhode Island parents
- Now supports Rhode Islanders across the lifespan with educational, health access, health insurance, care management, and wellness programs
- Approximately 120 staff across all programs, including staff co-located within governmental agencies and community organizations

The RIPIN Call Center

- A live answer phone helpline for any health insurance issue
- Operated in partnership with the RI Office of the Health Insurance Commissioner and the RI Executive Office of Health and Human Services
- Supports about 3000 clients per year
- Since 2017, has saved Rhode Islanders over $6 million in health care costs
- 94% client satisfaction rate

RIPIN

Health Equity Solutions

HEALTH EQUITY SOLUTIONS

VISION

For every Connecticut resident to obtain optimal health regardless of race, ethnicity, or socioeconomic status.

MISSION

To promote policies, programs, and practices that result in equitable health care access, delivery, and outcomes for all people in Connecticut

Agenda

- Context
- Considerations for regulators
- Applying concepts beyond the end of the PHE

PHE unwinding: not just a Medicaid issue

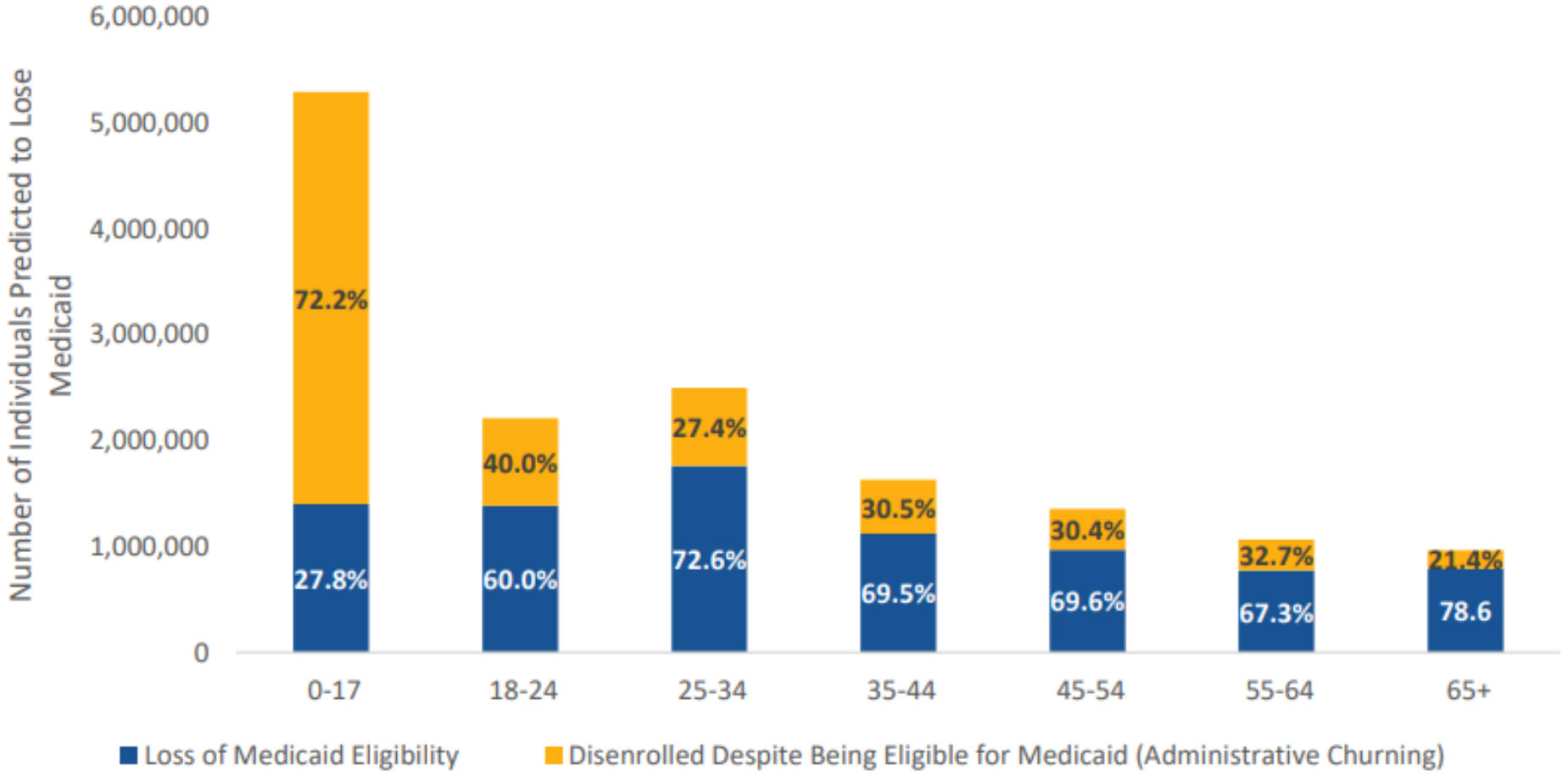
- Up to 15 million people expected to lose coverage
  - No longer eligible for Medicaid and need to transition to other coverage (Marketplace, ESI)
  - Terminated for procedural reasons, but still Medicaid eligible (*e.g.*, updating info)
  - Unlawfully terminated (Medicaid due process includes notice and fair hearing rights)

- People who lose coverage/fall through the cracks will turn to DOIs for assistance
  - Many won't learn of coverage termination until seeking care (e.g., filling prescriptions)
  - People don't necessarily identify their coverage as "Medicaid"

- DOIs should plan *now* to help prevent PHE coverage losses, help consumers transition to new coverage, provide assistance and resources for those who lose coverage

Predicted Coverage Losses

Figure 3. Predicted Medicaid Coverage Loss Due to Eligibility Loss versus Administrative Churning, by Age



Note: Each bar adds to 100%, showing the breakdown of predicted Medicaid coverage loss due to administrative churning versus loss of eligibility.
Source: Analysis of SIPP treating March 2015-Nov. 2016 as analogous to March 2020-Dec. 2021 PHE, among enrollees ever-enrolled in Medicaid during the 21-month period. Projections are from the Base Case scenario.

Source: ASPE; Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches

Context: Disproportionate Impact

- Less access to employer-sponsored plans
- Disproportionate housing instability or relocation
- Accessibility of information–source & content

Action: Standardize messaging

- Update websites, FAQs, and consumer-facing resources
- Link to Medicaid, Marketplace, navigators, AIDS Drug Assistance Programs, legal services
- Prepare for an increase in consumer calls seeking assistance/information when people lose coverage and train call center/other staff about unwinding issues
- Educate consumers on steps they can take to avoid disruptions in care (e.g., prescription refills)
- Resources: **State Health and Value Strategies'** toolkit and templates

Action: Prepare

- Consider autoenrollment into QHPs or easy enrollment options
- Strategize with Medicaid on the order in which redeterminations occur
- Monitor marketing to prevent adverse selection, unlicensed brokers, misleading information on non-compliant plans
- Enforce nondiscrimination protections
- Review network adequacy and plan capacity for influx of new enrollees

Action: Coordinate Community Engagement with Medicaid

Proven strategy for addressing disparities

- Before end of PHE: Clear, coordinated communication
- After end of PHE:
  - Clear, coordinated communication
  - Bidirectional information flow
  - Collaboration with outreach efforts from Medicaid and SBMs

Action: Leverage Trusted Messengers

1. Engage with community-based and faith-based organizations, especially those active in hard-to-reach communities
2. Align messaging and partnerships with other agencies
3. Establish feedback channels – community partners frequently notice trends faster than program administrators

State example:

California's "Coverage Ambassadors"

Ohio's Covid-19 PHE Unwinding Toolkit

Action: State Continuity of Care Laws

- Issue bulletins reminding issuers of their obligations under state continuity of care laws (e.g., for persons undergoing active course of treatment for acute medical conditions, or for pregnant persons in their third trimester)

- Use authority, where possible, to expand conditions protected and plans covered

- Issue guidance encouraging plans to honor past prior authorization, allow consumers to access drugs already approved through an exceptions process, and avoid unnecessary repetition of step therapy.

Beyond the PHE

- Autoenrollment/renewal
- Community engagement
- Messaging and outreach
- Aligning responses to FAQs

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Questions? Comments?

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Re: Unwinding the Public Health Emergency: How Departments of Insurance Can Help Consumers (updated)

Introduction

When the HHS Public Health Emergency (PHE) ends, the continuous eligibility requirement under the Families First Coronavirus Relief Act ends. State Medicaid programs will begin unwinding and conducting eligibility redeterminations, the first in many months for most enrollees. An estimated 16 million people will lose health coverage - some because they are no longer Medicaid eligible, and others because they do not complete the required paperwork to renew coverage.

State departments of insurance (DOIs) can play a key role to help prevent coverage losses, working with state Medicaid agencies and other partners, and helping consumers transition to new health coverage. DOIs will also likely be a first point of contact for consumers seeking assistance when they lose coverage.

NAIC consumer representatives appreciate this opportunity to provide the following best practices and recommendations for DOIs to prepare for PHE unwinding and to assist consumers who lose health coverage.

1. PHE unwinding will lead to significant health coverage losses

A recent study by the Urban Institute estimates that up to 16 million people will lose health coverage resulting from PHE unwinding. The Georgetown Center for Children and Families (CCF) projects that 6.7 million children are likely to lose their Medicaid coverage and are at risk for becoming uninsured for a period of time.

Some people who lose Medicaid coverage are no longer eligible for the program, for example, due to changes in income or aging out of eligibility categories (*e.g.*, Medicaid

expansion enrollees are no longer eligible when they turn 65, but might be eligible for other Medicaid categories like Medicare Savings Programs). Others who lose Medicaid are still, in fact, eligible. They may have not received notices sent by the state Medicaid agency, or did not understand and respond to requests for information as required.

Some states may unlawfully terminate individuals and families from Medicaid and the Children's Health Insurance Program (CHIP). The Centers for Medicare & Medicaid Services (CMS) recently warned states against terminating coverage for entire families without conducting individualized determinations, and reminded states of their obligation to consider all bases of eligibility before terminating, as required by law (see 42 C.F.R. § 435.916(f)(1)). States must also follow Medicaid due process protections, including pre-termination notice and hearing rights, required under federal law and the U.S. Constitution (see NHeLP's Unwinding the COVID-19 Public Health Emergency: Checklist for Redeterminations - National Health Law Program).

The people most impacted by PHE unwinding will be those who already face numerous challenges and obstacles to maintaining coverage and accessing health care. Medicaid enrollees experience economic and other challenges that make them especially vulnerable to coverage losses during PHE unwinding. Black, Indigenous, Latinx and other people of color; persons with chronic illness, complex medical conditions, and disabilities are overrepresented in Medicaid. As a consequence of systemic racism and other forms of discrimination, these populations are more likely to lack access to employer-sponsored insurance. People of color and LGBTQ+ people are also more likely to experience housing insecurity and, as a result, not receive mail. By definition, Medicaid enrollees are low income and can face significant other challenges, such as housing and food instability, low literacy, and limited English proficiency (LEP). HHS projects that 15 million people will lose coverage at the end of the PHE, but that children, young adults, Latino and Black individuals are disproportionately likely to lose coverage. Children under the age of 18 are the group most likely to lose coverage and the only group where the vast majority (roughly 3 out of every 4) are likely to lose coverage solely due to administrative processing errors and not a true change in eligibility status.

2. How DOIs can plan for PHE unwinding and help prevent coverage losses

Many Medicaid enrollees face termination because they do not respond to agency redetermination notices. Some may have moved during the pandemic and do not receive the notices; while others may simply not understand the notices and respond in time. Accordingly, many state Medicaid agencies are initiating consumer outreach and education efforts, encouraging Medicaid/CHIP enrollees to update their mailing

addresses and other important information needed to renew their coverage. Such efforts can also help prepare enrollees who lose coverage at the end of the PHE by identifying resources and/or directing them to subsidized coverage options.

State DOIs should join these efforts, partnering with Medicaid programs, state based marketplaces, and other agencies, as well as navigator programs and other trusted community messengers. Best practices on outreach and education efforts include keeping messages and notices simple and not unduly alarming. Notices should be easy to read, and meet requirements such as taglines for LEP individuals and accessibility for persons with disabilities, such as large print type. The resources developed by State Health and Value Strategies offer specific messaging guidance for communicating with consumers about the PHE unwinding, including templates.

Many DOIs already provide information and direct links to state Medicaid agencies, healthcare.gov or state exchanges, and should ensure that those links are up-to-date and prominently featured on DOI websites. DOIs should specifically refer to the insurance affordability programs (*i.e*. Premium Tax Credits and Cost Sharing Reductions) available with Qualified Health Plans (QHPs), but not through other forms of coverage. DOI websites should also encourage consumers to ensure their contact information is up-to-date with their insurers, urge consumers to respond to eligibility notices, and provide consumers tips to ease their transition to new coverage.

For example, Oklahoma's Insurance Department provides a "Get Ready Before the Storm" checklist for consumers to prepare for severe weather. DOIs could provide a similar checklist for consumers to prepare for PHE unwinding. Even consumers who seamlessly transition from Medicaid to other forms of coverage such as Marketplace plans for Employer Sponsored Insurance (ESI) face disruptions in care. DOIs should encourage consumers to take steps such as documenting their prescriptions, obtaining refills, and updating insurer information with providers.

DOIs can also disseminate this information to community-based organizations, community health centers, and other entities best positioned to reach the communities most likely to experience coverage loss. Partnering with state Medicaid agencies and state-based Marketplaces can both ensure consistency in messaging and improve dissemination efforts. Further, collaboration with other state agencies offers opportunities to elicit consumer feedback on transition plans and messaging to improve the effectiveness of these efforts. For example, Colorado has a stakeholder engagement plan and is incorporating feedback from its Medicaid Member Experience Advisory Councils in messaging toolkits and materials.

NAIC's Health Innovations work group should also partner with the Consumer Information Subgroup to update FAQs on health reform to include information on PHE unwinding.

3. How DOIs can help consumers who lose health coverage

Many consumers will not learn their Medicaid coverage has terminated until they seek services, such as refilling a prescription. Because state Medicaid programs are branded (*e.g.*, Oregon Health Plan, BadgerCare), consumers may not reach out to state Medicaid agencies if their coverage has been terminated. Many of these consumers, particularly those enrolled in Medicaid managed care plans, will likely turn to their state's DOI seeking assistance.

Consumers may also turn to their managed care plan. Some states have a distinct state agency or division regulating managed care plans across public and commercial lines of business. They can work directly with MCOs that also operate QHPs, to inform individuals who may lose their Medicaid coverage on how to obtain QHP coverage with the same issuer *before* a coverage gap occurs. Enrollees with disabilities and pre-existing conditions will especially need to avoid coverage gaps. Any state DOI or health care-specific state agency who proactively works with issuers that offer Medicaid managed care plans, as well as QHPs, will be in a better position to monitor for non-discrimination as well.

Again, consumer information is key. State DOIs should provide information on Special Enrollment Periods (SEPs), links to navigators/assisters, and provide consumer tips for people transitioning coverage. State DOIs should be adequately staffed to handle the influx of consumer calls, and collaborate with Medicaid agencies to increase navigator capacity during the redetermination period. DOIs should also provide links and referrals to other state safety net programs, such as the AIDS Drug Assistance Program (ADAP).

Many states have continuity of care laws (see NAIC Health Benefit Plan Network Access and Adequacy Model Act), for example, for persons undergoing active courses of treatment for acute medical conditions, or for pregnant persons in their third trimester. DOIs should issue bulletins reminding issuers of their obligations under state continuity of care laws. Where applicable, they should consider broadening the kinds of conditions protected, and closely examine which products are covered, to ensure these protections extend to the broadest possible set of plans. DOIs should also issue guidance encouraging plans to honor past prior authorization, and allow consumers to access drugs already approved through an exceptions process, and avoid an unnecessary repetition of step therapy.

State DOIs should also promote consumer resources warning against limited coverage plans, such as short term, limited duration plans, and sharing ministry plans. Tools from the Consumer Information Subgroup, including STOP, CALL, CONFIRM, can help consumers avoid junk plans and steer consumers to trusted sources of information, including navigator programs, licensed brokers, and the federal or state exchanges. DOIs also need to monitor smaller plans that might not have the financial capacity or network capacity (most plans have an internal network capacity number that they estimate when putting together their access plan) to handle an influx from PHE unwinding.

Finally, states may leverage or pursue "easy enrollment" or "autoenrollment" options (e.g. Colorado's easy enrollment) based on tax filings to ease transitions from Medicaid to marketplace coverage, particularly when premiums are eliminated by premium tax credits or state subsidies. While it may be difficult to implement such programs on a short timeline, they can be a long-term solution to administrative barriers to continuous coverage.

Summary of recommendations for DOIs:

1. Partner with state Medicaid/CHIP programs, ADAPs, brokers, navigators, and other trusted messengers on consumer education to update Medicaid information and what to do if terminated. If individuals are terminated for procedural reasons (*e.g.,* didn't return a form), they likely can get reinstated by providing needed information, and not just go uninsured or move to marketplace)
2. Ensure that messaging and consumer information is readable and accessible for persons with disabilities and LEP
3. Collaborate with Medicaid and Marketplace agencies to seek consumer input on messaging and disseminate information
4. Collaborate with community based organizations to disseminate information and engage in targeted outreach (see, for example, California's Coverage Ambassadors)
5. Provide links to Medicaid/CHIP, ACA marketplaces, navigator programs, etc. from DOI website, and inform consumers they may qualify for financial help with purchasing insurance
6. Update FAQs and other consumer facing messaging with information on PHE unwinding, SEPs, appeal rights
7. Issue bulletins reminding issuers of continuity of care obligations (where applicable), and monitor compliance and enforcement

8. Prepare for an increase in consumer calls seeking assistance/information when people lose coverage and train call center/other staff about unwinding issues
9. Educate consumers on steps they can take to avoid disruptions in care (*e.g.*, prescription refills)
10. For issuers in both MCO and QHP markets, DOIs should enforce nondiscrimination rules by monitoring marketing to ensure they are not selectively promoting their QHPs to the younger and healthier MCO enrollees losing eligibility using past claims data
11. DOIs should monitor junk plan marketing (*e.g.*, STLDIs, health care sharing ministries) and 2023 rate filings for any increases based on increased enrollment because of PHE unwinding

Resources

- CHIR - The End of the Public Health Emergency Will Prompt Massive Transitions in Health Insurance Coverage: How State Insurance Regulators Can Prepare
- CMS - Dear State Health Official Letter, RE: Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID-19 Public Health Emergency
- KFF - Medicaid and CHIP Eligibility and Enrollment Policies as of January 2022: Findings from a 50-State Survey Unwinding the COVID-19
- Public Health Emergency: Checklist for Redeterminations - National Health Law Program
- State Health and Value Strategies Resources and Tools Related to PHE Unwinding
- State Health and Value Strategies Templates
- Urban Institute Report funded by RWJ, on State Perspectives on the end of the PHE/ending of continuous Medicaid coverage requirement