

## **NAIC/CONSUMER LIAISON COMMITTEE**

NAIC/Consumer Liaison Committee Nov. 30, 2023, Minutes

NAIC/American Indian and Alaska Native Liaison Committee Dec. 1, 2023, Minutes

## Draft Pending Adoption

Draft: 12/15/23 rev

NAIC/Consumer Liaison Committee  
Orlando, Florida  
November 30, 2023

The NAIC/Consumer Liaison Committee met in Orlando, FL, Nov. 30, 2023. The following Liaison Committee members participated: Andrew R. Stolfi, Chair (OR); Grace Arnold, Vice Chair (MN); Mark Fowler (AL); Ricardo Lara represented by Lucy Jabourian (CA); Michael Conway (CO); Andrew N. Mais represented by Kurt Swan (CT); Karima M. Woods represented by Howard Liebers and Sharon Shipp (DC); Doug Ommen represented by Mathew Cunningham (IA); Dean L. Cameron represented by Shannon Hohl (ID); Dana Popish Severinghaus (IL); Vicki Schmidt (KS); James J. Donelon represented by Ron Henderson (LA); Kathleen A. Birrane represented by Nour Benchaaboun and Jamie Sexton (MD); Anita G. Fox represented by Renee Campbell (MI); Chlora Lindley-Myers represented by Carrie Couch (MO); Mike Chaney (MS); Mike Causey represented by Angela Hatchell (NC); Jon Godfread represented by Jacob Just (ND); Eric Dunning represented by Martin Swanson (NE); D.J. Bettencourt (NH); Michael Humphreys (PA); Judith L. French represented by Jana Jarrett (OH); Cassie Brown (TX); Jon Pike represented by Tanji Northrup (UT); Scott A. White (VA); Mike Kreidler (WA); Nathan Houdek represented by Sarah Smith (WI); Allan L. McVey represented by Erin K. Hunter (WV). Also participating were Larry Chapman (AL); Sonya Sellmeyer (IA); KC Stralka and Joanna Coll (IL); LeAnn Crow and Barb Rankin (KS); Ron Kreiter (KY); Adam Patrick (LA); Gary D. Anderson (MA); Paige Duhamel (NM); T.J. Patton (MN); Ryan Blakeney (MS); Carter Lawrence (TN); Richard Tozer, Julie Fairbanks, Julie Blauvelt, and Rebecca Nichols (VA).

### 1. Observed the Presentation of Bonnie Burns Excellence in Consumer Advocacy Award

Wayne Turner (National Health Law Program—NHeLP) and Bonnie Burns (Consultant to Consumer Groups) presented Commissioner Stolfi with the Bonnie Burns Excellence in Consumer Advocacy Award. The NAIC Consumer Representatives present this award to a state insurance regulator who they believe has best represented and advanced the interests of consumers at the NAIC.

### 2. Adopted its Summer National Meeting Minutes

Commissioner Conway made a motion, seconded by Director Fox, to adopt the Committee's Aug. 12 (*see NAIC Proceedings – Summer 2023, NAIC/Consumer Liaison Committee*) minutes with one sentence revised as noted by Commissioner Lara (Attachment One). The motion passed unanimously.

### 3. Received a Summary of the Consumer Board of Trustees Meeting

Commissioner Stolfi said the Consumer Board of Trustees met Nov. 30 to appoint the 2024 consumer representatives and the consumer representatives who will serve on the Consumer Board of Trustees in 2024. Commissioner Stolfi recognized the following nine NAIC consumer representatives for having served in this capacity for more than 10 years: Amy Bach (United Policyholders), Birny Birnbaum (Center for Economic Justice—CEJ), Brendan Bridgeland (Center for Insurance Research—CIR), Burns, Brenda J. Cude (University of Georgia), Marguerite Herman (Healthy Wyoming), Karrol Kitt (University of Texas at Austin), Peter Kochenburger (Southern University Law School), and Jackson Williams (Dialysis Patient Citizens—DPC).

Commissioner Stolfi recognized the following consumer representatives who are attending their last NAIC national meeting as an NAIC consumer representative: David Arkush (Public Citizen's Climate Program), Birnbaum, Tasha Carter (Florida Office of the Insurance Consumer Advocate), Yosha Dotson (Georgians for a Healthy Future—GHF), Kelly Headrick (Autism Speaks), Rachel Klein (The AIDS Institute), Colin Reusch (Community Catalyst), and Matthew Smith (Coalition Against Insurance Fraud—CAIF).

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### 4. Received the E-Vote Results for the Reaffirmation of its 2023 Mission Statement

Commissioner Stolfi said the NAIC members of the Consumer Liaison Committee reaffirmed the Committee's mission statement through an e-vote on Oct. 13 (Attachment Two).

### 5. Heard a Presentation from the LLS, NHeLP, and HIV+Hepatitis Policy Institute on How Recent and Upcoming Federal Actions Affect the State Regulation of the Health Insurance Market

Lucy Culp (The Leukemia & Lymphoma Society—LLS) said states have the authority to regulate association health plans (AHPs), which has allowed states to use cease-and-desist orders against unauthorized entities. Culp said problems have persisted, and in 2011, the federal Centers for Medicare & Medicaid Services (CMS) established a "look through doctrine" to allow state insurance regulators to look through the association to the size of each employer to determine whether that employer's coverage was subject to the small group market or large group market rules. Culp said that in rare circumstances, there would be "bona fide associations" that have shared purposes and common interests where all employees are combined to obtain large group status. In 2018, Culp said the U.S. Department of Labor (DOL) issued an executive order that modified the definition of employer to allow more employer groups and associations to form AHPs. This led to an easier pathway to "bona fide association" status to be regulated as large group coverage. In March 2019, there was a court ruling in New York that found the DOL exceeded its rulemaking authority under the federal Employee Retirement Income Security Act of 1974 (ERISA). In 2021, the DOL indicated they would engage in additional rulemaking, and a new rule is to be issued soon.

Culp said there is a Notice of Benefit and Payment Parameters (NBPP) proposed rule that would create minimum standards for state-based marketplaces (SBMs). Culp said the proposed rule creates new steps in the process of moving from a federal platform to an SBM, requires the operation of a centralized eligibility and enrollment platform, applies national standards for web brokers and direct enrollment to SBMs, creates standard open enrollment periods for SBMs, and creates network adequacy minimum standards for SBMs.

Turner said there is an NBPP proposed rule on essential health benefits (EHBs), which would allow states to add adult dental to EHBs and could also remove the prohibition on adult vision, home health, and orthodontia. Turner said the proposed rule consolidates options for state benchmarks and removes the generosity standard and typicality standard. Turner said other issues to watch include the No Surprises Act implementation; Interoperability Rule; 1557 Nondiscrimination Rule; Section 504 Disability Protections Rule; and over the counter (OTC) coverage on preventive services.

Carl Schmid (HIV+Hepatitis Policy Institute) said there is an NBPP proposed rule on standard plans that would allow each issuer to have two non-standardized plans for each standard plan rather than four non-standardized plans for each standard plan. All covered drugs in excess of state benchmarks are to be considered EHBs. Schmid said there is a warning to issuers against discriminatory plan design and new transparency requirements in coverage, which include cost-sharing services being available online and network provider rates and out-of-network amounts being available on websites. Schmid said the U.S. House and Senate are both considering bills on pharmacy benefit managers (PBMs).

### 6. Heard a Presentation from the NWLC on Expanding Access to Maternal Health Care Through Health Plan Networks and EHBs

Dorianne Mason (National Women's Law Center—NWLC) said there is a U.S. maternal mortality crisis. Mason said 1,205 women died from pregnancy-related complications in 2021, 861 women died in 2020, and 754 women died in 2019. Mason said there is a disparity in maternal and infant health care, with Black women dying at three times

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the rate of white women, and Indigenous women dying at two times the rate of white women. Mason said “weathering” is the cumulative effect of chronic stress, including chronic stress of racism. Mason said state insurance regulators can work to improve access to mental health, which will lessen the impact of “weathering” and, in turn, impact maternal mortality.

Mason said low-income people and women of color are at a greater risk of being uninsured. Mason said continuity of coverage is important and encouraged state insurance regulators to eliminate barriers to enrollment in health coverage. Mason said women are coming into pregnancy with preexisting conditions, such as hypertension, and this can then lead to a pregnancy worsening a preexisting condition. Mason said high-quality care is predicated on communication and trust. Mason said Black women report higher adverse interactions with medical professionals, including medical professionals ignoring reports of pain and providing a misdiagnosis or a delayed diagnosis. Mason said research has shown this implicit bias is correlated with lower-quality care.

Mason reviewed recent federal administrative actions, which include the Build Back Better Act and the American Rescue Plan Act. Mason said it is important to collect and analyze data to track the utilization of health care. Mason also said network adequacy standards help ensure access to quality providers. Mason said standards should include the need to have culturally competent care and coverage for midwives and doulas. Mason said there continues to be a wide variation of EHB benchmarks across states. Mason said plans should provide robust prenatal and postnatal services, provide coverage for birth centers and home births, and ensure state benchmarks meet federal Affordable Care Act (ACA) requirements regarding maternity coverage, no cost sharing for women’s preventive services, and coverage for breastfeeding education and breast pumps.

Mason recommended state insurance regulators ensure access to mental health services, monitor disenrollment of consumers in health plans, support network adequacy standards, support the availability of culturally competent care, and monitor pregnancy-related health care utilization and spending. In response to a question from Commissioner Arnold, Mason said there is an effort to increase birthing centers in rural areas but agreed the use of midwives and doulas can also be used to increase the types of providers individuals choose in response to the reduction of maternity care facilities in rural areas.

### 7. Heard a Presentation from United Policyholders and the CEJ on Addressing Property Insurance Market Failures with a Federal Catastrophe Reinsurance Program

Amy Bach (United Policyholders) said there needs to be continued support for risk mitigation though the use insurance rewards in the form of premium discounts and renewal assurances. Bach said the property markets are failing across the country, and these problems are not limited to one jurisdiction. Bach said innovation is imperative as private reinsurers have an unsustainable degree of control over the property/casualty (P/C) market, and reinsurance pricing and treaty conditions are reducing the affordability and availability of essential property insurance. Bach said government-sponsored insurers of last resort are in higher demand and are experiencing reinsurance challenges.

Bach provided an example of risk pooling and innovation. Bach said the following concepts should be considered: 1) a national all-risks disaster insurance program offering limited essential benefits that would pair with existing small business; 2) administration low-interest loans and parametric products; 3) community risk pools; 4) enhanced resources for state insurance regulators to evaluate catastrophe (CAT) models; and 5) the creation of independent, public CAT models as a yardstick for commercially derived CAT models.

Bach reviewed the fundamentals of a catastrophic property lost reinsurance program. Bach said this type of program would provide reinsurance for primary insurance companies offering residential and commercial property insurance that includes coverage for the perils of flood, wind, hurricane, severe convective storms,

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wildfire, and earthquake. To be eligible to obtain reinsurance through the fund, insurers would need to offer an all-perils product and actively facilitate and reward loss mitigation activities.

Birnbaum said markets that provide private property insurance are failing. Birnbaum said this is a significant problem because private property insurance is a product required by lenders and/or government agencies and essential for individual, business, community, and national resilience. Birnbaum said residual markets have grown, and consumers for whom the private market has failed are obtaining inadequate coverage and artificially inflated rates. Birnbaum said insurers have not accurately assessed risks, and this has resulted in hollowed-out policies that fail to meet consumer expectations. Birnbaum said the causes of the property market failures include failure to invest in loss prevention partnerships and loss mitigation, lack of preparedness regarding the impact of climate change, unstable global reinsurance markets, unaccountable CAT models, and state insurance regulators failing to monitor markets through data collection and analysis.

Birnbaum said the solution to the property market failure is to promote investment in loss mitigation and resilience needs to address climate change and catastrophic risks. Birnbaum said there needs to be a public-private partnership and stable reinsurance. Birnbaum set forth the following strategy: 1) create a federal public catastrophe reinsurance program modeled after the federal Terrorism Risk Insurance Act (TRIA); 2) have the federal government provide stable and low-cost catastrophic reinsurance for the extreme portion of catastrophic risks; 3) have states encourage all perils policy coverage and loss prevention investment with matching federal funds; 4) improve data collection on property insurance exposures and claims to assist the federal national catastrophe reinsurance fund; 5) establish thresholds for national catastrophe fund payments based on a percentage of a state's exposure with thresholds low enough to provide meaningful benefit to insurers, but high enough to encourage a competitive private reinsurance market; and 6) implement means-tested financial assistance for low-income consumers.

In response to a question from Commissioner Chaney, Birnbaum said the increased use of reinsurance by a company increases the reinsurance cost for the company. Birnbaum said this leads to higher insurance prices and financial instability. Birnbaum said a private/public partnership with federal government involvement will help address this problem.

### 8. Heard a Presentation from the CIR on the Rapid Growth of Pet Insurance, Consumer Issues, and Concerns

Bridgeland said premiums for pet insurance in the U.S. totaled \$3.2 billion in 2022, and the total number of pets insured in the U.S. was 5.36 million—a 22% increase in 2021. Bridgeland said pet insurance is increasingly sold through employee benefit plans, as employers use pet insurance to attract and retain employees. The average premium for dogs was \$640 per year and \$387 per year for cats. Bridgeland said dogs make up 80% of insured pets, and cats make up 20% of insured pets. Bridgeland reviewed the most common pet insurance claims for dogs (urinary tract infections, ear infections, gastroenteritis, diarrhea, and skin conditions) and for cats (urinary tract infections, diabetes, vomiting, kidney disease, and hyperthyroidism).

Bridgeland said the pet insurance market continues to grow, and the total market premium has increased an average of 25% per year since 2018. Premiums are typically based on the animal's age, health profile, and the level of coverage. Bridgeland said pet insurance policies may include exclusions, varying coverage options, deductibles, and payment limits. Providers have three main categories of products: 1) accident-only (less than 1% of plans); 2) accident and illness; and 3) wellness coverages (which are not insurance products). Bridgeland said common consumer issues in pet insurance include preexisting conditions, broadly worded cancellation clauses, and lengthy waiting periods for certain conditions.

Bridgeland said the NAIC adopted the *Pet Insurance Model Act* (#663) in 2022. The model establishes consumer protections related to policy renewals, waiting period disclosures, policy limits, and benefit schedules. The model

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law also limits preexisting condition denials, provides a 15-day free look period, and prohibits waiting periods for accident coverage. The model requires insurers to differentiate pet wellness programs from insurance policies and sets training standards for insurance producers.

Bridgeland provided the following recommendations for state insurance regulators: 1) adopt Model #663; 2) prepare consumer assistance staff to deal with an increase in pet insurance related complaints; 3) begin analyzing new, state-specific pet insurance data that will be reported for the first time in the 2024 financial annual statement blanks and in the Market Conduct Annual Statement (MCAS); and 4) develop a classification system for pet insurance complaints.

### 9. Heard a Presentation on How Much Life Insurance Purchased in the U.S. Becomes a Death Claim

Richard Weber (Consumer Representative) provided a presentation based on the paper *Lapse-Based Insurance*, published in 2016 and updated in 2021. The paper was written by David Gottlieb (London School of Economics and Wharton School, University of Pennsylvania) and Kent Smetters (Wharton School, University of Pennsylvania).

Weber said most individual life insurance policies lapse before expiration. Weber said over 70% of U.S. families own life insurance, and annual premiums exceed \$110 billion. Weber said between 1990 and 2010, there were \$30.8 trillion in life insurance issued and \$24 trillion in life insurance lapses. Weber said 25% of permanent insurance policyholders lapse within just three years of first purchasing their policies, and 40% lapse within 10 years. Weber said nearly 88% of universal life policies ultimately do not terminate with a death-benefit claim, and almost 85% of term policies fail to pay a death claim.

Weber said lapses are more prevalent for smaller policies and are more exposed to background shocks, including unemployment, medical expenses, and new consumption opportunities. Weber said insurance agents receive most of the sales commission in the first or second year and, anecdotally, consumers are more likely to lapse their policies when they are not in contact with their sales agent. When policies are sold primarily based on the illustration, Weber said customer dissatisfaction may result when they see lower results than initially illustrated.

Weber said commissions continue to be the driver of sales behavior in a number of cases and lapses often follow a failure to consider the client's best interests and the suitability of the recommendation.

Weber requested state insurance regulators to review how policy illustrations should be prepared under current state regulation and evaluate the experience of the New York Department's Insurance Regulation 187. Weber said state insurance regulators should move toward requiring insurance carriers and insurance producers to only make policy recommendations that are suitable to the consumer's circumstances and place the client's interest above the interest of the producer.

### 10. Heard a Presentation from the AHA and HCFA on the Drivers of Medical Debt, Current State Protections, and Recent Federal Actions

Janay Johnson (American Heart Association—AHA) said uninsurance, rising out-of-pocket costs for the insured, the proliferation of substandard insurance products, and complex billing processes all contribute to the prevalence of medical debt. Johnson said the consequences of medical debt include bankruptcy, stress, foreclosure, poor health, and poor financial credit. Johnson said there are disparities in medical debt and provided the following statistics on medical debt. A larger share of Black adults (16%) report having medical debt compared to white (9%), Hispanic (9%), and Asian American (4%) adults. Nearly half of women (48%) report having medical debt, compared to more than a third of men (34%). People ages 30–64 are more likely than younger adults and adults over 65 to report medical debt. Adults who were uninsured for more than half of the year are more likely to report medical debt (13%) than those who were insured for all or most of the year (9%).

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Ashley Blackburn (Health Care for All—HCFA) reviewed recent federal actions to reduce the burden of medical debt, which include the following: 1) the federal No Surprises Act; 2) an executive order directing federal agencies to examine pathways to reduce burden of medical debt; 3) voluntary reform by three nationwide credit bureaus; and 4) the Consumer Financial Protection Bureau’s (CFPB’s) rulemaking to remove medical debt from credit reports. Blackburn said states are also taking action to eliminate medical debt from appearing on credit reports.

Blackburn provided the following recommendations for states insurance regulators: 1) study the impact of high deductibles and cost sharing on patients; 2) require insurers to track and report on how many of their enrollees are experiencing medical debt, and what the causes are; 3) educate enrollees about their rights under state law; 4) require insurers to make information available to enrollees about their rights under state law; and 5) leverage the role of banking regulators where applicable.

### 11. Discussed Other Matters

Michael DeLong (Consumer Federation of America—CFA) questioned the transparency and openness of the Special (EX) Committee on Race and Insurance and encouraged the Committee to maintain open meetings and engage with consumer representatives.

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

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Draft: 8/28/23 (Rev. 12/14/23)

NAIC/Consumer Liaison Committee  
Seattle, Washington  
August 12, 2023

The NAIC/Consumer Liaison Committee met in Seattle, WA, Aug. 12, 2023. The following Liaison Committee members participated: Andrew R. Stolfi, Chair (OR); Grace Arnold, Vice Chair (MN); Lori K. Wing-Heier represented by Heather Carpenter (AK); Mark Fowler (AL); Ricardo Lara (CA); Michael Conway (CO); Andrew N. Mais represented by Kurt Swan (CT); Michael Yaworsky (FL); Dean L. Cameron represented by Randy Pipal (ID); Dana Popish-Severinghaus represented by KC Stralka (IL); Vicki Schmidt represented by LeAnn Crow (KS); James J. Donelon represented by Ron Henderson (LA); Kathleen A. Birrane represented by Jamie Sexton (MD); Anita G. Fox represented by Renee Campbell (MI); Chlora Lindley-Myers represented by Carrie Couch (MO); Mike Causey represented by Angela Hatchell (NC); Jon Godfread represented by Jacob Just (ND); Eric Dunning represented by Martin Swanson (NE); Scott Kipper represented by David Cassetty (NV); Judith L. French represented by Jana Jarrett (OH); Michael Humphreys represented by Jodi Frantz (PA); Cassie Brown represented by Randall Evans (TX); Jon Pike represented by Tanji Northup (UT); Scott A. White represented by Don Beatty (VA); Mike Kreidler (WA); Nathan Houdek represented by Sarah Smith (WI); and Allan L. McVey represented by Erin K. Hunter (WV). Also participating was Paige Duhamel (NM).

### 1. Adopted its Spring National Meeting Minutes

Commissioner Lara made a motion, seconded by Ron Henderson, to adopt the Committee's March 21 minutes (see *NAIC Proceedings – Spring 2023, NAIC/Consumer Liaison Committee*). The motion passed unanimously.

### 2. Heard a Report on the Consumer Board of Trustees Meeting

Commissioner Stolfi said the Consumer Board of Trustees is combining the different applications for the NAIC Consumer Participation Program into one application. He said there have been different applications, depending on whether a person is applying as a funded or unfunded consumer representative and whether a person is in the first or second year as a consumer representative. He said the combined application will be used for individuals applying to participate in the NAIC Consumer Participation Program in 2024. He said the Board discussed a request for action submitted by Erica Eversman (Automotive Education & Policy Institute—AEPI) for the NAIC to amend the NAIC *After Market Parts Model Regulation* (#891) to redefine “aftermarket” parts and establish criteria for insurers to inform consumers about the use of aftermarket parts. He said the Board discussed a potential conflict of interest submitted by a consumer representative.

### 3. Heard a Presentation from the CEJ on “A Meaningful Framework for Supervision of Insurer’s Use of Big Data and Artificial Intelligence”

Birny Birnbaum (Center for Economic Justice—CEJ) said the purpose of market conduct regulation is to ensure the fair treatment of consumers. He said unfair discrimination, from an actuarial perspective, is treating similarly situated consumers differently in rating or claims. He said this is defined as an unfair trade practice. He said unfair discrimination is also defined as discriminating against a person because of their race, religion, or national origin. He said discriminating against an individual is unfair and prohibited even if the treatment is actuarially fair. He said insurers may use data that is racially biased, which indirectly causes unfair discrimination based on race. He said industry claims a risk classification and scoring algorithm that is predictive is fair and that protected class discrimination can only mean explicit and intentional discrimination against a protected class.



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Birnbaum said state insurance regulators in 2020 acknowledged the increased potential for the use of racially biased data and algorithms to result in the unfair discrimination of protected classes when the NAIC adopted the Principles on Artificial Intelligence (AI). He said following the adoption of the principles, George Floyd was murdered by police in Minneapolis, and the U.S. was confronted with the fact that structural racism persists throughout the country. State insurance regulators recognized this watershed moment to declare action against racism in insurance, which led to the appointment of the Special (EX) Committee on Race and Insurance. Since that time, Birnbaum said the NAIC has made great strides in diversity, equity, and inclusion (DE&I) education and initiatives, but he questioned the progress the NAIC has made in addressing structural racism in insurance..

Birnbaum said the Innovation, Cybersecurity, and Technology (H) Committee's draft AI Model Bulletin fails to respond to the challenges and promises made by the NAIC in 2020. He said the bulletin does not expand on the AI Principles or offer guidance on how state insurance regulators should implement the principles. He said the bulletin tells insurers what they already know, which is that the use of AI must comply with the law and insurers should have oversight of their AI. He said the bulletin fails to provide essential definitions and does not define proxy discrimination.

Birnbaum said state insurance regulators should focus on consumer outcomes and not the process. He said AI governance and risk management procedures are necessary and important but not sufficient. He said insurers should be testing to ensure their data, algorithms, and applications do not result in unfair discrimination on both an actuarial basis and a protected class basis in all phases of the insurance life cycle. He said regulatory guidance is needed to define proxy discrimination and disparate impact to help establish at least one uniform testing methodology. He said this should include the reporting of test results by insurers.

Birnbaum said a governance requirement should include a requirement that insurers' AI outcomes are disputable, which is a broader requirement than transparency. He said the governance- only approach, which is called principles-based, does not make sense for addressing the regulatory oversight of AI. He said state insurance regulators can obtain the data and ability to ensure good consumer outcomes and compliance with state laws through testing for unfair discrimination, and that testing should be a central feature of state insurance regulatory oversight of AI.

Birnbaum said state insurance regulators need to define proxy discrimination and establish thresholds for testing results that would be considered proxy discrimination. He said the CEJ has proposed guidance for these. He said insurers should be able to identify and explain why a consumer outcome occurred and trace the outcome to a particular characteristic of the consumer. This would provide consumers with the ability to dispute the outcome, which is a broader requirement that an insurer explain how a model or algorithm works.

In response to a question from Commissioner Stolfi about the difference between governance and testing, Birnbaum said financial regulators use risk-based capital (RBC) with specific guidance on how insurers should measure their capital to produce an RBC ratio. Without this type of testing and guidance, insurers would have only a governance approach, and each insurer could define risk in any way they want. Birnbaum said the framework for RBC is the framework needed for the oversight of AI. This framework sets common metrics for testing and goes beyond pure governance.

Commissioner Lara asked Birnbaum to share his perspective on insurers' responsibility to test for unfair discrimination against other protected classes, such as sexual orientation.. Birnbaum suggested a phase-in approach and starting testing for unfair racial discrimination since data on race is available. Insurers, at some point, should be willing to ask policyholders for protective class characteristics on a voluntary basis.

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### 4. Heard a Presentation from the UP and the AEPI on the Appraisal Process for Automotive and Property Damage Claims

Amy Bach (United Policyholders—UP) said the UP has a Roadmap to Recovery Program to help consumers after a catastrophe and a Roadmap to Preparedness Program to help eliminate protection gaps and engage in consumer advocacy and action. She said the UP is working to restore confidence and fairness to the property claims appraisal process. She said disputes between insurers and insureds over the extent of damage and repair costs are extremely common. This leads to wasted time and judicial resources since appraisals can be completed without attorneys and litigation.

Bach provided an overview of how the insurance appraisal process is supposed to work, which is intended to be a faster and cheaper process than litigation in resolving a valuation dispute between an insurance company and a policyholder. She said each side picks their appraiser, and then the two appraisers are supposed to agree on an umpire to resolve any discrepancies in the valuation. For example, she said the appraisal process should resolve issues, such as how many square feet of lumber are needed or the grade of lumber needed, by engaging with experts in construction and labor costs rather than taking these types of disputes to court.

Bach said some insurers have removed appraisal clauses from their policies in states that do not require an appraisal clause. This means disputes have a higher likelihood of ending up in litigation. Bach said there are some variations in appraisal clauses. She provided an example of an appraisal clause that specifies that each party must select their appraiser within 20 days after the demand is received, and then an umpire is to be selected. She said not every company or state needs to have the exact same rules.

Bach said there are a lot of points of contention around initiating appraisals. For example, she said parties may be working to resolve a dispute, and then either the insurer or insurance company may demand to initiate an appraisal process. The parties can then face disputes about what umpire to select, which is when courts often need to get involved. Bach said there may also be questions about whether an appeal is binding, the effect of the appraisal process in a lawsuit, and whether the use of the appraisal process precludes a bad faith case. She encouraged the Property and Casualty Insurance (C) Committee to review this issue and work to reform the appraisal process.

Eversman said the appraisal clause is intended to be an alternative dispute resolution mechanism used to determine property loss claim value. She said it is not intended to determine liability. She said some appraisal clauses are more definitive, but they are usually not very detailed in private passenger automobile (PPA) policies. She said typical auto appraisal disputes arise with partial losses and focus on the types of parts to be used, the cost of parts, and whether a part should be repaired or replaced. She said there are new parts, aftermarket parts, and salvage parts. She said total loss values can also be contentious. She said insurers use appraisals as a shield by which an insurer will not use an appraisal until an insured sues in court to demand an appraisal. Insurers will also use appraisals as a sword to try to resolve non-monetary issues.

Eversman recommended that state insurance regulators mandate appraisal clauses in automobile policies for both full and partial property losses; require insurers to notify consumers that the right to an appraisal exists if they disagree with an offer; require insurers to use independent umpires; and establish a time frame for the right to an appraisal, along with a maximum consumer expense permitted. She said appraisal requirements must also have details, such as who may serve an appraiser and penalties for failure to comply with the appraisal requirements.

Eversman requested that the Property and Casualty Insurance (C) Committee establish a workstream to address the appraisal process for auto losses. Crow asked what the recommended maximum a consumer should pay for an appraisal is. Bach said the cost is a deterrent for consumers, and she suggested that insurers should advance

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the cost of the appraisal and then deduct half the cost of the appraisal from the final settlement. Eversman suggested a maximum cost of between \$500 to \$800 for auto claim appraisals. She said states should mandate appraisal clauses in policies, and either the insurer or insured should have the right to request an appraisal.

### 5. Heard a Presentation from the DREDF, the Whitman-Walker Institute, and the LLS on Federal Health Updates

Kellan Baker (Whitman-Walker Institute) said the Consolidated Appropriations Act of 2023 delinked continuous enrollment in Medicaid and the public health emergency (PHE), which ended continuous Medicaid enrollment on March 31. He said Medicaid enrollment grew by an estimated 23 million (32%) to 95 million individuals between 2020 and 2023. He said this stopped the churn between Medicaid coverage and private marketplace coverage. He said 7.8 to 24.4 million individuals will lose Medicaid coverage during the PHE unwinding, and states are moving at different speeds to complete PHE unwinding and Medicaid eligibility redeterminations. He said 74% of people who dropped from Medicaid coverage were disenrolled for procedural reasons during the unwinding, and many disenrolled beneficiaries are likely still eligible for Medicaid coverage.

Baker said state insurance regulators can help mitigate the impact of disenrollment from Medicaid by enhancing in-person assistance; working with insurers and state Medicaid agencies to develop outreach toolkits; ensuring that accurate information is available to consumers about inexpensive but potentially insufficient coverage alternatives; and monitoring qualified health plans (QHPs) for marketing, enrollment, and network adequacy. He said states should also consider an “unwinding” open enrollment period, expand continuity of care protections, and require pro-rating of out-of-pocket costs for mid-year transitions.

Silvia Yee (Disability Rights Education and Defense Fund—DREDF) said the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) applies to fully insured and self-insured health plans, as well as non-federal governmental group plans. She said enforcement authority is held by the U.S. Department of Labor (DOL), the federal Centers for Medicare & Medicaid Services (CMS), and state insurance regulators. She said racial and ethnic minorities often have worse mental health outcomes due to inaccessibility to quality mental health care services. There is also discrimination and a lack of awareness about mental health. Yee said there was a proposed rule issued on July 25 addressing non-quantitative treatment limitations (NQTLs) under the MHPAEA. This guidance provides 13 factual examples for review. One key change is that the proposed rule would classify certain benefits, conditions, and disorders based on “generally recognized independent standards of current medical practice.” Yee encouraged state insurance regulators to comment on the proposed rule to provide insights on how state and federal cooperation can best be operationalized to ensure consumer access to care for mental health and substance use disorder (MH/SUD).

Lucy Culp (Leukemia & Lymphoma Society—LLS) said Georgetown University has completed several “secret shopper” studies, and there is a trend of misleading marketing as people lose their Medicaid coverage. She said the proposed rule on short-term, limited-duration (STLD) insurance defines STLD insurance as being no more than a three-month contract term and no more than four months with the same insurer within a 12-month period. The rule prohibits stacking by issuers and applies to new policies. For on-coordinate excepted benefits, she said the proposed rule requires individual market indemnity products to be paid on a per-period basis, and hospital or other fixed indemnity products must be paid as a fixed dollar amount, regardless of expenses incurred. She recommended that state insurance regulators support the definition of STLD insurance in the proposed rule, support the proposal for hospital indemnity and other fixed indemnity insurance to qualify as an excepted benefit, and offer additional insights regarding products sold across state lines through association plans.

Commissioner Stolfi said Oregon passed a law that required three free primary care visits, and consumers could pick whether the three free visits would be for medical or mental health purposes. Due to established federal methodology requiring insurers to estimate which costs would be for medical care versus mental health care, Oregon had to amend the law to require a \$5 copay for these visits. Commissioner Stolfi said Oregon would be

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submitting comments about this since the implementation of a \$5 copay is not something Oregon wanted to impose on consumers.

### 6. Heard a Presentation from the Consumers' Checkbook, Georgians for a Healthy Future, and the United States of Care on Preventative Health Services

Caitlin Westerson (United States of Care) said the federal Affordable Care Act (ACA) requires most private health plans (e.g., non-grandfathered individual, group, and self-funded) to cover more than 100 preventive health services without cost sharing. She said the decision in the case of *Braidwood Management Inc. v. Becerra*, while temporarily stayed, puts access to critical preventive care at risk for more than 150 million people, including approximately 37 million children. If the decision is upheld and applies nationwide, she said two in five adults would skip necessary preventive care, and historically underserved communities will be disproportionately affected. She said even a small copay could deter those with low incomes from receiving preventive care. She said the following key preventive services, if eliminated, would disproportionately affect consumers with limited access to health care: 1) smoking cessation; 2) pre-exposure prophylaxis for the prevention of HIV; 3) colorectal cancer screening; and 4) postpartum depression screening. The communities most affected would be Native Americans, African Americans, Hispanic individuals, and rural populations.

Eric Ellsworth (Consumers' Checkbook) said documentation for providers and consumers regarding preventive services and payer guidance documents is extremely burdensome to search on insurers' websites. He said consumers equate not finding information on a benefit with that benefit not being available. He said plan formularies often do not distinguish coverage from preventive and non-preventive drugs. He said payer guidance documents that inform claims adjudication policies were often incomplete. He said it is especially hard for consumers to get complete information when an intervention includes both a medical and pharmacy benefit.

Yosha Dotson (Georgians for a Healthy Future) provided the following six recommendations for state insurance regulators: 1) utilize data calls and market conduct exams to assess compliance with preventive and cost-sharing requirements; 2) ensure continued preventive protections with state legislative and regulatory action; 3) enforce appeals protections for mis-adjudicated or denied preventive services claims; 4) ensure that QHP certification assesses formularies and other plan documents; 5) hold plans accountable for educating consumers and providers on preventive services requirements; and 6) establish uniform billing and coding standards.

### 7. Heard a Presentation from the AKF and the HIV+Hepatitis Policy Institute on Healthcare Appeals and Denials

Deb Darcy (American Kidney Fund—AKF) said the number of health care denials is a concern, and she referenced a ProPublica report that stated that one health insurer denied 60,000 claims in one month without a human reviewing the claims. She said health insurers must follow the laws, and doctors are expected to examine a patient's medical records before a health insurer can reject a claim for not being medically necessary. She said the U.S. House of Representatives (House) Committee on Energy and Commerce is looking into the activities of this company. In addition, she said a class action lawsuit was filed against the insurance company in the Eastern District of California. The class action lawsuit notes that the insurer rejected 300,000 claims over a two-month period, which indicates that the insurer spent an average of 1.2 seconds on each claim.

Darcy said the Kaiser Family Foundation (KFF) released a survey on consumer experience with health insurance and whether consumers understand what services will and will not be covered. She said the KFF survey reflects that 17% of health claims were denied for ACA plans, and less than 1% of denied claims were appeals. She said the survey reflected that 16% of consumers said their insurance company delayed or denied needed care and prior authorizations; 27% of consumers said their health insurance paid less than what they expected; 18% of consumers said insurance did not cover any of the care they received; and 23% said their insurance did not cover a needed prescription. She said the survey reflected that 40% of adults surveyed did not know they have the right

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to appeal a claim denial, and 24% of the consumers surveyed did not know who to contact when they have a problem with their health insurance.

Carl Schmid (HIV+Hepatitis Policy Institute) said there are 20 consumer representatives focusing on health insurance issues, and he suggested that state insurance regulators review existing data collected on health insurer denials. He suggested that state insurance regulators meet with representatives of the KFF, the federal Center for Consumer Information and Insurance Oversight (CCIIO), and the DOL. Regarding prior authorization, he suggested that states have a better understanding of individual state actions and proposed federal regulations through state presentations, federal presentations, and presentations by consumer groups and the American Medical Association (AMA). He also suggested that the NAIC update its models to address prior authorization. Regarding appeals and denials, he suggested that state insurance regulators better understand the reasons for denials, better understand why a low number of appeals are approved, and work to shift provider behaviors around appeals. He said state insurance regulators should work to encourage consumer knowledge of their rights to appeal a denial. He said state insurance regulators should investigate new ways in which to communicate with consumers and engage with each other to exchange ideas on how to enhance communication with consumers. He said state insurance regulators should review the use of AI for health claims, and he encouraged state insurance regulators to invite insurers to present on their use of AI. He also encouraged state insurance regulators with expertise in health insurance to work with the Innovation, Cybersecurity, and Technology (H) Committee to develop guidance on the use of AI.

Schmid said consumer representatives have submitted formal requests for action for an additional review of these issues by the Health Insurance and Managed Care (B) Committee; the Market Regulation and Consumer Affairs (D) Committee; and the Innovation, Cybersecurity, and Technology (H) Committee. Duhamel suggested that the denial of health claims would be a good topic for NAIC Zone meetings. Crow said the Consumer Information (B) Subgroup is working on how to increase consumers' knowledge regarding their rights to appeal a health claim denial.

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

SharePoint/NAIC Support Staff Hub/Committees/Consumer Cmte/2023 Summer/Consumer\_08 Min\_rev121423

Draft: 12/15/23

*Adopted by the Executive (EX) Committee and Plenary, Dec. 4, 2023*

*Reaffirmed by the NAIC/Consumer Liaison Committee, Oct. 13, 2023*

## **2024 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 2024 will be closely aligned with the priorities of the NAIC Consumer Participation Board of Trustees.

NAIC Support Staff: Lois E. Alexander

## Draft Pending Adoption

Draft: 12/13/23 rev 12/15/23

NAIC/American Indian and Alaska Native Liaison Committee  
Orlando, Florida  
December 1, 2023

The NAIC/American Indian and Alaska Native Liaison Committee met in Orlando, FL, Dec. 1, 2023. The following Liaison Committee members participated: Glen Mulready, Chair (OK); Trinidad Navarro, Vice Chair (DE); Lori K. Wing-Heier (AK); Dean L. Cameron represented by Shannon Hohl (ID); Grace Arnold represented by T.J. Patton (MN); Chlora Lindley-Myers represented by Carrie Couch (MO); Troy Downing (MT); Alice T. Kane represented by Paige Duhamel (NM); Mike Causey represented by Angela Hatchell (NC); Jon Godfread represented by Jacob Just (ND); Jon Godfread (ND); Andrew R. Stolfi (OR); Larry D. Deiter (SD); Jon Pike represented by Tanji J. Northrup (UT); and Mike Kreidler (WA).

### 1. Adopted its Summer National Meeting Minutes

Commissioner Downing made a motion, seconded by Commissioner Navarro, to adopt the Committee's Aug. 12 minutes (Attachment One). The motion passed unanimously.

### 2. Received the E-Vote Results for the Reaffirmation of the 2023 Mission Statement for 2024

Commissioner Mulready announced that the 2023 mission statement for the NAIC/American Indian and Alaska Native Liaison Committee was reaffirmed for 2024 via e-vote on Oct. 13 (Attachment Two).

### 3. Heard a Presentation from the Muscogee Nation Department of Health

Shawn Terry (Muscogee Nation Department of Health) discussed the history of the Muscogee Nation Department of Health, starting with the creation of the Muscogee Nation health care system. He said the Muscogee Creek Nation (MCN) is the fourth largest federally recognized tribe, with more than 100,000 citizens worldwide and 80% of its citizenship residing in Oklahoma. Terry said the MCN's impact on Oklahoma's economy is more than \$866 million and \$1.4 billion across the United States, according to a 2017 economic impact report produced by Oklahoma City University professor Dr. Kyle Dean. He said American Indian and Alaska Native (AI/AN) tribes have had a unique history with the United States, which has resulted in a complex web of federal Indian policy, treaties, and intergovernmental relationships with the services provided to AIs/ANs (e.g., housing, education, health care) having been guaranteed through treaties, executive orders, and other legal bases. Terry said this makes their history a trust responsibility.

Terry said the Indian Health Care Improvement Act, along with the Snyder Act of 1921, forms the statutory basis for the delivery of federally funded health care and the direct delivery of care to AIs/ANs. He said the Indian health care provision underwent a gradual evolution, and on Aug. 5, 1954, the Transfer Act was passed through Congress. This saw the responsibility for Indian health care pass from the Department of the Interior to the newly founded Division of Indian Health, which would later be renamed the Indian Health Service (IHS) as part of the U.S. Public Health Service (USPHS). Terry said the 1960s saw an increased demand for community control of the care provided within the IHS, which yielded an increase in the employment of Native American health care professionals, the establishment of community health boards, and the process of decentralization. He said this continued into the 1970s with the passing of the Indian Self-Determination and Education Assistance Act in 1975, thereby "strengthening the Indian's sense of autonomy without threatening his sense of community."

Terry said the MCN entered a pilot health care program with the federal government in the 1970s, which allowed the MCN to operate its own hospital after the local community hospital was on the brink of closure under the

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municipality. He said the hospital was a critical access hospital located in Okemah, OK, and was named Creek Nation Community Hospital. It has since been relocated and completed new construction in 2017. Since 1977, Terry said MCN Health has grown to be one of the largest tribal health systems in Oklahoma, providing more than 201,000 visits annually. He said the MCN Health facilities include two community hospitals located in Okmulgee and Okemah; one specialty hospital, Council Oak Comprehensive Healthcare, located in Tulsa; and seven outpatient primary care clinics. In addition to the hospitals and primary care facilities, he said the Muscogee Creek Nation Department of Health (MCNDH) operates many other services, grants, and programs, such as behavioral health; a special diabetes program; contract health, aka purchased/referred care; public health nursing, including mobile immunizations; a sexual assault nurse examiner program for adults and pediatrics; and pain management.

Terry continued by describing the development and growth of its programs and services that led to improving the health and well-being of not only the Creek Nation but also communities throughout Oklahoma. As a direct response to the effect of the COVID-19 pandemic, Terry said the nation purchased the former Cancer Treatment Centers of America facility in Tulsa in August 2021 and renamed it Council Oak Comprehensive Healthcare. He said this expansion helps ensure that citizens have health care access during a pandemic or bed-shortage crisis with seven ICU beds; 27 medical surgical beds; primary care; numerous specialty services, including endocrinology, neurology, pulmonology, addiction medicine, HIV, and hep clinic, among others; state-of-the-art radiology; 156 hotel rooms; and Da Vinci surgical devices. Terry said Council Oak also enables MCN to expand health care for native people and strengthen its services for the greater Tulsa community. In September 2022, it also added a new campus that provides inpatient services, bringing much-needed specialty care closer to MCN citizens.

Terry said native health care services are: 1) not an entitlement program, as the federal trust responsibility forms the federal government's duty to provide health services to tribes; therefore, health care for Native Americans and Alaska Natives is not an entitlement; and 2) not an insurance program. He said Native Blue is a product designed in conjunction with Blue Cross Blue Shield (BCBS) to cover native and non-native employees with 100% benefit for in-network providers; zero out-of-pocket costs for MCN employees when using in-network services; and pharmacy covered at 100% if prescriptions are filled within MCN Health facilities, and only a \$10 copay when using pharmacies outside of MCN Health. Terry said MCN has seen significant cost savings with this program because it streamlines the "Medicare-like" payments allowed to the tribes without any provider or citizen abrasion.

He said the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 mandates that the Medicare-like payment rate constitutes payment in full to Medicare-participating hospitals that deliver services to AIs/ANs referred through IHS-funded programs. He said the final rule includes all IHS-funded health care programs, regardless of whether the programs are operated by the IHS, tribes, tribal organizations, or Urban Indian organizations. He also said the Medicare-like rates regulations will reduce contract health expenses for hospital services and will enable Indian health programs to use the resulting savings to increase services to their beneficiaries.

Terry concluded with the future goals of the Muscogee Nation Department of Health and suggestions for state insurance regulators to consider using as best practices when determining how they might help facilitate state participation with tribal nations.

Commissioner Mulready asked Terry if the Medicare-like rates charged for 100% of Medicare had caused any friction. Terry said if a specialist in Tulsa does not want to accept 100% of Medicare, MCN wanted to be able to negotiate an acceptable rate, which MCN does individually with all specialists. He said with \$5 million spent on cardiology, MCN wanted to decide whether to do its own or pay/contract out. He said at Aetna Hillcrest Hospital, 25% of patients are under Medicaid; 30% have private insurance; 35% register as having Aetna; and 10% of the population goes through a contract/purchase referral system. He said 100% of MCN have something, so 0% are indigent.



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Commissioner Mulready asked if non-natives are seen at MCN facilities. Terry said the state-of-the-art Cancer Treatment Centers of America in Schaumburg, IL, does not have a state license. He said the center has a compact agreement to see non-native citizens. He said some parts of the facility are not open to the public normally, but during the pandemic, it became the center for infusion care for COVID-19 and treated all of Tulsa, OK. He said the county of Tulsa gave the center \$500,000 to do this.

#### 4. Heard an Update from Washington State Regarding SNI

Charles Malone (Washington State Office of the Insurance Commissioner) said three federally recognized tribes based in Utah—the Shivwits Band of Paiutes, Kanosh Band of Paiutes, and Confederated Tribes of the Goshute Reservation—formed the Sovereign Nations Health Consortium (SNHC), which governs two subsidiaries: 1) Sovereign Nations Insurance LLC (SNI) and 2) Native American Restoration Association (NARA), which is a membership association for non-Indians to receive tribal insurance benefits.

Todd Dixon (Washington State Office of the Insurance Commissioner) said in March 2022, the Office of the Insurance Commissioner (OIC) learned from other states that SNI was operating in other states. On May 25, 2022, he said the OIC opened an internal investigation. Then, on Sept. 23, 2022, SNI contacted Commissioner Kreidler to describe its consortium, insurance products, and legal authority to proceed with its operations. Dixon said the OIC held its first tribal consultation with state tribal leaders on Nov. 7, 2022, sharing with tribal leaders that the products offered by SNI did not meet the minimum requirements of the Affordable Care Act (ACA), were missing essential health benefits (EHBs), yet included non-compliant pre-existing condition limitations and other illegal restrictions. He said maternity coverage was subject to a \$5,000 deductible that is separate from the plan deductible plus 20% coinsurance for normal delivery and that the expected due date for delivery must be at least 300 days after the plan effective date for bills to be covered. Dixon said the plan covered three mental health visits annually followed by chatbot care thereafter. He said there was an additional \$1,500 copay for emergency room care with the copay being waived upon admission and an additional \$1,500 copay for ambulance services.

Malone said the plan had a graduated preexisting condition exclusion with no coverage for the first 12 months, \$15,000 coverage for months 13-24, \$30,000 coverage for months 25-36, and full coverage for months 37 and over. He said there was also a 24-month look-back period for preexisting conditions except for cancer, which had a five-year look-back period. Malone said the annual deductible for the plan was \$5,000 and three times that for families, and 20% coinsurance with a \$5,000 maximum coinsurance with a total out-of-pocket of \$10,000 which did not include office visits or prescriptions. He said the annual coverage maximum was \$100,000 and a lifetime coverage maximum of \$500,000.

Commissioner Kreidler said Washington state law, under RCW 43.376.020(1), requires the OIC to “make reasonable efforts to collaborate with Indian tribes in the development of policies, agreements, and program implementation that directly affect Indian tribes and develop a consultation process that is used by the agency for issues involving specific Indian tribes.” He said Policy 5, OIC Tribal Consultation and Collaborative Process (Attachment Five), is posted on Washington state’s [tribal relations page](#).

Commissioner Kreidler said the Governor’s Indian Health Advisory Council (GIHAC), which was created under RCW 43.71B.020, exists to address issues with managed care in the state’s Medicaid system. He said the GIHAC includes: 1) one representative from each tribe, designated by the tribal council; 2) the American Indian Health Commission (AIHC), which represents 29 federally recognized tribes; 3) an executive director; 4) a Medicaid director; 5) the governor’s office; 6) Commissioner Kreidler; and 7) many other interested parties. In addition, he said three Urban Indian programs provide health care in the Spokane, Seattle, and Portland areas. Commissioner Kreidler said WAC 284-170-310 requires insurers in Washington to offer contracts to all Indian health care providers in their service

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area and encourages following the Washington State Indian Health Care Provider Addendum while serving 313,600 AIs/ANs, 29 federally recognized tribes, and 54% of AIs/ANs live off reservation.

Commissioner Kreidler described the steps taken in educating tribal leadership and getting them on the same page to progress in protecting the vulnerable from health insurance benefit plans that were not compliant with federal ACA requirements nor minimum requirements. What the OIC heard from tribal leaders was: 1) do not allow these plans to be sold on our reservations; 2) do not allow these plans to be sold to Native Americans living off reservation; 3) address false marketing concerns of the plan to tribal members; and 4) for Washington state to use its 106 tribal assisters working for the state exchange to assist tribal leaders in opposing the plan. This revelation by tribal leaders led to the SNI leadership meeting with Commissioner Kreidler on Nov. 14, 2022, in Olympia, WA.

Malone said the OIC held a second tribal consultation with state tribal leaders on Dec. 6, 2022, and the OIC issued a cease-and-desist order to SNI on Dec. 20, 2022. The SNI then filed a demand for hearing on March 20, 2023. The third tribal consultation with state tribal leaders was held on May 8, 2023, which led to a settlement agreement being signed with SNI on Oct. 31, 2023. As part of the agreement, SNI agreed to end all insurance business in Washington; SNI agreed not to re-enter the market; OIC rescinded the cease-and-desist order and agreed to no fine; and the settlement agreement resolved the cease-and-desist order.

Commissioner Downing asked if Washington state had had conversations with any other states or tribes about SNI. Malone said there were some conversations in process, but the conversations had been a little contentious, and so they were not ready to be wrapped up yet.

Commissioner Mulready said it sounded like SNI does not want to have any legal action taken against it. He asked if Washington got the impression that SNI was looking for a legal fight. Malone said it was not evident from their conversations. Commissioner Mulready asked if any local tribe was part of SNI. Dixon said the state was not aware of any and that Washington state has incredibly good ties with all the local tribes that have been developed over the years. Commissioner Kreidler said he personally had close working relationships with the tribes prior to becoming the insurance commissioner.

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

SharePoint/NAIC Support Staff Hub/Committees/Consumer Cmte/AIAN/2023 Fall/AIAN\_12min rev 121523

## Draft Pending Adoption

Draft: 8/29/23

NAIC/American Indian and Alaska Native Liaison Committee  
Seattle, Washington  
August 13, 2023

The NAIC/American Indian and Alaska Native Liaison Committee met in Seattle, WA, Aug. 13, 2023. The following Committee members participated: Glen Mulready, Chair (OK); Trinidad Navarro, Vice Chair (DE); Lori K. Wing-Heier (AK); Dean L. Cameron represented by Randy Pipal (ID); Grace Arnold (MN); Chlora Lindley-Myers represented by Carrie Couch (MO); Troy Downing represented by Bob Biskupiak (MT); Mike Causey represented by Angela Hatchell (NC); Jon Godfread represented by John Arnold (ND); Alice T. Kane represented by Colin Baillio and Paige Duhamel (NM); Andrew R. Stolfi represented by TK Keen (OR); Larry D. Deiter represented by Tony Dorschner (SD); Jon Pike (UT); Mike Kreidler represented by Todd Dixon (WA); Nathan Houdek (WI); and Jeff Rude (WY). Also participating were: Peni Itula Sapini Teo (AS); Diane Carter (OK); Patrick Smock (RI); Carter Lawrence (TN); and Cassie Brown (TX).

### 1. Adopted its Spring National Meeting Minutes

Commissioner Navarro said the Committee meets to discuss insurance issues of importance to tribal members to promote education, understanding, and collaboration to enhance consumer protection in Indian country. Navarro said he would conduct the meeting on behalf of Commissioner Mulready, who was unable to be at the meeting in person due to a conflict but would be participating virtually.

Director Wing-Heier made a motion, seconded by Commissioner Rude, to adopt the Committee's March 24 minutes (see *NAIC Proceedings – Spring 2023, NAIC/American Indian and Alaska Native Liaison Committee*). The motion passed unanimously.

### 2. Heard an Update from Oklahoma on the *McGirt v. Oklahoma* U.S. Supreme Court Case

Mithun Mansinghani (Lehotsky Keller Cohn LLP) said the *McGirt v. Oklahoma* case that was brought before the U.S. Supreme Court was about tribal sovereignty in that it took away land from tribes' reservations and gave it to Oklahoma for state government. He said it has remained that way for 100 years and was looked at by the U.S. Congress (Congress) due to a criminal case. Mansinghani said the case of *Worster v. Georgia* in 1830 was the first case about state versus tribal sovereignty. However, it ended with an abandoned decision. He said increased assertion of tribal sovereignty was seen before land was carved out for Indian-owned casinos. Mansinghani said it was also at the forefront when tribal lending cases led to tribal members avoiding state and federal usury laws. He said tribes were then given patent ownership over pharmaceuticals, which non-tribal members tried to use to avoid state taxation and regulation. He said the Sovereign Nation Insurance Company (SNIC) has challenged state sovereignty through several laws in different states. Mansinghani said the scope of immunity being sought is higher in Indian country, with *McGirt v. Oklahoma* being recently cited for life and health insurance in New York and Wisconsin, as well as with regard to short-term disability insurance.

### 3. Heard a Presentation from HCSC on the Effect of Risk Adjustment Treatment of Tribal Enrollees Under the ACA

Josh Goldberg (Health Care Services Corporation—HCSC) gave a presentation on the effect of risk adjustment treatment of tribal enrollees under the federal Affordable Care Act (ACA). He said his colleagues spoke at the tribal roundtable last week about the challenges and successes of their work with the Oklahoma Department of Insurance (DOI) and that he would like to give a brief refresher at this meeting on the issue. He said when comparing the risk term and the rating term with regard to cost-sharing reduction (CSR) and the induced demand

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factor (IDF), the old model indicated that the silver zero cost-sharing plan was rated as number one and the limited cost-sharing plan was rated as number two. However, this is no longer true in the current marketplace. Goldberg said when comparing the predictive results to the actual results for accuracy and CSR Electronic Medical Records-EMR in all states, the silver plan rated above predictive in the chart, indicating it was higher or over-predicted. The limited plan rated under in the chart, indicating it was lower or under-predicted, which resulted in the company being underpaid because the zero cost sharing predictive ratio was too low, at 0.71. He said this had no effect at the federal level but varied at the state level, so there is a financial disincentive for companies to sell these plans to tribal populations. Goldberg said the Milliman Analysis compared two companies with zero split—one at 90% and the other at 10% by recalibrating the CSR factors to be at the higher level. When looking at the bronze plan, he said the modeling results magnified by 4% when added to additional benefits, while the preferred is equal for both companies. Goldberg said the federal government stopped making restitution of cost sharing in 2016 due to rating term consideration. He said Milliman produced a white paper in 2021 at the national level but did not have state-specific data, so it went back to get more granular data. The federal Centers for Medicare & Medicaid Services (CMS) has been working on this recently as well, so it is taking this new study seriously.

#### 4. Heard an Update from Alaska on the Risk Adjustment Treatment of Alaska Native Enrollees Under the ACA

Director Wing-Heier said health care clinics in Alaska enroll patients in the National Tribal Health Care (NTHC), and Alaska pays one month's premium for the silver plan when Alaska Natives come in for health care services, and the charges for medical care are usually significant. She said the NTHC sued Primera over this. However, this involves native politics, so the state cannot get involved in it. Director Wing-Heier said the issue is substance abuse, and Alaska natives are being targeted to enroll in the Alaska plan and being taken to out-of-state facilities for drug abuse treatment because Alaska pays for such treatment at a much higher rate. She said they are looking for the bad lead generators that are doing this and are taking action to stop them because such policies are not legal due to the fraudulent applications that are not approved in Alaska, and the care is being done in facilities that are not licensed. However, this has caused another problem. The patients are being thrown out of these facilities in another state with no way to get back home to Alaska. Commissioner Navarro said the recent revisions to the NAIC's *Unfair Trade Practices Act* (#880) from the Improper Marketing of Health Insurance (D) Working Group will help stop this type of fraudulent activity. Duhamel said New Mexicans are being sent to similar facilities, and she will circulate an article through Lois Alexander (NAIC) to all Committee members.

#### 5. Considered Drafting a Letter to the CMS Regarding Native American Issues Under the ACA

Commissioner Navarro asked if any committee members would like to speak to this suggestion but received no input.

#### 6. Discussed Other Matters

Commissioner Pike said the Sovereign Nation Health Consortium (SNHC) consisted of three tribes. He said Utah sent a letter to the SNHC attorney asking them to put in writing their intent about marketing to non-tribal members because the attorney had previously said SNHC would not be selling to non-tribal members. However, Commissioner Pike said that SNHC was selling insurance coverage to non-tribal members outside of tribal lands. SNHC's attorney has not responded.

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

Member Meetings/Committees/Consumer CMTE/AIAN/2023 Summer NM-AIAN/Minutes\_Summer National Meeting\_AIAN CMTE.docx

Draft: 12/15/23

*Adopted by the Executive (EX) Committee and Plenary, Dec. 4, 2023*

*Reaffirmed by the NAIC/Consumer Liaison Committee, Oct. 13, 2023*

## **2024 Reaffirmed Mission Statement**

### **NAIC/AMERICAN INDIAN AND ALASKA NATIVE LIAISON COMMITTEE**

The mission of the NAIC/American Indian and Alaska Native Liaison Committee is to provide a forum for ongoing dialogue between NAIC members and the American Indian and Alaska Native communities concerning insurance issues of common interest. Specifically, the Liaison Committee will provide a forum for an exchange of information and views on issues surrounding the availability of insurance for American Indian and Alaska Native consumers and tribal interests, an opportunity for American Indian and Alaska Native groups to bring insurance consumer protection issues to the attention of NAIC members, and a dialogue on best practices for dealing with insurance issues unique to sovereign tribal nations.

NAIC Support Staff: Lois E. Alexander