COVID-19 Related Business Interruption Claims, Coverage Issues, Disputes and Litigation

Summer National Meeting
Consumer Liaison Committee
August 14th, 2020

Amy Bach, Co-Founder & Exec. Director
NAIC COVID-19 PROPERTY & CASUALTY INSURANCE BUSINESS INTERRUPTION DATA CALL PART 1 | PREMIUMS AND POLICY INFORMATION JUNE 2020:
Business Interruption Coverage Questions

– Do forced closure orders, infiltration of insured premises and/or imminent risk of grave harm meet the common requirement of “direct physical loss of or damage to” insured property?

– Are losses due to mandatory closure covered under “Civil Authority”?

– Direct physical loss “to” vs. “of” (loss of use = loss of, not to)
- Loss projections/Losses in progress = Speculative/Unknown
- Trillion $ loss projections, solvency fears = Speculative/Unknown
- # of actual claims filed = NAIC data calls, Volume of litigation
- Regulators reminded insurers of the duty to investigate
- # of claims accepted/being processed = Unknown
- # of claims denied = “Most”/Unknown
- At least 16 Motions to Dismiss fully briefed
- Litigation outcomes/forums (MDL, State, Federal) = Unknown
- Legislation (Federal/State) = PRIA, etc., HR 7412, Presumptions
Small businesses bearing the brunt

- Many (most?) small businesses, especially restaurants, bars, concert venues that are mandatorily closed by public safety orders, don’t have B.I. coverage or have B.I. coverage w/virus exclusion

- Some Higher Ed Institutions have coverage for losses related to communicable diseases

- Some large businesses have BI coverage w/out virus exclusion
I would like to see the insurance companies pay
Q 1 and 2 results for one insurer:

Legal expenses defending BI claims cost the company about $19 million, it reported.

The company posted a $41 million underwriting loss, compared with a $48 million profit, which Johnston attributed to $231 million of catastrophe- and $65 million of pandemic-related losses and expenses (Best’s News, July 27, 2020)

Second-quarter net income more than doubled to $909 million in the second quarter after the company recognized an $825 million increase in the fair value of equity securities held.

Source: Best's Insurance News & Analysis - July 28, 2020
In 2003...

- Mandarin Oriental hotels in Hong Kong, Malaysia, Singapore and Thailand all lost business due to cancellations and reduced local food and beverage sales stemming from the SARS outbreak.

- Mandarin Oriental International Ltd. Received **$16 million** from its insurers to pay for business interruption losses suffered by the group’s hotels in Asia as a result of the severe acute respiratory syndrome outbreak.\(^1\)

Questions:

- What were regulators told by insurers at the time they added the 2006 ISO virus exclusion?

- If insurers paid out on SARS claims – shouldn’t there have been a rate decrease when the virus exclusion was adopted?

- Claims that pandemic losses were “never covered” are contradicted by the fact that SARS claims were paid
Food for thought:

• What were business policyholders told when their policies renewed with the exclusion added? No rate impact seems to have been associated with the exclusion.

• Most policies don’t mention “pandemic” and closures due to public safety orders are matters of first impression

• Novel Coronavirus = a new coronavirus that has not been previously identified. The virus causing coronavirus disease 2019 (COVID-19), is not the same as the coronaviruses that commonly circulate among humans and cause mild illness, like the common cold. www.cdc.gov Jul 15, 2020
Filed lawsuits, for more info see www.uphelp.org/COVID

- Covid Coverage Litigation Tracker
  
  https://cclt.law.upenn.edu/ (7/31/20)

- Weekly filing peaked on the week of 5/4/20

- Most frequent coverage sought
  1. Business Income
  2. Extra Expense
  3. Civil Authority

- Most Frequent Ins. Co. (Cases)
  1. Hartford Financial Services Group (125)
  2. Cincinnati Financial Corporation (68)
  3. Travelers Companies, Inc. (44)
Parallels w/the Pollution Exclusion
(Regulatory Estoppel Argument)

The New Jersey Supreme Court in *Morton Int’l. Inc. v. General Acc. Ins. Co. of Am.*, 629 A.2d 831, 852-53 *(N.J. 1993)* determined that the insurance industry, through its agents, predecessors to ISO, represented to state insurance regulators in 1970 that the “sudden and accidental” polluters exclusion merely clarified pre-existing insurance coverage.

The Supreme Court found that the insurance industry had failed to disclose its intent to restrict coverage for gradual pollution damage. The court determined that, “[h]aving profited from that nondisclosure by maintaining pre-existing rates for substantially-reduced coverage, the industry justly should be required to bear the burden of its omission by providing coverage at a level consistent with its representations to regulatory authorities.” (emphasis added).
The Morton Court:

• Found the “sudden and accidental” pollution exclusion to be unambiguous, and that it would have applied
• Barred the insurance industry from relying upon the exclusion, because they misrepresented the effect of the exclusion to regulators (to avoid a rate reduction)
• Considered representations by ISO predecessors to any regulator in any state: because ISO binds its members and the language is the same in each state, so a misrepresentation to the New York regulator should bar ISO members seeking to enforce language in Alabama
• ISO language is standard form, sold on a take-it-or-leave it basis, so the only negotiations that are relevant are between ISO and regulators
Questions? Comments?

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DIGITAL ADJUSTING AND CLAIMS HANDLING: PHOTO ESTIMATING HAS SERIOUS SIDE EFFECTS

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS
AUGUST, 2020

Erica. L. Eversman, J.D.
Automotive Education & Policy Institute
PHOTO-ESTIMATING: WHAT IS IT?

i. Consumer takes a picture of damaged vehicle
ii. Consumer submits photo to insurer
iii. Insurer adjusts claim based on photo(s)
iv. Insurer sends a check
Advantages:

- Easy and Fast
  - Puts insurer on immediate notice of claim
  - Allows insurer to provide assistance if requested by consumer
  - Provides fewer personal interactions
    - Safer for current pandemic situation
Disadvantages:

- Substantial under-reserving
  - Photos only show what consumer thinks looks damaged
  - Consumers don’t know what is important to capture
  - Insurer using desk reviewers to evaluate claims
  - Insurer understands vehicle may have substantially more damage; consumer does not
  - Many consumers don’t have vehicle repaired, thus not receiving full benefit owed under claim. Creates windfall profit for insurer.

- Consumers just don’t have the ability to protect themselves. [https://www.bodyshopbusiness.com/photo-based-estimating-joke-consumers-perspective/](https://www.bodyshopbusiness.com/photo-based-estimating-joke-consumers-perspective/)
Confusion Regarding Remedy Elected

- Auto insurers do not inform consumer of remedy being elected under policy
- Photo estimating suggests payment of loss in money remedy
- Once vehicle in repair, insurer now wants involvement in repair
- Insurer confusion over what ”election to repair” truly means
- Nothing in policy allows insurer to blend remedies or change mid-claim
State Laws May Preclude Photo-Estimating

- With pandemic, states have suspended requirements of in-person adjustment
- Consumer’s entitlement to have in-person adjustment necessary – unless insurer agrees it is only paying loss in money and has no need/right to review damage.
Cross-Border Claims Adjusting

- Easy to transfer adjustment activity to adjuster/appraiser not licensed in state
- Out-sourcing adjustment to TPAs not licensed in state
- Lack of accountability
  - Consumers told by TPA only insurer can provide estimate; when insurer contacted, told only TPA can provide estimate
Recommendations

- **Notify:**
  - *Require insurers to notify consumers photo-estimating will likely miss substantial damage that needs to be repaired*

- **Alert:**
  - *Require insurers to alert consumers that if they choose not to repair the vehicle at present, they can have it repaired at later date.*

- **Require:**
  - *Require insurers offering photo-estimating to over-reserve the claim by a specific percentage (e.g. 100 to 1,000%)*
THANK YOU FOR THE OPPORTUNITY TO PRESENT TO THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Erica. L. Eversman, J.D.
A Model Law to Address Systemic Racism in Insurance

Presentation to the NAIC Consumer Liaison Committee

August 14, 2020

Birny Birnbaum
Center for Economic Justice
The Center for Economic Justice

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

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

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

Birny, an economist and former insurance regulator, has worked on racial justice issues for 30 years. He performed the first insurance redlining studies in Texas in 1991 and since then has conducted numerous studies and analyses of racial bias in insurance for consumer and public organizations. He has served for many years as a designated Consumer Representative at the National Association of Insurance Commissioners and is a member of the U.S. Department of Treasury’s Federal Advisory Committee on Insurance, where he co-chairs the subcommittee on insurance availability. Birny is also a member of the U.S. Federal Reserve Board's Insurance Policy Advisory Committee.

Birny served as Associate Commissioner for Policy and Research and the Chief Economist at the Texas Department of Insurance. At the Department, Birny developed and implemented a robust data collection program for market monitoring and surveillance.

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

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

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

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

CEJ works to ensure insurance institutions maximize their role in efforts to reduce loss of life and property from catastrophic events and to *promote resiliency and sustainability* of individuals, businesses and communities.
Race and Diversity in Insurance:

Following the Murder of George Floyd, Insurer CEOs and Insurance Regulators Have Pledged to Fight Systemic Racism and Inherent Bias in Insurance.

Consumer Advocates Have Been Raising the Issue of Systemic Racism in Insurance for Many Years. Why Has the Issue Not Been Addressed, or Addressed With This Level of Commitment, by the NAIC Before Now?

Understanding This History Will Help Identify Actions Needed to Address Systemic Racism in Insurance Now.
Our Perspective on Why Systemic Racism in Insurance Has Not Been Addressed to Date

- Lack of Minority Voices and Experience in Insurer and Regulator Leadership

- Imbalance Between Consumer and Insurer/Producer Access to Critical Regulatory and Legislative Processes

- Trade Associations Fighting to Protect Practices that Reflect and Perpetuate Systemic Racism in Insurance

- Regulatory Authorities and Infrastructure Failing to Keep Up With Seismic Changes in Insurer Practices.
What Should a Model Law Include to Address Systemic Racism and Modernize Insurance Market Regulation?

- Reinforce Risk Pooling and Cost-Based Practices as the Foundation of Insurance;

- Ensure That Consumers, generally, and Minority Consumers, particularly, Have a Strong Voice in Regulatory Processes;

- Define Fair and Unfair Discrimination in Insurance, including Proxy Discrimination Against Protected Classes;

- Require Insurers and Regulators to Pro-Actively Identify and Minimize Proxy Discrimination Against Protected Classes and Provide Safe Harbors for Insurers For Such Actions

- Provide Meaning Oversight by Regulators of Insurers’ Use of Data, Algorithms and Artificial Intelligence, Including Modernizing the Definition and Oversight of Advisory Organizations and Statistical Agents.

- Improve Consumer Control over Their Data, including Fair Credit Reporting Act-type protections for All Personal Consumer Information Used by Insurers

- Improve Competition in Insurance Markets with More Accessible and Actionable Information to Consumers
Systemic Racism in Insurance

1. Intentional Discrimination / Disparate Treatment
2. Proxy Discrimination / Disparate Impact
3. Systemic Injustice

Intentional Discrimination and Proxy Discrimination Can Be Addressed by Regulatory Oversight and Statistical / Technical Treatment within the Cost-Based Framework of Insurance.

Systemic Injustice Means That Systemic Racism and Inherent Bias Have So Pervaded a Particular Community That Insurance Costs are Inseparable from the Class Characteristic. Addressing This Type of Unfair Discrimination is a Legislative Role, such as, Prohibiting Discrimination on the Basis of Race.
Define Fair and Unfair Discrimination

Fair discrimination means adherence to cost-based practices for pricing, claims settlement and other aspects of insurer operations. Fair discrimination means treating similarly-situated consumers in a like manner.

For pricing, including underwriting, rating and payment plan eligibility, means charging the same rates and payment options to consumers posing similar expected costs for the period of coverage.

Rate shall not be excessive, inadequate or unfairly discriminatory

For claim settlement, fair discrimination means similar claims outcomes for similar claims.
Unfair Discrimination

Unfair discrimination means

1. Treating similarly situated consumers differently without a justification based on expected claim costs or expenses associated with the transfer of risk for the period of coverage provided or claim presented to the insurer;

2. For all lines of insurance, discriminating on the basis of a protected class; or

3. For [personal automobile insurance, residential property insurance, life insurance and annuities], discriminating on the basis of [insert]

4. Use of any data or characteristic of the consumer, vehicle, property or natural or built environment unless approved by the Commissioner.
Unfair Discrimination

“Protected Class” means a group of consumers based on one or more of the following characteristics:

- Race
- Religion
- National origin
- [Other]

“Discriminating on the basis of” means disparate treatment or disparate impact.

“Disparate treatment” means outcomes determined by explicit application of a protected class characteristic.

“Disparate impact” or “proxy discrimination” mean outcomes that have a disproportionate impact on a protected class or practices that serve as a proxy for disparate treatment.
Unfair Discrimination

Disparate impact is not unfair discrimination if:

1. The insurer has taken reasonable actions to identify and minimize disparate impact; and

2. There is no alternative to the practice resulting in disparate impact that permits the insurer from achieving substantially similar legitimate business outcomes.

The Commissioner shall promulgate rules to identify a non-exclusive list of reasonable actions an insurer may take to meet the requirements of this section.
Strengthen Consumer Voices in Regulatory Processes

Establish a public agency dedicated to representing insurance consumers before the Department of Insurance and Legislature.

Fund the Bureau of the Insurance Consumer Advocate (BICA) through a $0.10 to $0.25 (depending on size of the state) assessment on every individual policy and certificate under a group or master policy issued in the state.

BICA has standing to intervene on behalf of consumers in any insurance regulatory proceeding, including rulemaking and review of rate and form filings.

BICA has access to non-public information received by the Department of Insurance subject to same confidentiality as the Department of Insurance and related to the purposes of the Bureau.

Director of BICA selected by the Governor from a list of recommended candidates prepared by an advisory committee of individuals engaged in consumer advocacy. Director has a 5 year term.
Oversight of Data, Algorithms and Advisory Organizations

Routine reporting by insurers of sources and uses of data and data vendors and providers of algorithms

Modernize definition of advisory organization to create a level playing field for providers of algorithms used by insurers for marketing, pricing, claims settlement and anti-fraud.

Filing of algorithms by advisory organizations.

Modernize definition of statistical agent and statistical plans.

Commissioner authority to permit use of new data sources / algorithms / AI in controlled environment for purposes of data creation, data collection and evaluation.
Fair Credit Reporting Act-Type Consumer Protections for All Consumer Data Used by Insurers

Disclosure of Data to be Used, Source of Data and Uses of Data
Permission / Consent by Consumer
Adverse Action Notice
Consumer Access to Consumer’s Own Data
Ability to Dispute and Correct Incorrect Data
Ability to Request Reconsideration Based on Corrected Data
Plus
Destruction of Consumer Data by Insurer When No Longer Needed for Business Purpose by the Insurer
Limited Use of Consumer Data to Stated and Disclosed Purposes. Opt-In / Consent for Any Purpose, with Particular Attention to Consumer-Generated Data from Devices Used for Insurance Exposure and Loss Assessment and Loss Prevention.
IMPROVING EQUITY IN HEALTH CARE ACCESS

Presented By: Deborah Darcy, Ashley Blackburn and Wayne Turner
Improving Equity in Health Care Access

• Agenda
  – Data on State of Health Disparities
    • Disproportionate Impact of COVID-19
    • Underlying Illnesses Prior to COVID-19
    • Underlying Illnesses Contributing to COVID-19
  – Access to Coverage & Care
    • Uninsured rates
    • Access to services
    • Case study
Improving Equity in Health Care Access

• Agenda
  – Health Equity: Nondiscrimination in health programs and activities
    • Sec. 1557: Non-discrimination in health care
    • State nondiscrimination guidance
  – Telehealth and health equity
    • State best practices
    • Telehealth challenges
  – Advancing health equity
State of Health Disparities

- COVID-19 has put a spotlight on health disparities.
- Black, LatinX, Native Americans, and Pacific Islanders have higher rates of COVID-19 fatalities.
- Underlying illnesses such as diabetes and hypertension have been associated with higher fatality rates to do COVID-19.
Disproportionate Impact of COVID-19

• Nationally, Black Americans make up 13 percent of the country’s population, but data from the Centers for Disease Control and Prevention (CDC) show that the black population accounts for nearly 22 percent of COVID-19 cases.
• Fewer than 22 percent of U.S. counties are disproportionately Black, but they account for 52 percent of COVID-19 diagnoses and 58 percent of COVID-19 deaths nationally.
• The COVID mortality rate for Black Americans is 2.3 times higher than the rate for White Americans.
Disproportionate Impact of COVID-19

- CDC data shows that among cases with known race and ethnicity:
  - 33% of persons were Hispanic (18% of the population)
  - 22% were Black (13% of the population),
  - 1.3% were Native American or Alaska Native (.7% of the population).
Disproportionate Impact of COVID-19

• Santa Clara County, CA, 24 percent of the county’s population is Latino, but Latinos represent nearly 32 percent of all COVID deaths.

• In Los Angeles County, the death rate for Pacific Islanders is 12 times higher than it is for whites.

• And the infection rate among the Navajo Nation has now surpassed the state of New York, the center of the pandemic in the United States – reaching 2,680 cases per 100,000 people.
Health Disparities and COVID-19

Underlying Illness - Hypertension

• Hypertension prevalence in adults (2015-2016)
  – Black-40.3%
  – White-27.8%
  – Asian-25.0%
  – Hispanic-27.8%

• COVID-19 Fatalities
  – 21% of the individuals had hypertension
  – 67% of the individuals had circulatory diseases
Health Disparities and COVID-19

Diabetes

• Diabetes prevalence in adults (2015-2016)
  – Black-19.6%
  – White-13%
  – Asian-14.5%
  – Hispanic-21.5%

• COVID-19 Fatalities
  – 15% had diabetes
Health Disparities and COVID-19
Other Comorbidities

- Renal Failure – 8%
- Vascular and unspecified dementia/Alzheimer's – 15%
- Cancer – 4%
Access to Coverage & Care

• What is equitable access to coverage and care for people of color, people with disabilities, people who are LGBTQ+ and people for whom English is not the first language?

  – Access to health insurance coverage with affordable premiums and cost sharing

  – Access to providers
    • Within reasonable geographic proximity
    • Without physical or language barriers
    • Able to provide culturally competent care
Access to Coverage

Figure 6

Uninsured Rates Among Nonelderly Individuals by Race/Ethnicity, 2018

Note: * Indicates statistically significant difference from Whites at the p<0.05 level. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic. Includes nonelderly individuals 0–64 years of age. NHPI refers to Native Hawaiians and Other Pacific Islanders. AIAN refers to American Indians and Alaska Natives.

Access to Care

Figure 1: With 19 closures, 2019 was the single worst year of the rural hospital closure crisis.

In today’s multicultural backdrop, the benefits of being bilingual in medicine can help reduce the challenges faced by some patients and their families who don’t speak English.
Inequities in Health Care Access: COVID-19

Texas:
- Highest uninsured rate in the country at 17.7%
- Leads the nation in rural hospital closures with 20 since 2010.

Rio Grande Valley:
- More than 90% LatinX
- 1/3 of families live in poverty
- ½ of the residents are uninsured
- More than 60% are diabetic or prediabetic with high rates of other comorbidities like obesity and heart disease.
- Hospital beds at or near capacity since beginning of July

Source: Texas Department of State, Health Services as of 7/29
Resources


- Addressing Barriers To Care For Patients With Limited English Proficiency During The COVID-19 Pandemic: https://www.healthaffairs.org/do/10.1377/hblog20200724.76821/full/


Health Equity: Nondiscrimination in health programs and activities
Sec. 1557: Non-discrimination in health care

ACA Section 1557

- Civil Rights Act
  - Race, color, national origin

- Rehabilitation Act
  - Disability

- Age Discrimination Act
  - Age

- Title IX
  - Sex

- HIV/AIDS
  - Gender identity and sex stereotyping
ACA Section 1557 – Applicability

• Any health program or activity, any part of which receives federal funding;
• Any health program or activity that is administered by an Executive agency; and
• Any entity created under Title I of the Affordable Care Act (including health insurance marketplaces)

• First time nondiscrimination on the basis of sex in health care
• Broadly applicable to many health insurance plans including Qualified Health Plans, Essential Health Benefits plans, and some large employer plans
HHS Changes to Section 1557 Regulations

- Exempts most health care programs and private plans from compliance;
- Eliminates nondiscrimination protections for LGBTQ+ persons;
- Ends requirements that help ensure that persons with Limited English Proficiency (LEP) can access health care services;
- Deletes protections against discriminatory health plan benefit design;
- Removes notice requirements informing consumers of their rights and how to file complaints;
- Limits enforcement by restricting the ability of plaintiffs to file court actions.
Federal courts uphold Sec. 1557 gender identity protections

- Courts in 4 federal circuits ruled that 1557 gender identity protections are statutory –
  - Prescott v. Rady Children's Hosp. (S.D.C.A. 2016)
  - Flack v. Wisconsin Dept. of Health Srvs. (W.D. Wis. 2018)
  - Boyden v. Conlin (W.D. Wis. 2018)
  - Tovar v. Essentia Health (D. Minn. 2018)
  - Kadel v. Folwell (M.D.N.C. March 2020)

SCOTUS decision in Bostock likely to affect other federal definitions of “sex discrimination”
Ninth Circuit upholds Sec. 1557 protections against discriminatory plan benefit design

“The primary issue before us is whether the ACA’s nondiscrimination mandate imposes any constraints on a health insurer’s selection of plan benefits. We hold that it does.”

Schmitt v. Kaiser Foundation Health Plan of Washington, 9th Cir.(Wash.), July 14, 2020
State nondiscrimination guidance

California
• Insurance Commissioner - Compliance with Health Insurance Antidiscrimination Protections in California Law
• Dept. of Managed Health Care - Compliance with California nondiscrimination requirements

Colorado
• Insurance Commissioner - LGBTQ Health Care Rights and Resources
• Division of Insurance - Ask a Question / Make a Complaint (against issuers)
• Civil Rights Division – Filing a Complaint (against providers)

Illinois
• Dept. of Insurance - Guidance Relating to Nondiscrimination in Healthcare Services in Illinois
• Dept. of Public Health - Non-Discrimination in Medical Treatment Guidance
Telehealth and health equity

• Telehealth can increase access for underserved communities, particularly rural areas, areas with physician shortages, and areas with limited access to primary care or specialty services

• Telehealth can be a convenient form of care, particularly for those with limited transportation access, work obligations, or child care responsibilities

• Telehealth should not replace in-person health care, but instead complement or add to existing services

• States should prohibit plans from meeting network adequacy requirements through significant reliance on services offered via telehealth

• Services should be culturally competent and linguistically appropriate (e.g., language access/interpreter services)
State best practices

- States are reimbursing telehealth service at the same rate as a comparable in-person service (CO)
- No cost-sharing for telehealth services during COVID-19 (CO)
- Some states are requiring health insurers to allow all in-network providers to deliver clinically appropriate, medically necessary covered services via telehealth (NH)
- Many states are allowing the home or any place to be the originating site (where the patient is located) (NC) or the distant site (where provider is located) (CO)
- Many states are now reimbursing for audio-only phone services (AZ, CT, KS, CO)
- Many states are expanding the list of services or providers who can participate in telehealth and be reimbursed (AL, MS, CO)
- Enrolling in Medicaid via telehealth (CA)
Telehealth challenges

- Confidentiality and privacy
- Fraud protections
- States and federal government should make significant investments in the development of telehealth technologies, focusing on organizations and providers that serve low-income and underserved populations
- Barriers including:
  - Limited access to broadband
  - No access to smartphones, computers, tablets
  - Lack of familiarity with devices and software
  - Few interpreters during telehealth interaction
Advancing health equity

- Convene stakeholders including issuers, patient/community advocates, to address disparities and identify and implement solutions;
- Step up outreach and education efforts for consumer complaints/know your rights;
- Improve data collection on access, utilization and complaints to include race, ethnicity, language access, SOGI;
- Continue robust plan review for compliance with EHB coverage standards and nondiscrimination protections including discriminatory benefit design and marketing;
- Issue guidance clarifying insurer obligations for nondiscrimination under state and federal law, and to ensure access for people including LEP, SOGI;
- Implement best practices for telehealth services including reimbursement, standard of care, privacy;
- Support investment in broadband access and technology.
Questions
Addressing the Needs of Patients and Consumers in the COVID-19 Pandemic

NAIC Consumer Liaison Presentation
Amy Killelea, NASTAD
August 2020
Presentation Road Map

- Utilization management overview
- Medication access considerations during a pandemic
- Utilization management that balances access and cost: HIV case study
- Regulator considerations
Utilization Management: Defining the Terms

<table>
<thead>
<tr>
<th>UM Technique</th>
<th>How it Works</th>
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<tbody>
<tr>
<td>Step therapy</td>
<td>Requiring a patient to start with a preferred drug before accessing another, usually more expensive drug</td>
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<tr>
<td>Prior authorization</td>
<td>Requiring a prescriber to certify, or provide medical records certifying, that a patient meets an issuer’s medical criteria before approving access to a drug</td>
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<tr>
<td>Cost-sharing tiers</td>
<td>Placing higher cost medications on specialty or other tiers with higher cost sharing for the consumer</td>
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<tr>
<td>Quantity limits</td>
<td>Limiting quantity of drug that can be dispensed at a time</td>
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<tr>
<td>Pharmacy restrictions</td>
<td>Requiring use of in-network pharmacy, specialty pharmacy, or mail order</td>
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Principles to Govern Utilization Management Regulation

- Ground UM decisions in clinical guidelines/evidence
- Streamline, and make transparent, UM clinical reviews and appeals processes
- Promote market competition through access to cost-effective medications
- Create safeguards for affordable access in the case of market failure (e.g., limited competition)
- Ensure uninterrupted access to treatment
Medication Access During a Pandemic

- Patient protections have been critical to ensure uninterrupted access to medications:
  - Relaxing or waiving PA requirements, particularly PA that requires in-person medical visits
  - Allowing 60 or 90-day fills of medications
  - Waiving early refill limits
  - Relaxing pharmacy network restrictions
  - Encouraging use of mail order or home delivery
  - Waiving cost sharing for COVID-19 treatment
Utilization Management: Arbitrary or Clinically Based?

Figure 2. Percentage of Qualified Health Plans That Required Prior Authorization for HIV Pre-exposure Prophylaxis by Rating Area in 2019

Prior Authorization Light for Pre-Exposure Prophylaxis (PrEP)

- **Truvada (TDF/FTC)**
  - ~$2,000 WAC
  - Safe and effective. May impact markers of kidney and bone health; clinical significance unclear

- **Descovy (TAF/FTC)**
  - ~$2,000 WAC
  - Safe and effective. Appropriate for individuals with bone and kidney markers; weight gain and lipid adverse effects

- **Generic (TDF/FTC)**
  - TBD (10-30% below brand for first competitor and up to 80% for multiple competitors)
  - Same as Truvada
Reasonable Prior Authorization for PrEP

- No prior authorization on Truvada or TDF/FTC
- No prior authorization to identify risk for HIV
- Prior authorization “light” on Descovy to ensure the individual has the clinical markers making TDF/FTC not clinically indicated (e.g., bone and kidney disease)
  - Electronic/simple provider process
  - Review of claims history to allow for automatic PA approval process
Regulator Considerations

1) Engage a range of stakeholders on solutions to cost and access; patient groups have solutions to pricing/access problems

2) Collect data from issuers on PA, including frequency and timing of approvals and denials

3) Require regular review of prior authorization criteria and issue guidance for issuers, particularly for conditions that are vulnerable to discriminatory plan design (e.g., PrEP USPSTF Bulletins)

4) Ensure continued access to medications during public health emergencies (e.g., waive certain issuer restrictions for duration of emergency)
Protecting Consumers During COVID-19: Recommendations for Regulators and Lawmakers

- Access to coverage
  - Ensure uninterrupted access to affordable insurance coverage through insurance churn

- Access to care
  - Ensure access to affordable COVID-19 and non-COVID-19 services

- Health equity
  - Forward policies that mitigate health disparities and that recognize disproportionate impact of COVID-19 on communities of color

- Long-term care
  - Ensure affordable access to long-term care and supports

- Consumer education
  - Develop comprehensive consumer education materials about COVID-19 and consumer protections to ensure uninterrupted access to care
Resources

- Amy Killelea, NASTAD (akillelea@nastad.org)
- AMA UM Principles
COORDINATION OF BENEFITS
THE NAIC MODEL’S
PHANTOM BENEFITS

Presented By: Bonnie Burns, California Health Advocates
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http://www.cahealthadvocates.org
Continuing Request

• California Health Advocates continues to request changes to the NAIC COB Model Act

  – The Act discriminates against Medicare eligible individuals

    • And only Medicare eligible individuals for honest enrollment mistakes

    • Allows consideration of Medicare availability, regardless of enrollment for benefits

    • Creates a phantom benefit for Medicare eligible individuals

  – The Model Act prohibits consideration of any other available health care benefits……..except Medicare
Medicare Eligibility

• Widespread ignorance leading to failure to enroll
  – 764,000 beneficiaries currently paying late enrollment fees

• Disconnect between Social Security & Medicare
  – Medicare eligibility: Automatic at age 65
    • No federal notice
    • No auto enrollment at age 65
    • Disabled: Auto enrolled after 24 months of SSDI
    • ESRD: Enroll at will
  – SSA full retirement: age 66+/- (depends on date of birth)
Ignoring Medicare While Working

• Largest number of employed seniors in 55 years
  – Don’t know eligibility has begun at age 65
  – Waiting for Social Security retirement benefits

• Medicare eligibility and employer health benefits
  1. Waiting till employment ends
  2. Duplicates employer costs and/or benefits
  3. Requires additional premium payment
  4. Completely unaware of Medicare eligibility rules
Effect of CHA’s Suggested Changes

• Amendments to NAIC Coordination of Benefits Model Act
  – Stops discrimination against Medicare eligible individuals not enrolled for benefits
  – Allows secondary payment once enrolled for Medicare benefits
NAIC Coordination of Benefits Model Act

• California Health Advocates suggested amendments

• Section 5 D. A COB provision may not be used that permits a plan to reduce its benefits on the basis that:

  (1) Another plan exists and the covered person did not enroll in that plan;

  (2) A person is or could have been covered under another plan, except with respect to Part B of Medicare; or (delete as suggested language)

  (3) A person has elected an option under another plan providing a lower level of benefits than another option that could have been elected; or

  (4) A person is eligible but not enrolled for benefits in Part A or B of Medicare. (add as suggested language)
Questions